STATE OF VERMONT
SENATE COMMITTEE ON HEALTH AND WELFARE

Re: Senate Bill 115
Date: 3/15/2007
Type: Prescription Drug Regulation

Committee Members:

Sen. Doug Racine, Chair
Sen. Ed Flanagan, Vice-Chair
Sen. Sara Kittel
Sen. Virginia Lyons
Sen. Kevin Mullin
Sen. Jeanette White

CD No: 07-56/T1

Reported By:
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Phone - 407.426.7676
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PROCEEDINGS

- - -

CD56/TRACK 1

ATTENDEE: This is the Senate Health and Welfare Commitee. Today is Thursday, March 15, 2007.



COUNTY OF SEMINOLE. )

I, Christina Gerola, Notary Public in and for the State of Florida at Large, do hereby certify that I was authorized to and did listen to CD 07-56/T1, the Senate Committee on Health and Welfare, Thursday, March 15, 2007, proceedings and stenographically transcribed from said CD the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 20th day of August, 2007.

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Christina Gerola
Notary Public - State of Florida
My Commission No.: DD617707
My Commission Expires: 12/10/10

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CD56/TRACK 2

THE CHAIRMAN: First of all, the -- Sharon Treat apparently was disappointed she didn't get a chance to talk to us yesterday, but she had some information that she wanted to share with us about the PMBS. I think we already resolved the PBM part mostly, and I don't think she would have any problems with what we did, but I don't know that. But anyway, her testimony is in front of you. And that's the way it goes.

I'd like to -- Robin, you have in front of you Robin's draft -- I believe we're going to do this, which would be as amendments and not as a strike all, which I thought was probably a better -- maybe a better way to present our changes on the floor. Rather than start at the beginning, I'd like us to resolve the last two issues, major issues that we have in front of us, which was section 13.

ATTENDEE: Mr. Chairman?

THE CHAIRMAN: Not 13. I'm sorry. Yes?



ATTENDEE: I know that this is probably the best way to go, but strategically, I would think if we did a strike all, I'm afraid that this could get separated into a lot of different votes. I don't know.

THE CHAIRMAN: Well, yeah. Let's think about that. I suspect it's going to anyway.

ATTENDEE: You think so?

THE CHAIRMAN: Yeah. I mean, as a strike all, anybody can come along and say I propose that section X be struck and this be substituted in its place.

I guess my thinking was for -- I mean, the underlying bill was the finance committee's bill, and they're going to present it. And we're going to come along afterwards and say -- and go through it piece by piece. And they're going to say we'll accept some of the amendments but there are three we object to. I'm being optimistic. There are 13 we object to. I don't know. Let's -- we can think about it. A strike all, we're still going to have to go through where the differences are. And with a strike all you end up with two bills in front of you, and trying to ascertain where the



changes are. And this way they're highlighted, because they are -- each section. Each section that's being changed is in this, and the other sections aren't.

But anyway, I'm rambling, and I don't know what the answer is.

ATTENDEE: (Inaudible) stress relief.

ATTENDEE: I guess.

ATTENDEE: (Inaudible.)

ATTENDEE: AHEC.

ATTENDEE: AHEC.

THE CHAIRMAN: You know, we really ought to pass seats around to these folks.

ATTENDEE: You think they need them?

THE CHAIRMAN: More than -- more than we do.

I'm counting on you acting like an adult.

ATTENDEE: I just came out of campaign finance reform. There's no adult left in me.

THE CHAIRMAN: So anyway, Robin, I think where -- what we had left you with was the task of putting a couple of options in front of us, and in two of the major areas. One was the -- the unconscionable pricing --

MS. LUNGE: Yes.



THE CHAIRMAN: -- section 17. So why don't we start with that, which is on page 10 of Robin's draft of amendments.

ATTENDEE: And this is Robin's draft of amendments?

THE CHAIRMAN: That's Robin's draft of amendments, yeah.

MS. LUNGE: So what I did in the draft -- this is Robin Lunge, legislative counsel. What I did in the draft of amendments is, as Doug said, two options.

The first option keeps the structure -- the overall structure of the unconscionable pricing section but modifies that serious public health problem section to try and tailor it more closely.

The second option is basically a price gouging type of statute which I based on the fuel price gouging statute we currently have in our consumer fraud chapter of law combined with some of the language from the main version, because that included prescription drugs. So that is the second option that you have.

So maybe I'll walk through the first option in a little more detail. So on page 10

it modifies the language throughout to say -- change problem to threat, because I think that gives it a heightened -- it gives it a heightened sense.

ATTENDEE: More threatening.

MS. LUNGE: Yeah, exactly. And just to be clear, because we were thinking also in terms of communicable diseases, which may notintuitively fit into the term health condition, I added the word disease to that first paragraph as well and throughout the lead-in sentences and in a couple of other places.

And most of the work was in the factors that the commissioner would consider. So I tried to tailor the factors so that they had clearer and tighter language.

So the first factor I changed to say that the commissioner would consider the factors when declaring that a health condition or disease is a serious public health threat if a large number of Vermonters suffer from the condition and the condition is short term and life threatening or has severe consequences to health or -- so that was limited to short term,



life threatening, or severe health risks, first, or if the condition is highly contagious and threatens a large number of Vermonters, which kind of gets the flu epidemic, contagious disease type thing.

ATTENDEE: Can I ask a question for clarification? What is a severe consequence to health, because its --

MS. LUNGE: That is something that the department of health could define more specifically in rule. So what I was thinking is that -- I mean, I don't know enough about clinical results to know if life threatening is enough, or if that is too narrow.

So there might be -- for instance, there might be flu epidemics that were severe enough that they made you really sick and could really seriously damage your health. I mean, flu is probably a bad idea because I think that could be life threatening. I just don't know the clinical stuff well enough to know --

ATTENDEE: So it has to still be suffered by a large number of Vermonters?

MS. LUNGE: It still has to be suffered by a large number and be short term.



ATTENDEE: And short term.

MS. LUNGE: So that first prong --

ATTENDEE: So the comma is after short term. So it's -- it's --

MS. LUNGE: So the comma is -- so the first prong is large number of people suffer from the health condition, and --

ATTENDEE: And it's short term.

MS. LUNGE: -- the large number -- right. So the condition has to be short term and life threatening or short term and severe consequence to health.

ATTENDEE: Okay. So the -- and -- short term goes along with severe consequence. I didn't read it that way. Sorry. Okay.

ATTENDEE: Can I comment? Because I think I'm responsible for the short term term.

My intent was to indicate that the life threatening is a short -- is not -- I'm sorry. The condition isn't short term, but it would soon be life threatening if it was not addressed.

ATTENDEE: No. No. No. I didn't mean -- I wasn't questioning short term.

ATTENDEE: But I wonder whether in this



usage short term makes one think that the condition is a short term condition which clinically usually means it's kind of self-limited and not a long-term problem.

ATTENDEE: So what would you recommend?

ATTENDEE: I would just strike that to say life threatening or life threatening in the short term.

ATTENDEE: I think that one of the issues there for me was that obesity, in my mind, is suffered by a large number of Vermonters, probably is life threatening or certainly has severe consequences to health, but I don't know that it constitutes a --

ATTENDEE: See, that's where the short -- it needs to be life threatening in the short term.

ATTENDEE: Well, okay, so that's where short term comes in.

ATTENDEE: So we can move then.

ATTENDEE: Short term on the other side.

ATTENDEE: Right. Right. Right. That makes me happier.

ATTENDEE: Also, do you think the word predictably in the short term -- in other

words, anything could just happen in the short term like a heart attack. But if you can predict, that sort of flows --

ATTENDEE: We're talking about the whole condition of the population in this context where we can be fairly sure that it will have a short-term consequence, maybe not for everybody, but for enough of the involved people to justify. So it's really not an individual by individual thing.

ATTENDEE: Before we go any further with this - I'm sorry - I think we should decide, before we get to the words, which option we want to work on, because we can go through the words on both of them. We're only going to pick one. So --

ATTENDEE: So --

ATTENDEE: Okay.

(Unreportable background exchange ensued.)

ATTENDEE: This is the preferred way of doing it. I think we've got the idea of what this first option would do. If you can describe how the second option works, and then we can decide between the two and then wordsmith only one of them.



ATTENDEE: That makes sense. So the second -- the second option would be added to the Consumer Fraud Act, which is where the price gouging for fuel is. It's in that same area. So I would add it to -- we already have a consumer fraud act provision in the bill. So I would add it to the end of that provision. So it would be a new subdivision E, and it would say that it's an unfair and deceptive act and practice in commerce and a violation of this chapter for any person during a market emergency or seven days prior thereto to sell or offer to sell any prescription drug for an amount that represents an unconscionably high price. That's mirrored after the language we have in the fuel, unconscionable pricing for fuel.

A price is unconscionably high if the amount charged during the market emergency or seven days prior thereto exceeds 15 percent of the sum of -- and again, everything in that sentence is modeled after our law except the 15 percent comes from the Maine law.

The price at which the product was sold or offered for sale by that business in the usual



course of business immediately prior to the date of the declaration of the market emergency or the price at which similar drugs in the same class were offered for sale or sold by another person similarly situated prior to the abnormal market disruption.

So it's 15 percent -- the price after the market disruption is 15 percent higher than what the same person was selling the drug for before the market disruption or someone else, if it's not the same person. For instance, if somebody started selling the drug after the market disruption, so you couldn't compare it back because they hadn't been selling it, you'd compare it back to what somebody else was selling the drug for. So you compare it to one of those two markers, and you also add in the increased cost attributable to the market emergency calculated using the same method the person used prior to the market emergency.

So it's not a strict 15 percent difference. You also allow some additional cost for reasonable expenses because of the market disruption.

ATTENDEE: The fact that they couldn't



send a truck in with it or fly it in or whatever, because there was an ice storm. Okay. I got that.

MS. LUNGE: Now, I'm -- one of the things --

ATTENDEE: Any initial reactions to this?

ATTENDEE: I tend to go with the gouging.

ATTENDEE: The second one?

ATTENDEE: Yeah.

ATTENDEE: Why? Because I was going to go with the first one.

ATTENDEE: Just because we're after the (inaudible) and money is (inaudible) in my mind. So instead of identifying a condition, it just seems illogical to (inaudible) --

ATTENDEE: I don't know how we define a market emergency in this one. That's --

MS. LUNGE: Well, that's a good point, and I actually meant to, and I guess I forgot to include our current definition of market emergency that's in title 9.

ATTENDEE: Do you want to pull that out here?

MS. LUNGE: Sure. It's in the consumer fraud act. If you want to just hand it to me,

that might be easiest.
ATTENDEE: I've got 9-A. Or is it just 9?
MS. LUNGE: Just 9.
ATTENDEE: Maine defines it as significant disruption to the production, distribution, supply, sale, or availability of a commodity that is caused by an event such as a natural or manmade emergency or disaster and causes ordinary competitive market forces to cease to function normally.
That's the way they define it.
MS. LUNGE: And the way we define it is a market emergency -- we have a definition and a process. So at least the process probably should be imported into this section, if you choose that one.
A market emergency shall be declared by the governor. The market emergency shall continue for 30 days or until it is terminated by the governor. The governor may extend the market emergency for additional 30-day periods.
Market emergency means any abnormal disruption of any market, in this case for petroleum products or heating fuel products, including any actual or threatened shortage in



the supply or any actual or threatened increase in the price resulting from severe weather, convulsion of nature, supply manipulation, failure or shortage of electrical power or other source of energy, strike, civil disorder, (inaudible) or terrorist attack, national or local emergency or other extraordinary adverse circumstances.
ATTENDEE: (Inaudible.)
ATTENDEE: Yeah. That's -- yeah.
ATTENDEE: I was just going to say, these are two distinctly different --
MS. LUNGE: Approaches.
ATTENDEE: They're really different approaches. And that one, I think, would need a whole lot more drafting to include medical, health emergencies, whereas I think the language in the first option is very specific to --
ATTENDEE: Because it isn't the availability of the -- of the drug, it's the vast situation in which it's needed --
ATTENDEE: An increased need for it.
ATTENDEE: (Inaudible.)
ATTENDEE: I think this other one is



actually more subjective, which makes me feel a little better, because the Health Department and the governor can say, you know, there's a flu epidemic, and people are dying, and all of a sudden prices have gone up 100 percent for these medications.
ATTENDEE: But there's been no convulsion of nature. I want to get that in there somehow though.
(Unreportable exchange ensued.)
ATTENDEE: So we don't like it for this one.
So option 1, folks? Okay. Let's go back to wordsmithing for that one and see if we still like it.
So we've done changing short term and life threatening to life threatening in the short term?
MS. LUNGE: Yes. So are there more thoughts on 1? Do people think 1 is narrowly tailored enough at this point?
Because that's -- again, these are conditions. So it doesn't -- basically what the commissioner would do is, the commissioner has to consider each of these together. So you



have to remember that not each one in isolation but the whole package.
So the first one is a large number of people with either life-threatening, short-term condition or -- actually, should the in the short term refer to both the life threatening and the severe consequences to health?
ATTENDEE: It certainly could. And that would get us off the obesity issue.
MS. LUNGE: Okay. So maybe we should move that to the end of that phrase. So if a large number of Vermonters suffered from the condition and the condition is life threatening or has severe consequences to health in the short term.
ATTENDEE: And it only modifies the last -- in the short term on both of them is what we're trying to do.
MS. LUNGE: I think by putting it at the end it does modify both, but if it makes you feel more comfortable, we can put it in both places.
ATTENDEE: I don't know if my 8th grade English teacher would --
MS. LUNGE: Would agree?

ATTENDEE: You should have your 8th grade teacher read the liquor control statutes.
ATTENDEE: I wouldn't want my English teacher looking at any of this stuff.
MS. LUNGE: Well, we'll put it in both. I mean, you can't have grammar and law in the same room. I'm sorry.
(Unreportable exchange ensued.)
ATTENDEE: Bernie Male (phonetic). Bernie Male was our grammarian in here.
(Inaudible.)
ATTENDEE: Okay. Why don't we keep going.
MS. LUNGE: Or if the condition is highly contagious and threatens a large number of Vermonters.
The second criteria or factor would be, if the cost to the state employer-sponsored insurance and private insurers of treating the health condition with prescription drugs would be extensive without intervention. Maybe that should be intervention by under this chapter or something like that.
But what I was trying to get there was narrow that again to say that you're looking at not just, well, obesity is really expensive to



treat, but, okay, we have this targeted, emergency-ish, maybe not emergency, emergency, but threatening situation, and it's going to be expensive to -- just in the absence of doing something.
ATTENDEE: It would be extensive or expensive without intervention.
MS. LUNGE: We could say extensive.
ATTENDEE: I think I'd like that word better. It's one of those the spell check doesn't quite find. Okay.
MS. LUNGE: Okay. So 3, if the cost of the prescription -- of a prescription drug or a class of drugs used to treat the condition is prohibitively expensive to the extent that that information is available.
So in addition to looking to how much it will cost in the aggregate, looking at the specific treatment, and if it's a very inexpensive treatment, even if in the aggregate it would be very expensive, you're going to factor that in. So that would sort of push us towards if there was a cheap treatment and the reason it was expensive is because there's a lot of people, you probably wouldn't trigger



this section.
ATTENDEE: Can I ask a question?
MS. LUNGE: Sure.
ATTENDEE: I -- maybe I didn't read this or pay close enough attention, but I don't see anywhere here where it talks about any kind of increase in the prices. I mean, if the price has -- well --
ATTENDEE: It doesn't say that.
MS. LUNGE: That's in another section of the bill which you didn't amend, at least not yet. So it's not in the amendment. But there is the definition --
ATTENDEE: But it does refer to the fact, because here the drug might be prohibitively expensive, but it's always been prohibitively expensive, and now the fact that 400 people have it instead of 39 --
MS. LUNGE: Right. This is the first step.
ATTENDEE: Okay.
MS. LUNGE: The way the bill sets it up -- sorry. I shouldn't have just put a whole gigantic piece of chocolate in my mouth.
ATTENDEE: Yes, you should have.



MS. LUNGE: The first step is that the commissioner of health has to declare this a public health threat.
ATTENDEE: Okay.
MS. LUNGE: So you don't even get to look at the change in prices until you get past this first step.
ATTENDEE: And all we're doing here is declaring the public health threat.
MS. LUNGE: Right.
ATTENDEE: Gotcha.
MS. LUNGE: Once that's declared, you look at the next section of the bill, which is on page 31, that says that there has to be over a 30 percent --
ATTENDEE: Oh, okay.
MS. LUNGE: -- price -- the price has to be 30 percent higher than these other measures.
ATTENDEE: Oh, okay. Thank you. Okay. Sorry.
MS. LUNGE: No, that's okay.
You look at whether the prescription drug or class of drugs is essential for remaining health or life, so if there is another treatment, that would be factored in, other

than, like, a drug therapy, whether consumers affected by the health condition are unable to afford the drug at the current price, and then a catchall for the commissioner to have other factors, depending on the circumstances.

ATTENDEE: I'm just going back to the sub 3 on your amendment. If the cost of prescription drugs or class of prescription drugs is (inaudible) is prohibitively expensive -- it is prohibitively expensive, and then on top of that it's 30 percent higher? I mean, it just seems like there's sort of two different definitions, prohibitively expensive and 30 percent higher.

MS. LUNGE: Um-hmm. I think --

ATTENDEE: I mean, it could be considerably (sic) expensive, but then it doesn't meet the 30 percent test.

MS. LUNGE: Right. Right. And then it would not be -- the state would not step in.

ATTENDEE: And it could be a hundred percent more expensive, but it's not prohibitively expensive.

MS. LUNGE: But it's five bucks, so then the state would not step in.



ATTENDEE: Okay. Okay. That makes -- that makes sense.

