2
3 STATE OF VERMONT
4 SENATE HEALTH & WELFARE COMMITTEE
5
6 Re: Senate Bill 115
7 Date: Thursday, March 1, 2007
8 Senate Health & Welfare Committee
9 Committee Members:
10 Sen. Doug Racine, Chair
Sen. Ed Flanagan, Vice-Chair
11 Sen. Sara Kittell
Sen. Virginia Lyons
12 Sen. Kevin Mullin
Sen. Jeannette White
13 Robin Lunge, Legislative Counsel
14
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1 PROCEEDINGS
2 - - -
3 (Start of Track 1.)
4 FEMALE ATTENDEE 1: This is a meeting of the
5 Senate Health & Welfare Committee. Today is
6 Thursday, March 1, 2007.
7 (End of Track 1.)
8 (Start of Track 2.)
9 CHAIRMAN RACINE: Okay. Senate Health &
10 Welfare, it is Thursday March 1st, my mother's 87th
11 birthday, which I just keep reminding myself I have
12 to call. And I'd like --
13 FEMALE ATTENDEE 2: Write it on your hand.
14 That's what I do.
15 CHAIRMAN RACINE: Well, I think I'll remember.
16 And we're going to continue on our discussion of
17 the prescription drug bill.
18 And let's start with -- you ready?
19 MS. MOFFATT: I'm getting (inaudible).
20 CHAIRMAN RACINE: Our acting commissioner of
21 health.
22 Sharon, if you would please take your spot
23 down there.
24 We started without you.
25 All right. We noticed the other day, when we

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1 were going through this bill, that the health
2 department is mentioned frequently. And the
3 question came up: Is there any analysis of what
4 this bill envisions the health department to do,
5 must do, and -- and what level of effort would be
6 required by that department to meet the
7 requirements of this bill? And we thought we
8 should hear from you.
9 MS. MOFFATT: Thank you for having me. I
10 apologize that we weren't here yesterday. And for
11 the record, Sharon Moffatt, acting commissioner of
12 health. And as appropriate, I would also suggest
13 that our medical director, Dr. Don Swartz, either
14 join me or be called up because I think he --
15 CHAIRMAN RACINE: However you wish to proceed.
16 MS. MOFFATT: What I thought I'd do is give
17 you our -- our particular comments, some work
18 that's already underway, and then I think actually
19 Dr. Swartz has some real life kind of experience to
20 that that would add to our testimony today.
21 So what I want to do is hand around to the
22 committee a memo essentially laying out some of the
23 areas and some of our particular comments. And I
24 will say I borrowed from Josh Slen a memo here. It
25 hopefully was a creative and functional way to try

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1 and track language of the bill and then our
2 testimony.
3 Let me just also say, before I get started on
4 the particular pieces, is we have been in touch
5 with the Oregon Health & Science University that
6 you mentioned in the bill and actually had some
7 very productive discussions with them, some
8 opportunities that lay out kind of what those
9 opportunities are going forward and how they might
10 be used in our work here.
11 And then I also want to spend a little bit of
12 time on talking about what AHEC, the Area Agency
13 Health -- Area Health Education Centers, are
14 already doing with -- for us and with us through
15 the health department, what's already kind of in
16 place and how we can kind of maybe jump off the
17 platform they've already created for us,
18 particularly in the educational aspect. And I
19 think again Dr. Swartz can speak of that too from
20 more of a practitioner experiential point of view.
21 So the memo that we have to you essentially
22 just lays out a couple -- some particular areas
23 that we wanted to offer comment on the bill and
24 suggestions and some areas of -- perhaps I'm going
25 into a lot of detail.

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1 But the -- the first area in terms of to --
2 the director of the office of health access shall
3 establish and maintain a pharmacy best practice and
4 cost control, essentially the essence of what you
5 have here. What we wanted to do is just make --
6 and again, hopefully the committee already has this
7 way on their radar screen. But beyond the cost
8 control aspects of it, what we see and experienced
9 and are aware out there in the practice fields are
10 the complexities that the individual patient needs
11 to be on the cost, actually even as they have to
12 deal with formularies, and then actually
13 challenging formularies, if they are on one
14 formulary and then how they have to actually go
15 through and show that that particular drug on a
16 formulary doesn't work for them, try another drug,
17 and then finally get approval on the drug they
18 have.
19 And we saw this particularly around the
20 Medicare Part D in -- in that whole different
21 formularies being used.
22 Don, do you want to speak a little bit to this
23 because this really comes from the consumer point
24 of view that we're hearing around that.
25 DR. SWARTZ: Thank you. For the record, I'm

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Donald Swartz, the medical director of the health department, and until fairly recently have been in -- in -- in practice, so that a lot of the issues that I'm talking about come out of my own memory bank and my own experience with patients.

I think that cost is critical. We have to figure out how to harness that. We have to figure out how to make our health system more efficient and more effective.

When administrators try to do that, of course, it's done at a fairly high level, and sometimes the impact on individual patients gets kind of lost or doesn't -- doesn't get adequately factored into the system. And one place is the -- the difficulty that providers and patients have in managing their way through a formulary prescribed by a pharmacy benefit management process.

The formulary may be absolutely right and absolutely well-constructed, but it's constructed based on the evidence. And the evidence is designed to iron out the differences between people and show what applies to everybody the best. Well, if you're not everybody, the drug -- the formulary may not be the one that works for you.

In order for you to get that, under most of

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the rubrics that are in place now, you have to demonstrate that you failed on the recommended drug, and maybe on the second choice drug, before you're finally allowed to have the drug that works for you.

Now, if you know from past experience what that drug is, then we're kind of asking people to go through a period of two weeks, four weeks of having their problem not treated.

CHAIRMAN RACINE: I'm sorry. I'm having a hard time following you, Doctor. Where on the bill is that?

DR. SWARTZ: I'm still on the first page.

MS. LUNGE: No. In our bill it's on page 2 and 3.

DR. SWARTZ: It's kind of a philosophical -- I think it's something we ought to be thinking about under the heading of pharmacy benefit management, and this isn't a specific...

FEMALE ATTENDEE 2: This is not -- the bill we were doing is -- is licensing and PBM.

CHAIRMAN RACINE: Robin can -- maybe you could enlighten us a little bit.

MS. LUNGE: In a part of the statute that isn't introduced in the bill, it talks about the

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exceptions process for Medicaid. So the part that I'm not clear about your comment on this part is whether you're commenting on that existing law on the Medicaid process and problems that you've seen in the Medicaid process or whether you're commenting more generally because my understanding is that the Medicaid process is -- there is an exceptions process where you can ask for an exception for a drug not on a formulary.

DR. SWARTZ: Yeah. That's correct. So my comments really are not that, what's in place now.

MS. LUNGE: Okay.

DR. SWARTZ: And how we might want to at least think about that as we're massaging other areas of that bill.

CHAIRMAN RACINE: Are you suggesting we get rid of the formulary?

DR. SWARTZ: The formulary is important.

CHAIRMAN RACINE: Okay.

DR. SWARTZ: What I'm trying to figure -- and suggesting that we assure that people who don't fit the formulary can reasonably, easily get the drug that works for them. And --

CHAIRMAN RACINE: Okay. Is it -- I'm sorry. I'm truly trying to focus on the bill. Is there

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something in the bill that affects that or are you going to be suggesting amendments to this bill which would solve the problem that you are raising for us that's not covered by this bill? I'm not sure I'm asking the right question.

MS. MOFFATT: No. I think -- you are asking exactly the right question, and we can go deeper or not. But I think we just are raising awareness in terms of the overall impact to the consumer. So no, we're not suggesting -- we're not making suggestions for the changes and all. Supporting the essence of the bill, we want to all fully understand then how any decision we make, as this bill unfolds, impacts the actual client at the receiving end.

FEMALE ATTENDEE 2: I guess I don't -- I don't understand that because we're -- the part that you quoted here related to that is "maintain." We've added the words "maintain." And -- and there is a process for --

(Inaudible.)

FEMALE ATTENDEE 2: Right. I mean we already have that in place. This doesn't affect that at all.

MS. MOFFATT: So that's where we're agreeing

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1 but want to make sure that, as we maintain that,
2 it's across all the system, not just a particular
3 area just for Medicaid, for example.
4 FEMALE ATTENDEE 3: I have a comment on that.
5 I had a constituent this last fall calling me, and
6 her daughter was on the -- on the state Medicaid
7 program. And she could not get this pharmacy
8 preferred drug because it wasn't on the formulary
9 or whatever, but it was something that worked, and
10 she'd never had the trouble before. But you know,
11 there was just what you're talking about. They
12 didn't maintain the service for this pharmacy
13 benefit.
14 You know, I did call down and talk to Joshua
15 Slen and all of them: And -- and you're right,
16 that she should've had it, you know.
17 And she did demonstrate that she tried other
18 generics and they didn't work. So it's
19 maintaining --
20 CHAIRMAN RACINE: So Doctor, your comments are
21 more general in nature and you will get into the
22 bill?
23 MS. MOFFATT: Yes.
24 CHAIRMAN RACINE: Okay.
25 DR. SWARTZ: Yep. And I think I've made the

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1 point. And I won't -- I won't take any more time.
2 Thank you.
3 CHAIRMAN RACINE: I'm quick. I'm just trying
4 to figure out where it fit in.
5 MS. MOFFATT: Certainly.
6 CHAIRMAN RACINE: We spent three hours
7 yesterday on details of the bill. So you just sort
8 of shifted gears on me.
9 DR. SWARTZ: I'm sorry.
10 CHAIRMAN RACINE: But you can proceed. No,
11 that's okay.
12 MS. MOFFATT: So we can continue to kind of
13 walk through our memo, which I think overall what
14 you'll see here is not necessarily suggestion for
15 changes, either support in particular areas or
16 areas that we wanted to just bring attention to.
17 So the next area in our memo related to the
18 federally qualified health centers. Robin, I'm
19 sorry. We don't have it.
20 MS. LUNGE: Page 5.
21 MS. MOFFATT: Page 5, thank you. And again,
22 we understand that Hunt Claire provided testimony
23 on that yesterday. We support that testimony and
24 again just raising awareness of the impact though
25 to FQHCs as we move more people through there. So

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1 that's all this comment is is mainly supporting the
2 testimony that Hunt had before you. So do we have
3 it?
4 FEMALE ATTENDEE 4: Can I ask a question about
5 that? Is -- I actually don't like this. And I --
6 when I read this, it looks to me as if we're -- we
7 are, as a state, encouraging -- trying to encourage
8 Vermonters to leave their private docs --
9 MS. MOFFATT: Bingo.
10 FEMALE ATTENDEE 4: -- and go to the FQHCs. I
11 don't like this, and I'm not going to support this.
12 FEMALE ATTENDEE 3: -- marketplace (inaudible)
13 have better pricing (inaudible) --
14 FEMALE ATTENDEE 4: No. They only -- they
15 only have better pricing on the drugs. I don't
16 think that's -- anyway...
17 MS. MOFFATT: To your point, Senator,
18 (inaudible).
19 FEMALE ATTENDEE 1: That's the point they were
20 making initially.
21 (Inaudible.)
22 MS. MOFFATT: Yes. Yes. That is our -- we
23 have that shared concern.
24 CHAIRMAN RACINE: Could you explain it from
25 your point of view, please.

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1 MS. MOFFATT: That if you have the incentive
2 to go to an FQHC for pharmaceuticals and they leave
3 their private health care provider, then there
4 becomes a disincentive to use the -- if you will,
5 the single health care provider out there. You
6 begin forcing -- maybe that's too strong a word --
7 but directing people to use the FQHC or the FQHC
8 lookalikes, and I just don't know that this is a
9 methodology to do that.
10 CHAIRMAN RACINE: So to take advantage of
11 lower drug prices, you would have to change your
12 doctors?
13 MS. MOFFATT: Right.
14 CHAIRMAN RACINE: That's the only way you can
15 do it?
16 MS. MOFFATT: Right.
17 CHAIRMAN RACINE: You can't just go there?
18 MS. MOFFATT: No.
19 FEMALE ATTENDEE 4: You'd have to be a
20 patient.
21 MS. MOFFATT: Right. You can't. You have to
22 be a patient. So you'd have to leave your primary
23 care doc to do that. So what we do is undermine
24 the solo practice out there, or even the small
25 practices, that aren't FQHCs.

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1 MALE ATTENDEE 1: So there is no way to keep
2 your doctor and get --
3 FEMALE ATTENDEE 4: No.
4 MS. MOFFATT: No. And actually, there's
5 particular laws regarding that at the national
6 level. And again, I don't want to speak for -- I
7 mean this is an area of expertise that -- that Hunt
8 has, so yes.
9 DR. SWARTZ: I would refer you to his
10 testimony which goes into this in some detail.
11 CHAIRMAN RACINE: Okay. All right.
12 DR. SWARTZ: And explains it very thoroughly.
13 MS. MOFFATT: The next area, which I believe
14 is on page -- bottom of page 6. It's section F.1
15 just below the stars where it talks about the
16 utilization review board and talks about adverse
17 effects, safety, appropriate clinical trials,
18 evidence based show the same meaning as -- well,
19 what we would just suggest here as you're
20 considering this language to also consider on
21 nonnarcotic alternatives the use of controlled
22 substances for the management of pain. Again, we
23 just want to offer up a little broader scope in
24 that area. That may have been the intent. We just
25 read it a little bit more narrowly. So we wanted

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1 to just offer that as a consideration there.
2 Dr. Swartz, do you want to speak about -- to
3 that part of it --
4 DR. SWARTZ: No. I think that's --
5 MS. MOFFATT: (Inaudible.) Okay. The next
6 area -- oh, gosh, I'm sorry. I'm flipping here. I
7 should have had our page numbers on here to
8 reference. Well --
9 (Inaudible.)
10 MS. MOFFATT: I'm trying to find in the bill
11 what the page number is. It would have made it
12 easier for us. I'm flipping. Next time we'll get
13 this format a little tidier for you.
14 MS. LUNGE: It's on page 23 I believe.
15 MS. MOFFATT: Page 23, thank you. So again,
16 the department -- and particularly they're
17 referring to the health department -- shall
18 establish an events based prescription drug
19 education program for health care professionals
20 designed to provide information, education, and
21 therapeutic costs. The department shall
22 collaborate with other states in establishing these
23 programs.
24 And then this is also where that reference is
25 to the Oregon Health & Science University and the

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1 dirt [phonetic] project. So let me mention a
2 couple of different things here.
3 First, I think this is an opportunity to let
4 you know that actually through funding that --
5 appropriations that the health department receives
6 that we then move on to the area of health
7 education centers. About $10,000 of some of that
8 appropriation that we move on to them they actually
9 use for a program called academic detail. And I'm
10 not sure if the committee has had testimony on
11 that, on what that is, what AHEC is doing in that
12 area. But it's -- there are about twenty-five
13 sessions that are provided around the state through
14 the area health education centers.
15 Let me just back up and say: What is academic
16 detailing? And actually, it's very interesting
17 because actually Dr. Swartz just got an invitation
18 to one of these just today. So this is just by way
19 of example.
20 They essentially have a team of -- a team of
21 experts, a pharmacist and actually generally an
22 internist that go around the state. They work in
23 small groups. They teach in small groups. And
24 what they do is they take it by a disease entity.
25 For example, they've worked in the -- right now

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1 they're working on the area of depression. So they
2 would go provide these sessions. And they talk
3 about what are the drugs of choice, if you will,
4 and what are the other ways to manage it.
5 And one of the reasons they use these smaller
6 sessions is that it actually provides a safe area
7 for providers to say, "Well, I prescribe this," and
8 not be threatened by, "Why did you prescribe that?"
9 It has this openness.
10 But what in particularly drug -- the academic
11 detailing does is -- and let me just read from
12 their letter that I think clarifies it.
13 It says: Pharmaceutical companies use a
14 person-to-person contact to influence practitioners
15 towards prescribing their drugs. This process is
16 known as detailing. Detailing is effective, and
17 pharmaceutical companies spend millions of dollars
18 each year to run these programs. Academic
19 detailing or counter-detailing is university based
20 education outreach.
21 And essentially it -- it actually goes to the
22 provider practice groups or sessions. Now -- and
23 they actually focus it by disease.
24 I will tell you that AHEC in our state is
25 actually doing some national work in that. They

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1 are also starting to work with Maine and New York
2 to actually further develop these academic
3 detailings. AHEC and the College of Medicine are
4 actually ahead of the curve in terms of providing
5 these types of sessions. They're actually also
6 using some additional money, not only the health
7 department money; but they're also using money from
8 Fletcher Allen, Blue Cross Blue Shield, and
9 actually the College of Medicine to actually
10 provide it.
11 When -- when -- in speaking with Liz Cote, who
12 is the executive director for AHEC, in terms of the
13 challenges, they say they're very well-received.
14 Actually, there are CMEs available, which is
15 another opportunity for providers to come.
16 But in addition to that, one of the barriers
17 they have is they can't get out fast enough to meet
18 the need. So although they hold about twenty-five
19 sessions around the state, ideally, if they had
20 another team of experts -- they only have one team
21 of experts that go out now and present this -- that
22 would be the gap that's out there now.
23 The research that goes behind actually
24 developing the educational sessions actually comes
25 from the attorney general settlement that was done

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1 in I believe it was Pfizer. So they've actually
2 used that funding to actually do the research to
3 create the educational tool.
4 So they have two levels. They have
5 researching, creating the class; and then they have
6 our money and other's money who actually put the
7 class out there, the implementation side.
8 Yes?
9 CHAIRMAN RACINE: I'm trying to figure out
10 your point.
11 MS. MOFFATT: My point?
12 CHAIRMAN RACINE: Is there --
13 MS. MOFFATT: There's two points I think
14 specifically is, one, there is some significant
15 work already going on in our state --
16 CHAIRMAN RACINE: So this is superfluous is
17 what you're saying?
18 MS. MOFFATT: It probably doesn't hurt to have
19 it, you know. But to direct us to do it I'm saying
20 is we would continue to do it. If there's a gap
21 that I was to identify for you, I would say there's
22 probably a forty or fifty-thousand dollar gap if we
23 were to do it more and faster of their -- and you
24 would use the AHEC existing system to do that.
25 CHAIRMAN RACINE: So if this -- if this

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1 section contains part of the law, evidence based
2 education program, you could -- you could do it
3 based on the fact that you're already doing it --
4 MS. MOFFATT: Right.
5 CHAIRMAN RACINE: -- is what you're telling
6 us? Okay.
7 MS. MOFFATT: Exactly. And if there was
8 additional funding, it would be to fill that gap.
9 So this --
10 CHAIRMAN RACINE: Okay. So you don't need
11 additional funding to do what this requires you to
12 do?
13 MS. MOFFATT: Not this particular piece.
14 There's another piece here though about the Oregon
15 health system that I'll talk about.
16 CHAIRMAN RACINE: So that's a separate issue?
17 MS. MOFFATT: That's separate.
18 FEMALE ATTENDEE 1: When we have -- and I'm
19 trying to remember when we billed AHEC the
20 detailing program was in. So that's already in
21 statute.
22 MS. MOFFATT: Right. And actually, that's
23 some of the --
24 FEMALE ATTENDEE 1: And I'm just trying to
25 remember where it is in the statute.

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1 MS. MOFFATT: Liz and I were talking about
2 this --
3 FEMALE ATTENDEE 1: Yeah.
4 MS. MOFFATT: -- this morning, and we couldn't
5 put our hands on it. And again, it goes back a
6 ways --
7 FEMALE ATTENDEE 1: Right.
8 MS. MOFFATT: -- because it's actually now
9 through appropriations that --
10 FEMALE ATTENDEE 1: Right.
11 MS. MOFFATT: -- the funding moves --
12 FEMALE ATTENDEE 1: It actually did go. I
13 think it was taken out of here and put in there.
14 I'm trying to remember what it was. So -- so I
15 mean the question is, if it was only an
16 appropriation for that program, maybe it makes
17 sense to include reference to the AHEC here. I
18 don't know how to do that. Robin (inaudible).
19 MS. MOFFATT: What we could do is suggest some
20 language, if you want to capture what's happening
21 in the infrastructure that we're already working
22 on.
23 CHAIRMAN RACINE: Okay.
24 MS. MOFFATT: Okay.
25 CHAIRMAN RACINE: Okay.

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1 MS. MOFFATT: So we can do that.
2 (Inaudible.)
3 MS. MOFFATT: And -- and then the next area
4 is --
5 DR. SWARTZ: The next one down.
6 MS. MOFFATT: The next area down is D on page
7 24. Thanks, Don. And this speaks to, in part,
8 the --
9 DR. SWARTZ: Marketing activities.
10 MS. MOFFATT: -- marketing activities and,
11 again, the reference to the attorney generals. And
12 to your point, Senator, that is -- that is
13 essentially what we are doing now, that it is
14 already happening, that money has already moved
15 over to -- now, I wasn't sure if you were implying
16 if there were additional findings from the attorney
17 general if that would move forward.
18 But just so you know, there's about 300,000
19 right now that moves from the attorney general
20 settlement to AHEC. So that's already, again,
21 happening. So I wasn't sure if you were referring
22 here to any additional future dollars that came
23 forward. So I don't know --
24 MALE ATTENDEE 1: This may be a (inaudible)
25 point, but the pharmaceutical companies have

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1 (inaudible) you know, on the education of
2 particular drugs and its (inaudible). There's a
3 question of their involvement in the presentation
4 and education of the doctors.
5 MS. MOFFATT: No, no. Pharmaceuticals it's
6 done -- it's done through university based.
7 There's no dollars involved. Any of the dollars
8 were actually through -- that are around the
9 attorney general were related to a settlement. So
10 that's the only -- but...
11 MALE ATTENDEE 1: But the pharmaceutical
12 companies aren't involved in the education now?
13 MS. MOFFATT: Not in this academic detailing,
14 no. That's all done through the College of
15 Medicines through the area and the health education
16 center. And the whole curriculum is done not with
17 the pharmaceuticals.
18 What they really do is look at a disease
19 entity and what's the best evidence based practice
20 for managing that and what are the -- for example,
21 what are the generic drugs of choice if you were to
22 use a -- if you need to use a pharmaceutical. So
23 they're not involved either in the curriculum
24 development or in the delivery of that or in the
25 feeding of individuals who go to those events.

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1 Okay?
2 CHAIRMAN RACINE: Okay.
3 MS. MOFFATT: So I think the next area, if I
4 could, that I want to speak to is the Oregon, which
5 is actually in the sentence above on page 24.
6 Is the committee familiar with what -- what
7 they actually do at the Oregon Health & Science?
8 You had mentioned reference to that.
9 CHAIRMAN RACINE: I don't think so.
10 MS. MOFFATT: So I'm going to do this very,
11 very briefly and all. But just so that they are,
12 there are several states, well over 15 and more
13 coming on. Actually, New York is the only one more
14 on the east coast. It tends to be more on the west
15 coast.
16 Essentially what their -- they do is they go
17 and do detailed research on the -- what are the
18 best formulary -- what are the best opportunities
19 within using pharmaceuticals.
20 And then they create reports, extensive
21 reports. It takes them almost thirty months to
22 develop, to do all the research behind it. They're
23 essentially a research entity. They research that,
24 put a report together. The reports are sometimes
25 almost two hundred pages in length. And then they

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1 send them to -- well, if you're part -- if you're
2 one of the states involved, you can get that
3 report, and then actually you get technical
4 assistance that could come to, for example, a
5 utilization drug review committee. So you'd have
6 actually the expertise in terms of what the
7 evidence based.
8 Now, they -- they -- they have a charge. It's
9 about -- it's $250,000 for three years. It's a
10 little over $80,000 a year to be a member state.
11 FEMALE ATTENDEE 1: Even though -- regardless
12 of population?
13 MS. MOFFATT: Regardless of population. They
14 decided quite a while ago that it's just going to
15 be: Here's what it costs us to do it, and everyone
16 takes a share.
17 They -- and then they have a targeted number
18 of reports or -- or drug areas that they focus on
19 and -- and actually have a whole timeline. They
20 actually have several, for example, coming up in
21 the coming year, drugs related to treatment of
22 ADHD, hormone -- hormone replacement, beta
23 blockers. Several of these are the reports one
24 would expect if you were coming on. If you came on
25 as a new state, you'd also have access to all the

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1 old reports. But I want to make sure the committee
2 is aware actually some of this is in the public
3 domain. So you could go and get the report.
4 What you get for that -- from them for $80,000
5 a year is the opportunity to work with other
6 states, see how they're applying, get technical
7 assistance around how to use the report. You
8 actually get a condensed report from the 200-page
9 report that actually gives you specific guidance.
10 And then I think in particular what Dr. Swartz
11 and I are concerned about is, so you have this
12 information: How does it actually impact the
13 consumer and what's the consumer education that
14 needs to happen around that?
15 So it's more than just getting a report. It's
16 really actually helping understand what the
17 implications of that report is in the state.
18 So one recommendation would be, although you
19 already have it here, that we would coordinate with
20 them to consider whether we would actually, as a
21 state, want to invest in being a member
22 organization. That would be a recommendation.
23 CHAIRMAN RACINE: And this is permissive
24 language that, if you wanted to do it, you would
25 have to be asking for appropriations to do it?

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1 MS. MOFFATT: Right, right.
2 CHAIRMAN RACINE: All right.
3 MS. MOFFATT: Okay.
4 (Inaudible.)
5 MS. MOFFATT: And then the actually last
6 particular point we have -- and again, it was a bit
7 back to the discussion we had around the attorney
8 general settlements and all weren't -- I guess that
9 question was was that redundant or was there a need
10 for the 100,000 -- $100,000 -- I wish it was a
11 hundred -- thousand dollars for the manufacturers
12 and all. We just were given that there's money in
13 the system and all.
14 So those are generally our comments and all.
15 I'll be happy to --
16 (Inaudible.)
17 MS. MOFFATT: Actually, we've done -- we've
18 done full consultation, myself, Dr. Swartz, and
19 actually Bill Wargo, our legal counsel. And
20 they're providing more information to us. They've
21 actually -- they have about a once-a-year
22 consortium meeting that you can go and get
23 additional training at. That comes up in May. We
24 found them extremely responsive and available and
25 ready to work with us.