ATTENDEE: So it has to be -- yeah. Yeah.

ATTENDEE: And it could be prohibitively expensive and not 30 percent higher, in which case, out of luck --

MS. LUNGE: Right. You're still --

ATTENDEE: -- you die.

ATTENDEE: Well, because it hasn't -- they haven't -- I thought this is --

ATTENDEE: Obviously not in the medical --

ATTENDEE: This is to prevent -- this is to prevent the pharmaceutical companies from raising the prices because we have --

ATTENDEE: An emergency.

ATTENDEE: -- an emergency.

ATTENDEE: That's correct.

ATTENDEE: That's what we're talking about?

ATTENDEE: That's what we're talking about.

(Unreportable exchange ensued.)

ATTENDEE: I mean, but the fact that it's prohibitively expensive is neither here nor there in terms of price gouging.



ATTENDEE: In terms of price gouging, that's correct.

ATTENDEE: In an emergency. Yes.

ATTENDEE: That's correct. You can't say you're medication (inaudible) and we're going to tell you to lower it --

ATTENDEE: Right.

ATTENDEE: -- just because it's too expensive --

ATTENDEE: Right.

ATTENDEE: -- unless that's 30 percent higher than --

ATTENDEE: Related to this public health threat.

ATTENDEE: Right.

ATTENDEE: Right.

ATTENDEE: Okay. Got it. All right. Are people comfortable with this?

ATTENDEE: And wherever you have a cutoff --

ATTENDEE: This doesn't help the AIDS epidemic at all, something like that, because the drugs started out to be hugely expensive and probably --

ATTENDEE: I don't know. How would you



read this, Doctor, related to -- put you on the spot, but that's why you're here.

ATTENDEE: The first thing I'd say is I'm (inaudible) commissioner. The next thing I'd say is that there are real costs to producing drugs, and those costs theoretically are reflected in the price. And we can't -- we shouldn't deal with that by telling pharmaceutical companies they can't charge what they need to to do it.

I think this gets around that. I think it sets up a class of drugs which are -- by making them very expensive just outright and then having them go up even more, because they're, for some reason, in high demand or -- I think it accomplishes that. It also sets the limit so that the cheap drugs aren't going to trigger, no matter if they go over the magical percent mark, that's not going to in and of itself create the emergency. So that's --

MS. LUNGE: On that point I would mention that on page 31 of the bill, where you're talking about the unconscionable pricing, remember this would all -- once the public health emergency or whatever you want to call

it is -- the commissioner of health certifies, okay, we're going to call this that, then it goes through an entire court process before anything happens. So -- and in the court process, the first step would be the state would have to show this price differential. But then there's --

ATTENDEE: It goes to the court process, somebody doesn't challenge -- how does it get in court?

MS. LUNGE: I think the AG's office would file on behalf of the department of health.

ATTENDEE: (Inaudible.)

MS. LUNGE: So that's the first step. But then the second step is that the companies would come in and say, you know, exactly sort of the cost of producing the drug and say no, no, yeah, we're over this 30 percent benchmark, but look, it costs this much to invent it, it cost this much to develop it, this is how much it costs to produce, our global sales are down so we have to increase our price here to make it available.

So in the court process there is that opportunity for that information to come in and



for the court to say, well, I don't -- you know, I don't think it would be fair to tell you you have to sell it at a lower price here in Vermont for this period of time.

ATTENDEE: (Inaudible.)

MS. LUNGE: I didn't hear the first part of your sentence, I'm sorry.

ATTENDEE: Yeah. The courts would not allow the promotion of (inaudible) because that would just be unreasonable, right?

MS. LUNGE: We would hope not. I mean, we would hope our judges would be reasonable and look fairly at both sides of the evidence and make a fair determination in terms of this kind of issue.

ATTENDEE: Basically what we have in front of us is a price gouging bill, but we aren't using price gauging's -- we aren't calling it that and aren't using similar price gouging legislation. It is -- it's not what it was initially intended to be. But it's a -- it's a price gouging in a case of an (inaudible) protection. It started off as something different in the finance committee.

ATTENDEE: (Inaudible.)



ATTENDEE: Well, it started out much different in the -- in --

MS. LUNGE: Yes.

ATTENDEE: This is probably closer to the finance committee.

MS. LUNGE: Well, the only other thing I would just point out in terms of that comment is that the 30 percent mark in this, which you have to look to the original bill, looks at other prices within the Vermont market. So the federal supply schedule for federal agencies, prices through Healthy Vermonters, or the most favored purchase price, which looks at a within Vermont seller/buyer.

So it -- it's a little bit different than a price gouging statute because it doesn't look back to before you declared it a public health, in the same way of market disruption.

ATTENDEE: It's more of an unconscionable pricing in the event of an emergency.

MS. LUNGE: Right. Exactly.

ATTENDEE: Okay. And do you think it's going to pass constitutional muster, Counsel?

MS. LUNGE: I don't know. You know, if it passes, we'll have to see. I mean, I think



it's -- I do think it's tighten than the DC law.

ATTENDEE: The finance committee version was tighter than the DC law.

MS. LUNGE: Yes. I think this is tighter than the finance committee version.

ATTENDEE: Okay.

MS. LUNGE: So I think it is closer to kind of the main law.

ATTENDEE: Right. I think this will be debated on the floor.

(Inaudible, unreportable exchange ensued.)

ATTENDEE: Are people comfortable with this option 1?

ATTENDEE: Yes.

ATTENDEE: Any comments?

ATTENDEE: I am not surprised.

ATTENDEE: Julie?

ATTENDEE: Well, I actually have a question for you. I have no problem with the way the discussion has gone.

But, Senator Racine, there was something you said that -- and I'm playing a little bit of catch-up with today's versions, so I apologize. You had said that there were two

standards, the 30 percent standard and then the -- what did you say, the unreasonable or the excessive price? And I'm looking for that --
ATTENDEE: Prohibitively.
ATTENDEE: Prohibitively.
(Unreportable exchange ensued.)
MS. LUNGE: It's in the serious public health threat. So when -- the first step is the commissioner of health decides whether or not something is a serious public health threat.
ATTENDEE: Yes.
MS. LUNGE: And they look at cost and whether or not it's an expensive drug in that consideration.
ATTENDEE: Yes. But it doesn't say anything about prohibitively. It just says that it's -- you said that was your phraseology of --
(Unreportable exchange ensued.)
ATTENDEE: No, it says it --
MS. LUNGE: On page 11 of the amendment in the public threat.
ATTENDEE: I'm sorry.



ATTENDEE: She's -- you're not looking at the right thing.
ATTENDEE: I'm not.
ATTENDEE: Page 11 over there.
ATTENDEE: Ah. Okay. I hadn't seen this language.
ATTENDEE: It's brand new.
(Phone interruption.)
(Unreportable exchange ensued.)
ATTENDEE: I'm wondering -- I'm wondering, now that I'm looking at these for the first time, with respect to B1, it's on the amendments, page 10 --
ATTENDEE: Yes.
ATTENDEE: -- where we would be saying, the commissioner shall consider the following factors, if a large number of Vermonters suffers and if the condition is short term and life threatening or has severe consequences to health --
ATTENDEE: That's actually been changed a little bit. I
ATTENDEE: Oh, I'm sorry. So -- I'm sorry.
ATTENDEE: So the life threatening in the



short term --
(Continuing inaudible background exchange ensuing.)
MS. LUNGE: The short term refers to the life threatening or the severe health consequence. So in a short period of time it's life threatening or --
ATTENDEE: Okay. Or if the condition is highly contagious.
What would you -- what would your opinion be with respect to high cholesterol, since you're giving examples.
MS. LUNGE: I don't -- under this I don't think it would --
ATTENDEE: Okay. Because -- okay, that was the example you actually brought up --
ATTENDEE: And obesity --
ATTENDEE: Well, high cholesterol --
ATTENDEE: In the short term --
ATTENDEE: -- is considered to be the silent killer.
(Unreportable exchange ensued.)
ATTENDEE: What about AIDS?
ATTENDEE: AIDS, that was also brought up.
ATTENDEE: And where would that fit,



because AIDS is obviously not -- it's life threatening long term, I wouldn't say necessarily short term.
I just don't understand -- I'm not sure why -- I'm not sure where this language came from. And if it was the committee, that's obviously great. I just don't understand what your intent is by saying "short term."
ATTENDEE: Our intent is to change what came from the finance committee, which seemed to be so broad as to include almost anything, any major health problem out there, including high cholesterol --
ATTENDEE: Yes, if it fit --
ATTENDEE: -- and obesity, diabetes.
ATTENDEE: If it fit the categories about the drugs being too expensive, absolutely.
ATTENDEE: Yeah. And we thought that was too broad. And we thought we probably -- I guess it's our considered layperson's -- laypeople's opinion that it wouldn't pass constitutional muster. We were concerned about that --
ATTENDEE: I don't think that's the issue with respect to the constitution.

ATTENDEE: So we were trying -- we were trying to narrow it so it's -- in the event -- as we're writing it here --
ATTENDEE: The issue --
ATTENDEE: -- and not --
ATTENDEE: Excuse me.
ATTENDEE: -- include all those -- all those albeit serious illnesses.
ATTENDEE: The issue as I read it in the District of Columbia case is not with respect to the breadth of the diseases that are covered but rather with respect to the breadth of commerce that is affected, which really doesn't have to do with the number of drugs but has to do with the number of players in the pharmaceutical manufacturing chain. That's really what the DC court was focused on, that in DC they were basically regulating activities that were outside the state. That's the commerce clause issue, the dormant commerce clause.
So the breadth of the coverage in terms of diseases wasn't the issue.
ATTENDEE: I understand that. Maybe Robin could explain what I said better than I did.



ATTENDEE: Okay.
MS. LUNGE: I think -- I mean, I think the committee was concerned about having it be broad enough to allow the cholesterol or obesity or heart disease type of situation, and so wanted it to be more narrowly tailored to an emergency situation, where you had a flu epidemic or something along that nature.
ATTENDEE: And I guess then the question is -- so it's a policy decision rather than a legal decision that you're really making.
MS. LUNGE: Yes.
ATTENDEE: Yeah.
ATTENDEE: Understood. That's very helpful.
And then in terms of -- like I was saying, there are 12 categories, like AIDS, bipolar disorder, schizophrenia. I mean, there's some of them that are very serious issues where we have some real pricing issues.
Where would those fall?
MS. LUNGE: I think those would fall outside, because I think the committee's policy, sort of decision, I think, was really tailoring towards more of a price gouging type



model, where it was a true emergency as opposed to --
ATTENDEE: Okay. Because, of course, those diseases are life threatening, needless to say --
ATTENDEE: (Inaudible) long term.
ATTENDEE: But so is cholesterol and --
ATTENDEE: Well, they are long term.
ATTENDEE: -- so is obesity and diabetes. I mean, they're, you know -- this is -- this is narrower.
ATTENDEE: It is narrower.
ATTENDEE: And it would be if something came up with something, I mean, I guess I would think some epidemic or something. I was trying to think of if there was a young person's disease or something, all of a sudden we had a huge amount of that in the short term.
ATTENDEE: Autism.
ATTENDEE: Like autism, I guess, if it was really a huge short-term and life threatening. It's not that it's, you know, in the last 10 or 20 years we have an increase of what, 10 percent, 20 percent of autism diagnosis.
ATTENDEE: I'm not sure autism fits into



this. It's not life threatening.
ATTENDEE: Right. Well, I'm just saying, if you had 80 -- you know, 60 percent of Vermont, you know, between the ages of zero and five were diagnosed with autism or something, if that was treated, if autism was treated with a pharmaceutical drug.
ATTENDEE: So you're basically -- you're basically just, again, to clarify, this language, as I see it and from the discussion I'm hearing, you're carving out maintenance drugs of any kind, even though the conditions associated with those drugs or the indications that those drugs are intended to treat are quite serious and life threatening. Is that your intent?
Because I can name a bunch of categories of drugs that I think are designed to treat very serious and life threatening illnesses, but they're maintenance drugs, because the conditions are not short term. They are long term. People have them for life.
Chemotherapy, we can talk about that. I just don't -- I'm just trying to understand the contours of -- of this. Chemotherapy is

actually a great example, because, you know, it's a -- typically speaking, it's a relatively short-term treatment, six months or so. The condition is a long-term, life issue. Often consumers or patients will have to come back to be treated again.

ATTENDEE: I think what you're suggesting there, though, Julie, is that we -- that it be -- that it could be written very broadly to include all those maintenance drugs, and I think we were uncomfortable with that. And I think they were --

ATTENDEE: I'm not -- actually, I'm just really trying to -- I'm not necessarily suggesting a change --

ATTENDEE: Yeah. I'm just --

ATTENDEE: -- I'm just really trying to understand the contours.

ATTENDEE: My feeling -- again, Robin can explain. I think it is -- for me, it's also part of the constitutional issue. And the question is how far we want to push this. I think one of the issues --

Robin, you're going to have to help me with this. But I think one of the issues was,



in the DC case, it said they didn't have a compelling, I guess state interest, although they aren't a state, and we needed a compelling state interest. I seem to recall you saying that's part of what you were doing in the finance committee version. And we're trying to say, how do we -- how do we establish a compelling state interest if it includes a broad range of drugs that would treat cancer, diabetes, cholesterol, and all those things. And that we felt that that was so broadly written that we hadn't made a significant enough change to make that case.

ATTENDEE: The compelling -- the compelling interest argument actually came from me in finance. And I've gone back now and I've actually had discussions with some people who represented PhRMA in the DC case; in fact, I just had a long call with them today. And the commerce clause prong that they relied upon, really, the compelling interest wouldn't help the state one way or the other. That's why I'm trying to say the narrowing of the conditions is not going to either hurt or help the constitutional case.



Again, if you want to make a policy decision, that's one thing. But the prong of the commerce clause that they were operating under really had to do with the breadth of the regulation by a state in terms of the industry; not in terms of the number of jobs, but in terms of the number of players and where they were located.

ATTENDEE: Then that would suggest to me -- again, I keep saying, as a non-lawyer here, that no matter how we write this, if compelling interest was not at issue, no matter how we write this, we're going to lose.

ATTENDEE: Actually, I --

ATTENDEE: Because that would change it enough -- that would change it enough from what the DC law has to make a difference. And we thought we were making a difference by creating a compelling state interest. And if that doesn't make any difference, then we're going to lose this thing no matter how we write it.

ATTENDEE: Okay. I don't think that's accurate, that we will lose it no matter how we write it. But just so you know, that I'm trying to think of other ways to approach this



so that we're not affecting so many different players in the market. Which would -- and I think there are some ways to do it. And again, I'm just starting to have these conversations today.

I think -- so, bottom line, fine, if -- again, I'm asking these questions, because -- I apologize. I wasn't here for part of these sessions, I apologize for that. I was really just trying to get a feel from where you all were coming from. I do think there may be other solutions that deal with some of the constitutional problems and also would be --

ATTENDEE: And I'm going to have a suggestion that we can't do that between now and the end of business tomorrow.

ATTENDEE: Exactly.

ATTENDEE: And if we don't do it, we don't have a bill this year.

ATTENDEE: Right. Right.

ATTENDEE: In the interest of having a bill this year, I would suggest we continue with what we have.

If you come up -- if you continue to look at this and you come up with some better way,

there's always time on the floor, and there's always another chamber here.
ATTENDEE: Exactly.
ATTENDEE: This is why I do not like this crossover deadline, because it stops us from doing something that I would otherwise suggest this committee do as part of its work.
ATTENDEE: I don't know why we have --
ATTENDEE: And I feel very comfortable with --
ATTENDEE: And I have a choice as the -- as the committee chair and we have a choice as a committee whether to stop and wait and see if we can come to a better resolution of this, or whether we continue and save this process.
ATTENDEE: And I strongly agree --
ATTENDEE: I'm going with the process.
ATTENDEE: -- with your way of proceeding. Let's continue. I really just wanted to let you know that I think there may be other solutions that get in some of those legal issues.
ATTENDEE: And what you just said about the compelling state interest is news to me.
ATTENDEE: It was news to me too, frankly.



And I just learned it today. I mean, it's always helpful to have a compelling state interest. So the more compelling you make it, that's always going to be helpful. But what they were saying to me on the phone, these Washington attorneys, who our office has dealt with before, both with us and against us, so we've dealt with them many times, they said, you know, that's really not going to save you here. You need to be thinking about other issues. And so that's why I'm thinking about some of those other issues now.
THE CHAIRMAN: Well, Robin will be with this bill in its next stages, even if we are not. But in terms of what we're trying to do here, which is to avoid price gouging -- I think I might need one here too.
(Unreportable exchange ensued.)
THE CHAIRMAN: What I think we're trying to do here, as a matter of public policy, is create a protection against price gouging in the case of a medical emergency. Now, we can debate whether we should be dealing with other public policies, but we're trying to deal with that public policy issue, and I think this does



it. So --
ATTENDEE: Okay. And thanks. That's very helpful, and I'm sorry for actually interrupting the flow of the conversation.
THE CHAIRMAN: It's all part of the discussion. But I think we're going to have to -- people comfortable, as comfortable as we can be? Okay. Let's --
ATTENDEE: The finance committee may not be comfortable.
THE CHAIRMAN: And we may end up having this debate on the floor, and it will be an informed debate. And there may be, by that time, to quote President Clinton and Prime Minister Blair, the third way --
ATTENDEE: The third way.
THE CHAIRMAN: -- to accomplish this one.
ATTENDEE: And what was that one?
THE CHAIRMAN: The third way. It's just like new policy (inaudible). The Vermont way. Okay.
The next -- was there another major area? Am I missing something here?
MS. LUNGE: That was the big, I think, option that I recall. There was also -- maybe



the other big issue you were thinking of was in the PBM section, the duty, or -- I sort of thought you decided to go with that other standard, or did you want to look at that again?
THE CHAIRMAN: I forget. It seems like there was something at the end, at the end, unconscionable pricing.
ATTENDEE: Have we done the --
THE CHAIRMAN: No, we haven't done that. Oh, we were going to ask -- I know what it was I was thinking, was the last sections on consumer protection and false advertising. That's why I was suggesting that maybe we wait and hear from Julie on that one. We had some concerns or I had some concerns -- I forget what they were.
MS. LUNGE: I think the issue was, yes, that was outstanding, and I did end up sort of including language so that you would have those verges, figuring that would be probably easier to draft that when I could think about that a little bit. So that's on page 12 of the amendment.
I think what you were -- what you were

considering was whether or not -- this is the section that says it's a violation to run ads that violate the federal standards for false and misleading ads. And the issue was do you want to include -- narrow it a little to say that that would only be a violation after the FDA has sent out either an untitled or a warning letter, or leave it broader and leave it to the discretion of the AG as to whether or not they could prove --

ATTENDEE: They would have to first prove it's a violation of the FDA and not the federal law and then take an action. And my concern was -- well, I'll just leave it at that.

ATTENDEE: I have a suggestion here, and it would actually narrow the applicability of this quite a bit. But I think it's something that everybody ought to be able to live with, and that would be to say that where there is a warning or untitled letter, that would be prima facie evidence of a violation of the Consumer Fraud Act, which means that the manufacturers could still come in and say no, we didn't violate for all the following reasons.

ATTENDEE: Can you just show us where you



are, exactly?

(Inaudible.)

ATTENDEE: Page 34 -- page 12.

ATTENDEE: Page 12 of the amendments.

ATTENDEE: And then the specific line that you're on?

ATTENDEE: Well, I guess -- I don't see a line --

ATTENDEE: Where it's sending the warning.

ATTENDEE: It's in bold.

ATTENDEE: Talking about the violation.

ATTENDEE: The part that's in bold, C1, 2466A, Section 19, 2466A, C1 would say something along the lines of it shall be prima facie evidence of a violation under this chapter for a manufacturer -- or actually, I would say, it would be prima facie violation of -- a violation of the Consumer Fraud Act of this chapter if the US Food and Drug Administration has sent a warning or untitled letter indicating that an advertisement by a manufacturer does not comply, blah, blah, blah, blah, blah.

And what that does -- and I think that that's an important -- I think it's important



not to wait for the FDA to act, because the FDA sends many warning letters, all of which are very real and make a real -- and are quite, in my view, valid. But they never follow up with cease and desist letters. They just don't do that. They don't issue injunctions. The FDA doesn't have that kind of police power, at least they don't -- or they don't use it.

But I'm working right now on probably six or seven pharmaceutical cases where the FDA has issued warning letters about the very ads that we're concerned about.

And so what this would do, by calling it prima facie evidence, as Senator Flanagan was just indicating, was it would -- it would shift the burden to the manufacturers to then show why it was not a violation. So we could say, look, the Food and Drug Administration says you have violated. You have misbranded.

ATTENDEE: So we don't have to prove it -- once again, we don't have to make the -- the FDA has already made that case.

(Inaudible exchange ensued.)

ATTENDEE: And I think, frankly, to the extent that you've been hearing from



manufacturers that they're concerned that, you know, these letters are sort of a non-administrative, non-hearing process, it shouldn't be an absolute violation. This way we're saying it's prima facie, they can come in and make their case in a court. And I -- I really think that ought to do it for everybody. Of course, that -- let me say, it does it for us.

And it's very much a cutting back on this provision in terms of our rights, because we just get -- it's just prima facie proof. We probably still have to prove the underlying case, but it gives some heavy weight to what the FDA has said. And that's really what we're looking for, is to give heavy weight to what the FDA has said.

ATTENDEE: Can the -- yes, I am. I'm sort of halfway asking a question.

ATTENDEE: I couldn't tell if you were raising your hand.

ATTENDEE: I'm sort of halfway asking a question.

ATTENDEE: And Robin and I, if you give us a minute, we can work on the language.

ATTENDEE: The question I have is, without such prima facie evidence, if it's the belief of the AG's office that a violation has occurred, how would you proceed under those conditions?
ATTENDEE: We'd bring in a case from --
ATTENDEE: Would you go first to the FDA, or would you -- or would you automatically --
ATTENDEE: We don't usually go first to the FDA. We usually launch our investigation.
In your situation, has the FDA issued a letter?
ATTENDEE: No.
ATTENDEE: Okay. We would -- we typically would not. Because that process -- we actually used to do that, like, 10 years ago, and it was so slow - it took them forever, frankly - that it just became irrelevant.
Does that -- is that -- does that answer your question?
ATTENDEE: Yeah, that answers my question.
ATTENDEE: But there are times -- and they're trying to do a much better job of this, because they're really getting a lot of heat from Congress now on what they do to review



advertising and marketing practices. They're trying to do it more quickly. So there are times when they've issued a warning letter about something we know nothing about. So the fact that they issued a warning letter then triggers, in our mind, oh, gee, there must be something that we -- or there may be something that we should be looking at here. So making it prima facie evidence would be helpful.
ATTENDEE: Okay. Robin, can you --
ATTENDEE: Oh, that's my other question, from yesterday.
Just, again, to Julie, you see here where it's talking about the drug advertising under federal law.
ATTENDEE: Yes.
ATTENDEE: Then would you -- are you capable, as an attorney general's office, to bring a claim under federal law?
ATTENDEE: No.
ATTENDEE: Okay. No, you cannot. So it can only be under what we have in statute in the state.
ATTENDEE: Correct.
ATTENDEE: So in that case, then you'd



have to go through the FDA to make a case.
ATTENDEE: Well, we could bring a case under the Consumer Fraud Act. We don't have -- in other words, we couldn't impose the penalties that are -- that exist under federal law.
ATTENDEE: Not the penalties but just the pursuit of the case.
ATTENDEE: We don't -- we can do it independent of the FDA.
We actually already have some statutes in Vermont law that indicate that if something is misbranded under federal law, it's also misbranded under Vermont law. We already have those statutes.
ATTENDEE: So do you need this?
ATTENDEE: So that was my question.
ATTENDEE: Yeah, I actually think that being specific about the fact that a letter has been issued as prima facie evidence would be helpful.
ATTENDEE: Okay. Robin, you have -- I wish we had line numbers on this. But anyway, halfway down, you see rule 4655, if (inaudible) was used, what does that mean?



MS. LUNGE: You'll see this first one is a cross-reference, a violation of section 4655 of title 18, the 4655 is the section in the unconscionable pricing statute.
ATTENDEE: Oh, I see. Okay.
MS. LUNGE: So if you went with option 2 --
ATTENDEE: So we're done with that.
MS. LUNGE: -- you wouldn't need that. Right. We're done.
ATTENDEE: If we go with option 2, we don't worry about that.
MS. LUNGE: Yeah.
ATTENDEE: And then there's a -- and then there's a change at the bottom of page 13, your amendment?
MS. LUNGE: Yes. This was a suggestion from Medco in terms of -- I reworked their language a little bit, but what they were looking for was to make sure that this section on pop-up ads wouldn't apply to pop-up ads or messages that were meant to provide information about pharmacy reimbursement, prescription drug formulary compliance. So a pop-up ad that said, oops, this isn't on this insurer's

preferred drug list, so that the doctor was getting necessary --
ATTENDEE: Okay. We said okay to that conceptually yesterday?
MS. LUNGE: Yes. So this is the language that addresses that issue.
ATTENDEE: All right.
MS. LUNGE: So should we -- do you want to go through it from the top?
ATTENDEE: Yes.
ATTENDEE: Go through what from the top?
ATTENDEE: Her amendments. These are amendments -- the amendments are the response to the work we've done the last couple of days. This is the first time we've actually seen it in -- seen them in black and white. They should be okay, but it may raise other issues. And I hope we don't redebate issues, but we have until midnight tomorrow.
MS. LUNGE: You do. Of course, I think you have a few other bills you wanted to look at.
ATTENDEE: I know we do. But this one is our priority.
MS. LUNGE: So on page 1, this is the



reworking of the language in the FQHC section. We changed it from encouraging Vermonters to use the FQHCs to providing -- doing a plan to inform Vermonters of the availability of health services provided by FQHCs, including the more affordable prescription drug pricing, and we struck that last sentence because it doesn't fit under a federal definition of patient.
ATTENDEE: Okay. Now, there was -- somebody in the room --
ATTENDEE: That was me.
ATTENDEE: That was you?
ATTENDEE: That was me.
ATTENDEE: I knew there was somebody in the room --
ATTENDEE: That would be me. I still don't like it, but it's better, and I won't fight it. Because we are -- I will just say this, and then I'll shut up. We are, in fact, encouraging -- one of the problems the primary care people have and local pharmacies is that we don't reimburse them at a reasonable rate.
Now we are telling people to go to the FQHCs and further driving people away from the primary care practitioners and the local



pharmacies. And it isn't just those people who receive Medicaid and Medicaid waiver programs, who we already underfund the primary care practitioners, we're telling the state employees, that have a good reimbursement rate, and the people under the supervision of corrections and workers' comp benefits that they shouldn't go to primary care practitioners, they should go to the FQHCs and abandon their primary care practitioners and their local pharmacies.
And I object to that. This is better, and I won't fight it, but I still disagree with it.
ATTENDEE: Let me ask, and I --
ATTENDEE: I agree with you.
ATTENDEE: Do you have to be income eligible to go to an FQHC?
ATTENDEE: No.
ATTENDEE: No.
ATTENDEE: No?
ATTENDEE: No. So we could tell all of our state employees -- and the state employees, the reimbursement to their primary care practitioner is at a reasonable rate. And they're already -- they're being underfunded by



Medicaid people, so whether they even want them or not is different. But -- so we're telling the state employees -- so anyway, I -- but I won't fight it, because this is something better.
ATTENDEE: Sara and then Jeannette.
ATTENDEE: I guess, you know, I hear your concerns. I feel like we have such limited federally qualified health centers, and we have them here in Vermont for a reason. We need their help. They do have a lot of wrap-around services that I can't get at my -- at a downtown doctor practice that I can get at a federally designated health plan.
And, you know, I think that, you know, if we could get one in every county, that would be wonderful. And we don't have that now. And I do think in some ways it will be so -- you know, if we have that problem, that people are leaving their primary cares and all going to these clinics or something, maybe that's -- you know, that's -- we're not there yet. We're at a long way away.
ATTENDEE: That's what we were telling people.

ATTENDEE: We're a long way away from that.
ATTENDEE: So is this a way to encourage market forces to have more -- better reimbursement rates and better drug prices through the state?
ATTENDEE: Right. Right.
ATTENDEE: I don't know that does it. So -- but it's better than this.
(Unreportable exchange ensued.)
ATTENDEE: I'm not happy, but it's better.
ATTENDEE: You had also asked about --
ATTENDEE: No, I'm not happier, even. I'll accept it.
ATTENDEE: You had asked about costs. The difference between Medicaid price and the 340B price, and in the bistate (phonetic) testimony that you should have somewhere, Hunt said that's something that's currently being studied. Jeff Lewis from the Heinz Foundation met with OVHA and offered to provide technical assistance. And they're in the process of reviewing a year's worth from April 1, 2006 to March of this year. They'll look at that year's worth of claims and compare those two.



And the other -- so we don't know specifically to Vermont. What we do know is from this chart that Steve Capell (phonetic) gave you. It shows you the -- and I think these are national. So again, this is not Vermont specific, but these are percentages.
ATTENDEE: (Inaudible.)
ATTENDEE: I don't know.
MS. LUNGE: This isn't Steve's chart. This is from Bill von Odenson (phonetic). It's attributed at the bottom.
So you can see the Medicaid is the yellow at 60.5 percent of the average wholesale price, and you can see that the 340B is the red, which is 49 percent. So it is about an 11 percent price difference.
ATTENDEE: Which one is the FQHC?
MS. LUNGE: FQHC is the 340B, so it's the red.
ATTENDEE: Okay.
ATTENDEE: So for 11 percent savings (inaudible) -- anyway, okay. I won't belabor it, but I don't like it.
ATTENDEE: Okay. Point made.
MS. LUNGE: So the next section of the



amendment is still in this section 1. There had been a suggestion to add VPharm. This is a section on the joint pharmaceuticals purchasing consortium. OVHA had asked to add just authorization, that it was clear that they need to seek authorization from CMS and to add the VPharm program.
In the third instance of amendment we just changed a mistaken reference from AA to C1, which is the correct reference.
In the fourth instance of amendment we're striking out the reference to the organ health and science university drug effectiveness review project. We did that in two different places. This was in the section about OVHA. Later on we do it again in the evidence based section.
In section 3, this is the part of the bill where we look at giving the AG's office permission to share the marketing information they get with the department of health. We're adding in also OVHA so that AGs can share with OVHA.
6, this section is in the price disclosure, where the companies are disclosing



those three prices, the average manufacturer price, best price and the wholesale price in the state to OVHA.
There was a section on page 10 in the original bill which referenced a federal standard for a methodology, and originally the bill allowed OVHA to adopt a different standard.
They said to me they were going to submit something to you. I don't know if they did or not.
ATTENDEE: I haven't seen anything.
MS. LUNGE: Jan, did OVHA submit anything on this? No? Okay.
What they said to me in an e-mail was that they'd have to look at that standard, and there may be reasons that they want to do it differently. But I said, look at it and tell the committee, not me. So if they haven't told you, then that's that.
ATTENDEE: I thought I heard something on that.
ATTENDEE: He gave us a whole handout, right?
(Inaudible.)

MS. LUNGE: Who?
ATTENDEE: Josh.
ATTENDEE: I don't think this is a problem, so --
MS. LUNGE: He previously had given you a handout before you decided to take this language out. So that was before. So it wouldn't have addressed this particular issue, because it was before you decided that.
In D, this is a technical correction, because there are three different prices now listed, and I hadn't added the three of them -- the third one into this section. So I just struck the specific references and reference section.
In the eighth instance of amendment, this is the section of the bill where you would -- this is the Healthy Vermonters discount card, and what you've decided to do was go ahead with implementing the 300 -- the increase from 300 to 350 but not include that complicated comparison of the families' unreimbursed expenses compared -- and insurance premiums compared to their household income.
So this section adds in the existing law



where that says that and strikes it at the bottom of page 4 to the top of page 5.
ATTENDEE: Is there a cost to this?
MS. LUNGE: It's a discount card and -- that allows the uninsured person to pay the pharmacy directly at the Medicaid price versus the average wholesale price, which is what, I think, uninsured folks pay.
ATTENDEE: So the cost is to the pharmacy --
MS. LUNGE: So there's no cost to the state.
ATTENDEE: The cost is to the pharmacy.
MS. LUNGE: Right. So depending on what the pharmacy purchased the drug for, it would mean for that particular person they're not getting the average wholesale price, they're getting the Medicaid price. Whether or not that's more or less than what they paid, we wouldn't know unless we knew exactly what the pharmacy paid.
ATTENDEE: You think they are selling Medicaid priced pharmacy drugs for less than what they paid for them at the pharmacy?
MS. LUNGE: That, I think, is a



complicated question, and I don't know. I think it will vary depending on what the drug is, quite frankly. But I don't know in the aggregate.
ATTENDEE: I mean, I know they get rebates and everything. But sometimes -- I guess I'll ask Anthony that.
MS. LUNGE: Yep, that was a good idea. Did I do this, skip one, no. Okay. So ninth, page 5 of the amendment, this is in the PBM section of the bill. And in your original bill it is on page 15. And this is the section where we say you have to give notice that -- unless the contract provides otherwise, that there are these options available. And you had discussed changing the standard for the PBM's duty. And what we discussed was having me look at current law to see what I could come up with. And what this -- this standard is from a case which defined a duty of a health insurance agent to the client.
ATTENDEE: So can I ask a question --
MS. LUNGE: So it's the closest kind of situation.
ATTENDEE: -- about the language that's



there?
MS. LUNGE: Yes.
ATTENDEE: Is it -- as I read it, and quickly, it says reasonable care and diligence and be generally fair and truthful.
MS. LUNGE: That's directly out of the case.
ATTENDEE: It is. Okay. But that doesn't mean that you're generally truthful, and is it (sic) you're always truthful, does it? Because when I read this, it looks like you're generally fair and --
MS. LUNGE: Well, I think that --
ATTENDEE: Is that, like, 9 times out of 10?
ATTENDEE: Yeah, I think 99 (inaudible) --
MS. LUNGE: The context of this particular case, I didn't -- quite frankly, I don't remember it in a lot of detail at this point. I've done so many things between yesterday evening and now.
ATTENDEE: Somewhere it's saying at least generally.
MS. LUNGE: Well, the case said the duty was to be generally fair and truthful. That's

the -- I took the language right out of the case. The context was a client who said, I think, that the insurance agent had misled them. And the insurance agent's defense was, well, it says right here in black and white in your contract. And the court was saying, you, the client, have a duty to read the contract; you, the agent, have a duty to be generally fair and truthful.

So I can't answer your specific question, because in the context of the case, it's not -- I don't know. You know, I can only answer in the --

ATTENDEE: Well, could we have them carry out the duties with reasonable care, diligence, and truth, you know, and be generally fair?

ATTENDEE: It doesn't allow for the white lies or little things, you know, like I'm really not happy to see you today and, you know, all those little things.

ATTENDEE: You know, it really -- it's awkward, but if it's -- if it's got some legal meaning --

ATTENDEE: That's -- the thing with legal language is that we don't know.



MS. LUNGE: I mean, this is a very --

ATTENDEE: We don't know what it means.