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1 And I -- I will say I'm in the process of
2 continuing to connect with a couple of my
3 counterparts in other states that are state health
4 officials. Particularly Washington has had a fair
5 amount of experience with them. And we also have
6 contacts in Oregon to see, from their on-the-ground
7 experience, are they satisfied with it. They're --
8 they are kind of the organization, the research
9 academic agency or setting that actually does this
10 extensive amount of work. So --
11 MALE ATTENDEE 1: How long have they been
12 working with us?
13 MS. MOFFATT: They're -- actually it goes back
14 well over six years now. More of their extensive
15 work started in 2000 when they actually produced
16 about -- I think in that -- they had a three-year
17 period of time, and their target was about eight
18 reports they accomplished. And when I say reports,
19 in those specific drug areas. And then actually,
20 if you check their Web site, they have a list of
21 timeline. So...
22 CHAIRMAN RACINE: Thank you very much.
23 MS. MOFFATT: Thank you. Thanks for having
24 us.
25 CHAIRMAN RACINE: And if you have other

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1 comments, please let us know.
2 MS. MOFFATT: Okay.
3 CHAIRMAN RACINE: (Inaudible) concern
4 (inaudible) education program and it was a huge,
5 new burden on you, and I'm pleased to find out that
6 it's not.
7 MS. MOFFATT: And thank you for asking us.
8 CHAIRMAN RACINE: Okay. All right. We have
9 seven witnesses left over from yesterday, and we
10 have about two hours. So that means sixteen
11 minutes and forty-three seconds each. And if we
12 could -- if the committee members could really try
13 to limit their questions to something that's
14 really --
15 (Inaudible.)
16 CHAIRMAN RACINE: No, no.
17 (Inaudible.)
18 CHAIRMAN RACINE: I'm looking -- all of us,
19 we've all asked questions and -- and --
20 FEMALE ATTENDEE 1: Can I ask something?
21 CHAIRMAN RACINE: No.
22 FEMALE ATTENDEE 1: Please?
23 CHAIRMAN RACINE: What?
24 FEMALE ATTENDEE 1: You had asked us if we had
25 suggestions (inaudible.) And how do you want us to

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1 do that? Leave them with Jan? I've e-mailed to
2 Robin already, and we have copies.
3 CHAIRMAN RACINE: Yeah. Leave them with Jan
4 and Jan will get them out to all of us and get them
5 in our -- in front of us --
6 FEMALE ATTENDEE 1: Okay.
7 CHAIRMAN RACINE: -- so that we do, indeed,
8 see them. That'd be fine. Okay.
9 Madeleine, thank you. And for all of you who
10 were here yesterday, I thank you for your
11 indulgence in letting those folks who had plane
12 tickets get out of here on those tickets.
13 FEMALE ATTENDEE 1: Because if they waited
14 until tonight they wouldn't get out probably.
15 CHAIRMAN RACINE: They wouldn't go anywhere
16 until (inaudible) again. Okay.
17 MS. LONGAN: I don't want to waste any of my
18 precious minutes here.
19 CHAIRMAN RACINE: Okay. Go.
20 MS. LONGAN: But I'll start out following up
21 just briefly on a comment that Dr. Swartz and
22 Sharon Moffatt were making. The first on page 2 of
23 the bill --
24 CHAIRMAN RACINE: And for the record, before
25 you --

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1 MS. LONGAN: I'm sorry. For the record, I'm
2 Madeleine Mongan from the Vermont Medical Society
3 here to support S.115.
4 On page 2, the scratched-out language was
5 about the commissioner of human resources using the
6 preferred drug if it would benefit them and provide
7 economic health benefits. And we -- we would --
8 this is -- I just want to mention this. We would
9 like there to be one formulary, like the Medicaid
10 formulary, all used for the state employees. We
11 realize that it's not --
12 CHAIRMAN RACINE: Where are you again?
13 MS. LONGAN: On page 2.
14 CHAIRMAN RACINE: Yeah.
15 MS. LONGAN: Sub B.
16 CHAIRMAN RACINE: Yeah.
17 MS. LONGAN: The scratched-out language.
18 We're just sort of sad to see that go. We realize
19 it's not going to happen. But it was a goal back
20 from years before that the Medicaid preferred drug
21 list would coordinate with the state employees'
22 preferred drug list, and it's looking like that's
23 not possible. And so --
24 CHAIRMAN RACINE: Why is it not possible?
25 MS. LONGAN: Well, the commissioner of human

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1 resources talked a little bit about it last time,
2 and I think it had to do with labor negotiations.
3 That's my limited understanding.
4 CHAIRMAN RACINE: Okay.
5 MS. LONGAN: I don't really know why, but --
6 FEMALE ATTENDEE 1: It has to do with the
7 lowest price, doesn't it?
8 MS. LONGAN: -- I'm just sort of mentioning
9 it, because, as Dr. Swartz said, having all the
10 different formularies adds to the complexities that
11 doctors face every day. But really the biggest
12 complexity is the Medicare Part D with its
13 fifty-seven formularies. So anyway, and I want
14 to --
15 FEMALE ATTENDEE 1: Fifty-seven?
16 MS. LONGAN: Mm-hmm, or something, seventeen
17 companies and fifty -- it might be fifty-one. I'm
18 not giving -- I'm not sure of the exact number.
19 CHAIRMAN RACINE: Okay.
20 MS. LONGAN: We're also here to support
21 Section 12 in particular, which is the academic
22 detailing section that Sharon Moffatt and Dr.
23 Swartz were speaking about. And I have some
24 handouts for you. I have three different handouts
25 for you on that. But because they've done such a

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1 nice job, I'm not really going to spend much time
2 on it.
3 CHAIRMAN RACINE: So you agree with the
4 previous testimony?
5 MS. LONGAN: We agree with it, and we support
6 this -- this section which focuses on evidence
7 based prescribing. And there's a -- there's an
8 article from the Boston Globe from I think it was a
9 couple days ago that describes how it works in
10 Pennsylvania. They --
11 CHAIRMAN RACINE: How do you feel about the
12 Oregon piece?
13 MS. LONGAN: The Oregon piece we think is
14 good. There are other alternatives. I've heard
15 from other doctors. There's one in British
16 Columbia another doctor told me about. So we'd
17 like that "such as" language.
18 We don't really have a position on contracting
19 with them versus, you know, using what's in the
20 public domain. But we think that having an
21 evidence based program is important.
22 The other two things I'm handing you are the
23 AHEC list of what the Area Health Education Center
24 is doing this year, which is hypertension and
25 depression. Depression is their new focus for this

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1 year. And then last year they had cholesterol,
2 and -- I don't know the -- Nexium -- I probably
3 need to save my own handouts. But -- but what was
4 it? Last year they had hypertension, cholesterol,
5 and heartburn; and this year they have depression
6 and hypertension. So we think they're doing a
7 great job, and there are some comments from doctors
8 supporting that program.
9 And as Sharon said, the challenge is to get
10 out to more than twenty-five practices just to kind
11 of spread this kind of evidence based prescribing.
12 So we're strongly supporting of that. Those are my
13 handouts.
14 We're also participating in something called
15 prescription policy choices, which is a 501.C.3
16 based in I think it's Maine. It might be New
17 Hampshire. I've only talked to them on the phone.
18 But that looks at evidence based prescribing. So
19 we're getting together with the New Hampshire
20 Medical Society, the Maine Medical Society, and the
21 area health education center to see if we can get
22 some economies of scale just in our three northern
23 New England states. So that's another thing we're
24 doing along those lines.
25 And now I'm going to shift gears and go to the

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1 Section 13, which is the privacy of prescription
2 information section, and that is on...
3 CHAIRMAN RACINE: 24.
4 MS. LONGAN: Okay. The first handout I have
5 is our policy, the medical society's policy, which
6 we just really found out about this.
7 The reason that we support this section is we
8 believe that having this information going as it --
9 I think you have a pretty good understanding of how
10 it works, which is it goes from the AMA and from
11 the -- the chain pharmacies to the data mining
12 company which forms the profile and sells it to the
13 manufacturing company.
14 We think giving this money to the
15 manufacturing -- giving this information to the
16 manufacturing company for its sales force is a way
17 to undermine the evidence based program that we've
18 been really working on having the evidence based
19 programs because I think Helen Really [phonetic]
20 was in this committee years and years ago. And it
21 was first de novo, and we support it going to --
22 CHAIRMAN RACINE: Years and years ago. That
23 was long after I was, but anyway. Okay.
24 MS. LONGAN: Yeah, okay. So that's our
25 policy. We just found out about this when

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1 New Hampshire passed the laws. It's not something
2 that I think was widely known. And here's an
3 article from the Boston Globe that describes the
4 sort of two things that -- I think at the beginning
5 and the end of that article that are important.
6 One is sort of like the president of the
7 New Hampshire Medical Society describing why they
8 support the bill, which is because he felt that
9 the -- that the drug detailers and sales reps knew
10 more about his prescribing than -- than he did
11 because the data isn't really shared with the
12 doctors, only with the pharmaceutical marketing
13 companies.
14 CHAIRMAN RACINE: And we're hearing, and I
15 think we're going to continue to hear, that there
16 are also other uses for this.
17 MS. LONGAN: Right.
18 CHAIRMAN RACINE: We heard this testimony
19 yesterday, and you were probably in the room.
20 MS. LONGAN: I was here.
21 CHAIRMAN RACINE: It helps with research. It
22 helps to alert physicians when they need -- they
23 need information about some bad combination of
24 drugs, bad reaction. What -- what -- I'm surprised
25 that the medical society likes this section given

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1 all the benefits that we understand doctors get
2 from this.
3 MS. LONGAN: Well, I'm not sure that doctors
4 get --
5 CHAIRMAN RACINE: That was the testimony. I'm
6 not saying I agree or disagree with it.
7 MS. LONGAN: Yeah.
8 CHAIRMAN RACINE: But I think that's --
9 MS. LONGAN: Well, what we heard yesterday was
10 there was -- there was a chart with a list of drugs
11 and a linkup to the -- the FDA I think in talking
12 about the safety issues. Ann Rugg testified in
13 finance, they asked her this question, if there was
14 a recall would she -- she said she didn't -- and I
15 hope I'm correctly stating this -- she didn't think
16 that they would use the pharmaceutical
17 manufacturing companies to get the word out to
18 doctors; they would use their own data.
19 So I think my main point is that there are
20 better ways to address both the safety issues and
21 the research issues than -- than using this -- this
22 information.
23 And in terms of the FDA, this is an article
24 that was a couple days ago written by a professor
25 at Harvard Medical School and the former editor of

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1 the New England Journal of Medicine, Marcia Angell,
2 who some doctors in Vermont are trying to bring to
3 Vermont to talk about these prescribing issues.
4 But it kind of explains the relationship
5 between the pharmaceutical manufacturing companies
6 and the FDA, which is that the pharmaceutical
7 manufacturing companies, since 1992, have been
8 paying user fees to the FDA to the tune of about
9 $300 million a year, which is I think about half of
10 their revenue. I can't remember if it's -- it says
11 in here -- slightly less or slightly more.
12 But basically what this money does is
13 encourages the FDA to move the new drug
14 applications through more quickly. And what this
15 author says is that it leads to a backlog in the
16 generic drug applications, which is, of course, of
17 benefit to the pharmaceutical manufacturing
18 companies. And also, it -- because the funding is
19 coming from the manufacturing companies for the
20 purposes of encouraging the drug applications to
21 move through more quickly that the safety aspects
22 of the -- of the FDA are being sort of a little
23 bit -- getting a little bit sort of short
24 (inaudible.)
25 So we think there are better ways to do that,

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1 and that would sort of be our point, in fact.
2 CHAIRMAN RACINE: Incidentally, if the doctors
3 feel that way, why aren't they all just opting out?
4 MS. LONGAN: There are three reasons why we
5 think the opt-out doesn't work very well. The
6 first one is that the opt-out is -- is too limited.
7 The way the opt-out works is that the information
8 would still go from the pharmacy, chain pharmacies
9 and wherever else, to the data mining company about
10 the prescriptions. It would -- it would not go --
11 the AMA's list of, you know, its numbers for
12 identifying doctors would not go for those doctors
13 that opted out. The profile would still be
14 created.
15 Well, actually the AMA information -- the
16 pharmacy information would go. The AMA information
17 would go. The profile would be created. The
18 profile would be sold to the manufacturing company.
19 The manufacturing company, by a contract with the
20 data mining company, would not be able to share
21 that information with its sales marketing force.
22 So it's within the corporation but not going to the
23 sales marketing force.
24 So -- so that information can be used for
25 other purposes. So we think that that's too

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1 limited. It could be used by the marketing
2 division inside the corporation. And if you --
3 I've been trying to penetrate the -- if I can find
4 it in my stuff here.
5 MALE ATTENDEE 1: Madeleine, (inaudible)
6 suspicious -- let's say healthy suspicion of the
7 pharmaceuticals.
8 MS. LONGAN: Well, I don't mean to be
9 suspicious, and they do wonderful work in
10 developing drugs. But -- and this is really the
11 first time that I've waded into this. And we
12 were -- New Hampshire started us out with this law,
13 and then, just trying to understand the answers to
14 these questions, I'm just trying to give you the
15 best information that I could find.
16 CHAIRMAN RACINE: You said there were three
17 reasons why the opt-out doesn't work. That was the
18 one.
19 MS. LONGAN: Okay. So getting back, that --
20 so that's one reason.
21 CHAIRMAN RACINE: I wrote down No. 2 already.
22 Fill in the blanks.
23 MS. LONGAN: Okay. So -- so No. 2 is
24 opt-outs, in general, don't work very well. And if
25 you -- you probably remember, many of you, that

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1 Vermont chose an opt-in on the banking and
2 insurance information, not an opt-out.
3 You heard yesterday that 6,000 in Vermont out
4 of the -- I mean in the United States out of the
5 800,000 -- that's less than -- so that's
6 three-quarters of 1 percent of docs have opted out.
7 Why don't they opt out? I mean we send out
8 information in our newsletter letting them know
9 about the opt-out. We think the opt-out is a good
10 thing. It's limited, but it's a good thing.
11 They -- they don't know about it. They don't read
12 our materials or other people's materials or they
13 don't think it's meaningful.
14 FEMALE ATTENDEE 1: (Inaudible.)
15 MS. LONGAN: Well, they're not really
16 isolated. If they opt out, their information --
17 their prescribing information would not go to the
18 sales rep. It goes to their office. It would go
19 everywhere else.
20 CHAIRMAN RACINE: Okay. No. 3?
21 MS. LONGAN: No. 3, okay, this is kind of a
22 follow-up to what Julie Brill said, which was that
23 the data miners can use another identifier, if they
24 don't have the AMA identifier, and then the
25 information can still go. And -- and the other

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1 identifiers are things like the licensing number,
2 which is publicly available on the Web site.
3 And just to get back for a moment to we've
4 been trying, as I said, to penetrate the IMS, which
5 is one data mining company, their annual report.
6 And what -- mostly what they use this for is what
7 they call their sales force effectiveness offerings
8 which has to do with selling the information to the
9 pharmaceutical manufacturers to measure, forecast,
10 and optimize the effectiveness and efficiency of
11 their sales representatives to target the marketing
12 and sales efforts of the sales forces into managed
13 sales territories. And one part of sales force
14 effectiveness offerings is something called
15 prescription tracking reporting services that
16 monitor prescription activity and track the
17 movement of pharmaceutical products out of retail
18 channels.
19 And they have this thing called exponent,
20 which monitors prescription activity from retail
21 pharmacies, long-term care, which I didn't know
22 about, and mail service pharmacies. And they have
23 this thing called early view which provides a
24 weekly prescriber level activity highlighting
25 competitive prescribing transfer, key

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1 prescribers -- okay.
2 Anyway -- and then it says that they -- IMS
3 Healthcare provides their clients, the
4 manufacturing companies, with timely and
5 comprehensive information on 2.4 million health
6 care professionals, including the health care
7 professionals' names, addresses, organizational
8 affiliations, license numbers, expiration dates,
9 and authorization statuses.
10 So my point is, just as -- they have many
11 other ways of kind of -- they don't necessarily
12 need this CME number from the AMA. They're --
13 they're very --
14 CHAIRMAN RACINE: Okay.
15 MS. LONGAN: So -- so anyway, so they -- so
16 those are my reasons we don't -- we support the
17 opt-out, but we don't think it does what we're
18 looking for.
19 CHAIRMAN RACINE: Okay.
20 MS. LONGAN: Okay.
21 CHAIRMAN RACINE: Anything else?
22 MS. LONGAN: And the research, I talked
23 briefly about the research. I'm trying to get
24 organized here.
25 One thing that we've already financed was

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1 that -- was an argument that the docs are not
2 looking for transparency or trying to avoid
3 transparency of their own prescribing. And that
4 is -- I just would like to say that's not true.
5 There's complete transparency of the doctors'
6 prescribing through -- the one that I know -- I
7 know about the public programs because they're --
8 so I know that the DUR board, OVHA, has every --
9 every prescription that every doctor writes for a
10 Medicaid patient. I would guess that the PBMs and
11 Blue Cross and Blue Shield and MVP have that
12 information or could have that information for
13 their -- for the doctors that prescribe for them.
14 So that's one form of transparency that we support.
15 The other one is Vermont is in the process of
16 creating a multipayer claims data system through
17 BISHCA. That system is going to get information
18 from Medicaid, from all the PBMs, and is going to
19 create a public data system that will have all this
20 information.
21 We're very, very supportive of this. It's
22 going to be done through a public process. There
23 will be rulemaking. It'll be out in the open.
24 They'll be -- you know, we'll have kind of pros and
25 cons about what the data is, how the data is used.

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1 We'll have -- we'll probably have some concerns
2 about, like when New York did reporting of
3 mortality on heart surgery, doctors were concerned
4 that it might cause doctors to take less of the
5 more difficult patients.
6 So we'll have some concerns, but it'll be a
7 public process. We'll get it all out there. We'll
8 talk about it and then talk about what makes sense
9 for the people in Vermont.
10 So we completely support that type of public
11 transparency and think that's the way to go, and
12 you know, don't -- don't like this in-the-shadows
13 sort of thing.
14 The last handout that I have for you, this is
15 something that's kind of -- we found kind of
16 interesting. It's something that we found out
17 about because of this process, which is Paul was
18 invited to be -- Paul Harrington was invited to be
19 on a panel where the pharmaceutical manufacturing
20 groups are getting together to talk about their
21 marketing strategies. And they are already looking
22 ahead to things like what they're going to do if
23 they don't have this data.
24 So they're already -- I mean there's a bill in
25 Congress that would sort of prohibit access to this

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1 data. And I don't know whether it will pass or
2 not. But -- and I know that Vermont is fairly a
3 rounding error in, you know, the kind of stuff
4 that -- that we're talking about. But -- but
5 they're already looking ahead to how they can deal
6 with this.
7 And the last point I want to make and sort of
8 mentioned here is they do mention something called
9 patient scape and patient level data. And one of
10 the things that was part of the finance testimony,
11 and may come up here as well, was that doctors are
12 using the patients as a red herring. It's really a
13 patient issue because of HIPAA.
14 Well, we don't really know whether it's a
15 patient issue or not because we can't penetrate
16 what's going from the pharmacy to the data mining
17 company. There are exemptions to HIPAA. And I'm
18 sorry to be sort of suspicious-sounding, but there
19 are exemptions to HIPAA. One is a business
20 associates agreement exemption, and another is a
21 health care operations exemption.
22 And this is kind of broadly stated. And I
23 don't know, but it's possible that patient
24 information could be going to them. And so my
25 request would be to keep the patients in the bill

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1 because it doesn't do any harm to keep them in the
2 bill if it's just duplication. If it's -- you
3 know, if it's needed, then it would be helpful to
4 keep it in the bill.
5 And the last thing I want to say -- and I'm
6 almost done. In fact, I'm going as fast as I
7 can -- is that in finance I learned one more thing,
8 which is apparently the manufacturing companies and
9 others go to the office of Vermont Health Access
10 and ask for prescribing information as a matter of
11 public record.
12 So Ann Rugg testified in finance that they
13 would like to see a public records exception for
14 this prescribing information, and there wasn't I
15 think time to work that out in the language in
16 finance. And I think it was sort of -- Robin would
17 probably know more, but I think it was kind of
18 deferred for this committee. But I just wanted to
19 sort of mention it. It was at the last paragraph
20 in Josh's memo.
21 So I think that's all that I have, and I'm
22 sorry to sort of rush through.
23 CHAIRMAN RACINE: Don't apologize. We're
24 happy to have you rush through.
25 MS. LONGAN: How did I do on my sixteen

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1 minutes?
2 CHAIRMAN RACINE: I don't know. I wasn't
3 paying any attention.
4 MS. LONGAN: Well --
5 CHAIRMAN RACINE: I've known you many years.
6 I've never heard you talk so fast.
7 MS. LONGAN: So if I have any left over, can I
8 reserve for rebuttal?
9 CHAIRMAN RACINE: What we're trying to do is
10 get through all of this, and then I've asked Robin
11 to identify the issues that are the most in dispute
12 and sort of outline the arguments, and then we'll
13 go through them one -- each of the issues one by
14 one. So if we need more information, we'll hear
15 from you.
16 MS. LONGAN: Okay. Thank you.
17 CHAIRMAN RACINE: Okay.
18 MALE ATTENDEE 1: (Inaudible.)
19 MS. LONGAN: What?
20 MALE ATTENDEE 1: (Inaudible) as far as I'm
21 concerned.
22 MS. LONGAN: Great PR?
23 CHAIRMAN RACINE: Okay. Bob Feeney, we're
24 doing that by phone? Is that --
25 (Inaudible.)

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1 CHAIRMAN RACINE: (Inaudible) pharmaceutical
2 company. Who's representing Mr. Feeney? Is
3 anybody?
4 FEMALE ATTENDEE 1: I think -- is (inaudible)
5 here? While I'm calling him, I will give you the
6 (inaudible).
7 CHAIRMAN RACINE: Okay. Maybe we should --
8 maybe we should move on; and as we get close to the
9 end of the next one, you can make the call so we
10 don't wait while you try and connect and make --
11 FEMALE ATTENDEE 1: Okay.
12 CHAIRMAN RACINE: -- make the -- and try and
13 get that schedule on board.
14 All right. Trinka?
15 MS. KERR: And I'll be very brief.
16 CHAIRMAN RACINE: And if you could give us
17 like a thirty-second warning, and then Jan can call
18 and get the next witness here. Thank you.
19 MS. KERR: Trinka Kerr, the state health care
20 ombudsman. And first of all, I wanted to let you
21 know that we are generally in support of almost
22 everything in this bill.
23 Prescription availability for consumers in
24 Vermont is still a big issue. Of the 2,500 calls
25 that we got last year, about 21 percent of them

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1 were access to care calls; and of those access to
2 care calls, 28 percent of them were about
3 prescription drugs; and that's not including any of
4 the Medicare Part D calls that we also got. So
5 it's still a huge issue for people trying to access
6 prescription medications. So we're -- the Office
7 of Health Care Ombudsman is in favor of anything
8 really that improves access to drugs. And --
9 MALE ATTENDEE 1: (Inaudible.)
10 MS. KERR: What?
11 MALE ATTENDEE 1: (Inaudible.)
12 MS. KERR: Right. And the ability to get
13 medications which is, you know, part of -- I think
14 this -- some of the parts of this bill will improve
15 that.
16 We also support just about everything that the
17 attorney general's office was in favor of. And
18 rather than repeat everything Julie said, I just
19 would state that. And also, basically what the
20 medical society is in favor of we're also in favor
21 of. The one --
22 CHAIRMAN RACINE: I'm sorry, Trinka. Who
23 do -- who do you work for?
24 MS. KERR: Okay. I --
25 CHAIRMAN RACINE: I'm just not clear on what

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1 the relationship --
2 MS. KERR: What the relationship is?
3 CHAIRMAN RACINE: Yes.
4 MS. KERR: Okay. The Office of -- the Health
5 Care Ombudsman is a project within Vermont Legal
6 Aid. We have contracts. We get our funding
7 through BISHCA and OVHA, but we're completely
8 independent of them.
9 CHAIRMAN RACINE: They can't call you and say:
10 Here's what we want you to say and --
11 MS. KERR: No. We can -- we can sue them, if
12 we want to. That's part of our contract.
13 CHAIRMAN RACINE: That's an ombudsman. That's
14 her point.
15 MS. KERR: We help consumers resolve problems
16 and beneficiaries. We're independent. We wouldn't
17 be doing it if we weren't independent of the state.
18 CHAIRMAN RACINE: Okay. Thank you.
19 MS. KERR: Okay. The one area that I am --
20 would recommend some changes has to do with
21 Section 6 on page 11. And I talked to Robin about
22 this a little bit because, from looking at Josh
23 Slen's little chart and comments, I didn't actually
24 understand what he was talking about. So it's
25 Section 6 on page 11. It's about Healthy

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1 Vermonters Plus. And Healthy Vermonters right now
2 is a -- is a discount program for prescription
3 medications where beneficiaries get a reduced
4 price. It's not actually like an insurance
5 program. It's more they get the Medicaid --
6 essentially the Medicaid price for medications at
7 the pharmacy. And that program right now is
8 available to individuals who are below 300 percent
9 of the Federal poverty level or who are up to
10 400 percent of the Federal poverty level if they're
11 over 65 or disabled.
12 So the piece that Josh seemed to be objecting
13 to had to do with expanding Healthy Vermonters to
14 include people up to 350 percent of the Federal
15 poverty level. And it involved this complicated
16 system where people would bring in their receipts
17 for unreimbursed costs for prescriptions; and if
18 those receipts totalled more than 5 percent of
19 their household income, then they would be eligible
20 for the discount program. Well -- and OVHA
21 objected to that as administratively burdensome,
22 which I actually think it really is. It would be
23 very hard to administer that.
24 CHAIRMAN RACINE: I could tell by the way you
25 presented that. You do this and then you go and do

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1 this and that was --
2 MS. KERR: Well, you know, I think that would
3 be very difficult. And if the legislature wants to
4 expand Healthy Vermonters, which would be a good
5 thing, I would suggest that you just increase the
6 Federal poverty level. You know, if you can't go
7 up to 350 percent, then maybe 325 or whatever.
8 But that whole system of having beneficiaries
9 keep track of how much they're spending, I mean
10 they -- they do that for another part of a Medicaid
11 program, and it's very, very difficult for everyone
12 involved.
13 CHAIRMAN RACINE: Okay.
14 MS. KERR: So that language about the
15 5 percent and the 15 percent is in the existing
16 statute. So -- right, Robin? I have that right?
17 So I think that -- I understand why OVHA
18 thinks that's administratively burdensome because
19 we actually think it would be too.
20 CHAIRMAN RACINE: Okay.
21 MS. KERR: And unless you have any questions?
22 CHAIRMAN RACINE: Questions? No?
23 Thank you.
24 MS. KERR: Thank you.
25 CHAIRMAN RACINE: Okay. So next we're trying

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1 to get Bob Feeney from E-I-S-A-L Pharmaceutical
2 Company on the phone.
3 FEMALE ATTENDEE 1: While we're getting him,
4 Madame, can I just ask you a question?
5 MS. KERR: Yes.
6 FEMALE ATTENDEE 1: I'm looking at this. This
7 is very interesting. P-D-R-P, prescription data
8 restriction --
9 MS. KERR: Program.
10 FEMALE ATTENDEE 1: Program.
11 (Inaudible.)
12 FEMALE ATTENDEE 1: Right, right. No. I just
13 didn't get the last P because it doesn't say the
14 last P on here anywhere.
15 (Inaudible.)
16 FEMALE ATTENDEE 1: I saw that. Yeah. I read
17 this very carefully.
18 MS. KERR: It was very interesting.
19 FEMALE ATTENDEE 1: How to segregate -- how to
20 adapt your technology systems in order to --
21 (Inaudible.)
22 FEMALE ATTENDEE 1: When? At age 4.
23 FEMALE ATTENDEE 2: That's actually when kids
24 gain their ethical decision making.
25 FEMALE ATTENDEE 1: Thank you.

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1 FEMALE ATTENDEE 2: So you're right on track.
2 CHAIRMAN RACINE: Okay. Is this Mr. Feeney?
3 Hello?
4 MR. FEENEY: Yes, I'm here. Can you hear me?
5 CHAIRMAN RACINE: Yes. Can you hear me?
6 MR. FEENEY: Yes.
7 CHAIRMAN RACINE: All right, Mr. Feeney. I'm
8 Dr. Racine. I'm a senator chairing the committee.
9 We have other senators here and a room full of
10 witnesses. We understand you would like to offer
11 some testimony on our Vermont Senate Bill 115, and
12 we're allocating fifteen minutes for testimony from
13 our witnesses. So if you can do that, we'd be
14 happy to hear from you.
15 MR. FEENEY: That's wonderful, and let me
16 begin by thanking you for affording me the
17 opportunity to do this. I don't know specifically
18 who has testified before the committee at this
19 point, but the hope was that, in that perspective,
20 as an industry participant, specifically a big
21 market company might shed some additional insights
22 for you in terms of the -- what some of the
23 unintended consequences of this legislation might
24 be.
25 Specifically, I don't know if you have a copy

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1 of the letter that I had provided beforehand.
2 CHAIRMAN RACINE: Yes. It's right here, and
3 it is now in front of the committee members. Go
4 ahead.
5 MR. FEENEY: Okay. I'll refer to some of the
6 contents of that letter. One of the things that
7 was touched upon was the -- the operational impact
8 legislation could have. Obviously there's
9 potential for a negative impact on operations in
10 terms of how companies are able to operate. And I
11 think it's worthwhile to mention in terms of the
12 additional uses the prescription data is also put
13 to, which I believe the other individuals who have
14 testified spoke to at length. Like I said, there
15 definitely is commercial applications for this as
16 well.
17 But we don't see that in a negative fashion;
18 we see that as a means for us to operate as a
19 company, as an industry, more efficiently. If this
20 data was not available to us, we could not stop
21 functioning in promoting our products; we'd be
22 forced to rely on very cumbersome and inefficient
23 methods, however, which we don't see as serving --
24 anyone -- anyone's end really. We would be forced
25 into a position, actually forced back to a

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1 position, where the industry probably was forty
2 years ago in terms of using very, very inexact
3 methods, very unreliable methods to aggregate the
4 evaluation of data which actually would have a
5 negative impact on operating efficiency and could
6 actually create the potential for upward cost
7 pressures.
8 One of the other points that I had stressed in
9 the letter deals with the utility of this data in
10 terms of -- specifically in terms of us -- giving
11 us the ability to identify those cohorts in the
12 physician community who have patient populations
13 that we think could benefit from our therapies.
14 Again, we do not see this as a bad thing.
15 And I specifically in the letter used an
16 Alzheimer's therapy Aricept, which is the leading
17 product in the market. Millions of people have
18 benefited from that. And this is -- you know, to
19 use that a specific example, Alzheimer's is a
20 disease state where the greatest impediment to
21 growth, historically, has been a continuing lack of
22 awareness and diagnosis and treatment.
23 We have never reached a point where more than
24 50 -- we estimate more than 50 percent of the
25 afflicted Alzheimer's population has been

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1 effectively diagnosed and treated. That has not
2 just been on our own research; that actually is by
3 third-party sources, including the Alzheimer's
4 Association.
5 In that case, being able to identify
6 physicians with a large geriatric population,
7 including those individuals that maybe have
8 manifested the early symptoms of Alzheimer's
9 disease, gives us an opportunity to engage those
10 physicians directly, allows -- educate them
11 appropriately. It's not an attempt to interfere in
12 the physician/patient relationship but make sure
13 the physicians are armed with the appropriate data,
14 including the therapies that are available to treat
15 specific disease states, like Alzheimer's disease,
16 so the patient population can be effectively
17 treated.
18 And in the case of Alzheimer's, we have -- you
19 know, we see repeated evidence -- and this is
20 supported by specific studies that we have
21 commissioned -- that show effective early diagnosis
22 delays nursing home placement by a year and a half,
23 and in specific cases, up to two years. So there's
24 not only a human element that's being -- that's
25 being served there, but there's obvious

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1 pharmacoeconomic benefits by sharing proper
2 treatment in order -- in order to keep people out
3 of long-term care centers.
4 And without this data readily available to us,
5 we would not -- we would be -- we would not be able
6 to engage in that exercise either, not be able to
7 target these physicians and specifically address
8 these patient populations that we think can
9 directly benefit from our therapies.
10 CHAIRMAN RACINE: Excuse me. If I can ask a
11 question there: Are there not other ways of
12 identifying physicians who deal with those
13 populations who are likely to have Alzheimer's?
14 MR. FEENEY: Potentially. But again, they're
15 very -- very ham-fisted approaches. There are ways
16 of identifying, for example, just -- just
17 physicians that deal with the geriatric population,
18 you know, that could -- that could represent a
19 very -- that the patient populations they serve
20 could be very broad based however. And we wouldn't
21 know specifically if there was a physician that
22 actually had a large -- a large proportion of their
23 practice that was -- that included people with --
24 with Alzheimer's and with -- or with precursor
25 symptoms of Alzheimer's, for example. And that's

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1 evidenced sometimes by comorbidities. So again,
2 it's not impossible.
3 But this gets back to the first point. The
4 way we would need to do that would potentially I
5 think be even more -- even more disruptive and
6 would definitely be incredibly inefficient.
7 CHAIRMAN RACINE: Okay. We have another
8 question.
9 SENATOR KITTELL: Well, I guess just along
10 that same line, Senator Kittell, I was just trying
11 to think when I just heard, you know, what's wrong
12 with sending a company -- or you would like to
13 target a certain population using your drug and you
14 could send a letter to them all. You could do a
15 number of things. And if they're interested, they
16 will get back in touch with you.
17 You have -- you know, the pharmaceutical
18 industry has vast resources; and if it's that
19 important, I would think you would use some of your
20 resources to be in touch with the population using
21 your product or not. I mean I think that's -- you
22 know, there are -- you could -- you know, you could
23 have a colored letter. You could have a letter
24 that says, "I'm here for you," you know, all sorts
25 of things to get their attention to say that, "I

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1 want to help those who prescribe Aricept,"
2 something.
3 MR. FEENEY: And you're talking a letter
4 writing campaign to individuals or to the physician
5 community?
6 SENATOR KITTELL: I think anybody that
7 prescribes -- I mean I'm just being facetious here.
8 You know what you want to do. But I'm just saying
9 there are other ways to get ahold of a population
10 using your drug.
11 SENATOR WHITE: And can --
12 MALE ATTENDEE 1: (Inaudible) fewer
13 commercials.
14 SENATOR WHITE: Right. Can I suggest -- this
15 is Senator White. I just -- I know that you find
16 that it would be cumbersome and less dependable,
17 therefore, probably more expensive to use other
18 methods. But the pharmaceutical industry spends a
19 fortune on TV ads to convince me that I should ask
20 my doctor about the purple pill or I don't know
21 what color yours is.
22 But I would think that if -- if you're really
23 interested in getting to that population, and
24 getting to the people who actually write the
25 prescriptions, take the money that you have on