MS. LUNGE: -- factually based, I think -- in this particular case, you know --

ATTENDEE: If you say so, it's good enough for me on this one, because if that language has come from a case --

MS. LUNGE: The language came from a case. I think it probably -- I think, if it makes you feel better, you can change that. I mean --

ATTENDEE: I'd like them to always be truthful.

MS. LUNGE: Well, what if you just took generally out and said to be fair and truthful?

ATTENDEE: Okay.

ATTENDEE: That sounds better.

ATTENDEE: Sounds good.

ATTENDEE: Does that sound fair and truthful to you?

ATTENDEE: Generally.

ATTENDEE: Generally.

ATTENDEE: Taking out generally.

ATTENDEE: You and Robin are our attorneys.

MS. LUNGE: Okay. So I'll take out



generally, and otherwise, are we good?

ATTENDEE: Okay. Yes. And this was to get rid of the word prudent.

MS. LUNGE: And the idea of a higher standard.

ATTENDEE: Okay.

MS. LUNGE: Okay. Tenth, in section 7, 9472C, which is on page 18, I just -- I generally rewrote this not to change content but just to make it more readable. So the change was that it used to say entering into contracts for pharmacy benefit management in this state by a health insurer, but it's not actually -- what's actually happening is you're entering into a contract with an insurer in the state, and the contract is for pharmacy benefit management in the state. So I don't think that changed the meaning, it just -- I think it's a little bit better written.

ATTENDEE: We're not leaving anybody out who isn't entering into a contract not with a health insurer?

MS. LUNGE: Well, we defined health insurer broadly, so it includes employers and other people you don't normally think of as



insurers.

ATTENDEE: Thank you.

MS. LUNGE: 9473 is the enforcement language that you had looked at yesterday between VISCHA and VAG.

ATTENDEE: And we're in agreement, which helped us a whole lot.

ATTENDEE: Generally.

ATTENDEE: Generally.

ATTENDEE: Okay.

MS. LUNGE: In the next instance of amendment on page 7 -- I'm sorry about the shading. I was trying to -- the proofers had done half of it the night before.

ATTENDEE: You changed your style here, but okay.

MS. LUNGE: That was for them, the proofers. It doesn't have meaning for you. It tells them what they haven't proofed yet --

ATTENDEE: Got it.

MS. LUNGE: -- or hadn't proved yet.

This next section is the section of the PBM part that talks about the audit. And we had talked about adding language clarifying that the pharmacy benefit manager didn't have

to offer an admin only contract. So what it says is that the PBM will notify the health insurers when they provide a quotation that a quote for admin services only contract will pass through blah, blah, blah, blah, is generally available, meaning in the marketplace. And whether the pharmacy benefit manager offers that type of arrangement, because it seems to me like it would be a little bit --



COUNTY OF SEMINOLE. )

I, Christina Gerola, Notary Public in and for the State of Florida at Large, do hereby certify that I was authorized to and did listen to CD 07-56/T2, the Senate Committee on Health and Welfare, Thursday, March 15, 2007, proceedings and stenographically transcribed from said CD the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 20th day of August, 2007.

_____

Christina Gerola
Notary Public - State of Florida
My Commission No.: DD617707
My Commission Expires: 12/10/10

STATE OF VERMONT
SENATE COMMITTEE ON HEALTH AND WELFARE

Re: Senate Bill 115
Date: 3/15/2007
Type: Prescription Drug Regulation

Committee Members:

Sen. Doug Racine, Chair
Sen. Ed Flanagan, Vice-Chair
Sen. Sara Kittel
Sen. Virginia Lyons
Sen. Kevin Mullin
Sen. Jeanette White

CD No: 07-57/T1

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PROCEEDINGS

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CD57/TRACK 1

MS. LUNGE: And then I took it out of A and B, because they're subdivisions of C1, so it's not necessary to -- to say it in each of those. And in C, I didn't know -- and it's possible we can take this out. But I don't know if A and B define all the possible permutations of admin services contracts, because I just don't understand the details of those contracts well enough. So I left the any other language in, but clarified that that would only be any other pricing arrangements or activities required by the contract, and then I also left in the if required by the commissioner, so that VISCHA, who has, in theory, more knowledge about these contracts than I do could say, you're not going to audit these types of arrangements.

So I think that that still leaves enough discretion for the commissioner to narrow that, and also that it wouldn't obviously apply to anything not in the contract.

The next section of the amendment is for



section 12, which is on the evidence-based education program. We added in that the department, in collaboration with the AG and OVHA, so this would add OVHA to the collaboration, the 14th, again, removes that specific reference to Oregon Health Science, et cetera.

Then we took out section 13, which is the prescription drug data confidentiality, and I replaced it with a place holder language report that said that we, alleged counsel, will report to that house committee on health care and the Senate committee on health and welfare on the status of the New Hampshire law no later than December 15, and that we'd include a summary of any court decisions and status of the litigation on the law currently pending in New Hampshire. So I didn't give us a lot of work to do, but I gave -- it's a placeholder.

ATTENDEE: When you write -- when you write the language, you can do that.

MS. LUNGE: So I don't know if -- I thought that's sort of what you had in mind. If you had a more detailed kind of report or study, we can certainly work on this.



ATTENDEE: No, I think it was -- it was pretty much the placeholder, saying if the situation changes, then it's going to be addressed. And we can address it. If we have a bill on the wall where we can address it after the crossover deadline and spend more time on this.

ATTENDEE: This is the first time I've seen this, but if you don't get a report until January, there might be some information available about the impact of the New Hampshire law. I would just suggest adding an any available information about the impact of New Hampshire's law about on the cost of prescription drugs and medication, because if the law is upheld, maybe they'll have some available.

ATTENDEE: What do you think, Robin?

MS. LUNGE: Well, my concern is that, I get I want to be a little more narrowly tailored, because I don't want to come back with a report that -- I don't have the capability or our office doesn't have the capability of doing any sort of detailed study or that kind of a thing.



ATTENDEE: What about a report on whatever is available from the State of New Hampshire about --

ATTENDEE: Well, that's why I meant to say, any available --

ATTENDEE: Not to do your own study, to say if New Hampshire has produced anything about how this has worked, we just want to get that too.

MS. LUNGE: So something along the lines of and any information provided by the State of New Hampshire about the effects of the law.

How does that sound?

ATTENDEE: Yeah. That's fine.

ATTENDEE: How about just saying related information? Why not just say the status of New Hampshire's law and so on, and any related --

MS. LUNGE: Information?

ATTENDEE: -- information.

MS. LUNGE: As long as I can say provided by the State of New Hampshire so that it's clear that it's something in the State of New Hampshire, and it doesn't mean that I have to call 15,000 people to try and find it.

ATTENDEE: Yes. That's fine.
ATTENDEE: But you have until December to do this.
MS. LUNGE: Yes. And, you know, we can change the date. It can be earlier. I was just thinking that if the point -- if you're thinking you might get some interesting information for the next year, your drafting deadline is actually before -- your introduction request deadline is before December 15.
ATTENDEE: Let's do this before. Let's do it November 1.
MS. LUNGE: That way you'll have it in time to make a bill request.
(Unreportable exchange ensued.)
MS. LUNGE: Well, I don't know because it hasn't been set yet, but it's usually in December at some point, and sometimes it's even the end of November. It's much earlier for the second year.
(Unreportable exchange ensued.)
ATTENDEE: Okay.
MS. LUNGE: Okay. All right.
ATTENDEE: 16 we just did.



MS. LUNGE: Or 16 is striking sections 14, 15 and 16.
ATTENDEE: Which were related to section 13.
MS. LUNGE: Yes. 14 was related to 13. 15 and 16 were that co-payment issue.
ATTENDEE: John?
ATTENDEE: I just wanted to raise a question on this next section, which is amendment dealing with the serious public health, threat and the question is whether that's the only circumstances under which someone can bring an action, and if so, I think you need to define that in the bill itself. The bill doesn't make clear that the term or that the only circumstances in which a case can be brought is when there's a serious public health threat. So I think you'd want to say, in section 4653 of the bill, that a manufacturer shall not supply, sell, supply, so and so on, a prescription drug necessary to treat a serious public health threat as defined in section 4654. It's --
MS. LUNGE: Okay. I mean, I read it as doing what you said, but -- and I did forget to



change threat -- problem to threat there. So we can -- that's an easy enough --
ATTENDEE: And then a related question is, if that is the only circumstances that you want to bring an action, you need to make that clear under section 4655, which allows for a suit -- brings a prima facie case for a suit any time the price is 30 percent above the federal supply schedule price. That's a different standard. And under that standard it says basically if you can show that it's at this price, you win, or at least the presumption is turned. So that's a different standard than bringing one when there's been a serious public health threat.
ATTENDEE: I don't think you want to change that. Do we want to change that?
MS. LUNGE: I guess I'm not --
ATTENDEE: That's a whole different discussion. We haven't been talking about that. We deliberately didn't.
ATTENDEE: I guess, this term which shows that federal supply schedule price, and just looking at this, if it's at 60.5 percent and the cash price is at 100 percent, then every



drug sold in Vermont, on average, would violate this section and create a private right of action.
ATTENDEE: We're not trying to do that. We're trying to do it in cases of public health.
MS. LUNGE: And I don't read it the same way that John does. In my mind, you look at the chapter as a whole, and it says it's not a violation of the chapter if -- except as in 4653. So I don't think you can go to 4655 without going through 4653 and 4654.
ATTENDEE: I don't think that's clear at all, so I just think you need to cross-reference those, if that's the case.
ATTENDEE: It doesn't hurt to cross-reference.
MS. LUNGE: No, it doesn't hurt to cross-reference. It's just going to take me a little while to do it.
ATTENDEE: That's okay. And I think in terms of this amendment, it might be good to present this as a new chapter, a new section 17, and do the whole thing. Because if we're trying to explain this on the floor, we're

going to say this is part of a broader section, and to understand the flow through, you've got to keep going back and forth.
MS. LUNGE: Okay.
ATTENDEE: Where if it's all -- the whole section is in front of people, we can focus on what we're doing.
MS. LUNGE: Okay. That's actually easier.
ATTENDEE: Okay. And then I think the rest of it we've done.
ATTENDEE: I've got a question about the very last -- can I just --
ATTENDEE: Before you do, I --
ATTENDEE: I'm sorry.
ATTENDEE: Yeah. The rest we discussed earlier, right? Okay. Okay.
Julie, go ahead.
ATTENDEE: I was not here when this language at the very end on page 13 and 14 of Robin's amendment was discussed. And I'm understanding that that was being authored by one of the PBMs. Frankly, I think this is the bolded language at the bottom of 13 and 14, it's way too broad. What this would allow is all kind of advertising for which the PMB is



getting money which don't assist the doctor in terms of improving patient care. So I would suggest that you strike out instant messages, pop-up ads or other, at the very last line of 13, so that it would just say this subsection shall not apply to software providing information to the health care professional about pharmacy reimbursement, prescription drug formulary for clients, patient care management. And frankly, I think that's all you need. I think the rest of this, utilization review by a health care professional, very undefined, could be, you know, are you buying our drugs or are you not, are you prescribing our drugs or are you not prescribing our drugs, the exact kind of thing they were talking about with respect to prescription privacy section that we didn't want to see, the patient as health insurer or as agent of either. I don't understand why you need a pop-up message about the patient's health insurer or the agent of the health insurer. It makes no sense to me.
Health care research, no idea what they're talking about. Why they would need a pop-up add on a Palm talking about health care



research. Or identifying pharmacies -- this is actually the worst one. Identifying pharmacies participating in the health insurer's network. That means that if CVS, Grupps (phonetic) and Rite Aid are all participating in the network, CVS pays Medco to put po-up ads saying send your patient to CVS, then that would be the pop-up ad that goes into the doctor's PDA, I don't see that as appropriate at all.
So I can understand pharmacy reimbursement, because that's important to a doctor. The doctor understands whether the consumer will be -- what the reimbursement circumstances will be. Prescription drug formula compliance, very important. I can live with that. Patient care management, a little bit vague, but sounds like it's in the right area that we'd want to see information. But the rest of it seems to be advertising to me, and I don't see why we should allow it. I think that's what this is designed to prohibit.
ATTENDEE: And going back, you don't think it should say instant messages, pop-up ads?
ATTENDEE: I'm a little concerned about the reference to pop-up ads. I'm a little



concerned -- that's the one that really triggered my concern, because a pop-up ad -- an advertisement is an advertisement, and I don't think that that one ought to be there. Instant messages, I guess I would rather have it say shall not apply to information to the health care professional about pharmacy reimbursement so that we're not talking about whether it's an instant message or a pop-up ad, it's just information going to them in these care areas.
ATTENDEE: However they choose to send it.
ATTENDEE: Exactly.
ATTENDEE: But not for these last things.
ATTENDEE: Either I don't know what they are, or I'm concerned that they may really be related to advertising and shouldn't be in there. That's really we're trying to avoid.
(Inaudible.)
ATTENDEE: Thank you.
(Unreportable exchange ensued.)
ATTENDEE: Anything new on this? Anything that you people want to have Robin redraft and bring it back to us tomorrow -- we aren't going to be here tomorrow.
MS. LUNGE: I'm actually almost done.

It's going to take me like maybe 15 minutes to finish this up. If you want to take a break, I can do it right now.

ATTENDEE: I've got these three sections.

ATTENDEE: Yeah, just one quick thing on section 12, which is the evidence based describing, and in your amendment, it's amendment number 13, and you add in the Office of Vermont Health Access, and if you read back on page 183, the department of health, you (inaudible). And with your amendment, you're adding OVHA. And I think it was -- it's my recollection and Dr. Schwartz's agrees with this and also (inaudible) that it was also their intent to add in collaboration with the attorney general and OVHA, and the UVM area health education center program who are already doing it now.

ATTENDEE: They're one of our grantees, right?

ATTENDEE: Yeah. And Sharon had made that in her boxes that she submitted to you.

ATTENDEE: That was very constructive. Thank you.

ATTENDEE: Especially after the chocolate.



ATTENDEE: Okay. I think we're almost there, but I've learned from past experience that you aren't there until you're really there.

ATTENDEE: It's true.

ATTENDEE: It's like in my business, you haven't really sold a car until you see the taillights head up the road. Okay. We will take a break and let Robin work on this. When we come back, we will try to wrap up our work on this bill, and I'd like to have us take another look and see what we can do in naturopaths. And after that I'd like to see what we can do with the HIV based reporting.

I know there have been discussions going on between Dr. Schwartz and members -- folks representing the community. There's been a lot going on, and we'll see if we can -- we can wrap that one up or if that one gets put off to another day, which has been one suggestion. That may be more than we can do today, but we'll try and work until about 4:30 or so.

ATTENDEE: Robin, do we have the language on the prostate screenings.

MS. LUNGE: Maria worked on that last



night, so yes, she has it.

ATTENDEE: So if we could reconvene here at 3:30 and we'll see where we are.



COUNTY OF SEMINOLE. )

I, Christina Gerola, Notary Public in and for the State of Florida at Large, do hereby certify that I was authorized to and did listen to CD 07-57/T1, the Senate Committee on Health and Welfare, Thursday, March 15, 2007, proceedings and stenographically transcribed from said CD the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 20th day of August, 2007.

_____

Christina Gerola
Notary Public - State of Florida
My Commission No.: DD617707
My Commission Expires: 12/10/10

STATE OF VERMONT
SENATE COMMITTEE ON HEALTH AND WELFARE

Re: Senate Bill 115
Date: 3/15/2007
Type: Prescription Drug Regulation

Committee Members:

Sen. Doug Racine, Chair
Sen. Ed Flanagan, Vice-Chair
Sen. Sara Kittel
Sen. Virginia Lyons
Sen. Kevin Mullin
Sen. Jeanette White

CD No: 07-57/T2

Reported By:
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PROCEEDINGS

- - -

CD57/TRACK 2

ATTENDEE: Tell us if we're all set. Do we have a new copy?

MS. LUNGE: You have a new copy. It should be in front of you, it has 1.2 at the top. Jan has the extras, so.

ATTENDEE: Thank you, I'm sorry. Thank you.

ATTENDEE: Okay.

MS. LUNGE: So I took out all the bold, except that the bold that's in here now is the changes that you just talked about.

ATTENDEE: Just last made, okay.

MS. LUNGE: So the first of those are on page 8, adding in AHEC as well as OVHA to the evidence-based education program, adding in the any related information provided by the state of New Hampshire to the report in section 13. That's on page 9. The bottom of page 9, you can see I reproduced the entire unconscionable pricing chapter, and on page 10 I changed problem to threat and referenced 4654 for clarity and then made those other changes in



that section. And then in 4655, for clarity, I referenced back to 4653, which has the other requirements so that it was a little bit clearer.

ATTENDEE: Okay.

MS. LUNGE: On page 14 in the -- in the fraudulent advertising, I added a new sentence. I took out the after sending blah, blah language and changed that to add a new sentence at the bottom, a warning or entitled letter, which is what it says on the FDA website. They're called issued by the U.S. Food and Drug Administration, would be a prima facie evidence of a violation. Then I reworked that sentence on page 15 about that pop-up ads.

ATTENDEE: Okay. What the pleasure of the committee on S-115?

ATTENDEE: I move S-115.

ATTENDEE: As an amendment to the finance committee version.

ATTENDEE: As an amendment to the finance committee version.

ATTENDEE: Any other comments? A motion is on the table.

ATTENDEE: I guess I want to be on the



record as explaining my vote, if I do vote for it. I'm still very concerned about whether or not it meets the constitutional requirements when it comes to the unconscionable pricing language. And I wish we had more time to work on it, but I understand the deadline pressures we're under, so overall, I guess I'm going to vote for the bill. But I'm still in hopes that we might be able to come up with some better language for that section of the bill.

ATTENDEE: Fair enough. And I will say, in response to that, I don't know if we'll ever be satisfied about the constitutionality of something, because that's not our jobs, and we're always guessing as to how courts would react to things. And the question I think before us when we started that section, do you want to push the envelepe. I think we're pushing a little bit or perhaps certainly not as far as was perhaps in the finance version.

ATTENDEE: We have our desire to push the envelope versus our oath of office which tells us not to violate.

ATTENDEE: I understand that. But I'll say that's a tough as a legislator to decide.



Because I was often asked as a presiding officer, in the years I did serve as a presiding officer, if I would rule on whether something was constitutional or not. You know, and I said that's not the job of the presiding officer. And you can make your own determination whether it is or not. And if you feel it is unconstitutional, I think your oath would say you shouldn't vote for it, but ultimately, that's not a legislative responsibility, although there's certain things we could do that we would say this is definitely a violation of the constitution.

I understand your concern. I have questions about that section myself, but I feel like there's a good -- it's a good policy statement (inaudible).

We have a motion on the table to vote favorably for these amendments to the finance version of S-115, and we were just discussing it.

Other comments or concerns?

ATTENDEE: I'm fine.

ATTENDEE: All those in favor of the amendments as you see in front of us as draft

1, S-115, 315, 2007, RGL, 140PM, 1.2, please signify by saying aye.
ATTENDEE: Aye.
ATTENDEE: Anybody opposed?
ATTENDEE: I'm just wondering, is Ed still in the building?
ATTENDEE: It's 501, and we will leave this open long enough for Ed to be recorded, if he so chooses, which I'll assume he will want to. And Robin says they'll need time to proof it, and so I'll probably sign it out, but it won't be on the calendar for notice tomorrow. And I will inform the finance committee of what we've done, and they'll probably invite us in.
I would report this, unless somebody is jumping up to and down to do that otherwise.
ATTENDEE: I'm not. Thank you.
ATTENDEE: Okay. I'd be happy to report it. Let me say thank you to the committee and all the people in the room, present and not present. I'm sure that not everybody is happy with this piece of legislation, but I appreciate the process that we all went through and the participation of the folks outside of the committee table. And I thought it was



constructive discussion.
ATTENDEE: My guess is there's probably very few pieces of legislation that has anybody jumping up and down in joy.
ATTENDEE: I had a couple over the years, but --
ATTENDEE: Where everybody --
ATTENDEE: Everybody, no.
ATTENDEE: Or even some people were so pleased that.
ATTENDEE: Very excited about some things I've been involved with. I'm not jumping up and down on this one. I'm going to say also, for the record, seeing everything we're saying is for the record anyway, I feel we've got a long ways to go with prescription drugs. And this was pretty much -- this was the result of work that you folks and others had done in past years. And most of what's here preceded my coming back into the legislature. But I'm still feeling like there's a lot that's been done in recent years, and we still don't have a sense whether it's working or not, or the numbers aren't there, (inaudible), the numbers are very small.



The pharmaceutical industry keeps telling us about their program for low income folks, and I don't see the state taking on an active role in promoting that. I think there's a lot that can be done with what we already have out there that could make a difference if the state of Vermont was more aggressive in pushing it.
I don't think we're ever going to stop looking at pharmaceutical prices absent national legislation. I think we're always going to be frustrated my our inability to act in certain areas.
But I hope you will continue the discussion and look to see what we can do with existing law and existing programs that will make a difference in prescription drug prices for Vermonters. To me, this bill is pushing here and there, but it's not going to have a dramatic impact on the prices that Vermonters pay, and I think that's unfortunate (inaudible).
ATTENDEE: The hope is we won't need all these drugs in the future; less drugs, not more.
ATTENDEE: That too. That's why we have



to have a hearing on prevention and wellness and nutrition.
(Unreportable exchange ensued.)
ATTENDEE: We'll send this out, and Robin will get it proofed before it makes it onto the calendar. Next we'll are move on to S39.
(Unreportable exchange ensued.)
ATTENDEE: I've got to admit that I don't remember where we are on this one.
ATTENDEE: Which one are we on.
ATTENDEE: S 39. I thought we were ready to go.
MS. LUNGE: I think Senator Mullin yesterday had proposed an amendment which I think --
ATTENDEE: Yeah, there is an amendment that I have in front of us that came from John.
ATTENDEE: John Holler (phonetic), MVP.
ATTENDEE: Substitute 4th day, has a proposal.
(Unreportable exchange ensued.)
ATTENDEE: Why don't you sit down and tell us who you are and what you're all about here.
ATTENDEE: You've got the bill?
ATTENDEE: No.

ATTENDEE: It was in my package.
ATTENDEE: Here.
ATTENDEE: Okay.
MS. SIDORTSOVA: My name is Stephanie Sidortsova. I'm here on behalf of MVP Health Care.
ATTENDEE: Who?
MS. SIDORTSOVA: MVP Health Care.
ATTENDEE: MVP, Okay. And you're substituting for John Holler, who would otherwise be here for MVP Health Care?
MS. SIDORTSOVA: He would, yes.
(Unreportable exchange ensued.)
ATTENDEE: What is your name again?
MS. SIDORTSOVA: Stephanie Sidortsova. Would you like me to spell that?
ATTENDEE: Sure.
MS. SIDORTSOVA: Okay. S-I-D-O-R-T-S-O-V-A.
ATTENDEE: Thank you.
MS. SIDORTSOVA: You're welcome.
ATTENDEE: Boy, I bet you that gets butchered.
MS. SIDORTSOVA: Yes, all the time.
ATTENDEE: Okay. Why don't you go ahead.



MS. SIDORTSOVA: Well, this bill, basically S-39 is based on the chiropractic statute, and this portion of S-39 omits one sentence that does appear in the chiropractic statute. And it basically states that the insurers may require that the naturopathic physicians be under contract with the insurer. And MVP is wanting you to consider this amendment for several reasons.
First of all, it would help them to manage the quality of the services being provided by the naturopathic physicians. Also, it would enable them to negotiate a fee schedule and help them to establish the credentials of the NDs. As I mentioned, this is language that's from the chiropractic statute, and as far as we're aware, there haven't been any issues with this requirement in the statute. There's been no problems with access or things such as that.
ATTENDEE: Do we do this -- require the health insurer -- do we allow the health insurer to require that an MD be under contract before they can be reimbursed? Because we're comparing here to chiropractors, not MDs.
MS. SIDORTSOVA: Correct. Actually, to be



honest with you, I don't know the answer to that question. I'm pinch-hitting for John. But I can check with him and get back to you on that.
ATTENDEE: My comment would be that if we do not, then we should not for naturopaths because naturopaths are primary care practitioners, they're not chiropractors, they're more comparable to MD primary care people, family practitioners.
ATTENDEE: Another way of looking at it is that we can put language in to make sure that you do -- I guess just quickly (inaudible), but if you -- we may say everybody's got to cover the naturopathic doctors, and then you would have this language in, and you would just not have them, you know, whatever you do, well, you have no contract with them, so you wouldn't have to cover them.
So we should put language in saying you have to -- obligate you to have a contract with them, all things being equal, and whatever --
ATTENDEE: So you're saying that if an ND is licensed to practice --
ATTENDEE: Right, all things being equal.



ATTENDEE: That's what the bill occurrence currently says. All they're doing is saying they want to set up a network of NDs.
ATTENDEE: The same as they do with chiropractors. And my question is if they don't do it for family practitioners, family practitioners, then we shouldn't do --
ATTENDEE: I think they do. Don't you have to stay in network.
ATTENDEE: That was my -- I want to make sure that they do it for MD -- the same thing would apply to all -- what I'm saying is I don't want us to be treating MDs any different than we're treating ND primary care practitioners. That's the point here.
ATTENDEE: How do we find that out?
ATTENDEE: I don't --
ATTENDEE: I think we're going to try to get an answer.
ATTENDEE: Yes.
ATTENDEE: Either from John or MVP. Do you understand the question?
MS. SIDORTSOVA: I do.
ATTENDEE: Could we put this bill on hold then for 15 minutes?

MS. SIDORTSOVA: 15, 20 minutes?
ATTENDEE: Yes.
MS. SIDORTSOVA: Sure. Absolutely.
(Unreportable exchange ensued.)
ATTENDEE: When you're back, we'll find the time to get back into it. Senator Flanagan, we just voted 5, 1. So we're at 6, 0. You voted for it?
All right. Let's move on to the HIV bill. Now, as you may recall, when we were last here on this one, -- whoops, everybody left. Everybody's gone.
ATTENDEE: They're not interested in this one.
ATTENDEE: Where we were with this was -- trying to -- I hope they're numbered.
(Unreportable exchange ensued.)
ATTENDEE: That's worse. That was a pile of paper. I think where we were with this was we were pushing toward -- pushing to consensus between the health department and the folks representing the service, HIV, AIDS, service organizations, if that's the right --
ATTENDEE: Yeah, I have a little update for the committee, what's going on.



ATTENDEE: We're just setting it up. And what I heard in the last few days is varied, that it goes from being somewhat optimistic that there's a consensus, to pessimism that a consensus can't be reached. So I don't know where we are at the moment.
There are some who feel that the money from the Feds will be jeopardized if this doesn't move sooner rather than later. There are others who feel that the money won't be jeopardized if it doesn't pass this year. And there may be some who feel that if the price of the federal money is lack of proper security for the (inaudible), that perhaps we should care more about the security than we should about the money.
But anyway, so that's sort of all over the -- all over the map on this. So with that, I'm hoping that somebody will come and sit down and say everything is all well and good and here's where we are. But I don't know.
(Unreportable exchange ensued.)
ATTENDEE: Short of that we make the decision. The decision may be to resolve the issue and move it. The decision could be that



we will take more time to resolve it, and we won't worry about passing it this year.
Where is Dr. Schwartz?
ATTENDEE: He's on the bill with the lawyer from the Health Department checking some specific language out right now.
ATTENDEE: Could you sort of tell us where we are based on what I just said and for the record?
MS. ZATZ: For the record, Gail Zatz on behalf of the HIV community. And I sent some language yesterday to Dr. Schwartz, and he looked it over, came back with a few proposed changes. Almost all of them were fine. There were a couple of them that required a little investigation, which they're doing right now.
ATTENDEE: Okay.
MS. ZATZ: But we're very close. And there are just a couple of outstanding issues that may be able to be worked out with some different language.
ATTENDEE: So you're --
MS. ZATZ: So I think we're pretty close.
ATTENDEE: So the mood of the moment is optimism?



MS. ZATZ: Yes.
ATTENDEE: And Dr. Schwartz is sharing your optimism?
MS. ZATZ: Yes.
ATTENDEE: I've got to say I think everybody has been acting in good faith. There have been some bumps in the road. I saw one e-mail along the way which might have suggested that. But -- and I'm hopeful that we can resolve this. This seems like we're very close, and I think everybody did come to the table saying we want to be able to resolve this, and there seems to be good faith on both sides. So hopefully we can do it. So we're going hold until we hear from Dr. Schwartz.
MS. ZATZ: Yes. And I have the redraft on my computer, and as soon as I make the changes I can e-mail it to Jan or -- no. No. To Jan or --
ATTENDEE: We're in this big holding pattern.
(Unreportable exchange ensued.)
ATTENDEE: This may open -- this may open things up. There's one that the Chair would love to see passed out of here today or

tomorrow, because it's got my name on it.
ATTENDEE: That's a good one.
ATTENDEE: Now, I understand there's bills up there with names of everybody on the committee on them.
ATTENDEE: Which one is yours?
ATTENDEE: S-177.
ATTENDEE: Child poverty in Vermont. We're going to solve that in a half an hour?
ATTENDEE: The bills propose to create a commission to address the issues of childhood poverty. If you recall, we had a hearing on this, and we were sort of at a loss as to what do we do. What do we do?
ATTENDEE: We want to do anti-hunger and child poverty in our committee too, in agriculture. We're interested in that.
ATTENDEE: I think we could maybe add hunger to this one.
ATTENDEE: Hunger. Sorry.
ATTENDEE: Oh, now we've got Dr. Schwartz in here, we've lost everybody else.
Are they conferring?
ATTENDEE: I'm not sure what they're doing, but we have conferred, and I think we're



done.
ATTENDEE: Okay. When they come back in, we'll have you all stand up and do a chorus of Kumbaya. That would be very nice.
ATTENDEE: Would that be nice?
ATTENDEE: It would be very nice, and it would certainly help this committee.
Anyway, I would like -- I would like to continue to focus attention on the issues affecting children in poverty. And of course it affects their families, it affects hunger and health care and it's a whole range of issues.
There was a commission a few years ago. Rabbi Joshua Chasin (phonetic) was chair of it, Representative Sally Fox, who is was chair of the corporations committee in the House served on it.
I think the language might need a little bit of work in terms of where the representatives come from, like there's nobody here from (inaudible). You might want to include them.
ATTENDEE: I'd like to put agriculture on it, because we're trying to connect up the food



bank with --
ATTENDEE: I want to get a sense of interest here, if the committee will be willing to take a look at this and perhaps vote and make some of those changes to it tomorrow and vote it out of here. It would obviously go to the appropriations committee, because it's going cost money.
ATTENDEE: I would be supportive to -- we probably want to change and shorten the size of the membership, just because 14 seems to be a little bit much. But --
ATTENDEE: Okay.
ATTENDEE: -- other than that, I think it's a very worthy cause.
ATTENDEE: And you won't be here tomorrow.
ATTENDEE: I won't be here tomorrow, so it doesn't matter.
ATTENDEE: We'll take that as a yes in concept?
ATTENDEE: Yeah.
ATTENDEE: Okay. Frankly, what this does is it keeps a focus on the issue. I was a little frustrated this year. We tried at the beginning of the year, we put a little tension



on the committee, had a hearing on this. And we had a couple of hearings with Steve Dale to talk about kids. And in every one of those cases I asked the members of the press out there to come in, and in every case they sort of blew it off and said, one case, they said, everybody has got an issue here, and we can't cover them all.
I just thought it was kind of sad that there was no interest in doing something about the status of children and helping the public understand. So I think a commission like this keeps the attention focused on it, and it gives a focus for some of the advocacy groups to point and say they're listening, and (inaudible). And it calls for hearings in each of the 14 counties, which may be excessive, but it might be good to obtain in Vermont as a state committee and say, hey, we want to hear from you, because there's certainly poverty in (inaudible).
ATTENDEE: Is there a reason why (inaudible).
ATTENDEE: No, we could make it a committee bill, if you prefer. That was just

last minute. If you'd rather, we could vote it out of here as a committee bill, I think. We'll check on that.
We could still do that?
MS. LUNGE: You can do it as a committee amendment to the bill as introduced and have it be from the whole committee.
ATTENDEE: It would still be S-177 which has my name on that. If we can do that, I'll change it to a committee bill. Okay.
Then if -- we wanted to talk about putting ag in it, trying to reduce the numbers, you know, as we're increasing the numbers.
ATTENDEE: I know, we've --
ATTENDEE: Let's look at it tonight and see what we might be able to do.
ATTENDEE: And add hunger. On the beginning, it says children, poverty. If you can add hunger there, and somehow make a sentence about hunger. And the food bank -- maybe they're already in there.
ATTENDEE: They wouldn't be hungry if they --
ATTENDEE: Yeah, but I think the word hunger, ant-hunger kind of thing. Because we



are talking about after school and programs and --
(Inaudible.)
ATTENDEE: Okay. All right. Thank you. We'll proceed with this one tomorrow. And the next is -- the next thing is I'd like, while we're waiting, while we're still circling here, to talk about what we're going to do in the next week or two.
ATTENDEE: Did we pass childhood poverty.
ATTENDEE: We're going to make a couple of changes to it. You can suggest changes, if you'd like, and do it as a committee bill, and we'll still allow it as a committee bill. And right now it's got my name on it. And Ed suggests we do it as a committee bill.
ATTENDEE: We could do an easy committee bill that would study nutrition as a (inaudible) bill and trans fats as an (inaudible).
ATTENDEE: As a commission rather than your bills.
ATTENDEE: No, because we already did the guidelines. We did a study of guidelines. Yeah. We've done that.