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1 public -- on the airwaves and put it toward the
2 marketing to the physicians instead of marketing to
3 me. I mean it isn't -- I don't believe that it's a
4 lack of money and resources.
5 FEMALE ATTENDEE 1: Just redirect it.
6 SENATOR WHITE: Yes, redirect it.
7 MR. FEENEY: I didn't mean to imply that it
8 was a complete lack of resources. But to clarify
9 the amount spent on direct consumer advertising --
10 and I don't know that that's what we're here to
11 speak about today -- is actually a small fraction
12 of the overall promotional budget for companies. I
13 don't have those specific numbers in front of me.
14 But it's still -- it's still -- it has increased
15 significantly over the last number of years to be
16 sure, but it's still a relatively small component
17 of the -- of the total promotional budget.
18 SENATOR WHITE: I wasn't meaning to imply
19 that -- that it -- it was a large portion of the
20 budget. But what I'm saying is, if you have a
21 limited amount of money for promotion, it would --
22 you would -- you make the decisions of where to put
23 that -- those resources and perhaps the decision to
24 put those resources to the public as opposed to the
25 physicians. I mean that's a decision you've made,

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1 and maybe the decision needs to be -- you need to
2 rethink your decision.
3 MR. FEENEY: And you know, I see the point
4 you're trying to make. I guess I would say some
5 people have criticized direct consumer advertising
6 because it does directly target the patient
7 population rather than the -- rather than the
8 physician community. It doesn't -- it's not an
9 imposition to communicate a lot -- a lot of detail
10 in terms of product profiles and in terms of their
11 efficacy and side effects so that people have --
12 you know, a lot of people would, you know, see
13 physician detailing as actually preferable because,
14 however it might be undertaken, it actually does --
15 you know, all it does is arm the physician with
16 data. It does not intend to undermine the
17 patient/physician relationship, and probably that's
18 an overly pejorative word because we don't
19 necessarily think TV advertising does that either.
20 But it -- but, you know, the engagement of
21 physicians directly does nothing more than just arm
22 them with the -- with the data that they need to
23 then make educated and informed physicians --
24 decisions for their patient population.
25 CHAIRMAN RACINE: Okay. Anyway, you may

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1 continue.
2 MR. FEENEY: Well, actually those were based
3 on the written correspondence that I provided.
4 CHAIRMAN RACINE: Okay.
5 MR. FEENEY: Those were the two -- the two
6 major points that I -- that I really wanted to
7 make. I don't want to -- you know, I don't want to
8 get into subject areas where I'm not -- you know,
9 what they were aware of where the data -- the data
10 has utility as well, including its use from a
11 public policy and health economics perspective,
12 from a safety perspective, and a regulatory
13 perspective as a tool to help implement and pay for
14 performance models, such are indicated under the
15 Medicare Modernization Act. I'm sure the other
16 witnesses have commented on those -- on those
17 elements at length. But just, you know, suffice it
18 to say that we -- we concur with those arguments as
19 well.
20 CHAIRMAN RACINE: Okay. May I ask who
21 represents you here in Vermont?
22 MR. FEENEY: Doveco represents us.
23 CHAIRMAN RACINE: Who's that?
24 MR. FEENEY: Doveco Worldwide is our lobbying
25 firm for federal and state and local government

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1 affairs.
2 CHAIRMAN RACINE: Okay. So you don't have a
3 presence here in Vermont?
4 FEMALE ATTENDEE 1: How do you spell it?
5 MR. FEENEY: We do not.
6 CHAIRMAN RACINE: You do not. Okay. How did
7 you find out about us? We're just sort of a
8 little -- a little state legislature here.
9 FEMALE ATTENDEE 1: From this.
10 (Inaudible.)
11 CHAIRMAN RACINE: How did you -- how did you
12 find out about this bill?
13 MR. FEENEY: We track -- we track developments
14 in all fifty states.
15 CHAIRMAN RACINE: Okay. And you made the
16 contact with us?
17 MR. FEENEY: Exactly.
18 CHAIRMAN RACINE: Okay.
19 MALE ATTENDEE 1: Good work.
20 FEMALE ATTENDEE 1: Good to see you know how
21 to do it.
22 CHAIRMAN RACINE: Okay. Any questions?
23 Okay, Mr. Feeney, thank you.
24 MR. FEENEY: Thank you very much.
25 CHAIRMAN RACINE: Thank you for participating

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1 here.
2 MR. FEENEY: Okey-doke.
3 CHAIRMAN RACINE: All right. Thank you.
4 (Inaudible.)
5 CHAIRMAN RACINE: Man, these guys are good.
6 FEMALE ATTENDEE 1: They know how to -- they
7 know how to find what they're looking for. They
8 can find the -- they can find the documents.
9 CHAIRMAN RACINE: You'll probably have a
10 personal phone call waiting for you when you get
11 home.
12 (Inaudible.)
13 CHAIRMAN RACINE: They can find us.
14 Okay, Mr. Otis.
15 FEMALE ATTENDEE 1: We are listed right on
16 here on this thing too.
17 CHAIRMAN RACINE: Are we?
18 FEMALE ATTENDEE 1: Paul Harrington is listed
19 as a presenter.
20 CHAIRMAN RACINE: Okay.
21 FEMALE ATTENDEE 1: Yeah. Yeah. Right. So
22 that's how they found us.
23 CHAIRMAN RACINE: Okay. I don't know if you
24 were in the room when I said we're trying to limit
25 it to fifteen minutes.

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1 MR. OTIS: Oh, I don't even want fifteen.
2 CHAIRMAN RACINE: Then --
3 MR. OTIS: I don't even want ten.
4 CHAIRMAN RACINE: Okay. Then keep going.
5 MR. OTIS: Five. Anthony Otis today
6 representing the Vermont Pharmacists Association,
7 the Vermont association of the chain drug stores
8 and Vermont retail druggists. If you will move
9 quickly, so I can stay on schedule here, to a
10 page -- I think it's page 28, you'll see Sections
11 15 and 16 in a slimmed-down father of S.115, which
12 was directly request of 1148. These two sections
13 were referred to in the Senate Finance Committee as
14 the Wal-Mart provision, and I want to be very clear
15 with you about what they don't do and why they're
16 unnecessary.
17 At the present time, I talked to two major
18 chains and to two independents, and they tell me
19 that they don't know of -- but they probably
20 wouldn't necessarily know -- if every community
21 retail pharmacy in the country insurers provide --
22 that you want the usual customer. So if you go in
23 the universe of PBMs and health care insurers, they
24 don't know of any who don't ask for and don't get
25 their usual customary price.

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1 So every time you adjudicate online, the
2 computer knows, and the PBM and the health
3 insurance knows, what your usual customary is and
4 what their copay is. And so we're basically
5 putting something in the statute that essentially
6 happens now without any statutory requirement.
7 MALE ATTENDEE 1: (Inaudible.)
8 MR. OTIS: I guess that's a public policy
9 decision whether you think it's necessary to put it
10 in when it accomplishes what already exists. I
11 mean the books would be full of things if you -- if
12 you, you know.
13 CHAIRMAN RACINE: Let me ask this. I mean why
14 if -- you have come in here to suggest we take it
15 out. Do you -- do you worry that if it -- would
16 you worry if it's still in here? Are you -- are
17 there -- are you able to represent who would like
18 to at some point charge the full usual and
19 customary rather than the lesser? I mean what's
20 the concern?
21 MR. OTIS: Well, I'm sorry. First, let me
22 apologize to Senator Flanagan. I didn't mean to
23 appear to be flippant in my -- in the answer to
24 that. We could have that, you know, in social
25 time.

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1 This is what happens in adjudicating
2 prescription drugs by pharmacies, of the ones that
3 I represent and of the similar ones around the
4 country.
5 FEMALE ATTENDEE 1: Can you use a different
6 word than adjudicating prescription drugs because
7 I'm not sure that I --
8 MR. OTIS: Electronically transferring the
9 information to the PBM or to the health insurer for
10 permission to pay -- to fill the prescription at a
11 certain price.
12 FEMALE ATTENDEE 1: Okay. So that's
13 adjudicating?
14 MR. OTIS: That's adjudication. That's what
15 we call it.
16 FEMALE ATTENDEE 1: Okay. I thought it was
17 that, but that's --
18 MR. OTIS: Well, it is in other places.
19 CHAIRMAN RACINE: Okay.
20 FEMALE ATTENDEE 1: That's what I thought you
21 were saying.
22 CHAIRMAN RACINE: Okay. So what you're saying
23 is it's unnecessary. If it stays in, you think
24 we're putting unnecessary words in the green books,
25 but it wouldn't harm who we are representing?

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1 MR. OTIS: As far as I know, it does not harm
2 who you are representing.
3 CHAIRMAN RACINE: Okay. Thank you.
4 (Inaudible.)
5 FEMALE ATTENDEE 1: I thought that too. It
6 was.
7 MR. OTIS: Well, the person comes to the
8 pharmacy, and they present their personal
9 information. And by providing that personally
10 identifiable information, the computer knows
11 whether they have -- if they're covered by someone,
12 unless, of course, they say, "I'm a cash payer. I
13 don't have Medicaid or Medicare or don't have any
14 private insurance." Okay. So the computer can
15 find them through this system, electronic system,
16 and determine whether, in fact, they can purchase
17 this drug and what is the price that they pay. The
18 pharmacist, of course, runs out what the pharmacy
19 will receive as the formulary price for filling a
20 prescription.
21 (Inaudible.)
22 CHAIRMAN RACINE: That's what I thought.
23 (End of CD 07-49/Track 2.)
24
25

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1 CERTIFICATE
2
3 STATE OF FLORIDA)
4 COUNTY OF INDIAN RIVER)
5
6 I, Kristen A. Houk, Registered Professional
7 Reporter and Florida Professional Reporter, do hereby
8 certify that I was authorized to and did listen to CD
9 07-49/Tracks 1 and 2, the Vermont Senate Committee on
10 Health & Welfare meeting of the Thursday, March 1, 2007
11 proceedings, and stenographically transcribed from said
12 CD the foregoing proceedings and that the transcript is
13 a true and accurate record to the best of my ability.
14
15 Dated this 3rd day of December, 2007.
16
17 ______________________________
18 Kristen A. Houk, RPR, FPR
19
20
21 Job No.: 907521A
22
23
24
25

1
2 STATE OF VERMONT
3 SENATE HEALTH & WELFARE COMMITTEE
4
5 Re: Senate Bill 115
6 Date: Thursday, March 1, 2007
7 Senate Health & Welfare Committee
8 Committee Members:
9 Sen. Doug Racine, Chair
Sen. Ed Flanagan, Vice-Chair
10 Sen. Sara Kittell
Sen. Virginia Lyons
11 Sen. Kevin Mullin
Sen. Jeannette White
Robin Lunge, Legislative Counsel
13
14 CD No: 2007-50/Track 1
15
16
17
18 Transcribed by:
19 Kristen A. Houk, RPR, FPR
Esquire Deposition Services
20 800.330.6952
Job No: 907521B
21
22
23
25

1 PROCEEDINGS
2 - - -
3 (Start of Track 1.)
4 CHAIRMAN RACINE: Next on the list is
5 Mr. Kimbell, who I do not see here. And after that
6 would be Sharon Shreet [phonetic] by phone, but
7 she's by phone.
8 John Hollar, you've been waiting very
9 patiently and quietly not causing trouble.
10 SENATOR WHITE: But he's causing all kinds of
11 trouble out there.
12 MR. HOLLAR: But I haven't talked yet.
13 (Inaudible.)
14 SENATOR WHITE: Out in the hall he's causing
15 all kinds of trouble.
16 CHAIRMAN RACINE: Okay. So why don't you --
17 why don't you go ahead.
18 MR. HOLLAR: All right. Thank you very much.
19 CHAIRMAN RACINE: You can tell we're getting a
20 little punchy here, so --
21 SENATOR WHITE: And if we don't get some air
22 pretty soon, we'll all be dead.
23 MR. HOLLAR: This room really is -- this room
24 is -- this room is stifling.
25 CHAIRMAN RACINE: If it's not noisy out there,

1 we could open the door a little bit.
2 (Inaudible.)
3 CHAIRMAN RACINE: If it gets noisy, could you
4 slam the door for us, please. Thank you.
5 All right.
6 MR. HOLLAR: Okay. I'm John Hollar of Downs,
7 Rachlin & Martin, and I'm here on behalf of the MVP
8 Health Plan. And I'm going to talk just about one
9 section, the -- well, actually the sections dealing
10 with pharmacy benefit. And under Section 7
11 (inaudible) maybe that does go into more than one
12 section -- but sections dealing with pharmacy
13 benefit plans, which go from page 13 to 22 of the
14 bill.
15 And my message is really simple, and that is
16 that, representing a large health insurer who
17 contracts with PBMs, we just don't think this is
18 necessary, and we think that it's going to add
19 additional costs to the PBM industry that are going
20 to be passed on to us.
21 I've -- this bill has been around for a while.
22 This proposal came up before, and I've testified to
23 this point before. I don't recall anyone -- any
24 consumer insurer business testifying that they need
25 protection from PBMs.

1 And the way these -- this industry works, they
2 contract with large, sophisticated entities who are
3 able to obtain -- like my client, who are able to
4 obtain all of the information that's required under
5 this bill. These are fully transparent contracts,
6 and we're able to -- to negotiate for all the
7 information that's provided here. So it's -- it's
8 always been a bit of a puzzle to me as to why this
9 has been proposed and has continued to resurface.
10 We --
11 CHAIRMAN RACINE: Who do you see as being
12 proposed? It seems like more of almost an
13 informational thing.
14 MR. HOLLAR: Well, there's a new regulatory
15 scheme and then a bill-back requirement and a cause
16 of action against the PBMs. You know, it's pretty
17 significant. I mean, to be honest, I haven't spent
18 a lot of time trying to study every in and out of
19 it because it's not going to apply to my client.
20 We looked at it, and have in the past, and said:
21 You know, this is intended to protect, presumably,
22 insurers like us.
23 So the question that MVP had is -- or the
24 response is: Well, we don't really need it.
25 And so then I guess the question is: Well, is

1 it going to do any harm?
2 And you know, it's not -- on the list of
3 priorities for us, it's not huge. I mean -- but
4 ultimately we think that, to the extent that PBM
5 costs go up, then the people who buy their
6 services, the cost to those people will go up. I
7 mean it's just kind of a basic law of economics.
8 So I just would ask you to -- to question --
9 you know, to determine who really this is intended
10 to protect because technically the role of the
11 legislature, generally, I think is to protect
12 consumers.
13 This is a little different. I think this is
14 aimed at protecting businesses. And the question
15 is: Which businesses are really asking and feel
16 that they need the protections that this would
17 offer and would it -- I mean is that necessary?
18 Does that outweigh the costs, you know, that sort
19 of transaction costs that are going to be involved
20 in setting this up, making sure there's compliance
21 and, you know, potential litigation around certain
22 areas?
23 CHAIRMAN RACINE: Well, then let me ask you:
24 What could we do to help you?
25 MR. HOLLAR: Well, lower our cost. I mean I'm

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1 here. This is what I do for MVP is testify in
2 (inaudible) like this that we think would raise
3 costs.
4 CHAIRMAN RACINE: Seriously.
5 MR. HOLLAR: And I'm being very serious about
6 that. We, you know, don't pass things like this
7 that will raise costs.
8 (Inaudible.)
9 MR. HOLLAR: I was down the hall talking to --
10 to the Senate Finance Committee talking about
11 another bill that will increase costs, not a lot,
12 but incrementally. And so you know -- so --
13 CHAIRMAN RACINE: And how do you see this
14 raising your costs?
15 MR. HOLLAR: To the extent it raises PBM
16 costs.
17 CHAIRMAN RACINE: How do you see yourself --
18 how do you --
19 MR. HOLLAR: Just I mentioned the bill-back
20 requirement to this.
21 CHAIRMAN RACINE: Okay.
22 MR. HOLLAR: The PBM industry will be
23 financing a regulatory apparatus to insure
24 compliance with this -- with this new scheme, and I
25 think there will be internal costs of compliance to

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1 determine, you know, whether to -- I mean there are
2 nine pages of statute here that impose different
3 burdens on the industry and on health plans to -- I
4 guess to waive certain requirements.
5 CHAIRMAN RACINE: Okay.
6 MR. HOLLAR: So you know, it's something --
7 I'd be happy -- I will talk to you about that, but
8 really for us it's about trying to provide
9 affordable health care. And so that's --
10 CHAIRMAN RACINE: Okay.
11 FEMALE ATTENDEE 1: So -- well, the first
12 thing I heard you say was that everything that's
13 here and required for transparency is already being
14 done if -- in the contracts between your
15 organization and -- and a PBM. So that part of it
16 really reinforces practice. So it wouldn't raise
17 cost. The part that would -- are you saying that
18 the part that would raise costs is what? The
19 regulatory piece?
20 MR. HOLLAR: Right. And again --
21 FEMALE ATTENDEE 1: So is the registration the
22 audit, you know --
23 MR. HOLLAR: There are also the cause of
24 actions that are included in here which creates
25 some --

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1 FEMALE ATTENDEE 1: And each piece is the
2 enforcement piece?
3 MR. HOLLAR: Potentially.
4 FEMALE ATTENDEE 1: Will that cause -- will
5 that increase costs only because of a need for
6 consumer -- consumer fraud protection liability
7 protection for you or for the PBM? How will that
8 raise cost?
9 MR. HOLLAR: Well, to the extent -- I guess
10 the best is really, to the extent it raises costs
11 for PBMs who do business in Vermont, it will raise
12 costs for the people who buy the services. I mean
13 I think that's just --
14 FEMALE ATTENDEE 1: Why?
15 MR. HOLLAR: Well, because they will simply
16 raise their costs for services in Vermont as a cost
17 of doing business here.
18 FEMALE ATTENDEE 1: Well, what costs will they
19 incur as a result of the enforcement section and
20 then of the regulatory section?
21 MR. HOLLAR: Compliance costs, so the cost of
22 complying in Vermont will go up.
23 FEMALE ATTENDEE 1: The license?
24 MR. HOLLAR: Well, just internal compliance.
25 They're going to have to hire people to review the

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1 statute and insure that all their contracts are
2 consistent with the statute. The bill-back costs,
3 they'll have to pay for the direct costs of
4 regulating the new regulatory apparatus, potential
5 litigation costs.
6 I guess the point that I would say is I'm
7 not -- you know, to what -- I'm turning the
8 question around here and saying: What are you
9 trying to accomplish here and for whom is really
10 the question I would phrase.
11 The cost -- and I would say this is not high
12 in terms of, you know, MVP's priorities. This
13 would not rank high. But I thought it was
14 important to at least tell -- relate to you, since
15 the bill -- the premise of the bill seems to be to
16 protect health insurers. But it's not viewed -- we
17 don't feel that this is necessary from our
18 perspective. So I thought --
19 FEMALE ATTENDEE 1: (Inaudible.) One last
20 question because I know Jeannette wanted to ask a
21 question. But if you felt that the PBM that you
22 were working with had done something aggregious,
23 then would you feel that the recourse that you
24 currently have to address those issues was --
25 MR. HOLLAR: Per contract, right.

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1 FEMALE ATTENDEE 1: Do you have that?
2 MR. HOLLAR: Sure.
3 FEMALE ATTENDEE 1: Do you have that
4 protection?
5 MR. HOLLAR: Sure, yeah.
6 FEMALE ATTENDEE 1: Is it through BISHCA? Is
7 it through the attorney general? Is it through --
8 MR. HOLLAR: It would be through a private --
9 I mean action through -- under the contract
10 directly against the PBM, and if they were engaged
11 in fraud, then through the attorney general's
12 office presumably, perhaps BISHCA. I don't know
13 the extent of their authority. I think their's is
14 limited. So -- but if it were -- if it were -- I
15 mean typically it would be a contractual matter if
16 we felt that we weren't given the data that was
17 required for under the contract. Then it would be
18 enforced like in business.
19 FEMALE ATTENDEE 1: Are the contracts that you
20 have public documents or are they private corporate
21 documents?
22 MR. HOLLAR: You know, I would assume that
23 those are proprietary just because these are
24 competitive -- you know, it's a competitive market,
25 both for us and the PBM against, you know, Blue

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1 Cross and their people. But I don't know. I could
2 check and see --
3 FEMALE ATTENDEE 1: Okay. And then check and
4 see also are they -- are they placed with BISHCA?
5 Are those contracts --
6 MR. HOLLAR: I don't think those are filed,
7 no.
8 FEMALE ATTENDEE 1: -- filed with BISHCA?
9 Okay.
10 CHAIRMAN RACINE: Jeannette?
11 SENATOR WHITE: Well, since I think the goal
12 here is to -- the way I look at it anyway is, the
13 goal is not to necessarily protect MVP from Blue
14 Cross because I think they are capable of
15 protecting themselves. But the ultimate goal is to
16 protect the consume -- the very end consumer and to
17 protect the interests of the -- of the state by
18 assuring lower costs and that a way to do that is
19 the transparency. So how would you -- do you have
20 any suggestions about how we would get to those
21 goals without this by -- in dealing with the PBMs?
22 MR. HOLLAR: Well --
23 SENATOR WHITE: Did that make sense?
24 MR. HOLLAR: Yeah. I mean this bill doesn't
25 give any information to consumers. So the issue --

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1 I guess the premise is that MVP -- with this
2 information MVP would be able to negotiate a better
3 deal and get lower-priced pharmaceuticals. And
4 I -- we just don't see that, because, again, the
5 information that would be required under this we
6 already get.
7 So I mean I guess I can -- I haven't been -- I
8 don't know that there's anything the legislature
9 can do that's going to improve on that relationship
10 because I think the PBMs provide a service. They
11 negotiate the best arrangements they can to get
12 lower-priced pharmaceuticals. And we -- you know,
13 and then they provide that service to us, and we
14 negotiate the best contract we can with the PBMs.
15 And it's a competitive market.
16 I think the last time this bill was up, MVP
17 had a different-- PBM. We have -- so it switches
18 because (inaudible) so they are able to negotiate
19 in this competitive market with the lowest-cost
20 PBMs. So you know, I think it's a pretty
21 competitive market that's acting efficiently to
22 bring down prices. So I can -- I'll explore that.
23 I don't -- I just don't know that I have an answer
24 that's going to be helpful for you on that.
25 SENATOR WHITE: Okay.

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1 FEMALE ATTENDEE 2: So when the PBMs do
2 negotiate with different health insurance plans,
3 they will get what -- your operation is for the
4 health insurance, and so it's different. The
5 contracts will be different probably for different
6 companies for their different populations.
7 MR. HOLLAR: I suppose that's right. I don't
8 know that. That would make sense.
9 FEMALE ATTENDEE 2: So I mean I'm just trying
10 to --
11 MR. HOLLAR: MVP is a large -- you know, the
12 Vermont operation is only about 5 percent.
13 FEMALE ATTENDEE 2: Right.
14 MR. HOLLAR: It has -- I don't know -- half a
15 million lives or more, so -- in the two --
16 three-state region.
17 FEMALE ATTENDEE 2: I don't know how they
18 operate. But I was just trying to think that --
19 you know, how they would -- you know, how much
20 focus you would put in certain areas, you know,
21 depending on the health plan population, you know,
22 a huge, young group you're insuring or a huge old
23 group, or, you know, they're all equal, what
24 issues, what kind of drugs and what kind of
25 experience is out there. It must be according to

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1 how the PBM was able to -- you know, the last
2 person on the phone, if they need a lot of Aricept
3 in this health plan and, you know --
4 MR. HOLLAR: Right.
5 FEMALE ATTENDEE 2: -- they really put the
6 pressure on to get the low price for the Aricept
7 and et cetera, et cetera.
8 MR. HOLLAR: Well, yeah. I think that's
9 right. I would assume that volume would translate
10 into lower costs, just like in any industry; but I
11 don't think that would affect -- this bill wouldn't
12 deal with volume. It deals with transparency. So
13 I don't think that size is going to make a
14 difference in terms of the information that you get
15 or the duties that are required by the --
16 FEMALE ATTENDEE 2: No. I was just -- I was
17 just trying to understand how they operate with
18 insurance plans. You represent the insurance
19 company --
20 MR. HOLLAR: Right, right.
21 FEMALE ATTENDEE 2: -- and how that money
22 might --
23 CHAIRMAN RACINE: John, do you have anything
24 else that you want to --
25 MR. HOLLAR: Okay.

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1 CHAIRMAN RACINE: -- that you want to?
2 MR. HOLLAR: That's it.
3 CHAIRMAN RACINE: Okay. See you.
4 MR. HOLLAR: Thank you very much.
5 (Inaudible.)
6 CHAIRMAN RACINE: We're being very generous
7 today. You missed your turn and --
8 (Inaudible.)
9 MR. KIMBELL: Don't think I don't appreciate
10 that.
11 SENATOR WHITE: Can you blame him, however,
12 for waiting outside instead of in here?
13 CHAIRMAN RACINE: (Inaudible.)
14 Steve, I don't know if you were in the room.
15 We're trying to limit it to fifteen minutes and
16 opportunities to communicate in other ways. And --
17 and as we start working through this bill as a
18 committee, there will be other opportunities, if
19 there are other issues that you want to explore.
20 MR. KIMBELL: I think I'll try to speak for
21 less than fifteen minutes; and if you do have any
22 questions, that will be fine.
23 Mr. Chairman, my name is Steve Kimbell. I'm
24 an attorney and lobbyist in Montpelier. I'm here
25 today on behalf of the corporation whose name is

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1 IMS Health. IMS Health is in the business of
2 collecting, packaging, and selling health care
3 data. They're an e-business. They're not a
4 pharmaceutical company. They don't make or sell
5 drugs. They have the health care industry,
6 including large pharmaceutical companies, as their
7 customers for data.
8 It is, incidentally, exactly the kind of
9 business, as I understand, the general public
10 policy discussion that we're trying to encourage in
11 not only Vermont but the economy generally. That's
12 just an aside and not well within this bill.
13 I did want to remind the committee that this
14 section of the bill, Section 13, on -- is a
15 brand-new section. In my -- in my copy, it's on
16 page 24.
17 This is -- and when I was in a committee
18 discussion earlier this session about the general
19 subject of the prescription legislation, it was
20 noted that some of the provisions you've been
21 considering have passed the senate at least twice,
22 maybe three times. I'm not sure. But this is not
23 one of those, and so I hope that you will bear that
24 in mind as you consider the possible ramifications
25 of Section 13.