ATTENDEE: I'm trying to keep something in the process.
ATTENDEE: That's for the next topic. What I'd like to do next week, and Jan and I earlier were trying to figure out the schedule, is those of us in Chipman County have heard a lot about chloramine, and I'd like to give those folks a chance --
ATTENDEE: Do we know what it is.
ATTENDEE: It's some icky thing in the water.
ATTENDEE: Chlorine?
ATTENDEE: Chloramine.
(Unreportable exchange ensued.
ATTENDEE: And Dr. Schwartz will be in testifying.
ATTENDEE: Ammonia and chlorine.
ATTENDEE: The EPA apparently is recommending it, and I don't understand it all. But it's in the water and the Champlain water district, and some people are complaining about it. And I'm hearing about it a lot. And they've asked to have some forum. So we'll invite some of them in to talk to us. We've invited the health department in to give us



their take on it and the Champlain Water District.
There's no bill. I don't anticipate a bill. But I think as citizens they are entitled to a hearing in this legislature, because the level of concern has gotten high enough where I think that I would like to be able to do that for them.
We also plan to take up -- I thought we should do -- I've been asked by more than one, S-166, which is Senator Lyons' bill, the mandatory overtime for hospital employees, do you want to do that next week?
ATTENDEE: I thought we had that worked out last year.
ATTENDEE: No, that was staffing.
ATTENDEE: And I have a question about this bill as to whether it's a health care bill or a labor bill.
ATTENDEE: It may be a labor bill.
ATTENDEE: And frankly, I think it's a labor bill. And avenue told the advocates for this one that I think it is. What it says is there cannot be mandatory overtime for nurses. And the reason is it's a safety issue. But I

don't understand why it's a safety issue if it's mandatory and it's not a safety issue if it's voluntary.
ATTENDEE: The flip side of that, it's a safety issue for the patient if they can't have coverage.
ATTENDEE: If they have no coverage?
ATTENDEE: If they have no coverage (inaudible).
ATTENDEE: But if somebody wants to work 80 hours a week, they can, and it's not unsafe, but if they're forced to work 80 hours a week, it is unsafe. So I'm having questions of whether it's safety or labor.
ATTENDEE: It will be interesting to hear testimony, if I've worked 10 hours or 12 hours, and someone is not coming in, and would you mind working another 12. That's a safety issue, I think --
ATTENDEE: I have concerns about -- I have concerns about being in the hospital when the resident or intern who's treating me has been there for 36 hours.
(Unreportable exchange ensued.)
ATTENDEE: You're looking at one of the



last really tough ones.
ATTENDEE: How many hours did you work?
ATTENDEE: Oh, 36. I'd go in one day and go home the next.
ATTENDEE: 36 on, 12 off.
ATTENDEE: You know, the VPR thing that I heard said that your mental acuity after I think it was 24 hours without sleep was worse than the legal limit for alcohol. And I also have an issue of being in the hospital with no nurses because they all went home.
(Unreportable exchange ensued.)
ATTENDEE: Anyway, can we go through the other bills we want to hear, instead of talking about the (inaudible) bills?
ATTENDEE: Yeah. The other one that I wanted to do is -- again, we don't have a bill. There's a draft floating around out here, enforcement of under -- sales of tobacco products to underage minors.
Bruce Cunningham, as many you may know, has been talking to me for a long while about that. He makes a pretty compelling case that the -- underage tobacco.
ATTENDEE: If we can find -- if we can



limit them from doing the stings, I have to tell you --
ATTENDEE: I would like to have that discussion. Again, I would like to give the man a hearing. He's convinced me something is going on out there. We'll invite in, I guess it's Mike Hogan who is the record control board.
ATTENDEE: That's another one that kind of has dual jurisdiction.
ATTENDEE: That one's another weird one, and we'll get Sandra Masden (phonetic) down the hall on that one.
So those were my choices. I want to hear what other people want to do.
ATTENDEE: I have a couple.
ATTENDEE: Okay.
ATTENDEE: S-81, the Mercury Amalgam, the Amalgam and the vaccines, and I --
ATTENDEE: Okay. What happened in the House on that?
ATTENDEE: I don't know what happened, but they don't cover the vaccines anyway. And if we can just get a date, even if it's sometime out in the future, that we can just get a date



for a hearing so that we can hear about it.
ATTENDEE: Will you take care of -- if we get you a date, will you work with Jan on who should be invited?
ATTENDEE: I will.
And the other one I would like to press is 126, the statewide direct care provider registry, S-126.
ATTENDEE: And same deal, you'll --
ATTENDEE: Um-hmm.
ATTENDEE: And would an hour on both of those be enough to set them up.
ATTENDEE: And I don't know if -- on that one, I don't know if we don't do it before the cross-over -- I'm just saying, it may well have already been dealt with by appropriations.
ATTENDEE: Okay. Will you find out before we schedule that?
ATTENDEE: I will, yeah.
ATTENDEE: And I think we have to be a little careful. I mean, I really feel very strongly about dental health, and we know in this committee last time --
ATTENDEE: I just want to hear.
ATTENDEE: And we've talked about it in

the past, and we are losing dentists. We had on a call --
ATTENDEE: We put an Amalgam separator into the environmental bill.
ATTENDEE: Yes.
(Unreportable exchange ensued.)
ATTENDEE: I am very skeptical what message we're sending out of this committee at this time when we are lacking dentists in this state. You can't -- if I have Medicaid, there is no dentist I can go to.
ATTENDEE: Are you saying we shouldn't have a hearing?
ATTENDEE: I am just saying that --
(Unreportable exchange ensued.)
ATTENDEE: Most people just see the word Amalgam, because that really is what it's about. So I guess I would ask if Senator White -- or I guess I would just say if we could say something to Peter Taylor, he's the head of the dentist group, to say that we're concerned, but we know they're doing best practices. I mean, I'm just --
ATTENDEE: I can say that, but I really do want to have a hearing.



(Unreportable exchange ensued.)
ATTENDEE: Right. It's for the poor people, so let's fill them up with Mercury. It isn't --
(Unreportable exchange ensued.)
ATTENDEE: It's like we're using the best practice, they're all dead now, but we use really good practices. We have to be careful of that.
ATTENDEE: I understand. And by the way, in the middle of this, we have a couple of House bills, and there will probably be more. At some point, the H-44 will arrive here.
ATTENDEE: What's that one? That's --
ATTENDEE: For lack of a better word, it's H-44, because however you describe it, somebody is offended.
ATTENDEE: (Inaudible) choices?
ATTENDEE: And what did you want to bring up, sir?
ATTENDEE: Well, I do have some things I want to bring up, but I had a question that you popped into my head. We were supposed to get something on Catamount, because the employer assessment starts April 1.



Seasonal employees, what's going on?
ATTENDEE: They've passed something, I think.
ATTENDEE: What's going on?
ATTENDEE: There was an agreement on seasonal employees to exempt them, and as the bill was working its way through, there was an amendment being talked about from the representative from (inaudible) to exempt part-time employees who are covered by somebody else's health insurance who are not exempt now, if an employer doesn't provide health insurance. And there was a concern that from there it would go to school and municipal employees, nonprofits. It was opening the door.
So I think there's been -- that bill has been sitting in ways and means committee while the politicking is going on behind the scenes to try to come to some resolution of the issue.
ATTENDEE: (Inaudible.)
ATTENDEE: It's in ways and means, so it doesn't get blown wide open, there's an accomodation reached and it goes to the floor, and it doesn't get out of control with



amendments that would cost a lot of money to the Catamount program.
So that's a technical amendments bill there. They're also close to voting out a bill out of House health which will -- is making more substantive changes to Catamount. That's the bill where we have -- we have several on the board.
ATTENDEE: 49, 182, that's why we would put that --
(Unreportable exchange ensued.)
ATTENDEE: That will be the vehicle for discussing those. So on the technical corrections bill, which I hope is quick and dirty and out of here, and then we'll have a more substantive bill that will allow us to have -- open the door on what we want to talk about.
And then there's also going to be at some point I hope within three weeks some joint hearings with House health to talk about where we go from here, where we go to try to cover more insured people, how we expand this, if that's the right vehicle, to include the underinsured, or whether we should continue or

go down another path.
ATTENDEE: That's -- 182 addresses a lot of those.
ATTENDEE: Yeah. But that -- yeah. I mean, there are changes we can make this year. There's sort of a short term --
ATTENDEE: Yeah. Yeah. Yeah. Okay. Yeah.
ATTENDEE: And then what are the long-range issues. And Ken Thorp is going to come in and help facilitate those discussions.
We have Jim Hessner (phonetic) on board now, and say -- we have technical corrections. We have what I'll call short-term changes, and then what I'll call long-term changes, and what we want to do with that is sort of set up what the health commission should look at this summer but he guided by the the two committees of jurisdiction, ours and the (inaudible) --
ATTENDEE: They're two separate bills, right?
ATTENDEE: Probably two separate bills and setting up a third discussion about the more long-range issues and where we go. So --
ATTENDEE: And then we already talked



about having at least a hearing on the different nutritional aspects. But I think what also would be nice, if we tried to set up an afternoon where we asked Commissioner Pelp (phonetic) to invite certain people from around the state that have started creative and innovative wellness and prevention projects in their community and have an afternoon devoted to that, and also try to somehow massage the press into trying to cover it --
ATTENDEE: Good luck.
ATTENDEE: -- just so that people in the state are familiar with the creative ideas.
ATTENDEE: We did that the first year, my first term. I worked really hard and invited a whole lot of people from around the state. And we had a big event, we had events in room 10 and room 11. We had Dr. Marks from the CDC. And maybe what we should do is how to work in here to promote --
ATTENDEE: How to package it.
ATTENDEE: How to package it, rather than just doing it, how to package it so we can -- as a committee, to bring in some folks who can speak to target goals and programs that are



model programs, not just in this state, you know, but we can also look and see what the CDC has.
ATTENDEE: Can I make a suggestion on that? One of the things that we did the legislation last year around the wellness initiatives, those grant applications were due March 7. They had a lot of people interested in them. They are reviewing grant applications. And I think that we can -- they -- not only we can tie this to that, because there are a lot of innovations out there, and beyond the ones that actually get funded, there are other ones that won't get funded that will still be worth looking at.
And they need us to say, what are the next steps, where do we go, are we going to have a million and a half in the next year's budget for this? And the departments and the different departments and agencies in the state government are getting pretty excited about this and are talking about putting more money into it.
The tobacco board has put a bunch of money into this for next year, they've recommended,



and different -- so we need to look at where we go next with this.
ATTENDEE: And don't forget that Jim was always pushing the insurers to do a dollar for (inaudible).
ATTENDEE: So where do we go next is a question, and we can tie it in with that.
ATTENDEE: We're going to get back to bills here, but Jenny had one more thing, really a short thing.
ATTENDEE: Small issue. It's an issue brought to my attention by a constituent, and it has to do with spousal coverage for disabled children. And so there are some instances where the disabled children are not -- they're not getting the money that is due.
ATTENDEE: Oh, really? From the State --
ATTENDEE: From --
ATTENDEE: -- or from the insurance companies?
ATTENDEE: From the divorced parent.
ATTENDEE: Oh. Oh.
ATTENDEE: Yeah. So if I can just bring the issue in --
ATTENDEE: I'm going to suggest to

everybody who's mentioned it, and I know we haven't gotten to Sara and Ed yet, but it's not -- I need to hear not only what you want to do but how we would do it and who would come in. So it's not going to be good enough to say let's spend an afternoon on nutrition and wellness without saying here's who we'll invite in. You'd have to help me set up the hearing, if that's fair. And if you two can work on that, and if you're in agreement on that and you want to set up an afternoon, Jan will work with us to set those things up.

I would just suggest that you not do a Wednesday afternoon, because we never know when we're going to get back down here. Tuesdays and Thursdays would be the time to do that. Wednesday would be a time to work on things where everybody affected is in the building. Because then if we're on the floor until 4:00, we haven't invited people from afar to come in. You know what it's going to be like in the second half.

And I also want to warn you that we're going to feel an obligation to take over the House bills that do come over. I have no idea



what's coming over. So given that those bills have met a deadline, and there's a hope that they would pass this year, then those will be our top priorities. I thought in this hiatus we would work on some of the things that are of interest to this committee and (inaudible). Fair enough?

Okay. Let's start with naturopaths, and if that can be quick. If not, we'll move on.

MS. SIDORTSOVA: Do you want me to --

ATTENDEE: Please.

MS. SIDORTSOVA: Basically, obviously health insurers do contract with doctors, and if somebody goes to see a medical doctor that does not have a contract with a particular health insurer, the insurer is not required to cover that service. So under this language in the bill, naturopathic doctors would be treated similarly to medical doctors.

ATTENDEE: Okay. Thank you.

ATTENDEE: But it's optional whether, if the doctor is not in the network, for the insured to cover that, to reimburse that physician?

MS. SIDORTSOVA: It is optional, yes.



ATTENDEE: And that's true for medical doctors, naturopaths, chiropractors, everybody?

MS. ZATZ: Right. The language here says may require. So it's up to the insurer.

ATTENDEE: Poor Maria is probably wondering what we're talking even about.

ATTENDEE: I'm just getting up to speed.

MS. SIDORTSOVA: Thank you for your patience. I just didn't want to assume on the record.

(Unreportable exchange ensued.)

ATTENDEE: Did you guys switch places, Virginia?

ATTENDEE: No, she's -- she's still around.

MS. ZATZ: Gail Zatz on behalf of the naturopathic physicians. I spoke with Laura Lee Schoenbach (phonetic), who the committee heard from, and a concern that she has with this language, and we actually just don't know the answer to that -- to the question right now is it would a health -- would all the health insurers, because they have been resistant to this bill just refuse to contract with naturopathic physicians, and that's the end of



that. So we don't know if the -- if there is any language surrounding -- of any other statutes related to when an insurer can refuse or under what conditions an insurer can refuse to contract with a provider. So we would want those same protections here, because we could see the possibility that they would all just refuse to contract.

(Inaudible.)

MS. ZATZ: And a session that we had, if the committee doesn't want to deal with this at this moment, this bill is going to go to the finance committee, so perhaps that issue might be addressed there.

ATTENDEE: I think that's a health care issue, though, it's not a finance issue.

MS. ZATZ: It doesn't matter to us. But we just don't know the answer.

ATTENDEE: If it's agreeable to the committee to put that assurance in there, we can ask you and Maria to take a look at that.

ATTENDEE: Yeah.

ATTENDEE: And if you could work that out before tomorrow or by tomorrow?

ATTENDEE: Put this language in the bill?

ATTENDEE: Put this language in, but --
ATTENDEE: With some assurance that --
ATTENDEE: They will contract with some naturopaths, instead of just saying we won't contract with any naturopaths, and therefore they'll have no coverage.
ATTENDEE: That's why I suggested some language, because what we heard for testimony was naturopaths, a lot of them don't have hospital privileges, they're not primary care physicians. You say they are. So to me, this language right off made me think that I could immediately not cover them, because there's three reasons.
So I would say that if we're going put this in, we almost should put some language in saying, you have to, all things considered, work at contracting with them. You can't immediately just say --
ATTENDEE: And the other concern that was raised is that they could set the fees so low, the reimbursement fees so low that --
ATTENDEE: We'll wait until tomorrow. And could you try to work that out and provide some language tomorrow.



(Unreportable exchange ensued.)
ATTENDEE: If the legislature makes this decision, we don't want it to be ignored.
ATTENDEE: We don't want to give them an out.
ATTENDEE: Senator Mullin had a proposal amendment that just got handed out to you.
ATTENDEE: Yes, and Maria drafted it. So if there's any technical questions, she'll be able to assist.
But basically, as I mentioned the other afternoon, it came to my attention that a number of states, they've actually taken this a lot further and created a men's health commission and everything else. But basically the run of this is just to make sure that people are covered for prostate cancer screenings.
ATTENDEE: They are not now?
ATTENDEE: Some insurance covers it, but they're not required to.
ATTENDEE: Does anybody not -- Does Blue Cross and MVP do it.
(Unreportable exchange ensued.)
ATTENDEE: I said I'm happy enough to put



(inaudible) --
ATTENDEE: I'm all for men.
ATTENDEE: We're the forgotten people, kind of like (inaudible).
(Unreportable exchange ensued.)
ATTENDEE: I think this is good, because it seems to me that it probably is what, caught early, is one of the more doable cancers as --
ATTENDEE: It is.
ATTENDEE: As is cervical cancer with women. So let's just do it.
ATTENDEE: We're --
(Unreportable exchange ensued.)
ATTENDEE: Requiring payment for prostate cancer screening, because there's -- whether earlier intervention makes as much difference with prostate cancer as with some of the others is up for grabs. But I don't think that's -- that doesn't justify not knowing that it's there.
ATTENDEE: If you know there's a problem, does Medicaid cover prostate screenings?
ATTENDEE: I do not know.
ATTENDEE: I bet you can't get a prostate screening coverage until you are over 55 or



something like that.
ATTENDEE: Is there an age on this? Of course, doctors aren't going to recommend it for a 30-year-old.
ATTENDEE: There isn't an age on this. But I did go see Steve Mire, and I said, look, we're not really going to have time in the Senate to really do the due diligence, and the only way I'm going to get my colleagues to agree to it is if you can give me the assurance that you will. And he seemed to be willing to do that.
ATTENDEE: And it does specify in here that they'll occur at intervals consistent with CDC recommendations. I didn't have a chance to see what they are, but there are some federal guidelines, or upon the recommendation of the health care provider.
ATTENDEE: So this covers individual need by having a health provider individualized to a specific patient (inaudible) from the CCD. That would be appropriate.
ATTENDEE: Isn't that what they do with mammograms too?
ATTENDEE: Yeah.

ATTENDEE: Yeah. One gender at time.
ATTENDEE: One gender at a time.
ATTENDEE: Kevin, would you like to move this at this point?
ATTENDEE: I'd like to move it, yes.
ATTENDEE: Any further -- it's the Mullin amendment, S-39.
Should we change the title to naturopaths and prostate screenings on the bill?
ATTENDEE: You should ask the naturopaths.
ATTENDEE: This is sort of called the Christmas -- this becomes a little Charlie Brown Christmas tree with only one ornament sitting on it.
All in favor of the Mullin amendment, please signify by saying aye. Those opposed, no. And we'll come back to the bill tomorrow to see if the language can be worked out to make sure that there is not a large loophole to avoid covering naturopathic physicians.
Okay. HIV, are we all -- no. Are we all here? Yes, we're all here.
ATTENDEE: Other side.
ATTENDEE: We even have a draft.
ATTENDEE: We have a draft it's all set, I



think you might even be able to vote.
ATTENDEE: It never works quite that easy.
ATTENDEE: Although we do have a question, a question to Maria. It's an easy question.
So there are no numbers on here. But -- sure, I'm sorry.
ATTENDEE: Is this as a strike all to what we have had in front of us, or is this a section of it.
ATTENDEE: No. This is as introduced with some changes. So you'll see the strike throughs and the bolds and all that.
ATTENDEE: Okay. Actually, it doesn't have a bill number on it, does it?
ATTENDEE: No.
ATTENDEE: This is a --
ATTENDEE: Committee bill.
ATTENDEE: It's a committee bill. Does it have a number?
(Unreportable exchange ensued.)
ATTENDEE: This is the sum and substance of what we've had in front of us.
ATTENDEE: Exactly.
So since you last -- Gail Zatz on behalf of the HIV community, since you last reviewed



the bill -- I can highlight the changes that we've made. So this is the question we have to legislative counsel. On the second page, it's front to back. So the second page, the second to last line, this sentence was existing law and regulations or rules were promulgated years ago. And I am assuming that the word rule now is used instead of regulation, and that's why the word rule there appears there, but no new rules are going to be promulgated related to this sentence.
So the question to legislative counsel is should we just keep the word regulation there, because it pertained to the regulations that were developed way back then and strike the new word rule, because no new rule is being promulgated.
ATTENDEE: I think maybe why was done -- and probably not actually done, I'm looking at this for the first time, but in general now we refer to -- any kind of regulation at the state level is considered a rule, and we use that term rule very specifically, whereas regulation is used to apply to federal administrative regulations. So it's just a distinction for



(inaudible) purposes.
ATTENDEE: So the word should be rule, but we just want to make sure a rule does not have to be promulgated to establish a list of disease, because that's already been done. And the department doesn't want to do another rule to establish the list, nor do we, because it exists already.
ATTENDEE: Yeah. That's certainly not the extent, I don't believe, here. That's something as we go through and work on legislation, we can amend existing laws to reflect current language and terminology when we do that.
ATTENDEE: So there is a rule, though, that will be promulgated, which is on page 3. So the department will develop procedures and collaboration with the Vermont ASOs related to ensuring confidentiality of the information. And also the department will develop procedures for backing up individually identifying information. And this becomes important, as you'll see later on, where we prohibit the use of laptop or network computers. Sometimes the department receives information on networked or

laptop computers, so they will develop procedures as to how to transfer that information quickly off of those computers to a non-networked computer.

The next change is on the 4th page at the bottom, number 3. The information will be used only for public health surveillance purposes.

ATTENDEE: That was sold to drug companies.

ATTENDEE: Right. Yes.

ATTENDEE: That was another bill.

ATTENDEE: Or to the National Inquirer, either way.

Next change is on page 6, letter f, little f, as in frank. And here, except as provided in this section, which is the rule about the receipt of information on networked or laptop computers, the department is prohibited from collecting, processing, or storing information on those types of devices. And also the rule pertains to the backup of information on --

ATTENDEE: So is that A-2 only, Gail?

ATTENDEE: Yeah, A-2 only. And the department also will use portable electronic devices to back up data. They'll put the data



on small electronic things and then transfer data to larger computers. And so they'll develop rules in relation to that.

The next page is on -- the next change is on page 7, about the 5th line up from the bottom. The HIV community will consult with the department relating to information that applies to HIV and AIDS.

We just wanted to clarify that, not as to all communicable diseases. And we also spelled out the acronym CAG as Community Advisory Group. And that is it. Otherwise it's all fun.

ATTENDEE: Wait a minute.

Dr. Schwartz, is this agreeable with the department of health?

ATTENDEE: Yes.

ATTENDEE: Speak now or forever hold your peace.

Anybody else?

(Inaudible.)

ATTENDEE: Yes, please. (Inaudible) wants to say something too.

ATTENDEE: Okay. Identify yourself, then.

ATTENDEE: My name is Peter Jacobsen. I'm



the executive director of Vermont Cares. After the last time I presented to you all about sort of the rock and a hard place we find ourselves with this bill, we've put together a series of client forums around the state and have found mixed reviews to this bill, of course.

ATTENDEE: I heard from one individual who did not like this bill at all.

ATTENDEE: Of course. And there are many more. So I imagine this is going to come out of committee today, and I'm just letting you know that I'm going to be inviting clients of Vermont Cares and to come down and share some stories about the stigma they've experienced around HIV to add a little more depth to this conversation as well. I wouldn't be offering due diligence if I didn't invite them to present that.

ATTENDEE: And I appreciate that. And after listening to folks, can we say that the reason we are supporting this bill is because the various reasons that we understand, but that the service organizations such as Vermont Cares are in support of it?

ATTENDEE: The service organizations by



and large are in support of this.

COUNTY OF SEMINOLE. )

I, Christina Gerola, Notary Public in and for the State of Florida at Large, do hereby certify that I was authorized to and did listen to CD 07-57/T2, the Senate Committee on Health and Welfare, Thursday, March 15, 2007, proceedings and stenographically transcribed from said CD the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 20th day of August, 2007.

_____

Christina Gerola
Notary Public - State of Florida
My Commission No.: DD617707
My Commission Expires: 12/10/10

# TAB O

STATE OF VERMONT
HOUSE COMMITTEE ON HEALTH CARE

RE: SENATE BILL 115

Tuesday, April 10, 2007
Standard Committee Meeting

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

ALSO PRESENT:
Robin Lunge, Legislative Council

CD NO: 07-124/T1 and T2

Transcribed By:

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PROCEEDINGS

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THE CHAIR: Now, that we're all here, we'll -- do you want to say anything about yourself?

MALE REPRESENTATIVE: Yeah.

MALE REPRESENTATIVE: Do you want to do it?

MALE REPRESENTATIVE: Oh, I couldn't say anything about myself. I leave that guy behind the fence. I just want to let you guys know that, you know, this was one of my top committees that I requested. I was made (inaudible) before we started the session and signed -- I am really thrilled to be here. And the reason I really wanted to be here is not because I have a lot of knowledge about health care, as much as I do see health care, and the cost of health care dominant across almost everybody's argument about what's wrong with the State, and what's going on with the State, and what needs to be done, whether you're (inaudible) about property taxes, or can't pay, you know, to get in to a see a doctor. I mean it hurts everyone in some fashion whatsoever. I think the number one thing that we had to get something done quickly, this would be the permanent thing in my



mind, because it (inaudible) than anything else. So I'm really happy to be here.

I'm pretty good at problem-solving. I'm pretty process oriented. I like to organize and structure things, and I like to work on problems that way.

My background, which was with IBM, and project management, the project management has to do with breaking down and decomposing a problem, and then being able to put together a plan on how to get to where you want to get to, and also at the same time manage the costs that are involved with it. So I think I have some background that I can bring to the table here that might be helpful, because I know how much we need to be doing here. But at the same time I do have a lot to learn about just the vernacular, so help me along when you can. If you see me kind of like off on the whatever, hey, wake me up, okay?

MALE REPRESENTATIVE: You sat next to a good person if you're process oriented. Do you like numbers too?

MALE REPRESENTATIVE: Yes.

MALE REPRESENTATIVE: Oh, glad I asked.

MALE REPRESENTATIVE: There's a particular view that is required to (inaudible).



MALE REPRESENTATIVE: It's a 304. It's got a new number.

FEMALE REPRESENTATIVE: (Inaudible), it was 221.

MALE REPRESENTATIVE: 224. I think something like that.

MALE REPRESENTATIVE. 270 something.

THE CHAIR: So since that we're all here, I just have, you know, sort of a general comment to sort of hold on -- you know, hold on to collective horses. And we're in for a busy week or two here with the committee, so I'd ask that we all pay attention to the schedule as much as possible, and there may be times like now where we need to ask that we come in off the floor. But I respect, you know, if anybody either individually, or collectively, there's just something going on down there that we need to attend to, and I'm pushing too hard, please -- please know that you can let me know publicly, or privately, or however the situation presents itself. We've got a lot of work to do, and only about a month to do it in, so let's go onward.

I was also hoping that we might -- we might try again to find a time again where we can do a



committee dinner --

FEMALE REPRESENTATIVE: Oh, yeah.

THE CHAIR: -- off time. So I was looking at (inaudible), maybe she can come up with a couple of possibilities. Maybe not now. I don't want to talk about it right now, but if people can think about their schedules and find an evening sometime in the next couple of weeks, we might be able to do that. We've tried now at least twice, and cancelled (inaudible). Okay. Robin.

MS. LUNGE: Robin Lunge, legislative counsel. You should have in front of you a copy of S115, it's passed the Senate, and also a section by section summary. So I'm just going to walk you through the bill. The meat of the matter starts at Page 2. This Section 1 of the bill amends the best practices and cost control program, which is a program in the Office of Vermont Health Access, which as most of you know is our Medicaid office. And there are a couple of different things going on in this section of the bill. First, you'll notice in Subsection A, which starts on Line 4 that we've merely added "establish and maintain." That's really more of a technical addition.

And then in the next subdivision we've

clarified that the current preferred drug list that we use in Medicaid would be based on evidence based information, and that is a practice which OVHA has been doing currently. This would sort of update our law so that it mirrors what the practice is.

In addition this section generally takes -- moves away from an approach that had been tried previously of striving for a single statewide preferred drug list, which would be a uniformed list of preferred drugs that all different state agencies, and different state folks who buys drugs on behalf Vermonters would use. So that would include state employees, et cetera.

What the Senate Finance Committee has done, because that approach hasn't been really successful in terms of getting everyone on one list, they moved to a different approach which was to create a joint pharmaceutical purchasing consortium. So it's the same purchasers, state funded purchasers, in that model. But instead of having one list, we would encourage the state enactors first voluntarily, and then eventually with a deadline to join together and purchase jointly where their lists coincide. So it wouldn't require one list, but it would eventually require state people to



purchase and negotiate together where they have commonalties between their lists.

MALE REPRESENTATIVE: Clarify questions now, or later?

THE CHAIR: Clarify your question now.

MALE REPRESENTATIVE: Yeah. Say that again. I didn't -- we've had numerous complaints about some of the PDLs, and updating the PDLs. Could you do that again in a little bit more detail, please?

MS. LUNGE: Sure. This wouldn't affect what an individual agency would do on their own PDL. So, for instance, OVHA would still update their PDLs, however, frequently they do that now, which I think is generally once a year, except, of course, for drugs coming on or off the market, or new drugs coming on the market.

What this would do is say to all the different purchasers "so you, State employees, have these ten drugs on your list which are the same as you, OVHA, have on your list." So for those ten drugs you could jointly ban together to negotiate and leverage more lives in terms of improving the costs for those purchasers.

MALE REPRESENTATIVE: For the purchasers, but --



FEMALE REPRESENTATIVE: But that's a "may," not a "shall."

MS. LUNGE: It starts out as a may -- the actual language on that --

MALE REPRESENTATIVE: 6 and 7.

MS. LUNGE: -- 6 and -- the bottom on 6 to 7. The reason I brought it up is because you have P language struck on 2 to 3, which talked to the statewide PDLs. So it doesn't address the problem that you just raised, which is changing. But it moves away from sort of this bulk purchasing approach that we first went after in terms of having the bill introduced. And it was as a committee bill, so the bill that was introduced came out of finance.

MALE REPRESENTATIVE: Can we go back to PDLs?

MS. LUNGE: Please.

MALE REPRESENTATIVE: How many of value -- what are the elements of this consortium? You said not (inaudible), state employees. Is that with (inaudible)?

MS. LUNGE: Yes, that starts on Page 6.

MALE REPRESENTATIVE: But we didn't get there yet. Okay.

MS. LUNGE: Well, we can go through it now



since we're on that topic.

MALE REPRESENTATIVE: Okay.

MS. LUNGE: I can go back to the changes instead of that. So the M-- in -- you'll see in C 1 the language --

MALE REPRESENTATIVE: So you're on page?

MS. LUNGE: On page 6 at the bottom --

MALE REPRESENTATIVE: Okay, yep.

MS. LUNGE: -- you can see that some language is added that the director, meaning the director of the Office of Vermont Health Access, shall directly, or by contract implement a joint purchasing consortium. It would be offered on a voluntary basis January 1st, '08 with mandatory participation by state and publicly funded, administered or subsidized purchasers to the extent practicable, and to the extent for the purposes of this Chapter by January 1st, 2010. The extent practicable gives OVHA and the other state purchasers a little wiggle room to figure out exactly how it would work, and who it makes sense to include, and who it doesn't make sense to include. So, of course, with state employees, they have a bargaining process which they have to work through since there are two different entities

there. You have the union and the Vermont Health Access Resources. So that gives the employees a little bit of wiggle room there to do that (inaudible) as well.

And then you can see -- just to answer your specific question -- at the end of that paragraph on Page 7, Line 6 through 10, that it gives the definition for state or publicly funded purchasers.

MALE REPRESENTATIVE: Well, I think it provides an explanation too.

FEMALE REPRESENTATIVE: At some point, whenever you want to do this, I would like to know in more detail why the current language didn't work. And my question for now is given what we heard from primary care physicians about paperwork and multiple everything, including multiple formulas that change constantly, what does this do to help that?

MS. LUNGE: It doesn't address that issue.

FEMALE REPRESENTATIVE: Is there some other part of the bill that does?

MS. LUNGE: No, that wasn't an issue that, I think, the Senate heard about actually.

FEMALE REPRESENTATIVE: Okay. Now, let's talk about that at some point.



MS. LUNGE: That's not something that I think is being addressed.

FEMALE REPRESENTATIVE: Thank you.

MS. LUNGE: In terms of the statewide PDL, I would suggest that you ask that question of OVHA, and permanent people in resources, workers' comp, other state players, about what the issue was in terms of (inaudible), because I don't know the -- I don't know what really happened. I can't really speak as to what the (inaudible).

FEMALE REPRESENTATIVE: And I would like to hear from somebody outside of those players as well.

FEMALE REPRESENTATIVE: Steven, I would also like address the PDL changing first of the year, and, you know, the issue we've heard about going to the pharmacy, and the drugs that you've been on for years is no longer covered by your insurance, and you're waiting weeks and weeks.

FEMALE REPRESENTATIVE: Especially when it's a mental health drug.

FEMALE REPRESENTATIVE: No, it's with any drug, It's a blood pressure drug. It doesn't matter what the drug is. I mean it still engages the safety of that patient.



FEMALE REPRESENTATIVE: Right, but I'm especially concerned about mental health care drugs.

FEMALE REPRESENTATIVE: Mental health drugs though, I think, if I remember -- some days I don't remember my name, so I'm going back here six years -- but in the original language the mental health drugs were excluded from PDLs because of that fear.

FEMALE REPRESENTATIVE: (Inaudible).

THE CHAIR: They're added in.

MS. LUNGE: Yeah, they've been added in now, I think, a year or two ago.

FEMALE REPRESENTATIVE: Okay. I remember that now. Okay.

THE CHAIR: And that was sort of a grandfathering thing that took place with the --

FEMALE REPRESENTATIVE: (Inaudible).

FEMALE REPRESENTATIVE: I just wanted to clarify that on those.

MS. LUNGE: So on Page 4, you'll notice some struck language. This is the section -- current sections of the law which set up an evidence based research program through OVHA. OVHA hadn't implemented that at this point, so what the tax transit decided to do was to move it out of OVHA



into the Department of Health, which also in some ways makes -- it makes sense to have a --

THE CHAIR: I'm sorry, so where are you now again?

FEMALE REPRESENTATIVE: Page 4.

MS. LUNGE: Page 4, Line 4.

FEMALE REPRESENTATIVE: Okay.

MS. LUNGE: You can see a (inaudible). I think Senate Finance's thought is that the Department of Health has a bunch of programs now that are sort of education focused, so they made sense of the whole -- so you'll see a little bit later in the bill, that even though this is stressed from OVHA, it's added in in the Department of Health. (Inaudible) when we get there.

On Page 5, this was language which had been in F 288, which is the pharmacy bill that passed the Senate, but never was taken up in the house. And there was also language that, I think, was in H 524, the Senate version, previously it created a plan to encourage Vermonters to use FQHC. Finance put that language in. The Senate Health and Welfare changed that language to a plan to inform Vermonters of the availability of services through FQHC.

If you'll remember from your colored chart that, I think, part of the purpose of this is adding to the cost containment chapter is that 340 B, pharmacy pricing, is the pricing which can be accessed for people who are patients of an FQHC, and that pricing is one of the lowest pricings, and it's lower in general than the Medicaid price. So that was -- the purpose behind that, the Senate Health and Welfare had some concerns about encouraging people to switch from primary care physicians that they might already be seeing in the community. So they preferred to not have the plan be quite as strong, so they changed, encouraged people to go there to inform about the availability.

FEMALE REPRESENTATIVE: Robin, (inaudible)?

MS. LUNGE: Yes.

FEMALE REPRESENTATIVE: Was that the main change there?

MS. LUNGE: Yes.

FEMALE REPRESENTATIVE: That was it?

MS. LUNGE: Yeah.

MALE REPRESENTATIVE: Don't we need to do that in law?

MS. LUNGE: Yeah -- you don't need to do it in



law. It's more just a direction to OVHA to take the lead on this.

MALE REPRESENTATIVE: Okay.

MS. LUNGE: So you don't need to do it in law, but if you want a state actor to take kind of a lead in that encouragement then --

MALE REPRESENTATIVE: Okay.

MS. LUNGE: -- then, I think, that was --

MALE REPRESENTATIVE: Okay.

FEMALE REPRESENTATIVE: How will we know that they're doing that? And, I'm sorry, that's not a clarifying question so much as it is a deeper question, but maybe we could come back to that in a second.

THE CHAIR: (Inaudible) questions here, I'm sorry.

FEMALE REPRESENTATIVE: (Inaudible). That's okay.

FEMALE REPRESENTATIVE: How is that question (inaudible)?

MALE REPRESENTATIVE: (Inaudible) had a question a little while back, and I -- part of it is exact memory -- Jenny talked about, I really would like to find out about that stuff, so we can be more detailed.



The other thing is, I'm looking at the language, the new language --

MS. LUNGE: Uh-huh.

MALE REPRESENTATIVE: -- and that seems like it's voluntary too, and depending on what the answer is whether the first one was, that was voluntary, I'm wondering why we're using that language again, even though in 2010 it says it will be mandatory. That's three years away -- in two years (inaudible).