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1 IMS is here and has asked me to come here and
2 speak with you because this bill -- and I think
3 it's something that you'll understand that they
4 take seriously -- would shut down a significant
5 line of business for them in the state of Vermont
6 and their company that's in business. So it's
7 almost as if you said you can't sell Dodges in
8 Vermont -- or that would be more (inaudible). But
9 that's why they're interested.
10 (Inaudible.)
11 MR. KIMBELL: Right. I don't want to go
12 there.
13 CHAIRMAN RACINE: Don't go there.
14 (Inaudible.)
15 MR. KIMBELL: (Inaudible.) So that's why --
16 you know, that's why we're here. Whether you agree
17 with what the company does or not, it's a
18 significant factor when the Vermont legislature
19 considers shutting down an established line of
20 business, at least to the people who are in that
21 business. So that's why they're here.
22 I also would ask you to consider, when a new
23 piece of legislation that takes that kind of action
24 is -- is considered, who's got the burden of proof
25 about why this should happen? I don't believe

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1 there's any evidence in the record that's been
2 developed so far in this building that prescriber
3 identified data and the way it's used increases
4 pharmaceutical costs.
5 Assistant Attorney General Brill referred to
6 expert testimony in the New Hampshire litigation,
7 and I should tell the committee -- I think you've
8 heard -- a similar bill passed in New Hampshire
9 last year. It's being litigated in Federal court.
10 Some of the issues are similar to what you heard
11 about in the D.C. case. It's commerce clause. And
12 I don't know how that's going to come out, and I'm
13 not asking you to make a decision based on that.
14 But it is being litigated over there.
15 Assistant Attorney General Brill said that
16 one of the experts in that case said that the use
17 of prescriber identified data did, in fact,
18 increase pharmaceutical costs, and that's not what
19 that expert said. He said pharmaceutical marketing
20 is very effective, and that was his testimony.
21 These guys really know how to sell, and one of the
22 tools they use is prescriber identified data.
23 And I think it's a subtle distinction, but
24 there wasn't direct testimony that if you take
25 prescriber identified data away from pharmaceutical

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1 companies, they'll sell -- they won't be able to
2 sell as many expensive drugs.
3 The -- the thrust of our testimony is, with
4 those introductions, this data exists only because
5 there's a commercial reason to produce it. It's
6 very expensive to produce, and I'll describe in a
7 minute how that happens. But all the exemptions in
8 this bill for research and government projects and
9 so on, it's meaningless words on paper because the
10 data will exist. The government has proven time
11 and again that it won't invest the kind of money it
12 takes to create this kind of database.
13 And in support of that, I would ask you to not
14 take my word for it because, as I said, my client's
15 got a vested interest in this, a monetary interest.
16 We sell this stuff, and you are proposing to ban
17 it. So of course, we're not happy.
18 But if you'll look at the second document --
19 the first document in your package is simply a
20 letter from the general counsel of my client
21 summarizing what I'm going to say today.
22 The second piece is an e-mail to
23 Senator Cummings from a physician named Elliott
24 Fisher who works over at Dartmouth in the Center
25 for the Evaluative Clinical Sciences. And he urges

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1 caution based on the need for this data in his
2 research, which I think some of you are familiar
3 with. His outfit does the variation research that
4 allows us to study different practices among
5 physicians regionally and try to figure out what's
6 best. So he's urging caution in restricting the
7 creation and use of this data. He said he would
8 prefer -- this is the third-to-the-last paragraph:
9 Although my preference would be for strong
10 Federal investment in a national private public
11 claims of prescribing database -- and I have argued
12 for it -- this is unlikely in the current funding
13 environment.
14 So the implication of Dr. Fisher's e-mail is:
15 I need this data to continue my work and please go
16 cautiously in legislation that might ban it.
17 The second document I'd ask you to look at has
18 got a header on it, right after that, "Northern
19 Economic Consulting, Inc." That's a company owned,
20 in part, by Arthur Woolf, who is an economist in
21 Vermont.
22 I hired Art to analyze this legislation and to
23 provide this letter. So you should take that into
24 account. But I think his reputation in this state
25 is such that he's not going to say what I want him

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1 to say. And I didn't edit this. This is what he
2 provided to me, and it's his analysis.
3 In the beginning of his second paragraph, he
4 says: If it passed, this section of the bill would
5 effectively end the ability of economists,
6 government officials, public policy analysts, and
7 other researchers to evaluate physicians'
8 prescription drug prescribing patterns. I have
9 recently been reading through some economic
10 journals, articles that have used the IMS data --
11 and by the way, Dr. Fisher refers to these too.
12 There's simply no way that these studies could have
13 been undertaken without the data. If the studies
14 were not done, we would know less than we do now
15 about characteristics of physicians and their
16 practices.
17 So I hope that you will take into account
18 those two at least relatively impartial sources.
19 They don't make their living selling this data.
20 One of them I hired to give me an analysis. The
21 other was -- spoke on his own volition because of
22 his concern about his work at Dartmouth, and I hope
23 you take that into account.
24 The fourth document I'm going to just point
25 out to you. You were given this yesterday by

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1 Laurie [sic] Corcoran who was one of your
2 witnesses. It does point out -- this is a
3 description of the AMA opt-out program.
4 It does point out that they did a Gallup
5 survey of physicians, and I won't read it to you.
6 But the net of that was about 84 percent of
7 physicians said that the opt-out option satisfied
8 their concerns about their prescriber data being
9 available to -- to pharmaceutical marketers.
10 Lastly, Mr. Chairman, I just would like to
11 appeal to your common sense here. It has long been
12 the practice of pharmaceutical companies to try to
13 figure out physician prescriber patterns and to
14 base their marketing on that.
15 And before this kind of data was available, it
16 was done through legwork. The marketers, the
17 salespeople got out and talked to pharmacists and
18 talked to physicians and talked to pharmaceutical
19 companies and figured out -- talked to senior
20 citizens groups, and figure out who was prescribing
21 what.
22 The availability of this data has made that
23 work much more efficient; and therefore, marketing
24 forces are shrinking. Pharmaceutical companies
25 don't need as many marketers on the street because

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1 of the data that my client can provide them. And
2 it has some very useful purposes, as you learned
3 yesterday from that (inaudible) and safety letter
4 about Federal safety programs. But it also -- I
5 think actually, if you pass this bill, you will be
6 increasing the cost of marketing. So that's my
7 last point, and I'd be glad to take your questions.
8 SENATOR WHITE: I have two that -- to your
9 last point here that they've been able to -- to
10 reduce the marketing forces because -- did that
11 actually -- did that result in a reduction in the
12 prices when they were able to do that because
13 you're saying that if we pass this, so that they
14 have to use that legwork again, it'll increase the
15 prices? But when they were able to reduce the
16 sales force or the marketing force, did it actually
17 result in a reduction of prices because, if it
18 didn't, then there's no reason to assume that it'll
19 increase it if they have to put them back.
20 And the second question is: I think you're
21 saying that -- and none of these people address the
22 commercial use of this property.
23 MR. KIMBELL: None of those people --
24 SENATOR WHITE: It was all in their packet.
25 What they talked about was the need to have the

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1 information for research capabilities, and they --
2 they didn't address the commercial use aspect of
3 it. But what you're saying is that --
4 (Inaudible.)
5 SENATOR WHITE: If there isn't a commercial
6 use that -- if you can't sell it for a commercial
7 use, there's not going to be the information?
8 MR. KIMBELL: Both Art Woolf and Dr. Fisher do
9 make that point in their -- and I'm not -- I know
10 you haven't had a chance to look at this, Senator,
11 until just now. But that point about their
12 apprehension, at least, that the data won't at
13 least -- and I think Art Woolf states that
14 categorically that it won't exist.
15 SENATOR WHITE: But they don't -- they don't
16 address the issue of the commercial use of it as it
17 relates to --
18 MR. KIMBELL: Whether it's good or bad.
19 SENATOR WHITE: Right.
20 MR. KIMBELL: No. You're absolutely right.
21 That's where I'm appealing to your common sense.
22 If I'm a pharmaceutical executive and I need to
23 market, I need resources to do it. Maybe you'd
24 rather that I didn't, but I do think that at some
25 level they've got a right to do that. And how do

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1 they do it? I know, from talking to these folks,
2 they used to get this same prescriber data by just
3 legwork, and now they get it much easier, and they
4 don't need as many marketers.
5 SENATOR WHITE: And did it reduce the cost?
6 MR. KIMBELL: Well, that was your first
7 question.
8 SENATOR WHITE: Right.
9 MR. KIMBELL: And I think you heard -- and it
10 was a good little snippet but not nearly enough --
11 from Laurie Corcoran yesterday. The pricing of
12 pharmaceuticals is much more complex than being
13 able to say: All right. This cost was reduced, so
14 we'll reduce prices.
15 SENATOR WHITE: Right.
16 MR. KIMBELL: There are a hundred
17 pharmaceutical companies, at least. They sell to
18 three wholesalers, as Miss Corcoran told you
19 yesterday. And the wholesalers sell probably to
20 either PBMs or direct to chain pharmacies. And
21 that pricing depends on neighborhood and the
22 competitive environment, what new drugs are coming
23 on, when patents -- how long patents --
24 SENATOR WHITE: Right.
25 MR. KIMBELL: So I don't think I can tell you,

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1 Senator, that there's a direct line between a
2 reduction in marketing force and the cost of drugs.
3 SENATOR WHITE: But you're -- your supposition
4 is that it will increase the cost. So if it
5 doesn't work this way, why --
6 MR. KIMBELL: I'm glad you're pursuing this
7 because what my testimony is is you will increase
8 the cost of marketing --
9 SENATOR WHITE: Right.
10 MR. KIMBELL: -- with this bill. Now, do
11 those costs get passed on? As I just said, I think
12 that pricing mechanism -- I won't go back to cars.
13 SENATOR WHITE: Right.
14 MR. KIMBELL: You know, what you get a car
15 for --
16 SENATOR WHITE: Right.
17 MR. KIMBELL: -- isn't always a factor of the
18 costs that went into it.
19 SENATOR WHITE: Right.
20 MR. KIMBELL: So I think -- I don't think
21 there's a direct connection. What I do think is
22 clear, common sense should tell you, this section
23 of the bill will increase the cost of
24 pharmaceutical marketing because they're going to
25 market.

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1 SENATOR WHITE: Common sense doesn't tell me
2 that at all because it didn't work the other way
3 when you reduced it. So I'm not convinced about
4 that. And I do have some concerns about that.
5 MR. HOLLAR: It did reduce -- it did reduce
6 the cost of marketing. That's my testimony, the
7 cost of marketing.
8 SENATOR WHITE: No. It didn't reduce the cost
9 of the drugs. I'm not concerned about the cost of
10 their marketing.
11 MR. KIMBELL: Well, that's what --
12 SENATOR WHITE: I'm concerned about the cost
13 of the drugs. How they -- how they determine how
14 much they're going to put into marketing and how
15 much they're going to put into profits is their
16 decision. So --
17 MR. KIMBELL: And that's not what this bill is
18 about obviously. I just think this mechanism, as
19 an attempt by the government to do something
20 positive, is actually counterproductive, if I
21 understand your goal. And I realize -- that's why
22 I appeal to common sense because people differ
23 about what good sense is.
24 I did want to just make one other point. I
25 believe Attorney General Brill testified that the

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1 AMA opt-out program was really I think the other
2 committee used the term red herring because the
3 data could be obtained otherwise. That's just not
4 true.
5 The AMA has contracts with companies, like my
6 clients, that they are the exclusive database that
7 they'll use. And even when those contracts
8 expire -- they're usually two years long -- the
9 conversion to using some other ID for physicians
10 would just be hugely expensive. And the other
11 sources, mostly the state registry lists and the
12 Drug Enforcement Administration lists, are not as
13 complete and they're duplicative. You could have
14 the same number for a doc in New York as you could
15 have in Vermont. So the notion that the AMA
16 opt-out isn't an effective remedy, if physicians
17 don't want to be contacted, is -- is not true.
18 And the last point is there's no physician in
19 the world who has to see a pharmaceutical marketer.
20 The remedy for obnoxious marketers is don't see
21 them again, and that's in the hands of the
22 physicians.
23 FEMALE ATTENDEE 1: I just -- I'm just going
24 to read this to you from this conference that's
25 being put out on: The absence of prescriber level

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1 data should not be thought of as a bad thing.
2 Pharmaceutical companies can put the spin to work
3 and turn this into an opportunity to develop
4 smarter sales representatives.
5 I mean it seems to me that the pharmaceutical
6 companies are already -- I mean I know that this
7 doesn't help your client, but the pharmaceutical
8 companies are already trying to figure out how to
9 put the spin on this and -- and use other -- other
10 data sources. Do I misunderstand this?
11 MR. KIMBELL: Well, I haven't seen that
12 document.
13 FEMALE ATTENDEE 1: It's a conference that's
14 being held.
15 MR. KIMBELL: But it sounds like you're
16 arguing on my side of the issue, that you could
17 pass this law -- I mean I don't -- but there are a
18 lot of ways to gather data. I mean you're
19 almost --
20 FEMALE ATTENDEE 1: Right.
21 MR. KIMBELL: I mean you're almost putting the
22 finger in the dyke. Data -- the word transparency
23 is probably better in the long run, more
24 information. And by the way, this bill references
25 patient identifying information. It's got nothing

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1 to do with that. HIPAA prohibits that. I don't
2 know why it's even in the bill. But we are talking
3 about prescriber data, not patient data.
4 FEMALE ATTENDEE 3: So the commercial use,
5 that's what you are already testifying your company
6 is selling this data?
7 MR. KIMBELL: Right.
8 FEMALE ATTENDEE 3: And so if we don't -- if
9 we pass this, they can't sell the data
10 commercially. So you want us to say they can sell
11 it for research or they can sell it for just
12 certain things?
13 MR. KIMBELL: No.
14 FEMALE ATTENDEE 3: They can't sell it just
15 for, you know, commercial bottom line to increase
16 the sales of drug companies?
17 MR. KIMBELL: No. The bill says you can sell
18 it for research. My testimony is, unless there's a
19 commercial purpose, the data won't exist because
20 it's very expensive to produce. So all those
21 exemptions in the bill are just empty words.
22 You're putting all of those out of business, as
23 well as the use for marketing.
24 FEMALE ATTENDEE 4: I guess some of the
25 frustration is that, you know, we're seeing data

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1 mining and the data from the health care system
2 being sold and a profit being made on it, and at
3 the same time we're not seeing a decrease in the TV
4 ads and the magazine ads and everything else that's
5 going on directly to the consumer. So that's kind
6 of -- there's that tension there with, you know,
7 information is going from the prescriber to the
8 company and then back to benefit the company again.
9 And -- but we're having -- and you say there
10 have been some cost savings perhaps in that. But
11 we haven't seen any translation to a need to
12 decrease the advertising directly to the consumer.
13 So I think that --
14 (Inaudible.)
15 MR. KIMBELL: Pharmaceutical companies are in
16 business to make money. I mean there's no question
17 about it.
18 FEMALE ATTENDEE 4: Yeah, absolutely. They
19 are in business to make money. And if we don't
20 have them, we don't have -- we don't have
21 effective -- clinically effective drugs.
22 MR. KIMBELL: And I just don't understand
23 why -- I mean I don't have a commercial television
24 for the simple reason I got sick of the ads, not
25 just pharmaceutical ads, but all sectors of the

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1 economy. So I don't know if this is a broad-based
2 attack on advertising, which I would sympathize
3 with wholeheartedly.
4 (Inaudible.)
5 MR. KIMBELL: They're the best? Okay.
6 Well --
7 (Inaudible.)
8 CHAIRMAN RACINE: Any other questions?
9 Steve, do you have anything else that you want
10 to --
11 MR. KIMBELL: No. Thank you for your
12 patience. I'm sorry that I was late. I appreciate
13 the time.
14 CHAIRMAN RACINE: Thank you.
15 Now we've got Sharon Shreet. We're going to
16 try. She's going to talk about the bill, right?
17 We've heard her before.
18 (Inaudible.)
19 CHAIRMAN RACINE: Senators of the committee,
20 while Jan is trying to get Sharon Shreet on the
21 phone, we have testimony that's arriving by
22 (inaudible) from --
23 FEMALE ATTENDEE 4: So I have a question,
24 Mr. Chair.
25 CHAIRMAN RACINE: Of?

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1 FEMALE ATTENDEE 4: Of just Robin.
2 CHAIRMAN RACINE: Okay.
3 FEMALE ATTENDEE 4: The law reads that you can
4 (inaudible) IMS. I couldn't get this information
5 about all the docs in Vermont prescribing drugs
6 from the pharmacies in Vermont?
7 MS. LUNGE: You want to set up a competing --
8 FEMALE ATTENDEE 4: Yes. I want to set up a
9 competing conference with the docs --
10 (Inaudible.)
11 MS. LUNGE: You would get the AMA list and
12 then revise that --
13 (Inaudible.)
14 FEMALE ATTENDEE 4: -- to the pharmacies that
15 I really care about the drug industry and research
16 and stuff and I'm trying to get a handle on who is
17 prescribing what here or something. I'm a grad
18 student or I'm a --
19 (Inaudible.)
20 FEMALE ATTENDEE 4: So I could just go to the
21 pharmacy and get that information? Is there any
22 law prohibiting that?
23 MS. LUNGE: The pharmacy would have to remove
24 some of the information because of HIPAA. So
25 they -- there's only certain parts of all the data

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1 the pharmacy (inaudible). And then I think the
2 process that was prescribed is that, in terms of
3 prescriber data, you get the AMA list which has the
4 doctor's number, and you get the pharmacy data --
5 (Inaudible.)
6 MS. LUNGE: And whoever you buy that from,
7 then you would match them --
8 (Inaudible.)
9 MS. LUNGE: -- and identify who is the
10 prescriber. That's sort of how --
11 (Inaudible.)
12 CHAIRMAN RACINE: Was there anybody else in
13 the room? We don't have any more on the list.
14 Yes, sir.
15 MR. FRIEDELL: Yes, sir. I stuck around from
16 yesterday. There was an amendment to the PBM
17 section that we discussed, and we worked on it last
18 night, and I'll be happy to go through them now.
19 CHAIRMAN RACINE: Okay. Please reidentify
20 yourself.
21 MR. FRIEDELL: My name is Andy Friedell. I am
22 a director of government affairs for Medco. We're
23 a pharmacy benefit manager. Terry Latanich spoke
24 on our behalf yesterday. I'll pass these around.
25 CHAIRMAN RACINE: You did not speak yesterday?

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1 MR. FRIEDELL: I did not speak yesterday.
2 CHAIRMAN RACINE: Okay. Your name is Andy
3 what?
4 MR. FRIEDELL: Friedell is the last name.
5 CHAIRMAN RACINE: Spell that, please.
6 MR. FRIEDELL: F-R-I-E-D-E-L-L.
7 (Inaudible.)
8 MR. FRIEDELL: I'd better keep a copy.
9 (Inaudible.)
10 CHAIRMAN RACINE: Okay.
11 MR. FRIEDELL: There are three amendments
12 here. There are three amendments here that we
13 discussed yesterday. Two of them we spoke about
14 specifically. One we spoke generally about.
15 First, before I get into these three
16 amendments, I would like to say that our preference
17 for the committee to consider would be that you
18 strike the PBM section of this bill for reasons
19 that you have heard from other testimony. This
20 information is available. It's not necessary right
21 now. We have an intensively competitive
22 marketplace.
23 Our customers -- you just heard who this bill
24 was presumably intended to -- to assist are not
25 asking for this legislation specifically. So our

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1 concern is that if this is a bill designed to help
2 lower prescription drug costs -- and there is no
3 evidence that this provision of the bill is going
4 to help lower prescription drug costs -- we would
5 ask you to consider striking this provision in its
6 entirety.
7 In addition to that, if that's something the
8 committee is not willing to do, we would like you
9 to consider these other amendments. But we really
10 feel that's worthy of strong consideration by the
11 committee given that there is no evidence that this
12 is going to lower costs.
13 You may hear testimony from Sharon Shreet that
14 a bill was passed in South Dakota that allegedly
15 lowered costs in that state by $800,000. What you
16 should also know about that piece of information is
17 that coincides with the state also renegotiating
18 their contract with their PBM.
19 People renegotiate their contracts with their
20 PBM when they want to lower costs. In fact, there
21 was testimony given to the Senate Finance Committee
22 that the State of Vermont actually renegotiated
23 their contract with Express Scripts and recently
24 lowered their costs by over 10 percent, 2.8 million
25 on the total drug spend of 21 million.

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1 So you renegotiate your contract with your PBM
2 to lowers costs. You put it out to bid. You try
3 to get a better deal. That's what happened in
4 South Dakota. So that was not in relation to
5 the -- to the -- to the legislation. It was in
6 relation to a new contract that -- so I would ask
7 you to consider that when you hear that piece of
8 evidence or if that's presented.
9 Specifically there are three amendments we're
10 asking you to consider here. I will pick first
11 from Section 9421, Pharmacy Benefit and Management
12 Registration and Audit. This was the issue Terry
13 Latanich spoke about yesterday. Our concern here
14 is that this administrative pass-through only
15 option is a requirement, and we want to make sure
16 that -- that this -- this is not a requirement on
17 all PBMs that it's as intended. And you spoke --
18 yes?
19 CHAIRMAN RACINE: Which one are you looking
20 at?
21 MR. FRIEDELL: It's this one here. It says
22 9421 Pharmacy Benefit and Management Registration.
23 CHAIRMAN RACINE: Thank you.
24 SENATOR WHITE: It's on our page 19 as well.
25 CHAIRMAN RACINE: Thank you.

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1 MR. FRIEDELL: From our discussion yesterday,
2 I understand the committee's intent here is that
3 the option is available and that it's not that
4 every PBM has to offer. Our concern with the way
5 it was worded is that you have -- because you say,
6 when you offer a bid on a contract, you also have
7 to offer this administrative services arrangement,
8 and that's not necessarily how everyone is going to
9 want to contract.
10 And so we would like to have language inserted
11 here that would reserve the right for some pharmacy
12 benefit management to not contract on those terms
13 and to -- just to simply make the client aware
14 that, if that's the way they want to do business,
15 then this particular PBM may not want to offer that
16 but that it's available in the marketplace for
17 them.
18 SENATOR WHITE: Isn't that what it says?
19 MR. FRIEDELL: It says --it says that -- our
20 menu is in there.
21 SENATOR WHITE: No. I mean it says: Shall
22 notify that a quotation for an ASO is available.
23 That's what it says.
24 MR. FRIEDELL: When the -- when the
25 pharmacy -- if you look at the strike section of

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1 the proposal, it's saying when the pharmacy benefit
2 management provides a quotation for any --
3 SENATOR WHITE: Right.
4 MR. FRIEDELL: So our concern is that they're
5 saying it's available from us, and that's --
6 SENATOR WHITE: Was that the intent?
7 MS. LUNGE: Yes.
8 SENATOR WHITE: To say that it's available
9 from them so that what we're -- what we would be
10 doing is requiring all PBMs to offer an
11 administration only, service only contract and you
12 don't necessarily do that?
13 MR. FRIEDELL: We may not do that. I mean
14 that's -- that's -- we don't want to be restricted
15 in the way that this legislation requires you to
16 offer that. I mean there are PBMs that will do
17 that, and there are PBMs that will compete on that,
18 and that will be something that's available in the
19 marketplace.
20 SENATOR WHITE: I read that differently, and I
21 guess I read it --
22 MR. FRIEDELL: And that was our discussion
23 yesterday during the hearing.
24 SENATOR WHITE: -- the way it wasn't intended.
25 MR. FRIEDELL: I thought -- from our

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1 conversation here yesterday, I thought you agreed,
2 or the committee agreed, that your read of it was
3 correct and that we needed -- we said we'd provide
4 you this language to just insure that your read was
5 correct. That's the first amendment. And I do
6 want to take questions or PBM issues in general.
7 The second one I'll bring up is the
8 prescribing piece. This is 2466A, Consumer
9 Protection of Prescription Drugs. This, again, I
10 think was something that was simply a
11 misunderstanding and was not the intent of the
12 bill. But our concern is that the language around
13 marketing and messaging has some language in there
14 that specifically prohibits software that is used.
15 It says: Electronic software that advertises,
16 uses instant messaging or pop-up messaging, or uses
17 other means to influence, or attempt to influence,
18 the prescribing decision of a health care
19 professional through economic incentives or
20 otherwise.
21 That's a very broad piece of language there,
22 and we want to make sure that you're not referring
23 strictly to the formulary because that formulary
24 discussion that the patient and the doctor can have
25 is specifically designed to influence the decision

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1 that -- the prescribing decision of the physician.
2 If there's a lower-cost alternative out there,
3 well, we think the physician and the doctor should
4 have that information to know there is a lower-cost
5 alternative. And we're -- we're fearful -- and I
6 think we said yesterday that that was not the
7 intent of this bill. But we are fearful that the
8 way the language was crafted is too broad and that
9 you need this additional -- this additional
10 exemption at the end which says that it's not in
11 relation to formulary compliance programs.
12 FEMALE ATTENDEE 3: What page is that on?
13 MS. LUNGE: 35.
14 MR. FRIEDELL: The third amendment that we
15 offered is in relation to page 20. This is the
16 registration audit piece, and I think this is one
17 we heard about in the past from testimony from MVP
18 Health that there are additional costs that this
19 bill could add to the pharmacy benefit management
20 provision.
21 And in here you'll see under C.1, there's a
22 section that says: In order to enable periodic
23 verification of pricing arrangements, ba, ba, ba,
24 ba, we have to verify the following. And there's
25 A, B, and C. There's an incredibly broad piece of

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1 language here.
2 It says: Any other verifications relating to
3 pricing activities of the pharmacy benefit manager
4 are required by the commissioner.
5 If this is broadly intended on all business,
6 and not simply the administrative services option,
7 that's a -- that's a very broad change to the
8 statute, and that would have pricing implications
9 on business in this state. So we have presented
10 amendment language here that limits that C.1 to the
11 administrative services -- administrative services
12 only contract that's being discussed in that
13 particular section.
14 CHAIRMAN RACINE: Is this your copy offering
15 administrative services only contract?
16 MR. FRIEDELL: I believe we do. We have cut
17 arrangements where we'll -- where we'll just offer
18 on a -- we'll price on administrative services, you
19 know. Basically what happens is we get a request
20 for a proposal from a customer. We evaluate the
21 terms. The customer will say: We want an
22 administrative services contract from you.
23 We will evaluate that, and we will decide
24 whether we want to compete on that business. So
25 it's not as though we say we're a company that

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1 offers administrative services contracts and we go
2 knocking on doors with that offering. We wait oon
3 requests for proposals that come to us. We look at
4 all the terms of it.
5 And it's difficult to say -- you know,
6 characterize one RFP, this is an administrative
7 services RFP, this is not one. But you know,
8 because they tend to be -- RFP can tend to be
9 several hundred pages. We go through, and our
10 folks in our proposals department will go through,
11 and evaluate the terms of that, and then we decide
12 if we're going to bid on that business and what the
13 terms of our bid will be.
14 But we have a variety of different terms on
15 contracting. In fact, contracting across our
16 industry is very versed. Every customer has
17 different contracts, and that's what our concerns
18 generally with legislation of this sort is, that it
19 can pigeonhole customers into certain arrangements.
20 MALE ATTENDEE 1: Where do you work?
21 MR. FRIEDELL: Excuse me?
22 MALE ATTENDEE 1: Where do you work?
23 Physically where do you work?
24 MR. FRIEDELL: Today I'm in Vermont. But I --
25 I have responsibility for the northeast. Medco is

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1 headquartered in New Jersey. My office is in
2 Province. I drove up from Province yesterday.
3 CHAIRMAN RACINE: Okay.
4 FEMALE ATTENDEE 2: And you've got to go back
5 before midnight.
6 MR. FRIEDELL: Well, I hear snow is coming.
7 CHAIRMAN RACINE: It's not going to come until
8 midnight?
9 SENATOR WHITE: Yeah.
10 CHAIRMAN RACINE: Okay. Thank you.
11 MR. FRIEDELL: Great. Oh, the other piece I
12 would suggest though, our primary interest in
13 striking section -- the other piece we would like
14 you to consider striking as well is the enforcement
15 provision because that was also mentioned yesterday
16 was the dual enforcement division between the AG's
17 office and the -- BISHCA.
18 SENATOR WHITE: And then it would just reside
19 with BISHCA?
20 MR. FRIEDELL: Right.
21 FEMALE ATTENDEE 3: Let me just ask one
22 question. The administrative service contract only
23 is -- means what?
24 MR. FRIEDELL: So basically, when you have a
25 PBM contract, you have a variety of ways of doing

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1 it. But we can now -- you know, we can have an
2 arrangement where we will -- you know, where we
3 will -- so we negotiate on behalf of our customers.
4 We have sixty million lives. We negotiate with
5 drug manufacturers. We negotiate with pharmacies.
6 We will negotiate rebates with drug manufacturers,
7 and -- and that's for our full book of business and
8 same with pharmacies, for our full book of
9 business.
10 Some customers will say: We simply want you
11 to administer our drug benefit and we're going to
12 pay you on a per claim basis, say a dollar a claim,
13 and that's -- that's all we want you to do.
14 That's typically what happens on Medicaid
15 contracts. People that get into the Medicaid
16 business will -- will just be paid, you know, a
17 certain set amount for every drug claim, and then
18 that's that little adjudication issue you were
19 talking about before. So when a person goes into a
20 pharmacy, they swipe that card. You're using our
21 system. We're -- you know, we're paying the
22 pharmacy, billing you back, and we're just getting
23 paid a set fee for that service.
24 FEMALE ATTENDEE 3: And you are not
25 negotiating prices for that drug with the

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1 pharmacies?
2 MR. FRIEDELL: Yes. We can have a -- we can
3 have a component of it that -- you can offer that
4 as well where you can have a discount --
5 FEMALE ATTENDEE 3: How about a services only
6 contract?
7 MR. FRIEDELL: You can have that. I mean
8 that's why it's difficult to comment -- to sort of
9 characterize a contract like this with this kind
10 of, you know, phrase like, as if there's Contract A
11 and Contract B because it really doesn't exist that
12 way in the marketplace today.
13 A customer can say: We want you to give us a
14 retail network discount. And then we'll negotiate
15 here, but we can offer you AWP minus on brands and
16 AWP minus on generics.
17 And then they'll look at our competitors and
18 see what they're offering.
19 And then we can say: You know, we have a mail
20 service option, which your members may be
21 interested in, where we can offer you deeper
22 discounts, if they want to use mail. We can offer
23 you rebates, which we can pass through to you
24 directly, or we can keep the rebates ourselves, in
25 which case we're at risk for the rebates and for

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1 which you get a deeper discount on those -- on
2 those network prices.
3 So those are -- you know, those are all the
4 various questions that go in.
5 Typically the administrative services
6 contract -- basically it's just a fee on each
7 claim, and there aren't the rebates involved,
8 information of that sort. There aren't a lot of
9 other services provided for the client.
10 FEMALE ATTENDEE 3: So I can see (inaudible)
11 population you're --
12 MR. FRIEDELL: Yeah.
13 FEMALE ATTENDEE 3: -- dealing with a lot --
14 MR. FRIEDELL: Well, but also it's how it
15 works for the client because we respond to the
16 client's bid. If you look in that testimony that
17 was given to finance from the State of Vermont, you
18 changed your formulary; and that was what really
19 generated that $2.1 million savings. You
20 changed -- I think you restructured the tiers so
21 there was better incentives to use generics over
22 certain brands, and that's where you got that
23 savings from. So the customer made that decision.
24 You know, you, the State of Vermont, was
25 probably working with a consultant, and the

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1 consultant probably said to the state: You know,
2 if you change your tiers of your formulary, it
3 could generate savings.
4 So they talked to their PBM about that, or
5 perhaps they were dealing with the PBM directly on
6 that discussion. But if they were going to put it
7 out to bid, they would talk with a consultant about
8 that. And then, you know, they would set out the
9 terms: We want to formulate the structure in this
10 way so we can try and save more money.
11 And then we, and all our competitors, will
12 choose if we're going to bid on that piece of
13 business.
14 FEMALE ATTENDEE 3: So if we can all negotiate
15 with PBMs rather than insurance companies, wouldn't
16 that be better?
17 MR. FRIEDELL: Some do that. Some carve out
18 and some -- some don't. It's -- and that's the
19 competitive nature of our industry. I mean
20 sometimes we deal directly with, you know, a lot
21 carve-out business. Large employers will carve
22 out. Other times large employers will use, or
23 smaller employers will use, health plans, and the
24 PBM will be part of it.
25 For instance, United Healthcare is one of our

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1 clients. So people who use United Healthcare will
2 have -- make most cases for their pharmacy benefit.
3 But then other times, if it's Aetna or Cigna, they
4 have their own pharmacy benefit. And then -- and
5 then if you use Aetna or Cigna, you would use their
6 pharmacy benefit manager.
7 CHAIRMAN RACINE: Thank you.
8 MR. FRIEDELL: Great.
9 CHAIRMAN RACINE: Susan, you had something?
10 MS. GRETKOWSKI: Yeah.
11 CHAIRMAN RACINE: Quickly, please.
12 MS. GRETKOWSKI: Quickly, I promise.
13 Hello everyone, Susan Gretkowski of Maclean,
14 Meehan & Rice on behalf of PhRMA who also testified
15 yesterday.
16 I would just like to talk briefly to one very
17 specific point in this bill that was discussed
18 yesterday by PhRMA, and that was the unconscionable
19 pricing. I think there was a question of what were
20 the differences that the drafters, Robin, has put
21 into the Vermont bill versus how is the D.C.
22 statute structured and will that make a difference
23 on a ruling of whether the Vermont law would be
24 held to be constitutional or not.
25 I can run through very quickly some of the

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1 differences between the two laws and then, you
2 know, basically say why did they -- it will not
3 make a difference in terms of the determination of
4 constitutionality.
5 One of the differences: The D.C. law pegged
6 the determination of an excessive price to 30
7 percent above what was charged in a high-income
8 country. The Vermont bill talks about 30 percent
9 over the lowest price that could be obtained in
10 state, basically the Federal supply schedule, a
11 Medicaid pricing, something like that. So that's
12 one difference.
13 The D.C. law only covered patented drugs in
14 what would be subject to this determination of
15 unconscionable price. The Vermont law covers all
16 drugs, patented drugs, non-patented drugs. Robin
17 said yesterday there was -- she used a different
18 definition of most favorite price. She used one
19 from the Wisconsin statute.
20 But probably the most significant difference
21 between the two are, the way the D.C. law works, is
22 it says that: Any drug would be determined to be
23 considered unconscionably priced if it is
24 30 percent or more over the price charged by four
25 defined high-income countries.

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1 What Robin and folks -- and Julie and folks
2 have done here in the Vermont proposal is to say
3 not every drug just determined on its face will be
4 determined that way, but the health department will
5 determine whether there is a serious health problem
6 and what goes into those determinations, and then,
7 if there's a condition that's said to be a serious
8 health problem, drugs to treat that condition would
9 then be subject to that 30 percent or more above
10 the Federal supply schedule and all of that. So it
11 appears that that is what --
12 MALE ATTENDEE 1: (Inaudible) in light of the
13 court decision?
14 MS. GRETKOWSKI: Yes, which I'm going to get
15 to right now. So basically those changes would not
16 make a difference on a ruling on the
17 constitutionality of the Vermont statute.
18 First, it is still a transaction that occurs
19 outside the state. You've still got an
20 out-of-state manufacturer and an out-of-state
21 wholesaler. There is one exception to that, which
22 is Burlington Drug. They are an in-state
23 wholesaler. So for that tiny piece of the
24 business, which is about 20 percent of the drugs
25 coming into Vermont, that you could touch by what

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1 you -- if you pass this section of the bill.
2 However, the 80 percent of the drugs that come into
3 Vermont through out-of-state wholesalers you would
4 not be able to touch. So it's still a problem with
5 the interstate commerce clause.
6 However, there is very specific language in
7 the D.C. decision that addresses this police power,
8 compelling state interest, protection of the
9 general health and welfare of folks. And if I
10 could, this is very short. I'd just like to read
11 it. I'm sorry. I have a sucker in my mouth. I've
12 got a cough.
13 FEMALE ATTENDEE 1: There's a lot of suckers
14 around here.
15 MS. GRETKOWSKI: And this is at the very end
16 of the section on the interstate commerce clause
17 from the D.C. District Court.
18 It says: Finally, the District's reliance on
19 its general police powers to regulate matters of
20 legitimate local concern is to no avail in this
21 situation. While the District clearly retains such
22 police powers, creating a public health exception
23 to the commerce clause, such as the one advanced
24 here, would, quote, eat up the rule under the guise
25 of an exception.

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1 It says: The view that an ordinance is valid
2 simply because it professes to be a health measure
3 would mean that the commerce clause of itself
4 imposes no limitations on state action other than
5 those laid down by the due process clause.
6 It says: Simply stated, the District's
7 reliance on its police powers, meaning its
8 protection of heath and welfare of its citizens,
9 alone cannot overcome the otherwise
10 unconstitutional reach of the law.
11 So I would just say to you that again, you
12 know, there were attempts to change this to pass
13 constitutional muster; however, this is very clear
14 language. A lot of the times constitutional law
15 cases are not always that clear on their face to
16 understand what they're actually saying. This is
17 very clear language. So even taking that
18 compelling state interest attempt doesn't appear
19 that that's going to pass constitutional muster.
20 So that's it.
21 Now, I know -- I know, Mr. Chair, you said
22 earlier that, as you're going to be working through
23 this bill, you are going to be talking through the
24 sections where there are issues, and you said there
25 may be an opportunity for more testimony or

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1 perhaps, if you would like, you know, a legal --
2 not a real big legal brief but more of a paper, you
3 know, on something like this.
4 CHAIRMAN RACINE: Well, you know, you can
5 leave us what you have. I will warn you that I
6 don't think of us as a court charged with making
7 judgments on constitutionality. I understand we
8 don't want to do something that on its face is
9 unconstitutional.
10 MS. GRETKOWSKI: Right. And I --
11 CHAIRMAN RACINE: But I will listen to other
12 lawyers who might argue the constitutionality. If
13 that's what -- if that's what we're going to hear,
14 then that wouldn't be compelling to me. I'd wait
15 for the courts to decide that. But I will defer to
16 other --
17 (Inaudible.)
18 CHAIRMAN RACINE: I don't know that I -- I
19 have not tried.
20 MS. LUNGE: Yeah, I called.
21 CHAIRMAN RACINE: Okay.
22 SENATOR WHITE: Yesterday when --
23 FEMALE ATTENDEE 2: Julie Corcoran --
24 SENATOR WHITE: Yeah, testified, did I
25 misunderstand her or -- because what we're trying

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1 to get here is -- at here I believe is price --
2 unconscionable pricing when -- when something
3 happens and then we have price gouging. And we
4 passed the -- last year the fuel bill. Did I
5 understand her to say that we could get at this
6 same -- the result by addressing it under that,
7 making that a general price gouging law, expanding?
8 MALE ATTENDEE 2: I think that not in the last
9 session, but the session before, when John Bloomer
10 [phonetic] was here, we had some type of emergency
11 price gouging measure that we passed.
12 SENATOR WHITE: Yeah. But it was limited
13 to --
14 MALE ATTENDEE 2: (Inaudible.) I don't know
15 if it passed all the way through, but it seemed
16 like --
17 SENATOR WHITE: But it was limited to one --
18 MALE ATTENDEE 2: I don't think so. I think
19 it was in case of emergency. That's why I --
20 SENATOR WHITE: It was a general thing?
21 MALE ATTENDEE 2: I think so.
22 SENATOR WHITE: I don't remember that one. I
23 do remember the --
24 MS. GRETKOWSKI: And that's what she was
25 talking about, you know, what she was referring to

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1 in Maine, is it covered, fuel, oil, gas,
2 pharmaceutical drugs --
3 SENATOR WHITE: Right.
4 MS. GRETKOWSKI: You know, everything. And
5 basically the governor could, you know, in a really
6 severe state of emergency, you know, not a
7 blizzard, but a really severe state of emergency,
8 the governor would declare that; and then there
9 would be a freeze of pricing for thirty to sixty
10 days and a maximum of sixty days. That's what she
11 referred to in Maine. Apparently several states
12 have passed those in light of the Katrina
13 situation.
14 So that if -- you know, if that's what your
15 focus of this is trying to be, if there truly is a
16 disaster or an emergency of like epic proportions,
17 if you wanted to protect the price of
18 pharmaceuticals going up, you know, the avian flu,
19 that type of thing, the law, like she referred to
20 in Maine, should do that.
21 SENATOR WHITE: So it wouldn't have to
22 necessarily be a Katrina level of --
23 (Inaudible.)
24 SENATOR WHITE: Yeah.
25 MS. GRETKOWSKI: Apparently, from the ones

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1 they tell me, the ones that have passed, they are
2 very severe. They're not just a blizzard, an ice
3 storm. It's really severe.
4 SENATOR WHITE: But since we're talking --
5 okay. I mean if we had an outbreak of -- I don't
6 know -- what --
7 CHAIRMAN RACINE: Bird flu.
8 SENATOR WHITE: Bird flu or whatever, that
9 would -- that probably would be. Okay.
10 Let's get a copy of -- it was public law
11 Chapter 5.
12 MS. GRETKOWSKI: I have that. I can e-mail it
13 to you.
14 SENATOR WHITE: Okay.
15 CHAIRMAN RACINE: That would be helpful.
16 SENATOR WHITE: I would like to see that.
17 MS. GRETKOWSKI: Okay.
18 CHAIRMAN RACINE: Okay.
19 MS. GRETKOWSKI: Thanks for your time.
20 CHAIRMAN RACINE: All right, folks. Thank
21 you.
22 SENATOR WHITE: Thank you.
23 (Inaudible.)
24 CHAIRMAN RACINE: Who?
25 (Inaudible.)

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1 CHAIRMAN RACINE: No, no, not right now, not
2 right now.
3 So I'm not sure we are going to be here
4 tomorrow afternoon, given the weather. I think
5 some people are planning to head home tonight.
6 SENATOR WHITE: What is happening? I haven't
7 heard.
8 CHAIRMAN RACINE: It's supposed to start
9 snowing at midnight. It's supposed to -- depending
10 on which forecast, several inches of snow by
11 sometime in the morning, sleet mid-day, and then
12 snow again. One forecast says up to a foot.
13 Another one says twelve to fifteen, more north than
14 south. But it sounds like it's going to be a very
15 ugly day tomorrow.
16 MALE ATTENDEE 2: So Burlington will be hit
17 but Rutland won't?
18 (Inaudible.)
19 CHAIRMAN RACINE: See, what we have to be more
20 concerned about --
21 (Inaudible.)
22 CHAIRMAN RACINE: What we ought to be more
23 concerned about, Senators, it isn't snow. It's
24 Stowe and Killington.
25 (Inaudible.)

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1 CHAIRMAN RACINE: That would be I think the
2 concern.
3 (Inaudible.)
4 CHAIRMAN RACINE: But anyway, I'm going to
5 leave tomorrow open. There are a few things
6 kicking around. We can discuss this bill as a
7 committee. There's still the HIV bill out there.
8 There are other things. One thing I'm -- and
9 we'll -- we'll have to come back to this.
10 (Inaudible.)
11 CHAIRMAN RACINE: I don't know if you guys --
12 MALE ATTENDEE 3: I heard one comment about an
13 amendment that had been offered earlier, but I
14 don't know how to present that to you.
15 CHAIRMAN RACINE: Okay. Then we'll be back at
16 this.
17 MALE ATTENDEE 3: I didn't want to interrupt,
18 if you were -- if there would be an opportunity
19 now.
20 CHAIRMAN RACINE: Okay. We'll be -- we'll be
21 back at this.
22 SENATOR WHITE: They said we don't need to do
23 a lot of this because BISHCA takes care of all the
24 regulation --
25 CHAIRMAN RACINE: Right. I'm not sure what

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1 you're saying to me. Do you want to do something
2 now or do you want to wait until --
3 MALE ATTENDEE 3: It was an amendment offered
4 by Josh Slen that he wanted you to think about. We
5 have a problem with it.
6 MS. LUNGE: And you haven't -- you haven't
7 gotten that language yet.
8 SENATOR WHITE: Which we haven't seen.
9 CHAIRMAN RACINE: We haven't seen it yet.
10 Okay.
11 MS. LUNGE: So Josh just e-mailed it to me.
12 He said it's referenced in his memo, but I haven't
13 made copies of that for you yet.
14 CHAIRMAN RACINE: Then we'll wait. Okay.
15 That's interesting. Maybe you two guys can work it
16 out, seeing as you sort of work for the same guy.
17 MALE ATTENDEE 3: Well, that's right. But I
18 didn't know if you (inaudible) --
19 CHAIRMAN RACINE: No. We aren't going to take
20 any motion today.
21 One of the things I will try to do in our
22 break and have when we get back is I'm looking for
23 some testimony or some evidence that the various
24 components of this will do what I hope we can
25 accomplish, which is lower consumer costs. And

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1 what I had -- what I see in front of us are a lot
2 of provisions, which I have opposition to them, but
3 I haven't heard clearly in many cases that what's
4 in front of us will lower consumer costs.
5 I understand that there's a hope that they
6 will reduce costs. And I didn't go through what
7 this committee has been through the last several
8 years. So maybe that testimony is out there, and I
9 can read it or I can hear about it. But I need to
10 hear more on many sections of this before I'd say,
11 yes, I can go -- I can vote for this and say this
12 is going to reduce the cost of pharmaceuticals.
13 That's going to be important information.
14 MALE ATTENDEE 2: Were we able to get any
15 information from NCSO from the other states of
16 whether or not it's actually lowered?
17 CHAIRMAN RACINE: Yeah. And Sharon Shreet
18 can -- obviously can help us. But I'm going to
19 work with Robin, and we'll talk about how we can --
20 how we can get some of this. I need -- I need to
21 hear more because we -- we set this up -- we set
22 this out there. We heard from Robin. We heard
23 from Ann. We haven't heard -- we haven't heard
24 from a lot of people who will say: This will do X,
25 Y, Z and will reduce costs in such and such a way.

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1 And I need -- I need to hear that. So just
2 so -- and that's what I'm going to look for so we
3 can discuss that on the week that we get back.
4 We've got one week when we get back before
5 crossover. And there are a few other things that
6 we're going to try to do in that time, but this is
7 the biggy. So...
8 FEMALE ATTENDEE 1: I -- I know that we --
9 people have asked before and had that deadline
10 extended. Given the fact that we lost two and a
11 half days by the other snowstorm, and now we're
12 going to lose another day --
13 CHAIRMAN RACINE: Possibly.
14 FEMALE ATTENDEE 1: -- I think it's --
15 CHAIRMAN RACINE: I'm not cancelling tomorrow.
16 I'm just saying it's possible.
17 FEMALE ATTENDEE 1: Yeah.
18 MALE ATTENDEE 2: -- work in reverse order
19 because, as long as it's passed the committee of
20 jurisdiction, it's okay. But it's already passed
21 finance, which normally would go the other way.
22 CHAIRMAN RACINE: That's a mystery to me, and
23 I'll let the pro tem decide. And in terms of the
24 deadline, this is a pro tem priority. So we'll see
25 if we -- if we aren't done, we will see what he

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1 thinks of his deadline.
2 FEMALE ATTENDEE 3: Maybe we can get him to
3 change it. Well, tomorrow could be something
4 that --
5 CHAIRMAN RACINE: But I would like -- I would
6 like to keep working on this, and we'll have four
7 more days when we get back before the deadline. So
8 you know -- and what I'm trying to do is through
9 all of this testimony I think we're narrowing down
10 those issues that are the most controversial.
11 MALE ATTENDEE 2: There is a section somebody
12 hasn't asked us for.
13 CHAIRMAN RACINE: There are lots of sections
14 that nobody has asked us to change or implement.
15 (Inaudible.)
16 CHAIRMAN RACINE: Okay. Thank you all very
17 much, and we'll --
18 (Inaudible.)
19 CHAIRMAN RACINE: And for those of you around,
20 if you are around tomorrow, you can check in and
21 see what we're talking about.
22 (Inaudible.)
23 (End of CD 07-50/Track 1.)
24
25

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1 CERTIFICATE
2
3 STATE OF FLORIDA)
4 COUNTY OF INDIAN RIVER)
5
6 I, Kristen A. Houk, Registered Professional
7 Reporter and Florida Professional Reporter, do hereby
8 certify that I was authorized to and did listen to CD
9 07-50/Track 1, the Vermont Senate Committee on Health &
10 Welfare meeting of the Thursday, March 1, 2007
11 proceedings, and stenographically transcribed from said
12 CD the foregoing proceedings and that the transcript is
13 a true and accurate record to the best of my ability.
14
15 Dated this 3rd day of December, 2007.
16
17 ______________________________
18 Kristen A. Houk, RPR, FPR
19
20
21 Job No.: 907521B
22
23
24
25

TAB L

STATE OF VERMONT

SENATE COMMITTEE ON FINANCE

2

3 Re: Senate Bill 115

4 Date: March 20, 2007

5

6 COMMITTEE MEMBERS:

7 SENATOR ANN CUMMINGS, CHAIR

8 SENATOR CLAIRE AYER, VICE CHAIR

9 SENATOR MARK MacDONALD, CLERK

10 SENATOR BILL CARRIS

11 SENATOR JAMES CONDOS

SENATOR HULL MAYNARD, JR.

13 SENATOR RICHARD McCORMACK

14 CD No: 2007 83

15 Esquire Job #928014

16

17

18

19

20

21

22

23

25

Page 2

1 ---
2 PROCEEDINGS
3 ---
4 CD No.: CD 2007 83
5 SPEAKER 1: -- but if it is okay, I would like
6 to have a little more time to prepare to go
7 through those.
8 MS. CUMMINGS: Okay.
9 SPEAKER 1: But I will talk about those. I
10 will tell you that the 11th --
11 MS. CUMMINGS: We can have you come back
12 tomorrow morning.
13 SPEAKER 1: That's okay. I can do the two big
14 ones --
15 MS. CUMMINGS: Okay.
16 SPEAKER 1: -- that are the subject of most
17 conversations around here, and I can talk to you
18 about them in general terms --
19 MS. CUMMINGS: Yeah.
20 SPEAKER 1: -- what we did.
21 I will say one that was sort of a major
22 issue when it arrived down the hall was the
23 enforcement provision. It's our 11th proposal
24 amendment, section seven of the bill, and there
25 was some discussions between the Attorney

Page 3

1 General's office and Fishka --
2 MS. CUMMINGS: Oh, yes.
3 SPEAKER 1: -- about who would have primary
4 enforcement. And basically what we did -- what we
5 did is we kept sending them out of the room until
6 they agreed, so this one --
7 MS. CUMMINGS: Oh, good.
8 SPEAKER 1: So this one maybe I will let them
9 explain it.
10 MS. CUMMINGS: Actually, I think we sent that
11 out of here somewhat uninformed. One said that
12 the Attorney General had to have the permission of
13 Fishka to enforce, and we didn't think that was
14 acceptable, and we sent them to the hall --
15 SPEAKER 1: And I think basically --
16 MS. CUMMINGS: Yes.
17 SPEAKER 1: I think basically the way we worked
18 it out, anybody in the room who has followed this,
19 if you want to correct me, I do not mind being
20 corrected, because last week became somewhat of a
21 blur, at least for me.
22 MS. CUMMINGS: This enforcement is ongoing.
23 SPEAKER 1: Right, the enforcement provision
24 basically was Fishka would retain primary
25 enforcement for any dealings with insurance

Page 4

1 companies, because that's their job, but there are
2 others who are -- who are not insurance companies,
3 that the Attorney General would be involved with
4 enforcement actions.
5 The two bigger changes, and were the
6 subject of a lot conversations in our committee,
7 and I think will be the most -- the subject of the
8 most conversation between the two committees, was
9 the so-called confidentiality of prescription
10 information, otherwise known as data mining.
11 MS. CUMMINGS: Data mining.
12 SPEAKER 1: Data mining. And we essentially
13 struck that from the bill, after quite a bit of
14 discussions. And the committee was somewhat split
15 at first, and then came to the conclusion that we
16 should, and for a variety of reasons, I think
17 every committee member had a somewhat different
18 reason for doing this.
19 It -- from my prospective, it was a
20 concern that I did not see how this reduced costs
21 for pharmaceuticals for Vermonters, and when I
22 started looking at this bill, what I said to the
23 committee and to the assembled witnesses was that
24 I was interested in reducing costs for Vermonters.
25 And I was not convinced, and I don't think anyone

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1 really tried to convince me, that this provision
2 would actually save money.
3 Now, what I heard, and what we heard, was
4 folks most interested in this was the Vermont
5 Medical Society.
6 You know, you couldn't have choreographed
7 that any better then you did, and she brought me
8 flowers, how nice. I don't think she is bringing
9 me the flowers.
10 And I understand -- and I understand the
11 concern expressed by the Medical Society that
12 their information should be -- should be
13 confidential. On the other hand, I think most of
14 us felt that the marketing is occurring one way or
15 the other, and that really it's up to physicians
16 to be able to say no if they don't want to hear a
17 certain kind of marketing or certain marketers,
18 that they have -- they have the ability to say no.
19 That they are -- that the better effort
20 for the state to make would be to put its efforts
21 into the counter-detailing and physician
22 education, and the information coming through the
23 data mining was yet more information. And from
24 my -- I know the doctors don't agree with me on
25 this, so it is hard for me to express this, but I

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1 was thinking if I was a physician and I was
2 prescribing a whole lot less of pharmaceutical X
3 than my colleagues, that's information that would
4 be worth having. I can process it. I can decide
5 whether I am right or not, but it would
6 challenge -- perhaps challenge me in my own
7 thinking, and I thought that might be of value. I
8 don't know if any physician in the state of
9 Vermont agrees with that or not.
10 That was part of -- part of my thinking.
11 I think the -- I think the bottom line for the
12 whole committee, I think it came to a unanimous
13 recommendation on this one, was that there is the
14 lawsuit underway in New Hampshire. We don't know
15 how it is going to be resolved. If it is resolved
16 in a way that negates what New Hampshire has done,
17 why should Vermont go through the expense of
18 fighting the same battle, if that's going to be
19 the outcome. And if that is what the outcome is,
20 then perhaps there is another way of getting at
21 this or perhaps it should be dropped entirely.
22 But what we did, what we call -- we called
23 it a placeholder, section 13. We asked for a
24 report back, and that's basically so we don't
25 forget it, and we hear what happened in New

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1 Hampshire. We hear if it is -- if it is approved
2 by the courts and it goes into effect, that we
3 hear what's happened as a result of it.
4 So we felt it wasn't -- it wasn't worth
5 jumping right into this, that we wanted more
6 information. We wanted to see what the results of
7 the action in New Hampshire was before we said
8 this is the right thing to do.
9 Again, going to my earlier concern about
10 saving -- saving money for Vermonters, this could
11 actually -- could actually cost Vermonters money
12 if we are prosecuted. That's not -- if we are
13 taking a case, that's going to cost money by the
14 Attorney General's office in the federal courts.
15 It wasn't a clear call by the committee.
16 It was debated by the committee. That's the
17 conclusion that we came to. Obviously the day
18 before we were at the other conclusion, so...
19 The other section was section 17, and this
20 one -- the unconscionable pricing, and this one
21 had an interesting evolution.
22 What we heard was that this was tried in
23 the District of Columbia, and that it had been
24 ruled unconstitutional. And what we heard is that
25 your committee decided to rewrite this, and with

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1 Robin Lunge helping you with the language, to try
2 to create a compelling state interest as -- as a
3 way to answer the concerns that the court had when
4 in D.C. they ruled it unconstitutional.
5 MS. CUMMINGS: We also -- it was an outside
6 phone conference.
7 SPEAKER 1: So we went through that process,
8 and we looked at this. And the way we read your
9 language was that it was various -- it was very
10 broadly written, that it was about public health
11 concerns, serious public health concerns. But the
12 way we were reading it, and I think people in the
13 room, including Dr. Schwartz from the Health
14 Department, saying you could read this to mean --
15 include diabetes, high cholesterol, high blood
16 pressure, obesity and a whole lot of other things,
17 and our concern was that that was so broad as to
18 not be able to create that compelling state
19 interest.
20 So we were actually trying to type it up
21 and what we created here was more of a public
22 health emergency, and what we have got here is
23 more of a price gouging bill, which is different.
24 It is a different policy than what you were trying
25 to get at. It is price gouging along the lines of

Page 9

1 what would appear in an emergency --
2 MS. CUMMINGS: The flu shot.
3 SPEAKER 1: Flu shots, an outbreak of some
4 disease that we don't know about today, and to
5 prevent any sort of price gouging on the part of
6 the industry in a time of public crisis. And we
7 looked at one way of doing it was to include in
8 the price gouging legislation on the books dealing
9 with the fuel oil and gasoline, and it just didn't
10 fit. It was just apples and oranges.
11 So we wrote this, but the intention was to
12 prevent price gouging. It is a different approach
13 trying to get something to pass constitutional
14 muster. It is a different policy as well.
15 What we heard at the end of this
16 discussion was very clearly from everybody in the
17 room, and yes, I know we heard it earlier as well
18 from one witness, was that both sides agreed, and
19 it seemed like everybody in the room agreed, the
20 attorneys, that the compelling state interest
21 wasn't the problem, and that wasn't going to --
22 that wasn't going to solve the problem, that the
23 court was very clear.
24 I am not a lawyer, so it's hard for me to
25 describe this, but there was a violation of the --

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1 which clause, the commerce clause, and that we are
2 on very thin ice no matter how we wrote it.
3 And then there was some discussion, well,
4 maybe we should just go back to the finance
5 committee language, because it is not going to
6 make any difference. I don't know how to -- I
7 don't know how to resolve that one.
8 But again, I don't feel that the state
9 will be benefiting from a court action that's
10 going to cost us money if the outcome is fairly
11 predictable.
12 The flip side of that argument, and I have
13 heard this, and it is, again, it is debatable, it
14 is not what our committee decided, but I can
15 understand why others might think this way, is
16 that we are pushing the envelope, and Vermont over
17 recent years has really been trying to push the
18 art of the possible and see where the openings are
19 with the pharmaceutical industry to get us
20 lower-cost drugs. And that's the goal. And that
21 by continuing to push, even in these instances
22 where we think we might be on shaky ground,
23 certainly sends -- first, we don't know what other
24 court might rule if our language is different, but
25 secondly, it keeps putting the pharmaceutical

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1 industry on notice that we are going to continue
2 to be aggressive in the state of Vermont.
3 That wasn't as compelling an argument to
4 me as trying to do something that was effective,
5 and frankly, trying to get this bill through, I
6 think those provisions became the most
7 controversial. But the rest of this bill, more or
8 less, is what's passed the Senate twice in recent
9 years and passed the House in one year, and ended
10 up being part of the bigger bill that was vetoed
11 by the governor. And my goal here is to get
12 something through that will have an impact on
13 prices, and will also get a signature or at least
14 enough votes that we can still pass this bill
15 without a signature.
16 MS. CUMMINGS: Any questions from the
17 committee?
18 SPEAKER 2: So it came down in which language
19 form?
20 SPEAKER 1: We came down in a language trying
21 to -- to create a very compelling state interest
22 that on the unconscionable pricing, yes, that we
23 would pretty much be defined as a healthcare
24 crisis rather than a serious public health
25 problem, because we thought the serious public

Page 12

1 health problem was so broad, that it didn't create
2 a compelling state interest.
3 What I said after that, I just want to be
4 clear, was after we went through that whole
5 discussion, then we heard very clearly from a lot
6 of people in the room that that's not going to
7 make any difference anyway. And I don't know how
8 to evaluate that. That's for the lawyers.
9 MS. CUMMINGS: We were looking as, I think,
10 part of the whole chronic care initiative, that --
11 at that kind of a public health crisis. So yes,
12 you have tied it more up to the shortage of flu
13 vaccine when the prices started to spike a couple
14 years ago.
15 SPEAKER 1: That's right.
16 MS. CUMMINGS: There was limited amounts, so
17 the price started to go up, until there was little
18 action taken, but -- that kind of thing.
19 SPEAKER 3: Did you have legal -- I used the
20 term -- in discussions of this bill several weeks
21 ago, I used the term compelling state interest,
22 and was corrected by counsel for the Attorney
23 General that we were talking about the state
24 interest as opposed to compelling, saying that
25 those were different levels of compulsion.

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1 SPEAKER 1: You lost me already.
2 SPEAKER 3: Was there any legal counsel that
3 this, in fact, compelling to the state?
4 SPEAKER 1: We didn't really get into the
5 discussion of compelling as opposed to plain old
6 state interest.
7 MS. CUMMINGS: We will have Julie, if we can
8 get her, go over --
9 SPEAKER 3: Because I got the impression from
10 Julie that it made a difference.
11 MS. CUMMINGS: And we will talk -- and Robin is
12 out today, we will have her in, but those are --
13 you know, the rest of the bill is essentially the
14 same. We will have Robin walk us through it.
15 SPEAKER 1: I can walk through it as well with
16 her, because like I said, some are more technical,
17 some are policy choices, but I think they are
18 rather minor policy changes. There is one on FQHC
19 that we -- the language says a plan to encourage
20 Vermonters, and we have rewritten that to inform
21 Vermonters.
22 MS. CUMMINGS: That's -- and that's really one
23 of those things that's in your committee. We
24 didn't do much on FQHC. That has always been in
25 your committee.

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1 SPEAKER 1: Well, there was a concern that if
2 we are encouraging Vermonters, we are encouraging
3 them to leave their primary-care physician and go
4 to FQHC, and you know, (inaudible), that was a
5 great idea, because our FQHC is in Franklin County
6 and (inaudible) she didn't like the idea of urging
7 people to leave their primary-care physician.
8 MS. CUMMINGS: FQHC we have got around here,
9 their lookalikes are doubling in size.
10 SPEAKER 1: So there are issues like that that
11 I could discuss the policy.
12 MS. CUMMINGS: Okay.
13 SPEAKER 1: Some of them I think are more
14 technical in nature. We listen to a lot of
15 witnesses. We change language. Generally, I
16 don't think there was much -- the PBM language was
17 somewhat controversial, but I think it stayed more
18 or less the way you --
19 MS. CUMMINGS: The fiduciary stated --
20 SPEAKER 1: -- discussed that.
21 MS. CUMMINGS: Well, the description of the
22 standard, the fiduciary standard as opposed to
23 contract standard. Okay. We will have --
24 SPEAKER 1: Basically that one is intact.
25 MS. CUMMINGS: Okay.

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1 SPEAKER 1: To me that --
2 MS. CUMMINGS: That's what we have been trying
3 for about four or five years already maybe.
4 SPEAKER 1: Right. Right. So --
5 MS. CUMMINGS: The other ones were --
6 SPEAKER 1: -- part of one of the big ones was
7 not to create a bill that won't get through.
8 MS. CUMMINGS: Well, okay.
9 SPEAKER 1: In its stead to craft a bill that
10 might and put -- and could actually reduce cost,
11 and that's the goal and there is a lot of good
12 things in the bill.
13 MS. CUMMINGS: Okay. Any questions at this
14 point?
15 Thank you. When we get --
16 SPEAKER 1: Thank you.
17 MS. CUMMINGS: When we get our technical staff
18 back, we will walk through it, and we will have a
19 chance to read it. Okay. Thank you.
20 SPEAKER 1: Thank you very much.
21 (Thereupon the proceedings ended.)
22
25

Page 16

1 CERTIFICATE
2
3 STATE OF FLORIDA
4 COUNTY OF BROWARD
5
6 I, Sara Glazer, Notary Public, do hereby
7 certify that I was authorized to and listen to CD
8 2007-83, the Senate Committee on Finance, Tuesday,
9 March 20, 2007 proceedings and stenographically
10 transcribed from said CD the foregoing proceedings
11 and that the transcript is a true and accurate
12 record to the beat of my ability.
13
14 Dated this 8th day of April 2008.
15
16 ____________________________
17 Sara Glazer
18 Esquire Job #928014
19
20
21
22
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25

STATE OF VERMONT

2

3 SENATE COMMITTEE ON FINANCE

4

5

6

7

8 Re: Senate Bill 115

9

10 Date: Friday, March 23, 2007

11

12 Type of Committee Meeting: Standard

13

14 Committee Members:

15 Senator Ann Cummings, Chair

16 Senator Claire Ayer, Vice-Chair

17 Senator Bill Carris

18 Senator James Condos

19 Senator Mark MacDonald, Clerk

20 Senator Hull Maynard, Jr.

21 Senator Richard McCormack

22

23 CD Nos.: 07-87/T1, 2, 3

24 07-88/T1

25 07-89/T1

Page 2

1 PROCEEDINGS
2 ---
3 CD 87/TRACK 1
4 MS. CUMMINGS: Senate Committee on Finance, March
5 23rd, 2007. So, the first thing we've done is, we've asked
6 Robin to come and walk us through the proposed amendments to
7 the bills which are in your folder and in the white bag and
8 just let us know -- we had Senator Sine in, and he explained
9 the two big changes and said the rest were somewhat
10 technical, and Robin tell us what they are and how technical
11 they are.
12 MS. LUNGE: Good afternoon. I'm Robin Lunge,
13 Legislative Counsel. Probably the easiest thing to do is to
14 work off the section by section summary which shows a
15 comparison of the bill as introduced as it came out of this
16 committee with the Senate Health and Welfare amendments. If
17 you'd like me to go through the language more specifically at
18 any particular section, I'm happy to do that.
19 So, the first instance of amendment amends Section
20 1 of the bill, and the -- that section where it talks about
21 the FQHCs. And what you'll remember is that the FQHC
22 language said that there would be a plan created for
23 increasing the usage of FQHCs, and two things happened in
24 that language in Senate Health and Welfare. First of all,
25 there was some concern about Vermonters moving from their

Page 3

1 primary care physicians to FQHCs, so they changed it from a
2 plan to encourage folks to move to a plan to informed
3 Vermonters about the availability of FQHCs and why the
4 prescription drug pricing is cheaper there than elsewhere.
5 And also, the
6 last -- a phrase was struck at the end of that subdivision
7 which had talked about creating patients of record, and
8 that's no longer allowed under the definition of patient
9 that's required under federal law. So, the second part was
10 truly required by federal law.
11 The second instance of amendment amends the part of
12 the bill that talked about the joint drug purchasing
13 consortium. And it merely added the V Farm Program to the
14 list of programs that would be included, and the V Farm
15 Program is our wrap-around program for Medicare Part D, so
16 that's really a technical change, also. And also, OVA asked
17 to add language that if it was necessary, that they seek
18 authorization from CMS, to approve that if it was necessary.
19 So, it's -- it's -- the language is put in the conditional,
20 so if it's not necessary, they don't have to do that. Just
21 it makes it clear that if they had to do that, we were
22 expecting that.
23 There is also -- the third instance of amendment
24 changes a reference -- a cross reference that was incorrect,
25 so that is technical. The fourth instance of amendment is in

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1 Section 2 of the bill, and would strike -- this is the
2 section where we were directing OVA to seek independent
3 research from independent sources. And Senate Health and
4 Welfare just took out the example of organ health and science
5 university.
6 MS. CUMMINGS: Right. We'd already taken it out,
7 seek them, and you said seek such as them and now it's just
8 saying seek.
9 MS. LUNGE: Exactly.
10 MS. CUMMINGS: Okay.
11 MS. LUNGE: The fifth instance of amendment adds --
12 this is in the pharmaceutical marketer disclosure part of the
13 law. What you had done is add the Department of Health as
14 one entity that the AG could share information that they
15 received, some of the disclosures, Department of Health still
16 has to keep it confidential. Senate Health and Welfare also
17 added OVA, so the AG and would be able to share with both OVA
18 and DOH. Again, OVA and DOH keeps things confidential.
19 MS. CUMMINGS: Right.
20 MS. LUNGE: In the sixth instance of amendment,
21 Senate Health and Welfare, this is the section that would
22 require drug manufacturers to disclose to OVA certain prices
23 for drugs. This was the part of the bill where you added
24 from Texas law a third pricing indicator, and it was an
25 average manufacturer price, etcetera. There is -- in -- in

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1 one part of that law, it said that OVA would use a federal
2 standard of methodology or adopt its own standards by rule,
3 and Senate Health and Welfare thought it made more sense to
4 use just the federal standards so that there was -- the
5 people who were reporting all knew that they were use one
6 each the same standard that they would use for the Feds.
7 In the 7th instance of amendment, this is really a
8 technical change because when you added that third pricing
9 indicator, there was one place where two of the prices were
10 described, and I neglected to change that reference, so the
11 7th instance changes refer to the subsection in lieu of those
12 two particular prices. So, that's also technical.
13 In the 8th instance of amendment, it -- it's
14 addressing the Healthy Vermonters Plus Program. This is the
15 pharmacy discount card that we offer in Vermont, and
16 currently the law says that OVA will seek permission from CMS
17 to get a waiver to extend the discount card to additional
18 populations. And what you had done was strike the
19 requirement to get the waiver, so because we -- that had been
20 clarified that that was no longer necessary. So that would
21 have just had the program be implemented. OVA came in to
22 Senate Health and Welfare and said, well, actually, in the
23 current law it says that we would increase this to
24 individuals whose household income greater than -- between
25 300 and 350, but also to families whose prescription expenses

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1 including premiums equal five percent or more of their
2 household incomes or whose total medical expenses equal 15
3 percent or more of household income and that's going to be
4 really, really complicated to administer. Then the
5 healthcare ombudsman came in and said, I can see how that
6 would be really, really complicated to administer, so why
7 don't you just leave it to increasing it to 350. So, that's
8 what Senate Health and Welfare did, was make that change.
9 So, you'll see in the 8th instance of amendment it adds new
10 language from current line, just strikes the language about
11 percentage of income stuff.
12 In the 9th instance of amendment, we start to get
13 into the PBM sections of the bill. There were two sections,
14 Section 7 and 8. The 9th, 10th, 11th, and 12th all address
15 PBM, the PBM sections. So, the first thing Senate Health and
16 Welfare did in the PBM section was, you'll remember that that
17 section says the PBM has to disclose -- notify the health
18 plan if the following things are available: 1., a prudent
19 PBM standard, 2., certain disclosures of information,
20 etcetera. What Senate Health and Welfare did was modify the
21 prudent PBM standard to the current standards under Vermont
22 law that an insurance agent owes to a customer. So, this is
23 a slightly lower standard than the prudent PBM standard. And
24 you can see that language on Page 3 of your amendment at the
25 top at A-1. It says that the PBM would discharge its duties

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1 with reasonable care and diligence and be fair and truthful
2 under the circumstances then prevailing that a pharmacy
3 benefit manager acting in the like capacity and familiar with
4 such matters would use in the conduct of its enterprise of
5 like aims. So, that language, reasonable care and diligence,
6 be fair and truthful under the circumstances was language
7 which I found in a case, a Vermont case dealing with that
8 duty between the agent --
9 MS. CUMMINGS: So, this is something between
10 contract law which is what has been wanted, and --
11 MS. LUNGE: And the original bill is Page 15.
12 MR. MAYNARD: Fiduciary.
13 MS. LUNGE: Yeah. So on Page 15 of your bill as
14 introduced on Line 4, you can see your language which was,
15 discharge its duty with care, skill, prudence, and diligence
16 under the circumstances then prevailing that a prudence PBM,
17 blah, blah, blah; the rest of that's the same.
18 MS. AYER: What does it mean be truthful under the
19 circumstances? That just sounds so, like, I'll stick with
20 you as long as I can.
21 MS. CUMMINGS: The truth is as how long as it's
22 convenient.
23 MS. LUNGE: What I can tell you, that would be
24 something a court would sort out. But in this particular
25 case, it was a case where The Court looked at a circumstance

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1 under which the customer was saying that they didn't
2 understand something that was in the contract, that was
3 written in the contract, and so it was dealing with whether
4 or not the insurance agent has to specifically explain each
5 and every provision in the contract. And what The Court
6 basically did was, say, well, we think an agent has to
7 discharge their work with reasonable care, diligence, and be
8 fair and truthful under the circumstances. So, that was kind
9 of the standard they used to apply and -- but they also said
10 in that case that, well, you, the customer have an obligation
11 to read the contract, too, and if it's in plain -- if it's
12 simply put in a contract and understandable, then that's your
13 duty.
14 MR. McCORMACK: So, it leaves it to The Judge.
15 MS. LUNGE: Well, with any sort of standard,
16 that's -- I mean, this is a standard that any court --
17 MR. McCORMACK: It's a different standard --
18 MS. LUNGE: Right. You --
19 MS. AYER: But under the circumstances means it
20 would vary by case?
21 MS. LUNGE: It could. It would -- well, it would
22 vary by the circumstances.
23 MR. McCORMACK: Who wanted the information?
24 MS. LUNGE: Who was asking for the information, is
25 an insurance agent talking to somebody who's an expert in

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1 insurance law and who probably knows the ins and outs, so
2 they didn't explain every detail knowing in their mind they
3 were talking to an expert. So, I think in this kind of a
4 standard, it's often very fact based, so The Court is going
5 to look at, well, who --
6 MS. AYER: That's generally what that means.
7 MS. CUMMINGS: You couldn't tell me you couldn't
8 read.
9 MR. McCORMACK: Except by the X on the bottom of
10 the page.
11 MS. CUMMINGS: A lot of people can sign their
12 names, but really don't speak English or don't read well, I
13 mean, enough to comprehend it. But in ordinary conversation,
14 you might not know that. Okay. So, you think that's --
15 that's a middle standard.
16 MS. LUNGE: Well, I think the discussion in Senate
17 Health and Welfare was, they wanted to replicate what they
18 thought was sort of the standard that probably would be used
19 in the circumstances now without citing if this didn't exist.
20 MR. McCORMACK: Piggybacking with the standard to
21 what they thought was closer to the advocate.
22 MS. LUNGE: I think that was their intent. I'm a
23 little bit fuzzy now, it was a while ago, but I think that's
24 what I was trying to do.
25 MR. MAYNARD: Not to the level of fiduciary --

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1 MS. LUNGE: Right. No. They clearly did not want
2 to stick with the fiduciary.
3 MS. CUMMINGS: But it is above contractual.
4 MS. LUNGE: Yeah, I think so. I'm not an expert on
5 all the different standards, but I think it's meant to be the
6 standard that an agent -- I tried to find something that
7 looked as close as possible to what this transaction kind of
8 included.
9 MS. CUMMINGS: Yeah. That's probably the closest
10 transaction you're going to get, okay.
11 MS. LUNGE: In Vermont law, I should say. So, in
12 the tenth instance of amendment, we reworked Subsection C,
13 which is on Page 18 of your original bill, and this is
14 not -- this re-working of the language was not meant to
15 change meaning, I think it's just a little clearer and
16 readable, so this is not really a substantive change. In the
17 11th instance of amendment, you'll see --
18 MS. CUMMINGS: Oh, yeah. C was where we had
19 pharmacy benefit manager as somebody who does pharmacy
20 benefit managing? We had trouble with that.
21 MS. LUNGE: Right. So, I think this reads a little
22 better and more clearly. 11th instance of amendment is the
23 enforcement provision in the PBM section. You'll recall that
24 Julie Brill from the AG's office and Herb Olsen from Bishca
25 were going to talk about some new language, and this is the

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1 new language. What this basically does is separate out, you
2 can see on Subsection D of the amendment which is on Page 4
3 near the top, that this gives Bishca the exclusive authority
4 to investigate, examine, or otherwise enforce the provisions
5 of this subchapter relating to a PBM in connection with the
6 PBM's contractual relationship with a health insurer.
7 So, it separates out the traditional area of
8 jurisdiction for Bishca and puts that separate from the
9 general enforcement.
10 MS. CUMMINGS: Okay.
11 MS. LUNGE: In the 12th instance of amendment,
12 we're now moving into Section 8 in the original bill. This
13 is the part which set up the registration of PBMs and also
14 has the language about the administrative services only
15 contract. And Senate Health and Welfare inserted a new B and
16 C. And what this language does is, it clarifies that while
17 the PBM has a duty to notify when they respond to an RFP,
18 that administrative services only contracts are available in
19 the marketplace, that it doesn't require each PBM to offer
20 that type of contract. So, the PBM could then, if they're
21 quoting a different kind of contract to somebody, they might
22 have a little notice that said, and by the way, there's also
23 something called an administrative services only contract, we
24 offer that, or we don't offer that, but it is available in
25 the marketplace.

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1 And then there's some technical amendments in
2 Subsection C which were meant to just offer clarity. And I'm
3 trying to remember exactly what they were. I think -- let me
4 just look real quick. Oh, yes. What I did was, in your C,
5 which is on Page 20, big A and big B on Lines 11 and 16, both
6 have lead-in language, if applicable under administrative
7 services only contract; we moved that language to C-1, the
8 lead-in so that it was clear that this -- the audit provision
9 only applies to an administrator services only contract.
10 MS. CUMMINGS: Because the other one has --
11 MS. LUNGE: The other ones have audits or -- I
12 didn't hear what you said.
13 MS. CUMMINGS: My remembrance of the testimony was
14 that the other contracts audits is part of -- the ability to
15 audit is part of most of those or you have the ability to ask
16 for that as --
17 MS. LUNGE: I think -- what I recall from Senate
18 Health and Welfare is that there was testimony that you have
19 the ability to in your contract specify that you want to
20 audit, but the testimony -- there was some disagreement in
21 the testimony as to whether or not an audit was appropriate
22 in a non -- in a contract for something other than
23 administrative services only. So, this part of it could be a
24 substantive change from your version in terms of the -- what
25 the audit applies to, but what Senate Health and Welfare

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1 decided to do was to only require the audit in the
2 administrative services contracts where you're getting full
3 pass-throughs of discounted stuff. And I think what they
4 heard that -- was that in the other type of contract which
5 might, for instance, say, you're guaranteed a 10 percent or
6 20 percent or X percent discount, that an audit didn't
7 necessarily help the consumer. But I don't know that --
8 MS. CUMMINGS: I thought that an administrative
9 only contract was one where you said, we'll administer your
10 pharmacy benefit plan and we will guarantee you a 10 percent
11 discount over what you're paying now, average wholesale
12 price, whatever the standard is, and that's what you get.
13 And that's the one where we wanted people to know they had
14 the ability to ask for an audit because that's the one where
15 there was a question about -- you know, how much money are
16 you making from the pharmaceutical companies in the way of
17 market share, that that was the one; the other one's where
18 you could negotiate for a percentage of the market share,
19 rebates, where -- that they were much more complicated and
20 that there was generally -- it's sophisticated, and that
21 there was generally an ability to audit at least --
22 MS. LUNGE: I think you might want to ask people
23 about that because I don't know the contract in enough detail
24 to really -- I can't tell you what I think is most
25 appropriate for an audit because I don't know the contracts

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1 well enough. There was conflicting testimony in Senate
2 Health and Welfare about the range of contracts that an audit
3 might be helpful and appropriate in.
4 MS. CUMMINGS: So, that one, we may want to red
5 flag here for a few minutes.
6 MS. LUNGE: And I think arguably under your
7 language, it could -- it could -- it could have been more
8 broadly applied than to just the admin services only. So,
9 but what this section would now do is require the audit only
10 in the admin services only contracts.
11 MS. CUMMINGS: Okay.
12 MS. LUNGE: Okay. Sorry I don't have more
13 specifics on that.
14 MS. CUMMINGS: Okay.
15 MS. LUNGE: The next section or amendment is in
16 Section 12 of your bill, which is the evidence-based
17 education program which starts on Page 22 of your original
18 bill. And what this would do is add in a couple other folks
19 to -- who the Department of Health would collaborate with.
20 Currently they -- in your version, they were collaborating
21 with the AG, Senate Health and Welfare added in the
22 University of Vermont Area Health Center Program because they
23 currently have a grant to develop the evidence-based
24 education materials. So, it makes sense to involve them in
25 the development and the Office of Vermont Health Access

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1 because they have the drug utilization review board and they
2 get a lot of information about sort of effectiveness and that
3 kind of thing because they consider that --
4 MS. CUMMINGS: I'm not finding that in the side by
5 side.
6 MS. LUNGE: I might have -- I did the side by side
7 quickly on the airplane, so let me see. It's on Page 3, and
8 it looks like I left that out, so --
9 MS. CUMMINGS: Yeah, okay. That's where I thought
10 it would be, and I was finding a hole.
11 MS. LUNGE: You're right, sorry about that.
12 MS. CUMMINGS: Okay.
13 MS. LUNGE: I'll double-check this and clean it up.
14 In the 14th instance of amendment, again they struck that
15 same reference to Oregon. In the 15th instance of amendment,
16 they removed the prescription drug confidentiality program --
17 MS. CUMMINGS: Right.
18 MS. LUNGE: -- and inserted instead a report on
19 from leg. counsel to the committees on the status of the New
20 Hampshire litigation and any other information we might be
21 able to get from the State of New Hampshire about what was
22 going on there.
23 MS. CUMMINGS: And this was the data mining?
24 MS. LUNGE: Yes, this is the data mining section.
25 MR. McCORMACK: So do we continue to data mine?

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1 MS. CUMMINGS: Yeah.
2 MS. LUNGE: So, they struck 13, and related to 13
3 was 14, so 14 also got struck as a result. They also took
4 out 15 and 16 which were the provisions about a person
5 paying --
6 MS. CUMMINGS: What -- on 14 --
7 MS. LUNGE: This was --
8 MS. CUMMINGS: That if you go to Wal Mart in the
9 normal, it's $4 and your co-pay is 10, they want you to pay
10 the 10?
11 MS. LUNGE: That's 15 and 16.
12 MS. CUMMINGS: Oh, what's 14?
13 MS. LUNGE: 14 is related to the data mining
14 section.
15 MS. CUMMINGS: Okay.
16 MS. LUNGE: That was Bishca's confidentially
17 provision related to that, so that doesn't make sense to
18 leave in if you take out 13. So 13 and 14 are together, 15
19 and 16 are together. They did take out 15 and 16. They
20 heard from a couple of different witnesses that this was --
21 they didn't think that these provisions were necessary, that
22 they thought the current electronic system currently does
23 this anyway and that it's in -- it's a requirement that's in
24 the contract between the insurer, the health insurance
25 companies, and the pharmacists. And there's an example of a

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1 contract that had language that included that. So, they took
2 it out because they thought it was happening anyway.
3 Section 17 is the unconscionable pricing section.
4 And Section 17 is reproduced in its entirety in the
5 amendment. And I'll go through --
6 MS. AYER: In which amendment?
7 MS. LUNGE: -- what the changes are.
8 MS. CUMMINGS: Their amendment.
9 MS. LUNGE: Their amendment. So, the first change
10 in that section is on Page 6 of their amendment in Section
11 4653. And what this section now -- the one change is that
12 the previous language had read, serious public health
13 problem, I believe, and that -- they changed that to threat.
14 We also added the reference to Section 4654 to be a little
15 bit clearer that the requirements of 4654 were something that
16 had to be looked at. In 4654, there are several changes to
17 the criteria. These are the criteria that the commissioner
18 of health would look at when declaring that there's a public
19 health threat. So, most of the changes they made are in
20 Subsection B.
21 So you'll notice B-1 is significantly changed. You
22 had that the commissioner would consider how many Vermonters
23 suffer from a health condition. Senate Health and Welfare --
24 I guess the overall point of these changes in their mind was
25 to -- they wanted to exclude chronic illness from -- as a

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1 possible target of a serious public health threat. They
2 were thinking more along the lines of, like, a flu epidemic
3 as opposed to obesity or chronic heart disease or something
4 that -- widespread like that. So, that's kind of what was
5 behind the changes in the section. So, one, you can see now
6 reads, if a large number of Vermonters suffer from a health
7 condition and the condition in life threatening in the short
8 term -- so that would exclude a chronic illness that's life
9 threatening in the long, in 20 years -- or has severe
10 consequences to health in the short testimony or if the
11 condition is highly contagious and threatens a large number
12 of Vermonters, to, if the cost to the state employer
13 sponsored insurance and private insurers of the treating
14 health condition with prescription drugs would be expensive
15 without intervention allowed for under this chapter.
16 So, that's also a little bit more narrowly tailored
17 than your two. Three, if the cost of prescription drug -- a
18 drug or a class of drugs used to treat the health condition
19 is prohibitively expensive to the extent that the information
20 is available. So again, that's also a narrower spectrum of
21 situations. Four, I believe is the same, five is the same,
22 and six is the same. In 4655, we added a reference to 4653
23 because there was some confusion as to how these sections all
24 fit together. So, we tried to clarify that by adding cross
25 references. But otherwise, this section is the same, I

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1 believe. Then I'm pretty sure that that's it in terms of
2 modifications to this section; the rest is just reproduced
3 because it was easier to reproduce the whole section than
4 just make those particular changes.
5 So, the next instance of amendment is in Section
6 19. Because Senate Health and Welfare took out the
7 prescription drug confidentiality section, I removed the
8 cross reference to that that was in 2466-A, Subsection
9 A. So, that's a technical amendment that goes with removing
10 that section. Then in the C of that section, this is the --
11 the advertising provision that says -- that references the
12 federal standards for false advertising. And Senate Health
13 and Welfare added a sentence at the end to clarify how the
14 letters issued by the FDA would be used. So, they added a
15 warning or entitled letter which is the names that they use
16 on the FDA website issued by the US Food and Drug
17 Administration shall be prima facia evidence of a violation
18 of federal law and regulation. So, that's the change there.
19 And I believe -- oh, in D, we also made a change.
20 This is in the electronic prescribing software section which
21 prohibited advertising in that type of product. Senate
22 Health and Welfare added the clarification that this
23 subsection wouldn't -- shall not apply to information
24 provided to the health care professional about pharmacy
25 reimbursement, drug formulary compliance, and patient care

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1 management. So that in the prescribing software, it would
2 still be allowable for the software to say, hey, that drug's
3 not on this insured's preferred drug list or something like
4 that.
5 MS. AYER: Robin, I've lost track of where we are
6 on both sheets.
7 MS. LUNGE: We're at the end of the amendment.
8 MS. AYER: Technical provisions?
9 MS. LUNGE: There were no changes in the technical
10 provisions.
11 MS. AYER: So, what we're looking at was not even
12 in the end of the this original bill; is that right?
13 MS. LUNGE: Which --
14 MS. AYER: I'm looking for the paragraph that has
15 the sentence to it trying to follow along.
16 MS. LUNGE: In yours?
17 MS. AYER: Yeah.
18 MS. LUNGE: Okay. So, In yours, it was on page 35,
19 D. Has a sentence added to the end. And also the previous
20 one I was talking about about the advertising is on Page 34,
21 C. It would be added on Line 13.
22 MS. CUMMINGS: Okay. Questions for Robin? Okay.
23 I'm not sure who's next on the agenda. Okay. I'm sorry.
24 Julie Brill is next.
25 MS. BRILL: Good afternoon. I'm going to mention

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1 something that I hadn't mentioned to Robin earlier, but I
2 think a pretty important provision was dropped out by Senate
3 Health and Welfare perhaps by mistake. It's important to
4 OVA, they asked for -- well, let me start over. I'm Julie
5 Brill from the attorney general's office, and we're here to
6 talk particularly about the unconscionable pricing provision.
7 We think that Senate Health and Welfare was trying to address
8 a constitutional problem that actually does not exist, and
9 failed to address the constitutional problem that arguably
10 does exist. So, we have language which we're hoping will
11 address the constitutional problem that at least was found by
12 the District of Columbia Court and not unduly narrow the bill
13 in that provision in other ways. That's the primary reason
14 I'm here, the first one.
15 The second primary reason I'm here is, the Medical
16 Society has prepared amendments to the data mining section,
17 and we very much would like to see the data mining section
18 either as enacted by this committee or as being proposed by
19 the Medical Society. Probably since I actually don't have
20 their draft with me, they've shown it to me, and I've seen
21 it. But probably it would make sense for them to testify
22 about that and then maybe I can come back and answer any
23 further questions you might have on that one. But I will say
24 with respect to that, if you're going to go with their -- not
25 with your original language, which is our preferred

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1 provision, but instead you're going to go with the Medical
2 Society's alternate, they're proposing either an opt in on
3 opt out for doctors, that they can opt in or opt out to the
4 database -- to the prescription disclosure of their
5 prescription information, we very much would urge you to make
6 it an opt in, we do not believe in opt outs in our office.
7 And in Vermont, we have a very strong history of enacting opt
8 ins, not opt outs. In the credit reporting issue, financial
9 privacy, there are a number of others areas where we have
10 urged this legislature and you have always agreed with us
11 thus far to do opt ins, not opt outs. And I can get into all
12 the reasons why and all the consumer data that's out there
13 regarding computer inertia, etcetera. But leave that aside,
14 so that's the other primary reason I'm here.
15 But I just noticed in talking with -- in looking at
16 what Robin went through that there was an -- a third
17 provision that OVA wanted, and it is related to prescription
18 privacy issue, and that is -- and I -- did they -- did Ann
19 Rubb come in here to testify to you all when you heard this
20 bill? She might have only made it over there.
21 MS. CUMMINGS: She may have, but --
22 MS. BRILL: I was not here when she was here.
23 Bottom line is -- did she come -- anyway, bottom line is, OVA
24 has a real concern that their information will start to be
25 mined, that is, the information that Medicaid has with

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1 respect to prescription practices. And they have a very rich
2 database. And they have asked the legislature to have their
3 information made confidential, but there would be an
4 exception for the attorney general's office and others. And
5 that language appears to have dropped out of the bill.
6 Whether or not you do anything --
7 MS. CUMMINGS: I thought we'd done that, so --
8 MS. BRILL: That was supposed to be in here.
9 MS. CUMMINGS: Yeah.
10 MS. LUNGE: It came up after you voted the bill
11 out, so the language actually got developed after Senate
12 Health and Welfare started on the bill, but they never got to
13 that point of discussing it because they took that section
14 out. So, they never heard Ann on this.
15 MS. BRILL: The bottom line is, whatever you do on
16 the Medical Society and the attorney general's joint proposal
17 on data mining, this proposal that OVA has is a separate
18 proposal and should -- we would your urge you to insert it,
19 whatever you do with respect to our proposal on data mining.
20 And what it does is, it would ensure that the Medicaid which
21 is very rich also on prescription practices couldn't be used
22 for the same purposes. So, if you don't have that language,
23 we can get it to you real quickly. I think it was just one
24 of those loose ends that we
25 weren't -- and I actually thought it was in the bill. And it

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1 was clearly not in the bill now.
2 MS. CUMMINGS: I remember the discussion, and I
3 thought it was in the bill. But we may have lost it.
4 MR. MAYNARD: I think it may have been one those
5 things, fix it on your way over.
6 MR. McCORMACK: Could you give me an update on opt
7 in in terms of how many states -- I don't need to know
8 exactly, but a feeling for how opt in is faring, because I
9 thought we were kind of in the small end of the minority.
10 MS. BRILL: We are. I mean there are many, many
11 ways in which Vermont, the Vermont legislative and Vermont
12 laws are more protective of privacy than lots of other
13 states, and you can start with criminal searches and go all
14 the way down. But with respect to the kind of consumer
15 issues that I focus on, I think we're the only state, or
16 there may be one or two others that now require permission
17 before a consumer report can be reviewed, so we're on the
18 minority there. In terms of financial privacy, there's
19 probably about five states that have some form of opt in as
20 opposed to opt out. So we are in the minority, there's no
21 question. But it is a strong tradition that we have here in
22 terms of protecting privacy. And the reason is because, of
23 course, opt outs, the reason why companies who want to use
24 this kind of data, they want an opt out because consumers
25 don't respond to it. And the reason we want an opt in is if

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1 they really want to use the data, they should do a good job
2 selling to consumers or doctors or whomever you're talking
3 about the need for that data. They do a real good job in
4 selling lot of other things, they should be able to sell the
5 need to use the data.
6 So, that -- and I could talk to you much more about
7 that.
8 MR. MAYNARD: I just wanted to know, how many
9 times do we really realize we're signing an opt in?
10 MS. BRILL: Exactly, exactly. I mean, most
11 consumers have no idea what they're reading. And companies
12 have the ability to communicate clearly with consumers; you
13 look at the on television, they really have the ability to do
14 it if they want to. So leaving that aside for a moment, what
15 I'd like to do is, again, I'll let the Medical Society
16 present its proposal on data mining. Our first choice is, go
17 with your language. We understand that it's being litigated
18 in New Hampshire; we are concerned about waiting for the end
19 of that litigation because it's not just going to be a trial
20 court decision, there will be appeals, it will go on for
21 years. And as my Senator from Orange County just said, you
22 know, the data mining will go on in the meantime unless we do
23 something about it. So, it's important I think to act now on
24 this issue rather than wait four or five years waiting down
25 the road for the litigation to end.

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1 And so our first choice is your language, our
2 second choice would be the Medical Society's proposal with an
3 op in, not an opt out. And I'll answer any questions after
4 you see that language. I do have language on unconscionable
5 pricing, if I can say that word, unconscionable pricing.
6 MR. McCORMACK: I didn't know you moved to Orange
7 County.
8 MS. BRILL: It's probably about ten years ago. I
9 do have copies for other people. Some people who are sitting
10 around here have seen this because they asked me for it
11 because I know you wanted to act fairly quickly. I wanted to
12 make sure people who are interested had a chance to see some
13 of the language. But before we look at specific language
14 that I'm proposing, maybe I can take a step
15 back -- I think I should take a step back and describe what
16 is really at issue with respect to the constitutionality of
17 unconscionable pricing. And if -- if I didn't bring enough
18 copies -- actually, I have one more. I kept -- there's one
19 more.
20 MR. McCORMACK: There's one here.
21 MS. BRILL: And I can get more -- if someone
22 doesn't get it out here, I can email it to them. The
23 District of Columbia court struck down --
24 - - -
25 CD 07-88/Tracks 1, 2, and 3

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1 - - -
2 MS. BRILL: -- that it was happening in the
3 District of Columbia.
4 MR. McCORMACK: It was the results --
5 MS. BRILL: Right. It was the results in the
6 language. If you look at my draft, let's see if it's clear
7 here. If you go to the second page. You're going to be
8 looking at some of the language I'm striking out. But it
9 was -- in particular what they were concerned about was, the
10 language that said, supply for sale or impose minimal resale
11 requirements for a drug that results in the prescription drug
12 being sold in DC for an unconscionable price; in other words,
13 a lot of those activities were happening outside of the
14 District of Columbia. That was the primary reason why the
15 law was struck down. As I said, there were also some
16 supremacy clause issues, which I also think do not apply
17 given how we've changed our draft from the District of
18 Columbia's bill or law.
19 So, what I tried to do, and actually I will tell
20 you that I have consulted now with people, law professors and
21 Washington, DC attorneys at very large firms who argued both
22 sides of the District of Columbia case. So, I have consulted
23 with everybody that was involved in developing those
24 arguments down in Washington. What I have done is revised
25 the language in the District of Columbia law so that we will

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1 be focusing on commerce in Vermont. We will not be focusing
2 on commerce outside of Vermont. I think that takes care of
3 the constitutional infirmity. I don't think you need to make
4 more narrow or -- make more narrow this business about what's
5 a serious public health threat. You don't need to only focus
6 on short-term conditions and not-long term chronic
7 conditions. That doesn't help the constitutional argument.
8 And all you're doing is narrowing the provisions and focus of
9 the law without addressing the real issue which is, is this
10 thing going to be struck down or want to be struck down.
11 MR. McCORMACK : Narrowing, I'm not sure I -- the
12 narrowing is not only focused on -- (inaudible).
13 MS. BRILL: That's a way to put it, yes. That is
14 what I think needs to happen. And instead, Senate Health and
15 Welfare -- and part of this, frankly, it's not their fault;
16 they looked to Robin and I and said, what should we do here.
17 And I hadn't yet had all these discussions with all the
18 people about what was really going on in the District of
19 Columbia case. So they're looking to us, and we're saying,
20 you know, yeah, make it more compelling, and really that
21 wasn't what the issue was. So, you know, they were looking
22 to us for guidance. So, I want to make that really clear.
23 But so what, though, at the end when they came up with this
24 language, I said to them, what you're doing is, you're
25 focusing on narrowing the conditions that are covered, but

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1 you're not narrowing, as Senator McCormick just said, you're
2 not narrowing the location of the activities, and that's what
3 we need to do. We don't need to narrow the conditions
4 covered, we do need to narrow the commerce effected, that's
5 exactly right.
6 So, going through the draft, you'll see that what
7 I've done is, in terms of affected parties, the people who
8 can bring a lawsuit, it has to be someone in Vermont who's
9 directly affected by the unconscionable pricing. That's the
10 only change on -- and what I did is, I took this draft that
11 you have in the front of you is Senate Health and Welfare's
12 language with my modifications to it, okay. So going to the
13 second page, this is probably the most important change to
14 Section 4653 that the prohibition is that a manufacture of
15 prescription drug or its licensees shall not sell in Vermont
16 a prescription drug necessary to treat a serious public
17 health threat provided for in 4654 in this state for an
18 unconscionable price. So, it's, the manufacturer shall not
19 sell in Vermont the product for an unconscionable price.
20 This business about supply for sale or impose minimal resale
21 requirements or that the action can result in a public -- in
22 a prescription drug being sold in Vermont, that is stricken
23 but that all activities that could occur outside, okay?
24 MR. MAYNARD: Was does define unconscionable price
25 or else --

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1 MS. BRILL: Yes, that comes up. You defined it,
2 and it was also in Senate Health and Welfare's. I'm actually
3 not changing that, but doesn't come up. But we're not there
4 yet in the bill.
5 MR. McCORMACK: Is there case law on the right of
6 the state to regulate an activity with the state that by so
7 doing regulating --
8 MS. BRILL: There's tons of case law on this issue,
9 and it's all very fact determinative. And what we're really
10 trying to do here, to be honest with you, is, we're trying
11 avoid a facial attack on this law that would not be based
12 upon a prosecution that we might bring. We think that it
13 would be much better for a judge to understand what we're
14 going to do with this law in light of an actual prosecution.
15 What happened in the District of Columbia was, it was a
16 facial attack, there was no prosecution that was actually
17 pending. They just said, look at the words of this statute,
18 Your Honor, and it's way too broad. And what we're trying to
19 say is, no, it's not going to be broad, it's going to be in
20 Vermont, and let's look at the actual prosecutions that we
21 bring before we say, yeah, it may affect a little bit too
22 much commerce outside the state.
23 But yes -- so, the short answer to your question is
24 yes, there's tons of case law.
25 MR. McCORMACK: But it doesn't have bold principles

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1 in this --
2 MS. BRILL: No, no. This is the grayest of the
3 gray areas in constitutional law, in my view; I always found
4 it that way. I'm sorry, but Senator Maynard, to go to your
5 specific question, the definition of unconscionable pricing
6 is in 4655. I didn't mean to not respond to you. It's a
7 page later at the bottom. But before you get to that, 4654
8 is actually something that we created. It is not in the
9 District of Columbia's law. And I have meant to talk about
10 Robin about where it came from. I don't actually remember,
11 she may remember --
12 MS. LUNGE: I'm sorry, what --
13 MS. BRILL: 4654, this whole business about going
14 to the health commissioner for a finding.
15 MS. LUNGE: It's not based on another state's law.
16 It's based on concepts as best --
17 MS. BRILL: Okay. This is actually another
18 requirement that we're imposing that is in addition to a
19 requirement of the District of Columbia's law. And what
20 we're imposing is a requirement that before our office, the
21 attorney general's office, or a private person can ever go to
22 court, you have to have a finding by the commissioner of
23 health. That's a very unusual process. And, you know, we're
24 giving a lot of -- we're giving the manufacturers or any
25 licensee or whoever else might be subject to this law an

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1 additional opportunity to argue that there is no
2 unconscionable pricing here. This process of allowing them a
3 kind of a first shot at the commissioner before we could ever
4 get to court is unusual. So, I just wanted to outline that
5 we're not --
6 MR. McCORMACK: Serious public threat out as a
7 criteria?
8 MS. BRILL: You could take this entire provision
9 out, and I do not believe you would have any constitutional
10 difficulty if you do that. I do not think that this is
11 necessary in light of the District of Columbia's case. But
12 given this bill it at this point, and in fact, it was in your
13 draft, if you don't want to take it out, we certainly
14 understand that. I just wanted to highlight for you and for
15 Senate Health and Welfare that this is an additional
16 protection, if you will, for potential defendants that you
17 will have added to this bill. I just wanted to highlight
18 that.
19 But we do think the changes that I'm proposing to
20 this -- assuming you want to keep it in -- actually, I didn't
21 remember that Senate Health and Welfare changed the word,
22 "problem" to threat. I actually like the word, "problem"
23 better than threat, and even though it's not in my draft, I
24 would propose you go back to the word, "problem." But in any
25 event, what we have proposed here is that you go back to your

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1 language, the Senate Finance language with respect to B-1, 2,
2 and 3, and the reason is, again -- do you see where I am,
3 Senator Ayer?
4 MS. AYER: Uh-huh.
5 MS. BRILL: I'm sorry. So, you've got -- what your
6 language required was that the commissioner of health may
7 issue a declaration that a health condition is prevalent in
8 Vermont to such an extent as to constitute a serious public
9 health threat, and then we can request -- that's A-1, A-2 is
10 that our office can request that they have a hearing.
11 Now in B, it lists the factors that need to be
12 considered when declaring that a health condition or disease
13 is a serious public health threat. And what you see in
14 originally what Health and Welfare -- what Health and Welfare
15 did which is the language I've proposed to be stricken, is
16 that they have really narrowed 1, 2, and 3, as Robin said, so
17 that chronic conditions wouldn't be considered, you'd have to
18 have a large number of Vermonters affected. They really
19 narrowed it in ways that I didn't -- No. 1, are certainly not
20 necessary to fix the constitutional infirmity, and also,
21 would really narrow it so that you're not even necessarily
22 talking about all the public health threats that are out
23 there. I mean, chronic diseases kill people just as well and
24 easily, although over a longer period of time, as do
25 short-term epidemics. And the idea that you would only be

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1 focused on short-term epidemics that are potentially
2 affecting a large number of people didn't make rational sense
3 to me. It just doesn't make sense. And I felt like they
4 were trying to make it more compelling because they thought
5 that would address the constitution problem. I don't even
6 think it makes it more compelling, but it doesn't address the
7 constitutional problem anyway.
8 MR. MACDONALD: But if -- unconscionable pricing,
9 it doesn't matter you do it.
10 MS. AYER: Well, it doesn't even matter what it's
11 prescribe for.
12 MS. BRILL: It would need to be a serious public
13 health threat, as you've created this additional layer. It
14 would have to be prescribed for something that would fit the
15 factors. My point is that they've so narrowed some of the
16 factors that you would have very few conditions that would
17 ever meet this test.
18 MS. CUMMINGS: You would be looking at a pandemic.
19 MS. BRILL: Flu vaccine, and we did have a problem
20 with flu vaccine a couple years ago. But that's what they're
21 talking about here. And I thought that that -- our office, I
22 don't want you to think this was just me -- our office felt
23 this was too narrow here. I'm sorry, Mark?
24 MR. MACDONALD: The real opportunity to get a lot
25 of money in unconscionable pricing is on the chronic stuff

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1 where you've got a lot of sales.
2 MS. BRILL: That's exactly right.
3 MR. MACDONALD: Ebola, you get one shot.
4 MS. CUMMINGS: Some of the highest prices are on
5 the things used most often.
6 MS. BRILL: Yes. That's absolutely true. There's
7 also a real problem with some miracle drugs, there's no
8 question, that are for very rare diseases that are keeping
9 people alive, but they're costing 30, 40 $50,000 a year for
10 consumers. And, you know, question whether those ought to be
11 examined in a health commissioner's hearing as to whether or
12 not those prices are unconscionably high. There were some
13 recent articles in the Wall Street Journal about some of
14 these conditions and how consumers are completely unable to
15 afford the payments and what some of the manufacturers are
16 doing to try to help them afford it. There's a lot of
17 discussion and debate around this.
18 So, that's another reason why I think 1, 2, and 3
19 need to be changed because as you all passed it, you didn't
20 say it had to be a large number of Vermonters, for instance,
21 in V-1, you just said, the number of Vermonters is to be
22 considered. Whether it -- it might be that it's a small
23 number of Vermonters, but if the other factors are that the
24 costs are extremely high, and there are many who can't afford
25 it, then the fact that it's a small number of Vermonters

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1 affected wouldn't kick you out, you would still be able to
2 meet this test.
3 MS. CUMMINGS: And it still has the 30 percent
4 higher than the government standard, so you have that, they
5 do have to meet their cost and research costs for --
6 MS. BRILL: Yes, exactly. And they always have
7 that defense. It's just a prima facia case. And that goes
8 to Senator Maynard's question of, well, what's the test of
9 whether it's an unconscionable price. We haven't even gotten
10 there yet, but yes, all that would still need to be met. So,
11 we would your urge you again now having fully considered the
12 constitutional issues -- and in fairness to Senate Health and
13 Welfare, they didn't have the benefit of this discussion that
14 I'm now giving you because I haven't yet been able to
15 communicate with all the people that were involved in the
16 District of Columbia case. But in light of now what is
17 clearly -- what clearly went on there, the amendments that
18 we're proposing we think address the problem but don't unduly
19 narrow the bill.
20 So we're saying with respect to B-1, get rid of the
21 language about, if a large number of Vermonters suffer from
22 the health condition, and the condition is lire threatening
23 in the short-term or has severe consequences, etcetera,
24 etcetera.
25 MS. AYER: I thought this was the definition of a

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1 health threat.
2 MS. BRILL: Correct. No, it's the factors that
3 shall be considered when you decide if something is a health
4 threat. It's kind of like the definition, but it's more like
5 factors that will be considered in a hearing, that's really
6 what it is.
7 MS. CUMMINGS: Because if the definition would say,
8 you know, more than 200 Vermonters are affected by this and
9 it would be more narrow. This is --
10 MS. BRILL: We're saying it's -- this is your
11 language, we're proposing going back to your original
12 language. So, if you look at the top of --
13 MS. AYER: I guess I'm getting confused between
14 unconscionable pricing and public health threat, which we're
15 defining and for what purpose.
16 MS. BRILL: So taking a step back, and I apologize
17 for maybe going a little too quickly.
18 MS. AYER: Well, I might be going a little too
19 slowly.
20 MS. BRILL: No, no, you're not. What you all
21 added, you in and this committee added the unconscionable
22 pricing section is before you get to unconscionable pricing,
23 the commissioner has to find that the indication that the
24 drug is used for the condition, the health condition, is a
25 serious public health threat. So, there's this additional

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1 step. So, before you get to unconscionable pricing at all,
2 and this business about is it above 30 over the federal
3 supply schedule, all that, first we have to go to the
4 commissioner and the commissioner has to find that there's a
5 serious public health threat.
6 MS. AYER: So this isn't going to affect the four
7 Vermonters with some rare disease, to start with, that's a
8 different --
9 MS. BRILL: We still can bring a case to the
10 commissioner saying, we've got a serious public health
11 threat, it only affects a small number of Vermonters, but
12 because it's a rare disease, but the price of this product to
13 treat them is unconscionably high. Now, the commissioner
14 wouldn't decide that final issue of, is it unconscionable
15 high. The commissioner would look at these five factors to
16 decide whether there is a serious public health threat. Then
17 our office would go to court and say, is this price
18 unconscionably high for this serious public health threat.
19 MR. MAYNARD: But you're basically, if I understand
20 correctly, suggesting we take any reference out to public
21 health threat.
22 MS. BRILL: I like the word, "problem" better than
23 threat.
24 MR. MAYNARD: Well, what about serious public
25 health problem? I mean, or do you have to have a standard to

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1 make it unconscionable?
2 MS. BRILL: You do not. 4654 could be deleted in
3 its entirety.
4 MS. AYER: That sort of answers my question.
5 MS. BRILL: It could be deleted earlier. And
6 again, I apologies because I'm going kind of fast because
7 there are other people that want to speak this afternoon.
8 MR. McCORMACK: But if it's deleted entirely, just
9 take it out the section?
10 MS. BRILL: Yes. You would just say -- in 4653
11 you'd say, a manufacturer of prescription drugs or its
12 licensee see shall not sell in Vermont a prescription drug
13 for an unconscionable price, is what you would say.
14 MR. McCORMACK: And that does not have a
15 constitutional problem?
16 MS. BRILL: Correct. It would not have a
17 constitutional problem. But given the fact that that was in
18 the bill as you guys introduced it, "you guys" meaning you,
19 the members of Senate Finance, you know, you already
20 determined that you thought that that was an appropriate step
21 to take, we can live with keeping that in. We're not
22 suggesting that you have to take it out. I'm telling you you
23 can take it out if you choose to; but if you leave it in, do
24 not make it so that it's so narrow that very few conditions
25 will come under the definition.

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1 MS. CUMMINGS: So what you're doing is, as I'm
2 reading is, you're deleting the word, "threat."
3 MS. BRILL: I would actually suggest you change it
4 to problem.
5 MS. CUMMINGS: I like threat because it's -- sorry.
6 But we're then defining that word the way we did more as just
7 not as a pandemic, but that a chronic condition, if suddenly,
8 because we seem to have a lot of MS in this state, MS drugs
9 went over the 30 percent above what the feds could get it
10 for, that standard, then we could take action or ask for a
11 hearing. So, there's a floor on this. You can't just say,
12 you know, we want you to sell it for the Wal-Mart four bucks.
13 MS. BRILL: Exactly. And Tamoxifen is another
14 example. I'm sorry, Tamoxifen. We brought an anti trust
15 case on that issue because there was lot of manipulation of
16 the market price of Tamoxifen; it's something that's needed
17 by women who have breast cancer, and it probably is used for
18 other conditions, as well. You know, it is not a short-term
19 condition. People who take Tamoxifen take it for potentially
20 years. And, you know, I -- at the very end of the debate in
21 Senate Health and Welfare said, are you trying to exclude
22 these, and they said, yes, because we're trying to address
23 this constitutional concern. And again, you know, people
24 dying from breast cancer have the same health outcome as
25 people who are dying from the flu.

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1 MR. MAYNARD: I think I can -- I opened a can of
2 worms when I said taking out threat. We were talking about
3 two things. Just not defining threat and going back to the
4 old language or going back to the old --
5 MS. BRILL: Well, it's defining it, you're giving
6 it factors, you're basically defining it. But I think
7 Senator Cummings said it best. It really doesn't matter if
8 you call it threat or problem, leave that aside. What's
9 important is, what are the factors that you're going to
10 require the health commissioner to look at. And what I'm
11 suggesting is, the language I put in here is exactly the
12 language you all had enacted or proposed, it's going back to
13 those factors that you all had suggested rather than the
14 narrowed factors that Health and Welfare has proposed.
15 That's what I am suggesting you go back to.
16 MS. AYER: Can you give me an example of how this
17 would narrow -- give you me a hypothetical --
18 MS. BRILL: How Health and Welfare would narrow --
19 MS. AYER: What you could do with the original
20 version versus what you can do with current version of Health
21 and Welfare, just something really brief?
22 MS. BRILL: Sure. I think Tamoxifen is the example
23 I would give.
24 MS. AYER: All right.
25 MS. BRILL: So, Tamoxifen is a hormone drug that is

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1 designed to attack or to keep breast tumors from coming back
2 that are hormone receptive, okay. And women who are required
3 to take it have to take it for years. Well, it is life
4 threatening, it is not life threatening in the short term,
5 okay, it is life threatening in the long term. It does have
6 severe consequences to health, but not in the short term.
7 So -- and it is not a condition that is highly contagious.
8 So, that one would be taken out automatically. I could give
9 you --
10 MS. AYER: That's good enough. I just wanted to
11 make sure I had a --
12 MR. MAYNARD: Might bankrupt you in the short term,
13 but it may --
14 MS. BRILL: Right, right, right. But it is a
15 long-term condition. It is, in essence, a life -- a
16 maintenance drug that is required to maintain life for women
17 who need it.
18 MS. AYER: Thank you. Good example.
19 MS. BRILL: Okay. So, going on to the changes.
20 So, we suggest you go back to your factors, we think that's
21 very important. Going to 4655, we've taken out --
22 MS. CUMMINGS: Wholesale.
23 MS. BRILL: Right. I think the reason we're
24 suggesting taking out the word, "wholesale," and I will
25 propose this here -- I need to think about this a little bit

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1 more -- is because the wholesale price is often established
2 outside of the state. But that's one of the things Robin and
3 I were having a late night conversation with a professor
4 yesterday about exactly the contours of all this. But for
5 right now, I will propose you take out the word, "wholesale,"
6 you insert in Vermont a couple of times in this
7 unconscionable pricing provision. And then the rest of it I
8 believe stays the same.
9 So, that would be our proposal, to address the real
10 constitutional issue and not a different constitutional issue
11 that doesn't exist.
12 MS. AYER: Madam Chair, I could be mixing up the
13 bills at this point -- imagine that -- but did we have a
14 discussion about the idea that most of the big transactions
15 for drugs aren't actually -- don't take place necessarily
16 inside the state, that we're looking at a very small pond?
17 MS. BRILL: Well, we are narrowing the pond. I'm
18 not sure that it's all that narrowed. You know, we -- we are
19 not -- we would not be going after wholesaler here, as you
20 see it requires us to go after the manufacturer, the
21 manufacturer's licensee, but the manufacturers do sell to a
22 wholesaler here, so there is a lot of commerce that is taking
23 place in Vermont.
24 MS. AYER: So, who can you get for this --
25 MS. BRILL: The manufacturers.

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1 MS. AYER: You're not going to get my guy Frank at
2 the pharmacy; right?
3 MS. BRILL: No. It's not -- we're not focused on
4 retailers here. We had a long discussion about that last
5 night.
6 MS. AYER: We haven't changed this, we're just
7 going back to where we were before which is --
8 MS. BRILL: That's the intent, but saying it's got
9 to be commerce in Vermont, that's exactly right. We're not
10 expanding it to focus on wholesalers or to focus on
11 wholesalers in terms of them being a defendant or to focus on
12 retailers. It's really designed to target the issue that
13 was raised at trial, that's the changes that we're proposing.
14 So in addition, I just want to underscore again the
15 need to get that OVA language in which appeared to have just
16 dropped out, dealing with privacy of their data, the
17 confidentiality of their data. So I'm available to come back
18 after you hear the Medical Society's proposals.
19 MS. CUMMINGS: I think what I said to Chairman
20 Racine is that I would like to give their committee a chance
21 to look at this. If they agree it's a reasonable compromise,
22 then we're all set, and the same with the other proposals,
23 and then they can come in Monday and tell us if they like it,
24 don't like it. We can decide if we like it or don't like it
25 today, and now we can see where we go, okay?

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1 MS. BRILL: Sounds great. Yeah, sounds great.
2 Thank you.
3 MS. CUMMINGS: Now I don't mean Monday, the first
4 day of the week. There's the legislative week and the other
5 week. First day of the week we're here. Okay. Madeleine
6 Mongan and Paul, okay.
7 MS. AYER: I've been saying Mongan for years.
8 MS. MONGAN: It's Mongan. I don't mind. So, I'm
9 Madeline from the Vermont Medical Society, and thank you for
10 having us back to talk about section -- in your bill, Section
11 13, the prescription privacy section. Paul's going to talk
12 about our compromise, and he'll be right up. But I just
13 wanted to give you a little bit of information that we have
14 developed since I was in here last. One of the questions
15 that you asked me was --
16 MS. CUMMINGS: A little bit?
17 MS. MONGAN: I'm going too hand these out, but I'll
18 be done in two minutes.
19 MS. CUMMINGS: I don't care how long you talk, I'm
20 just looking at the thickness of it.
21 MS. MONGAN: Well, I brought copies for everyone.
22 This is not how thick it is.
23 MS. CUMMINGS: Okay.
24 MS. MONGAN: It is an excerpt from the IMS annual
25 report from 2005 and what it shows -- you had some questions

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1 about it that I didn't know the answer to when I was in here
2 before. And it describes their sales force effectiveness
3 product, and on the second page which is what this is all
4 about and there's several components of that. And then on
5 the last page you can see that the revenue that this company
6 has from their sales force effectiveness product is 847
7 million dollars in 2005, and that it's been quite an
8 expansive growth in the two years before that. So, that's
9 all I wanted to bring that to you.
10 And then I have two other things that are sort
11 of -- give you an idea of how businesses are looking at the
12 New Hampshire law. And the first is -- I'll give you the
13 shortest one first. This is a short article from Forbes
14 Magazine that they're looking at the New Hampshire law and
15 the trial that's pending now and trying to figure out what
16 happens. And in the last sentence of this, you can see that
17 an analyst from Bear Stearns is reported in Forbes as saying
18 that he -- that this analyst thinks that The Judge is not
19 going to buy the free speech claim and that New Hampshire
20 will prevail in the lawsuit. But that's again just
21 background information.
22 And the other piece of information about the
23 business community's response, really, the pharmaceutical
24 manufacturing companies response to the prescription price
25 bill is this -- is this agenda for conference that Paul is

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1 going to be speaking at in a couple of weeks, which -- which
2 I'm not going to go into in detail at all, but it shows how
3 the pharmaceutical manufacturing companies are already
4 adapting their business practices to the prospect that they
5 might not have this information available. They're already
6 figuring out what to do about that and how to address it.
7 So, that's the information that I was just going to
8 bring to you today. So, Paul. I have what I have our
9 compromises are. Paul's going to come up and talk to you
10 about.
11 MS. AYRE: Who is CBI?
12 MS. MONGAN: It's on the form here. But the --
13 (inaudible) but it is the --
14 MR. HARRINGTON: Good afternoon. I'm Paul
15 Harrington, the executive vice president of Vermont Medical
16 Society. And as Madeleine and Julie Brill from the AG's
17 office has indicated, the Medical Society is here to
18 encourage you to retain in the S115 Section 13 that would
19 have Vermont follow New Hampshire's lead, and in order to
20 help control the costs of drugs here in Vermont, prevent
21 pharmaceutical company marketers from having detailed
22 information about -- of other physicians' prescribing history
23 when they go to that physician's office and try to basically
24 encourage that physician to stop prescribing generic drugs or
25 their competitor's drugs and prescribe their company's

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1 pharmaceutical product.
2 I'm just going to give you a little bit of
3 background. The Vermont Medical Society learned about this
4 proposal a year ago. Each year, the Medical Societies of New
5 England get together. Last spring we met in New Hampshire.
6 And our then president, Dr. Peter Dale, a physician here in
7 Central Vermont, learned from his counterpart in New
8 Hampshire that they passed this legislation preventing drug
9 marketers from having information about physicians'
10 prescribing. And the first question out of Dr. Dale's mouth
11 was: I had no idea they had this information. And that's
12 basically the common reaction from physicians, certainly in
13 Vermont and in New Hampshire.
14 This is something that physicians are unaware of,
15 that the drug marketers going to their office trying to talk
16 to them about the -- their company's products, has detailed
17 information about what their prescriptions were as early as
18 last week. And having that information are able to track the
19 effectiveness of the market. They can basically go in and
20 say, well, gee, if we say these kinds of things, that seems
21 to have an impact or a change in the prescribing patterns or
22 what have you. So, it's a terrific tool for the
23 pharmaceutical companies. And as Madeline said, they pay
24 this data mining company, IMS, 447 million dollars a year in
25 order to get this information. And organized medicine's not

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1 completely absent from this.
2 The American Medical Association provides
3 information to IMS that connects the physician with this
4 prescription information, and the American Medical
5 Association gives about 40 million dollars per year for
6 selling the information to IMS, the data miner, and another
7 company called Verispan. And in this article from Forbes
8 that Madeleine gave you, you can see the sums involved where
9 it cites the American Medical Association gives 40 million
10 dollars a year for the sales of their physician directory.
11 And then this article which probably is only US sales, it
12 talks about IMS and Verispan making 400 million dollars a
13 year to help support a 270 billion dollar pharmaceutical
14 industry here. So, you can understand the financial stakes
15 involved in this discussion.
16 So when the Vermont Medical Society learned that
17 New Hampshire had passed this law, the clear direction was,
18 we need to follow suit. We had a panel discussion at our
19 annual meeting last fall that Senator Ayre attended, it was
20 at the Basin Harbor Club, heard from Attorney General Sorrel,
21 representative from the AMA, and then state legislatures and
22 the president of the New Hampshire Medical Associates
23 describing why they did this. And we operate a little bit
24 like a legislative, we have an annual meeting, bring up
25 resolutions which were now get the bills, had a debate on

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1 that resolution passed unanimously that the Vermont Medical
2 Society take this marketing tool out of the hands of drug
3 marketers in order to help control pharmaceutical costs here
4 in Vermont and also protect the confidentiality of physicians
5 prescribing -- that is, from drug companies. We're not
6 trying to curtail the information for research purposes,
7 certainly insurance companies have that information through
8 claims. But we are trying to take this away for commercial
9 purposes.
10 The conference that Madeline indicated, and I'm
11 going to be joined by representatives from New Hampshire and
12 then West Virginia and -- yeah, West Virginia talks about
13 legislative efforts. And if you just open this brochure up
14 to the first inside page where it starts talking about some
15 of the topics under consideration before they hear about the
16 legislative activities. And I think in you're on Day 1, main
17 conference on the left-hand side; and just read the subject
18 matter for the first session at 8:45. Strategies for
19 preparing your sales force for targeting and selling to
20 physicians without prescription level data, and it goes on to
21 say, the absence of prescription level data should not be
22 seen as a bad thing. Pharmaceutical companies can put the
23 spin to work in and turn this into an opportunity to develop
24 smarter sales representatives.
25 And then perhaps even more telling in the session

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1 that begins at 9:30 in the morning, tap into current systems
2 and optimize data availability through closed loop marketing.
3 Goes on to talk about how much pharmaceutical companies have
4 invested in this. And then as you go to the last several
5 lines, the next generation solution can predict which
6 physicians should be visited and with what information in
7 order to better inform physicians about products resulting in
8 increased prescription rates.
9 So, I mean, this is a -- frankly, a Washington
10 based two-day conference, the attendees are paying $2,000 to
11 attend this conference, and it's all about how can we
12 basically, you know, encourage physicians to prescribe more
13 of the pharmaceutical company product. And they anticipate
14 that legislatures such as Vermont are going to put
15 restrictions on this kind of marketing tool, and they're
16 trying to figure out, okay, what do we do absent that
17 information that we relied on for so long and we pay close to
18 a billion dollars in order to obtain, so we've got to find
19 some other techniques here.
20 And just as Attorney General Brill and Madeline
21 indicated, we strongly support the Section 13 and the related
22 Section 14 as the bill came out of this committee; however,
23 we recognize that Senate Health and Welfare has taken a
24 different approach on this and feel that because the -- as
25 this Forbes article indicates IMS and Verispan, the data

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1 mining companies, have sued in federal and district court in
2 Concord, New Hampshire to try to prevent the New Hampshire
3 law from going into effect. And you can -- given the amount
4 of money involved, you can understand why they would try to
5 prevent New Hampshire's law from going into effect and slow
6 down this from become a snowball effect here. We don't think
7 that that is reason to not move ahead here. I had a chat yet
8 afternoon with a physician from Windsor county, Dr. John
9 Ledman, and he basically said every physician he's talked to
10 supports Vermont going ahead here.
11 If you do decide to find some common ground with
12 the Senate Health and Welfare Committee, we have developed
13 alternative language that certainly is not our preference,
14 but we think could be in place in order to get the
15 information about the New Hampshire lawsuit and then
16 presumably move ahead with Section 13, if you so desire. And
17 this language would show -- Madeline has passed it out, would
18 basically require the marketer to at least know -- let the
19 physician know that that marketer has this information about
20 this prescribing history. And so there would be a
21 requirement that the marketer disclose to the physician or
22 other prescriber any identifiable prescription information
23 that they have available. It would also -- and this is the
24 first paragraph, Paragraph A, provide the prescriber with the
25 information sheet about any programs that the manufacturing

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1 company or participants then collects and reviews
2 identifiable prescription information for commercial
3 purposes.
4 We kept going back to this commercial practice. We
5 in no way, shape, or form want to stifle the information for
6 research and for legitimate claims review, but commercial
7 activities -- to put and end to here in Vermont. And in the
8 third piece of this legislation would be to require the
9 marketer to basically -- if the physician feels given this
10 information that heretofore they have not been aware of the
11 detailed records that the marketers are keeping about the
12 physicians' prescribing pattern, and presumably the marketer
13 is going to try and make a good case as to why they should
14 have that information, if they make a compelling case, allow
15 the physician to opt in so that that could continue.
16 An alternative that we also discussed with Senator
17 Racine is an opt out; that would not be our preference, you
18 know, I think Julie Brill talked about consumer inertia. I
19 would not subscribe inertia to physicians, but they are busy
20 people, and they're not going to -- they want to treat
21 patients, they don't want to fill out for forms. So, I think
22 having the opt in is a strong preference. And then finally
23 in Paragraph C, the attorney general would be given the
24 authority to develop these forms and the opt in or opt out,
25 if that's your desire to do so, and hopefully do this in an

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1 expedited manner so that we could put an end to this or at
2 least inform physicians and then when you have the December
3 15th report specified in the Senate Health and Welfare
4 substitute amendment to Section 13, you can pass Section 13
5 next year, if that's your desire.
6 The -- I think we're all aware of the importance of
7 trying to control health care costs. We think this is an
8 important technique to do so and basically take some of the
9 current tools that insurance companies, pharmaceutical
10 companies use to, as the conference brochure indicates, to
11 encourage increased prescription rates. You will probably be
12 hearing from other witnesses about two private sector
13 initiatives that fall within the scope of this discussion.
14 The American Medical Association, the organization that gives
15 currently 40 million dollars a year to participate in this
16 does have an op out program. And it's interesting in the
17 flyer -- and I don't have enough of these, unfortunately,
18 to -- I'll pass this around.
19 MS. AYER: Excuse me. I didn't hear the beginning
20 of the sentence. Who has that program?
21 MR. HARRINGTON: The American Medical Association.
22 And on the cover of the flyer is this statement: Restricting
23 administrating access to prescribing data should be every
24 physicians individual choice. We agree with the sentiment,
25 we disagree with an organization that makes 40 million

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1 dollars off this kind of program being in control of what is
2 an opt out.
3 The second thing you'll probably hear about is a
4 program that the AMA is sponsoring that is paid for by IMS,
5 the company that is making close to a billion dollars on this
6 program, that basically would provide to physicians a history
7 of their prescribing patterns relative to specific drugs and
8 then encourage them to be aware of research around particular
9 drugs. In that this company has such a large financial stake
10 in working hand and glove with the pharmaceutical industry to
11 increase the number of prescriptions, having that kind of
12 effort actively a part of this marketing program, seems to me
13 a little bit like the trojan horse. You kind of bring this
14 attractive program into the physician's office and then at
15 the -- you're all aware of the story of the trojan horse.
16 So, while this may be a worthwhile initiative and certainly
17 worthy of consideration, it's a completely separate issue to
18 this discussion in our estimation. And we believe that it
19 really is somewhat unrelated to what we're seeking to do and,
20 that is, prevent pharmaceutical companies from having access
21 to this prescriber level data with the intent of trying to
22 encourage physicians to prescribe their particular drug.
23 Certainly, I've heard comments, well, if physicians
24 object to this marketing, why don't they just close their
25 door to the marketers, and some physicians do. But as most

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1 of you know, part of the attractiveness of drug marketing are
2 the free samples. And for a lot of physicians, those free
3 samples are what they give to their low income patients. So,
4 there's a, you know, sometimes some physicians, I think, take
5 advantage of the marketers to get the free samples to help
6 their low income patients. And certainly marketers can
7 provide important information about their particular product,
8 but we do not feel they should be able to provide that
9 information with the full knowledge of what drugs the
10 physician prescribed the week before.
11 So with that, I'd be happy to answer any questions.
12 MS. CUMMINGS: Any questions from the committee?
13 MS. AYER: Can you just -- could you just tell me
14 again in a couple of sentences what is the program -- which
15 is the trojan horse that's really not related?
16 MR. HARRINGTON: This is another AMA sponsored
17 program called Therapeutic Insights. It's funded by IMS, the
18 data mining company. And basically, they initiated the
19 program looking at particular conditions and then the drugs
20 that are appropriate for that condition. This issue I have
21 deals with the management of migraine in adults, and it
22 presumably would be tailored to a physician's prescribing
23 patterns so that physician, again, what they've been
24 prescribing, but prescription rates are in Vermont and
25 nationally and then try to educate the physician on what the

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1 best drugs are for that particular condition.
2 Certainly, physicians have that information readily
3 available from other sources. Again, when I was talking to a
4 physician yesterday and I told him about this, he says,
5 there's no way I want to spend more time with a drug marketer
6 going over my prescription patterns. So, we think this may
7 be worthwhile for some physicians, and we'll certainly
8 discuss it with our governing council, we're meeting next
9 month, but it should in no way be seen as an alternative to
10 what we're trying to achieve here.
11 MR. MAYNARD: That's an individualized report.
12 MR. HARRINGTON: It -- it certainly compares the
13 drugs prescribed in Vermont and nationally and then, you
14 know, absent the passage of Section 13, the marketer would
15 also have the drugs that the physician prescribed, as well.
16 So whether that would be in the report or in the marketer's
17 hands as he or she went through the information from Vermont
18 and nationally, I'm not a hundred percent sure.
19 MS. AYER: I feel compelled to say just for the
20 record that the Basin Harbor Club is in my district, and I
21 bought my own dinner. I didn't want you to think I was there
22 as a guest of the Medical Society.
23 MR. HARRINGTON: We were happy to have you there.
24 MS. AYER: Thank you.
25 MR. HARRINGTON: It was a great venue, and we'll go

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1 back there.
2 MS. AYER: Okay. Well, it's right down the road
3 from me.
4 MS. CUMMINGS: Okay. Other questions? If not,
5 thank you.
6 MR. HARRINGTON: You bet.
7 MS. CUMMINGS: And we now have Steve Kimbell.
8 MR. KIMBELL: Senator Cummings, thank you for
9 indulging us again. I'm Steve Kimbell, I'm an attorney and
10 lobbyist from Montpelier, and my client is a company called
11 IMS Health, of which Mr. Harrington just provided you some
12 information. I'm not going to repeat the testimony that I
13 provided this committee before. Like you, Madam Chairman,
14 I'm not exactly sure why we're back here for the second
15 round, but that's not my business, it's yours. And I did
16 present testimony from the general counsel of IMS Health
17 about the company and from Dr. Elliot Fisher over at
18 Dartmouth indicating that this information is very useful for
19 his work at the Center for the Evaluative Clinical Sciences,
20 which does a lot of variation data, and also from economist
21 Art Wolf who indicated that banning commercial use of this
22 data was likely to make drugs more expensive, not less
23 expensive. So, I won't belabor those matters.
24 As Senator Racine said when he was in here, I think
25 it was earlier this week, his committee's action in at least

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1 postponing consideration of this pending more information
2 from New Hampshire was that there was no evidence, in his
3 opinion, that banning use of this data for commercial
4 purposes would reduce pharmaceutical prices. And in the
5 absence of that evidence, that was his focus, he said, this
6 what were we're trying to do, we're trying to reduce drug
7 prices. And at that time I don't think there was any
8 evidence on either side of the issue. Since then a paper
9 done at a place called the Political and Economic Research
10 Council which on its website, you can look at it you want,
11 it's PERC and it describes itself as a nonpartisan centrist
12 policy institute for research and public education, and so
13 on. But they have done a study entitled, The impact of
14 provider identifiable data on health care quality and cost.
15 So, we're starting to get some scholarly information on this
16 subject which should lead to informed legislative decision
17 making.
18 The study -- a draft -- this is a draft of the
19 study dated March 15, so it wasn't available when you had
20 your hearings or when Health and Welfare did. And the full
21 study still hasn't been fully edited; it's going to be
22 published in a journal, and you know there's certain rules
23 about handing it out. But the lead author, Michael Turner
24 Ph.D., did authorize me to distribute to you the executive
25 summary, and I will leave it with you. But in brief, the

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1 study concludes that access to provider identifiable data by
2 pharmaceutical companies actually serves as a price
3 constraint, and he explains why. They also conclude that
4 banning commercial use of provider identifiable data will not
5 lower drug prices. They also conclude that the use of
6 provider identifiable data helps extend life expectancy; that
7 is, it saves lives because it gets drugs to the market
8 quicker and in the hands of the right physicians. And
9 provider identifiable date enables reductions in size of
10 pharmaceutical sales forces and prevents mismatches in
11 marketing.
12 So, I will leave that executive summary -- the
13 entire study is 60 or 70 pages and long, and I regret that it
14 hasn't been published yet, but I am grateful that I was at
15 least able to give you the executive summary. And once
16 again, this is a place called political and economic research
17 council PERC, P-e-r-c is there website. I went through it,
18 they've got a board of directors, and they are, apparently, a
19 thing tank. You can research them because obviously they --
20 MR. McCORMACK: Do you have copies?
21 MR. KIMBELL: Oh, sure. I've got as many as you
22 like, and I've got a few extras here for folks. Do we have
23 enough?
24 MS. CUMMINGS: Do you have a question?
25 MS. AYER: Can you tell me who funds Political and

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1 Economic Research Council.
2 MR. KIMBELL: You know, their website doesn't say.
3 I read it this morning, but, Senator Ayer, PERC, if you
4 Google that, you can find it. And you're right, you know,
5 you're right to ask the question. I don't know
6 where -- so, let me hand out some of these and -- so now I
7 think we do have some evidence on the question, would banning
8 the use of this data will do, and you can judge the quality
9 of the evidence, but I don't think there's any evidence from
10 the other side or the question.
11 Secondly, I did want to talk about the program that
12 Paul Harrington discussed that the AMA is sponsoring along
13 with my client, and that's called Therapeutic
14 Insights. And -- well, let's back up before I drag you
15 through it. I'd just like to point out a couple things about
16 this document --
17 MS. AYER: Is this the one we were just talking
18 about?
19 MR. KIMBELL: Yeah. I just wanted to point a
20 couple things about this. This is the third page in the
21 packet that Paul had. And if you'll note up at the top about
22 the third line down it says, in cooperation with the
23 Connecticut State Medical Society. So, this is an example of
24 this program as it's being done in Connecticut on a pilot
25 basis, and going to be rolled out rest of the country. And

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1 by the way, notwithstanding the fact Vermont Medical Society
2 has a very low membership in the AMA of its members, this
3 would still be available to Vermont physicians; it doesn't
4 depend on AMA membership, is what I'm saying.
5 And the key point about this, and I just vigorously
6 disagree with Paul that this isn't related to their
7 compromise proposal what their compromise proposal is
8 basically to have the pharmaceutical marketer give the
9 physician the data they've got on them before they talk to
10 them on or when they talk to them. And that data is, of
11 course, for use by a marketer, not for clinical use by a
12 physician. So, it really would add to the amount of paper
13 coming into a physician's office and not be particularly
14 useful. The same proposal was made in California by
15 physicians there saying, we were surprised, we didn't know
16 you had this information, we want to see it ourselves. And
17 the AMA and my client, IMS, and the California physicians
18 agreed on a protocol to figure out how to get this
19 information to physicians in a useful way. They did a focus
20 group with a bunch of docs, they said, how would it be
21 helpful for you to get your personal prescribing information.
22 And this program, Therapeutic Insights, is the result. It
23 started in January with, as Paul said, migraine which is a
24 disease, chronic disease for which a lot of pharmaceuticals
25 are prescribed, and it affects an alarming number, percentage

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1 of the population. I think this piece says 25 percent, which
2 was a little stunning to me, but a chronic disease.
3 And if you just look on the left-hand corner of
4 this document where it's in gray, it's a nice summary of how
5 this program is going to work. It's a quarterly continuing
6 medical education newsletter, so if you looked at the whole
7 document, physicians are going to be able to read the 10 or
8 12 pages, fill out a multiple choice quiz, and send in a
9 certification that he did it, and he's going to -- he or she
10 will get an hour of counting medical education for doing
11 that.
12 MR. MAYNARD: Now, is this an individualized?
13 MR. KIMBELL: I'm going to get to that. And it's
14 intended to provide primary care physician with evidence
15 based guidelines for selected medical conditions, so we're
16 going to go disease by disease. Migraine is the first one,
17 Type II Diabetes is the second; they're going to roll out one
18 disease per quarter. Will serve -- this CME activity will
19 serve as a clinical context for your review of personalized
20 physician prescribing reports that you can request after each
21 issue. So, each doc is to going to be able to ask on-line
22 for their personalized date.
23 MR. MAYNARD: Like a stock report.
24 MR. KIMBELL: But related to this disease. And
25 show -- these reports are for your use only and are intended

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1 to improve clinical practice, which was the goal of this, not
2 just provide useless information. Improve clinical practice
3 and prescribing habits, it's as a function of self
4 assessment. And here's the key, Senator Ayer, to review your
5 confidential, personalized prescribing data, go to, and then
6 it gives an AMA website. So, instead of just dumping up a
7 bunch of new data on physicians as the Vermont Medical
8 Society proposal would have you do, this program will give
9 physicians clinically relevant information comparing their
10 prescribing patterns with those in their state and
11 nationally. So, it's really a constructive way to go about
12 this. It was constructed by physicians, not by my clients,
13 IMS, Paul is correct that IMS is paying for it, because they
14 would like the data that they produced to be useful as well
15 as to make money off of.
16 I must say I think that the shallowness of the
17 Medical Society's position is emphasized by their use of the
18 large numbers that are involved in the pharmaceutical
19 industry today. I'm not sure how that's relevant. I'm on a
20 drug now that I wouldn't have been on a year ago because the
21 medical standards changed for cholesterol. You know, it used
22 to be where I was was okay, and now it isn't. So, I'm taking
23 some drug my doc told me to take. It's increasing. If that
24 saves my life, maybe the increased usage keeps me out the
25 hospital, is actually saving money. But I'm not sure what

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1 those red herrings about 400 million or billion dollars have
2 to do with this issue. I think the question here is: Will
3 banning commercial use of this data lower prescription drug
4 costs. The only evidence you've got before you, in my
5 opinion, is that it will not; in fact, it will have the
6 opposite effect. And furthermore, Vermont physicians, if
7 they want to participate actively in this AMA program, will
8 have their clinically relevant personalized prescribing data
9 disease by disease as this program rolls out.
10 So, those are the points I wanted to make. I think
11 the Health and Welfare Committee took a lot more -- had time
12 to take a lot more testimony than your committee did, Madam
13 Chair, on this question, and reached the conclusion that they
14 did, at least to wait, see if we can get some data from New
15 Hampshire about the impact that this has.
16 MS. CUMMINGS: Okay. Questions?
17 MS. AYER: So, I don't care about this program one
18 way or the other. Physicians choose to do it. But why would
19 I go on-line to find out what I do?
20 MR. KIMBELL: Because you probably don't now.
21 MS. AYER: Well, it's true that the practice I work
22 in has a very limited set of things that they do.
23 MR. KIMBELL: I mean, over time, Senator --
24 MS. AYER: You don't think people know what their
25 --

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1 MR. KIMBELL: Well, I think physicians I talked
2 with my doc, Randolph, he's a primary care doctor. He
3 doesn't know what he does. He's got so many -- I mean, on an
4 organized, statistical --
5 MS. AYER: He doesn't know that he usually
6 prescribes --
7 MR. KIMBELL: -- how much I did this year, last
8 year, what are the trends going forward, what should I be
9 doing.
10 MR. McCORMACK: It would be like when you go on the
11 Internet and looking at your stock portfolio and see how
12 you've done and what you've bought and what you've sold it.
13 MR. KIMBELL: Well, yeah. Or did I prescribe a lot
14 more drugs last year than this year with the same number of
15 patients; if so, why; what am I doing, how do compare with my
16 peers in the state, how do a compare with my peers national.
17 I don't know, if I was were a physician, I would think that
18 would be useful, tool. And it's not something that the
19 pharmaceutical marketer is going to bring into their office,
20 as Paul suggested. It's an on-line tool for physicians to
21 use when they want to use it.
22 MS. AYER: Well, for the sake of argument, it
23 doesn't really matter if they take it into the office or not,
24 it's that Steve, the detailer who always comes into our
25 office with -- to sell us birth control pills knows that even

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1 though we receive him with open arms and always listen to
2 what he says, we don't prescribe Orthonotin for most of our
3 patients, we prescribe some other drug.
4 MR. KIMBELL: Probably a generic that's less
5 expensive. In fact, Senator, I'm glad you made that point
6 because --
7 MS. AYER: But we listen to Steve because we
8 understand that he occasionally and maybe even often brings
9 us other new information.
10 MR. KIMBELL: I mean, that's a judgment. Somebody
11 said earlier --
12 MS. AYER: It's like listening to lobbyists, some
13 of them are good, and some of them you don't trust.
14 MR. KIMBELL: Well, and you've made that comparison
15 before. Physicians don't have to let in pharmaceutical
16 marketers who behavior badly into their offices. Some of
17 them, as you say, must be constructive because your employer
18 sees them.
19 MS. AYER: Some we spend time with, some we don't.
20 MR. KIMBELL: I'm glad you raised that because one
21 of the points is, these marketers are pounding on physicians
22 to prescribe brand name drugs instead of generics. Well, one
23 of the nice things about working, for a data company is that
24 they actually have some data. And I didn't make copies of
25 this, but I'll leave this one with the committee. This

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1 compares Vermont and the United States. Where there's a
2 generic alternative, the red is generics, the blue is brand
3 name.
4 MS. AYER: Don't they have to do that by law now,
5 that's the law.
6 MR. KIMBELL: Well, none the less, I'm just saying,
7 what you've got in place is working. If we're using this
8 data to force docs or convince docs to prescribe brand name
9 drugs in private plans where they can do what they want, you
10 know, it may be the law in government programs, but in
11 private plans, you pay Price A for a brand name, Price B for
12 a generic, and Price C for a preferred brand name. Well, the
13 marketing, if it's being used for what the proponents of this
14 provision claim, it's not working. And I'll just leave one
15 of those with the committee. I'm sorry I didn't bring
16 multiple copies, but that --
17 - - -
18 CD 07-89/TRACK 1
19 - - -
20 MS. GRETKOWSKI: -- hopefully on two issues, the
21 prescription data piece as well as the unconscionable pricing
22 parts of the bill. On the prescription data piece,
23 specifically on the Medical Society's proposed compromise or
24 alternative, I would submit to the committee that we are far
25 too far along in the process at this stage of the game to be

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1 entertaining a new idea and a new concept.
2 You know, this bill has already been through this
3 committee, Senate Health and Welfare, it's been noticed on
4 the floor for a second reading, and now it's back here again;
5 some of us aren't sure exactly why. But there has not been
6 time to fully vet it. And just as an example of one problem
7 that exists and the way that they have drafted it, in terms
8 of the disclosure that the pharmaceutical sales rep would
9 have to make to the physicians when he or she goes into that
10 physician's office, it said, it shall include the name of the
11 prescriber, name of the patient, if available, name of the
12 drug, date of the prescription, and amount of the drug
13 prescribed.
14 Well, according to our clients, that information is
15 not made available from IMS to the pharmaceutical company.
16 What it actually made available is the name of the prescriber
17 and the drug that is prescribed. All of these other things
18 are not made available. So, that's just one example of
19 potential problems with adopting without really a full
20 vetting of all of the issues that are in here would lead is
21 to if you were just to take this and insert this in the bill
22 as is as it. And again, I go back to this name of the
23 patient. I think there has been testimony throughout this
24 process that this information that goes from -- actually from
25 the pharmacy to IMS to then the pharmaceutical companies, is

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1 patient de-identified, there is not an issue there. And I
2 just found it surprising that our Medical Society would
3 actually be saying that they thought it would be okay if
4 patient names were actually available, that that's going to
5 be more information that is going to be replayed throughout
6 this process. There are serious HIPAA problems here, federal
7 law, confidentiality of medical information.
8 The other point I would like to make in connection
9 with the Medical Society's proposal is, you folks several
10 years ago passed a Price Disclosure Law which basically says
11 that when a pharmaceutical rep goes into an office, they have
12 to give the doctor the relative prices of the other drugs in
13 that therapeutic class. And so, that's been in effect, that
14 has been happening, the attorney general's office developed
15 the guidelines around exactly what has to be included in
16 that. The attorney general's office actually approached us
17 before the section started because they were starting to get
18 complaints from physicians from nurses and physicians'
19 offices that this is too much paper. You know, they're
20 coming in with reams of paper, and I think AG even testified
21 to that here, and we're working with them to try to
22 streamline that. What would this do on top of that, you
23 know, if they're going to be coming in piling on more
24 information on top of that, is that going to just sort of
25 compound the problem.

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1 So those are really my two points specifically with
2 respect to their proposal. And again, I would just really
3 echo Senator Racine's comments to this committee, you know,
4 In terms of there has been no data that this will actually
5 lower the cost of prescription drugs and just all the other
6 points that he made.
7 So, secondly, on the unconscionable pricing. It is
8 true that you do not have an interstate commerce problem if
9 you have a transaction that is between, say, a manufacturer
10 outside the state and a wholesaler or perhaps an independent
11 pharmacy inside the state. There you have, you know, the
12 transaction occurs in the state of Vermont. However, that's
13 as far as it goes. If you have a transaction between an out
14 of state manufacturer and an out of state wholesaler who then
15 may be sells to a chain, pharmaceutical or chain pharmacy,
16 that then makes drugs available in Vermont, that is not a
17 transaction in the state. And actually this goes back to
18 Senate Ayer's question of, exactly what would this as
19 proposed by the attorney general now, what would this affect.
20 So, there are no pharmaceutical manufacturers in Vermont;
21 there is one wholesaler in Vermont, and that's Burlington
22 Drug, and they account for about 20 percent of the drugs that
23 come into Vermont. The other 80 percent of the drugs that
24 come into Vermont go from a whole -- manufacturer out of
25 state to a wholesaler out of state to a chain out of state

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1 and then coming into -- you know, the distribution channel
2 into Vermont. That would not be touched by this. That would
3 -- if we tried to touch that transaction between the
4 manufacturer and the wholesaler out of state, that would be a
5 violation of the interstate commerce clause. So, I guess
6 practically speaking, you know, what are you really
7 accomplishing by doing this. Apparently back in -- I think
8 it was 2000 when you folks were doing S300, there were
9 discussions about doing price controls in that bill, and
10 apparently Burlington Drug did testify at that time. They
11 have not weighed in on this at this time.
12 So, the question is, what would happen to them,
13 would they stay in Vermont if -- and again, the attorney
14 general is right, she has not aimed this at the wholesaler.
15 But again, if the manufacturer is going to be subject to this
16 with interstate wholesaler, will they continue to sell to
17 that interstate wholesaler. No. 2, there were multiple
18 constitutional issued involved in the DC litigation, it
19 wasn't just the interstate commerce clause. The other one
20 was the supremacy clause, and this -- I'm not going to get
21 into a whole lot of detail here, but basically, patent law is
22 federal law on the federal level. And the claim was that by
23 trying to go after drugs that were patented drugs, that would
24 have been a violation of the supremacy clause, that federal
25 laws have supremacy over state laws. What the attorney

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1 general has done in this particular case is to try to get
2 around that constitutional challenge by saying, this not only
3 applies to patented drugs, which is what the DC law did, but
4 it also applies to unpatented drugs, which are basically
5 generic drugs. So, the DC case found that there was a
6 violation of the supremacy clause with respect to patented
7 drugs. So if that's going to continue to be upheld, the only
8 thing that would be affected by this would be the cost of
9 generic drugs.
10 And I think you've had testimony in this committee
11 that the cost of generic drugs in the United States tends to
12 be lowest, at least vis-a-vis Canada and lower than a number
13 of other countries. So, would anything actually, practically
14 speaking, be affected by this according to the DC litigation.
15 So -- and again, there were a couple other constitutional
16 issues with this, as well. So, it's not 100 percent fixed if
17 you figure the interstate commerce clause issue. So, that's
18 my testimony.
19 MS. AYER: Going back to the first part of your
20 testimony, the proposed defendant. We're reading it
21 differently, and I guess I just want to make sure I have that
22 right. What I read in A is that marketer -- and that would
23 be the drug detailer case I go back to every time -- tells
24 the physician any identifiable prescription information
25 relating to the physician, so his or her drug practices, and

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1 accessible to the pharmaceutical marketer, so the physician
2 would know the name of his own patient or her patients. I
3 think that's not giving the physician any new information.
4 MS. GRETKOWSKI: Well, why is it in here, is my
5 point. I mean, if all the pharmaceutical marketer has is,
6 Dr. Ayer, and you prescribe, you know, Lipitor and whatever
7 it is you're prescribing --
8 MS. AYER: And the marketer doesn't have it, then
9 the marketer doesn't need to give it to the physician, but
10 even if the marketer did, it's information that was the
11 physician's anyway.
12 MS. GRETKOWSKI: Well again, I think there's
13 significant HIPAA issues involved if that were to be the
14 case, there's no question about that.
15 MS. AYER: I agree with that. I didn't see this as
16 permissive is that a -- whatever --
17 MR. MAYNARD: I'm not sure I follow the
18 unconscionable pricing chain. As far as out of state
19 wholesalers.
20 MS. GRETKOWSKI: Okay. To not be in violation of
21 the interstate commerce clause, the transaction has to occur
22 within the state. So, when you have -- and all
23 pharmaceutical manufacturers are out of the state, there's
24 none in Vermont. So you have an out of state manufacturer
25 selling to an in-state wholesaler. That is the transaction

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1 that occurs within the state. And that is the transaction
2 that again, does not violate the interstate commerce clause.
3 In Vermont there is one wholesaler in Vermont which accounts
4 for about 20 percent of the drugs. Everything else comes
5 through out of state wholesalers, so the out of state
6 manufacturer sells to an out of state wholesaler. That would
7 be the transaction that this is trying to get at. And it
8 can't get at that because that transaction occurs outside
9 Vermont, okay? So, you have to be outside, you know, it just
10 -- that's an interstate commerce clause problem, so --
11 MS. LUNGE: And I don't know the answer, that's why
12 I'm asking. Do you know -- I think there are also
13 manufacturers who sell directly to hospitals or to chain
14 pharmacies or to chain -- you know, big chain stores like Wal
15 Mart or grocery stores with pharmacies. So, I would assume
16 that those transactions also happen in Vermont but not
17 absolutely everything goes through a wholesaler; for
18 instance, things that go through a PBM wouldn't go through a
19 wholesaler. So, I just don't if you know anything about the
20 prevalence of that.
21 MS. GRETKOWSKI: I don't know anything about the
22 prevalence of it, but again, if a manufacturer is selling to
23 a chain, it's where that transaction occurs. So if Brooks is
24 headquartered out of New York or Connecticut or whatever,
25 that is where the transaction occurs. You know, you would

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1 have to have the chain headquartered in Vermont and then --
2 for that transaction to actually occur in Vermont. Just
3 because a manufacturer sells to a chain and that chain
4 happens to have stores in Vermont, and that drugs sold in
5 those stores in Vermont, that is not enough to get you to
6 have the transaction actually occurring in the state of
7 Vermont.
8 So, now, if there is a direct sale -- Robin, just
9 to go further with your question, if there a direct sale from
10 the manufacturer to an entity in Vermont, you know, if
11 they're selling directly to a hospital, something like that,
12 then you -- you don't have an interstate commerce clause.
13 MS. CUMMINGS: Or directly to the consumer.
14 MS. AYER: Prescription assistance programs?
15 MS. CUMMINGS: No. I'm just saying or drugs are
16 sold directly to the consumer, there's a transaction
17 somewhere in that chain.
18 MS. GRETKOWSKI: Right. But again, they're not
19 sold from the manufacturer directly to the consumer; again,
20 you go through that whole --
21 MS. CUMMINGS: You go through the chain.
22 MS. GRETKOWSKI: Right.
23 MR. McCORMACK: So, we're busting all the points.
24 MS. GRETKOWSKI: You know, I guess my question
25 would be Rich Harvey who has opened up an independent

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1 pharmacy here in Montpelier, if he is buying directly from
2 the pharmaceutical manufacturers, that would be covered under
3 this. If he isn't, then it's not.
4 MS. CUMMINGS: Well, we'll leave that to legal
5 research. This sounds like one that we have a multiplicity
6 of legal opinion.
7 MS. AYER: But this is all going to unconscionable
8 pricing, is that correct, it's not just --
9 MS. CUMMINGS: So, we will have -- let our legal
10 folks research it and give us an opinion. Any other
11 questions?
12 MR. MAYNARD: Do you want to hear again from the
13 AG's office?
14 MS. CUMMINGS: Yes. And I'll give her time to do
15 some work on that. I also want to give time for the other
16 committee to take a look at all of this and tell us their
17 thoughts on it.
18 MS. AYER: Susan, could you just go through really
19 quickly again why the DC case will affect generic -- price of
20 generics more than -- I just didn't get it.
21 MS. GRETKOWSKI: Okay. Patents are controlled by
22 federal law. It's sort of a creation of federal law. And
23 so, and there's all kinds of public policy reasons built in
24 behind the federal patent law basically saying that if an
25 entity, you know, whether it's the -- you know, invention of

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1 this or that or the next -- or a drug, you know, all of the
2 time and effort that goes into getting a product that you can
3 actually take to market that is effective, be it a light bulb
4 or a prescription drug, that needs to be recognized and
5 protected and then also encouraging the development of new
6 technologies or whatever it is. So, that is protected by
7 federal law. So in the DC case, what they looked at is
8 saying that the DC law, by controlling or being able to
9 control the prices pegging them to other countries, DC pegged
10 it other countries not the way we did it in this particular
11 bill --
12 MS. AYER: Countries, you said?
13 MS. GRETKOWSKI: Countries. It was the four
14 highest income countries, so that's what they're 30 percent
15 was pegged to. Ours is pegged to, you know, the federal
16 supply schedule, Medicare, things like that. So what they
17 said was, that is infringing on the productions afforded to
18 the inventor under the Federal Patent Act, and therefore that
19 violates the supremacy clause of the constitution. Because
20 there's a number of clauses in the constitution and what the
21 supremacy clause says is --
22 MS. AYER: Right now we're talking about patented
23 drugs?
24 MS. GRETKOWSKI: Yeah, just patented drugs. So
25 what the supremacy clause says is, there are certain things

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1 that are -- that Congress has reserved to regulate itself,
2 that the states really do not have the ability to regulate.
3 So, if there's a violation of -- if a state tries to encroach
4 on something that is controlled by federal law, that's a
5 violation of the supremacy clause, okay. Now, the DC case or
6 the DC law was only vis-a-via patented drug. What is in here
7 is patented and non-patented drugs.
8 So, assuming that the DC law will be upheld on
9 appeal, the supreme clause will preempt the ability to apply
10 this to patented drugs, okay? Because that's what was found
11 on the trial court -- or the district court level. However,
12 generics -- well, it's -- first of all, it's unclear exactly
13 what's going to happen with generics. But if it is upheld,
14 the generics can be covered by this. You know, my question
15 is, generics are the -- most of the time the most inexpensive
16 drugs. I think there's been testimony throughout this whole
17 process that they are cheaper in Vermont than they are in
18 countries -- or they're cheaper in the United States than in
19 other countries. So, practically speaking, will this really
20 have any effect, you know, if you're going to be limited to
21 generics and if they're basically, you know, very low cost at
22 this point.
23 MS. AYER: So just to make sure I got it. So, the
24 DC case only addresses medicines under patent, and if it's
25 upheld, as you believe it will be, then our law will only

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1 apply to generic.
2 MS. GRETKOWSKI: That would be my reading of it.
3 MS. CUMMINGS: Okay. We'll let legal counsel shed
4 light on that one. Any other questions, committee? Okay,
5 not. Thank you. I'll let you mull on this through the
6 weekend. Give me a deliberational call if you want to
7 hear --
8 (CD ended.)
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1 CERTIFICATE
2
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4 STATE OF FLORIDA)
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6 COUNTY OF POLK)
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8
9 I, Evelyn M. Adrean, Notary Public, Registered
10 Professional Reporter, Florida Professional Reporter, do
11 hereby certify that I was authorized to and did listen to CD
12 07-87/T1, 2, and 3, 07-88/T1, and 07-89/T1, The House
13 Committee on Finance, Friday, March 23, 2007 proceedings and
14 stenographically transcribed the foregoing proceedings and
15 that the transcript is a true and accurate record to the best
16 of my ability.
17
18 Dated this 21st of August 2007.
19
20
21 ____________________________
22 Evelyn M. Adrean, RPR, FPR
23 My Commission #DD360489
24 Expires October 5th, 2008
25