MS. LUNGE: Okay. So I'm going to skip down now to Page 7, Line 12, we talked about this language (inaudible). This is the section of the statute that talks about the Drug Utilization Review Board. That's the committee within OVHA that makes recommendations to the (inaudible) director about what drugs to include on the preferred drug list. You'll see we've added, again, references to evidence based, and different considerations like side effects, appropriate clinical trials, and then we reference an evidence -- I'm sorry, a definition for evidence based which you'll see later on in the bill, which would be part of the evidence based education program in Title 18.



6, the director, again, this is an OVHA --

THE CHAIR: So that same definition, wherever that appears, applies to here?

MS. LUNGE: Yes --

THE CHAIR: Okay.

MS. LUNGE: -- so we have a uniform definition in the statute.

THE CHAIR: Oh, I see, you cross referenced there. Thank you.

MS. LUNGE: And I'll point that out when we get there. 6, the director -- this is language which used to be in the bill earlier about the PDL, and I moved it to make more sense, I think, just because it referenced certification of the DUR Board to include it in this section. But it would have the director encourage participation in the joint purchasing consortion by inviting representatives to participate as observers and non-voting members in the Drug Utilization Review Board, so that would be other --

FEMALE REPRESENTATIVE: Terms?

MS. LUNGE: -- as a way to sort of encourage voluntary (inaudible), get them getting information that OVHA is getting in that setting about evidence based drugs, and why OVHA might be picking one drug

versus another drug.
FEMALE REPRESENTATIVE: And this is new, but is this new language?
MS. LUNGE: Well, the joint purchasing consortion is basically new. The rest of the language is not exactly the same. I'd have to compare if it's exactly the same. It's very similar to language that is in existence now referring to the statewide PDL.
FEMALE REPRESENTATIVE: So it's just for state joint purchaser this year?
MS. LUNGE: Yes. Yeah.
MALE REPRESENTATIVE: Another question here, did I misunderstand you? I thought you said you moved this from OVHA into (inaudible).
MS. LUNGE: That's been the evidence based education program, which also some people call counter-detailing, that I moved. Then I did move from another area of the statute, but it's still all within OVHA. So I physically moved the words, but I didn't move the program in theory.
MALE REPRESENTATIVE: So does this do something materially different in the way it's worded now? Do you believe --
MS. LUNGE: Than current law?



MALE REPRESENTATIVE: Yes.
MS. LUNGE: No, no. In terms of just encouraging people to participate, and (inaudible). So I don't think it's a real big substantive change.
Section 2 of the bill is later on in Section 1998 D. It's still the cost containment section. And this would add in language that would ask OVHA to seek assistance for the evidence based considerations of the PDL from entities conducting independent research, and the effectiveness of prescription drugs. I can't remember if when Steven and (inaudible) were here, if he talked about the Oregon Health and Science University Drug Effectiveness Review Project. But I think we talked a little bit about that during the FDA approval process, which is when a drug is compared against a placebo, not against other drugs in the same class. What this project in Oregon is doing is comparing drugs in the same class as -- so that you get the comparison of "okay. This one maybe a little more expensive, but it's a lot more effective, so it's a better bang for your buck kind of thing."
FEMALE REPRESENTATIVE: So why was that



stricken?
MS. LUNGE: Because Senate Health and Welfare didn't like the idea of just naming a particular entity. So it's not meant to change, you know, what type of information. Just it wouldn't name that particular entity.
THE CHAIR: Same reason we took out (inaudible).
FEMALE REPRESENTATIVE: Yeah, right.
MS. LUNGE: On Page 8 in Section 3, this changes the part of the statute having to -- setting up the pharmaceutical marketer and disclosure law. And it's actually related to this letter that Julie Brill sent you. It's the same section. It's the same program. But currently in statute -- I think we touched on this when we were talking about the big picture, but we have a law which requires pharmaceutical marketers to disclose all of the gifts that they provide to prescribers in the state. And so what this first section of law would do, it would allow currently all of that information that goes to the Attorney General and it's confidential -- the details are confidential with the Attorney General, although they do make a report which is available on the website. So what



this would allow, is the Attorney General to share the confidential trade secret information with OVHA and the Department of Health in part in order to give OVHA more information in terms of developing their Medicaid program, and things like that are helpful, but also in terms of developing the evidence based information program.
THE CHAIR: And also it would be the counter-detailing?
MS. LUNGE: Yes. The counter-detailing program, yes. The idea being that if you have a sense of what the marketing practices are, you know how to -- if you have limited resources, you know what area you might want to target in the counter-detailing program. So you might start with a particular condition, or a different condition because it seems like that's the information -- that's an area where doctors need sort of more information from a neutral source.
FEMALE REPRESENTATIVE: So, in other words, from me looking at it, it's like being able to follow the trail. So you just brought the trail (inaudible) with us?
MS. LUNGE: You could, yeah. That section doesn't have any other additions. On Page 9,

Section 4, this is still that same section of law. And in the law we have a bunch of different items that are exempt, so you don't have to disclose these items. And what this currently says is a marketer would not have to disclose unrestricted grants for continuing medical education programs. And this is changed by striking that it would require that type of grant to be disclosed. And then you --

FEMALE REPRESENTATIVE: That means disclosed to --

MS. LUNGE: The A.G.

FEMALE REPRESENTATIVE: -- the A.G. so they can share -- okay.

MS. LUNGE: And some of the information is public, but some of it is confidential. So the previous section allowed the A.G. to share the confidential information. There is also, as I said, reports which show general marketing trends which is available in that -- through that report.

THE CHAIR: So is the report something more than this single of sheet of paper, or is this the report to the extent of the report (inaudible)?

MS. LUNGE: Unless Julie is doing it differently this year, on the website there's



actually a lengthy report of several pages which goes into a lot more detail.

THE CHAIR: Okay.

MS. LUNGE: So this might be what the A.G. thought that is required to report to you. But normally in the past two (inaudible), we had a much lengthier report posted on the website.

You can also see on the bottom of Page 9 that disclosures for unrestricted grants for continuing medical education are limited in nature to the value, nature of the purpose of the grants, and the name of the grantee, but would not include disclosure of the individual participants in the program. So an example would be UVM Medical School gets an unrestricted grant to offer a continuing medical education program. The marketer would have to disclose the amount of the grant, the value, the nature, the purpose, and that UVM got it. But UVM would not have to disclose that Harry went, or, you know, Dr. X went to that particular program.

So on Page 10, the next section, is a new section that's added on price disclosure and certification. This section is modeled on a Maine Law and also Texas, and I can't really remember right now if it's law or bill. I think it's law.



And what this would require is for a manufacturer to disclose to OVHA for the drugs that OVHA purchases for the following three prices -- and you can see these on Lines 10 through 13 -- the average manufacturer price, the best price, and the price that each wholesaler in this state pays the manufacturer to purchase the drug. So it provides OVHA with more information about what they are paying for the drugs that they buy. This information is currently provided to CMS, but it's not information which OVHA gets.

So B --

THE CHAIR: Yes, (inaudible)?

FEMALE REPRESENTATIVE: Isn't this language that we had all the controversy about six years ago because of the fact that we don't have a manufacturer in the state, and how can we force a manufacturer to give us information when they're not working in the state?

MS. LUNGE: We have got to look at Maria to see if she remembers this. I wasn't here six years ago, so I don't know. Do you recall if (inaudible)?

MARIA: I can't recall what happened six minutes ago. I'd have to look over it. I don't



remember exactly what the controversy was.

FEMALE REPRESENTATIVE: I remember -- I don't remember exactly what it was either.

MARIA: Yeah.

FEMALE REPRESENTATIVE: But I remember there was something about this language and the fact, because of the interstate commerce laws, we can't force companies in other states -- we can't force laws on them.

MS. LUNGE: Now, no one has raised the commerce clause issue yet in this -- for this provision, although it has been raised for a number of other provisions, so I'm wondering if there was another provision in the previous versions of some of the drug bills that passed which had to do with creating a price "with you, board, which had more to do with controlling prices directly in a price setting type of manner," which I'm sure the commerce clause was raised.

FEMALE REPRESENTATIVE: Right.

MS. LUNGE: This, I think, would only require that the manufacturer disclose what OVHA is paying for the drugs they buy in this state, so I'm not sure that there would be a commerce clause problem with that, because we're only talking about

transactions for our state entity in this state. So we're not trying to say you have to disclose what somebody else does, or anything like that. It's pretty narrow. But I'll see if I can look into that a little bit more, and also I could ask in Maine if they have had any issues. I think it's operating in Maine, but I'm not sure.

FEMALE REPRESENTATIVE: I thought it was there, and in the works in Maine. I didn't think it was operating yet. I think it was actually (inaudible).

MS. LUNGE: Okay. I can check, because certainly their PBM bill law that passed, it's just barely getting up and running, but I don't think this part was enjoined if it was passed, or (inaudible) with a big bill like this. But I'll check with Maine and see if this is up and running. And I think Texas just passed it, but it's not a bill, so for theirs I'm sure what the (inaudible).

THE CHAIR: Question back here?

MALE REPRESENTATIVE: Do we know how many drug dispensers there are in the wholesalers that we have in Vermont?

MS. LUNGE: One.

MALE REPRESENTATIVE: That's what I thought.



Okay. That's where my memory served me well.

MS. LUNGE: And what that would do is basically provide OVHA with a comparison, because one of the Federal requirements is that OVHA gets the best price. So if, for instance, the wholesaler in the state was getting a better price than OVHA, then OVHA wouldn't have this problem, because they say under Federal law they're supposed to be getting the best price. So that's why that price is in there, I think, so you have a comparison for OVHA to determine whether or not they think they're getting what they're supposed to be getting under the Federal law.

FEMALE REPRESENTATIVE: Now, in Number 2, this is the best reference to find in -- and what is that citation? That's Federal a --

MS. LUNGE: That's a Federal Medicaid law.

FEMALE REPRESENTATIVE: Medicaid, thank you.

MS. LUNGE: Both of those drugs are carried under the Federal Medicaid section.

FEMALE REPRESENTATIVE: Got you.

MS. LUNGE: So in B, B sets up how the methodology for the prices would be reported, so the manufacturer would improve some of its methodology, and how they calculated the price, and



with the way it came out of the Senate's office, the office would use the National Drug Rebate Agreement entered into by the Federal U.S. Department of Health and Human Services. So, I think, Senate Health and Welfare felt like it made sense to just use the Federal standard, because that's what they wish the manufacturers are reporting to be (inaudible).

MS. LUNGE: On Page 11, the pricing is list clarified so that the pricing information is just for drugs to find under the Medicaid Drug Rebate Program, and would only have to be submitted to OVHA after it's submitted to CMS.

In D, the change in this section was actually a technical change. You can see in the stricken out part, that on Line 6 it only refers to the average manufacturer price and the best price, which was in the original draft of the bill, and then the -- the incurred price, which is the wholesaler price was added when the committee looked at the Texas law, because that was something in the Maine and Texas law.

So what this requires is that the manufacturer report the information on those three prices. And when they do that, that the president, chief



executive officer, or a designated employee of the manufacturer would certify to the office in a form provided by OVHA that the reported prices are the same as those reported to the Federal Government, and then there's a definition of who a designated employee would be. This was a provision which was in S 288, and I think VH 524 previously. And there was some controversy, I think, between who would be the certifying person. In this version the designated employee is a new addition, and I think gives a little more flexibility about who makes that certification.

MALE REPRESENTATIVE: Do we account for false reporting?

MS. LUNGE: I would need to know what our false reporting law in Vermont is, and I don't, because I don't cover that issue, but I can see if I can find out.

MALE REPRESENTATIVE: Okay.

THE CHAIR: So this is just tweaking existing law now?

MS. LUNGE: No, no, this is all new.

THE CHAIR: Oh, this is all new?

MS. LUNGE: But D was in two previous bills, so the --

THE CHAIR: But never passed?
MS. LUNGE: Right.
THE CHAIR: Yeah, okay. They were signed in (inaudible).
MS. LUNGE: No, right. (Inaudible). It didn't pass the body.
THE CHAIR: It couldn't get in the budget. (Inaudible).
FEMALE REPRESENTATIVE: (Inaudible) to any other state?
MS. LUNGE: Maine and Texas. This whole section is Maine and Texas.
FEMALE REPRESENTATIVE: All right. So this is (inaudible).
MS. LUNGE: I can't remember if Maine -- Representative O'Donnell is just asking, are they actually operating in Maine? I can't -- I don't -- they did not stick with me about when Maine and Texas passed this. I think they're both in law. I can't remember when they started, but I could check on that.
FEMALE REPRESENTATIVE: Also check how anything in this bill that might be in a court, or in the process of the court in other states?
MS. LUNGE: Yes, I have done that. And there's



no litigation that I know of currently on this provision, but it might be because it just passed this session or something. So I'll double check on that. I know that if this was passed before very recently there isn't currently litigation pending on this provision. More on the -- I'll mention that when I get to any litigation that I know about. But none of the previous stuff is under litigation.
So E would clarify also that all of this information that's submitted to OVHA is confidential and not a public record. OVHA is allowed to share it to a certain extent in order to -- to the NASD providing services. So, for instance, to -- in order for them to verify what price they're actually getting, if they need to disclose some of that information to their current pharmacy manager -- benefit managers, then it might be okay. But that information would be limited in use, and should remain confidential if (inaudible).
FEMALE REPRESENTATIVE: And -- may I?
THE CHAIR: Yeah.
FEMALE REPRESENTATIVE: And this sounds like a similar provision to what we have in the laws that protect consumer privacy of financial information,



that the financial institution does business with other companies that they can share information with.
MS. LUNGE: I'm not that familiar with those other laws.
FEMALE REPRESENTATIVE: Okay.
MS. LUNGE: But it's -- the way you're describing it --
FEMALE REPRESENTATIVE: The conflict seems to be the same.
MS. LUNGE: Yeah, I think the conflict is similar. And then (inaudible) enforcement authority to the Attorney General would be considered in effect.
Section 6, The Healthy Vermonters Program, I think we talked about it a little bit when I was here last time. This is a discount card which allows certain Vermonters who have exhausted their drug coverage, or people who are uninsured for prescription drugs, to get the Medicaid price at the pharmacy. There's no cost to the state, because the state isn't subsidizing it. The state is just allowing that individual to get the price that the Medicaid program pays. So what this section of the statute does, is you'll notice on



Page 13, that previously The Healthy Vermonters Plus Program provided a little bit of an expansion in that (inaudible). And there is language in here initially that requires approval of CMN (phonetic), because it was unclear whether or not a waiver was needed. This was part of the Maine RX lawsuit a few years ago. Since that time it's become clear that we don't need a waiver to do this, because we're not using Medicaid funds to support it. And in order to implement the program, that language was struck. I don't believe OVHA asked -- ever asked for the waiver, so I don't think it was denied. I think it just wasn't acted on. So the stricken language would eliminate that requirement in law that you go after a waiver that you don't need.
And then in C, in the language that you see at the bottom of Page 13, the testimony in this section by OVHA was that they were concerned that the way the law previously had set up the expansion, that it would be very difficult to administer, because you can see on Line 25 through 28 one of the new population in addition to 300 to 300 percent of the federal poverty level are families who incur unreimbursed expenses for

(inaudible) including insurance premiums that equal 5 percent or more of the household income, or whose total unreimbursed medical expenses equal 15 percent or more of the household income. And the number -- because it's Medicare Part B now, more people have prescription drug coverage at these income levels than previously. So the population that is involved here is (inaudible). They don't have an exact estimate, but it's a smaller number of people. So OVHA was concerned that the amount of administrative burden for that small group of people was going to be high. And the health care on (inaudible) also testified that she could certainly see that that would make sense, and her suggestion was to just limit the expansion to the 300 percent in the Federal poverty level. So that's what happened.

MALE REPRESENTATIVE: 350, going to 300, 350?

MS. LUNGE: From 300 to 350, yes, sorry.

On Page 14, again, this is the section directing that the department seeks a waiver (inaudible).

MALE REPRESENTATIVE: Right.

MALE REPRESENTATIVE: So this was never implemented because it was contingent upon getting



soon a waiver approval, which they never asked for?

MS. LUNGE: Yes.

MALE REPRESENTATIVE: And they didn't need?

FEMALE REPRESENTATIVE: How could they do that?

MS. LUNGE: At the time that this was put in it was unclear that they didn't need it. At the time, I think, people thought they did need it, so -- but -- and also at the time it wasn't being put in the process -- like recently they have gone through this whole process with requesting waivers and waiver amendments, and at the time that was not -- it was a few years before the whole global commitment. And I don't know why OVHA didn't ask for it as part of global commitment. Maybe because they felt like it didn't make sense to ask for it in this small expansion or something, but at the time it would have been a stand alone waiver request that -- it was a different posture. I just bring that up because, I think, it probably made more sense to them not to ask for it then than recently where we've had all of these waivers and waiver amendments going through when they could have just put it in.

MALE REPRESENTATIVE: So is this happening, or no?



MS. LUNGE: Up to 300 percent is happening, but 3 to 350 is not happening.

FEMALE REPRESENTATIVE: Oh, 350.

MS. LUNGE: So --

MALE REPRESENTATIVE: How long is the up to 300 percent going (inaudible)?

MS. LUNGE: In -- I --

THE CHAIR: A few years.

MS. LUNGE: A few years, yeah. Longer than I've been here, so over four years.

THE CHAIR: Thank you. That's enough.

MS. LUNGE: Should we start on PBM regulations?

FEMALE REPRESENTATIVE: I'm (inaudible).

THE CHAIR: I'm -- I'm going to suggest that we go to 12:15, if the committee is okay with that.

MS. LUNGE: I need to just maybe ask Lauren to go dial into a conference call, because I'm scheduled to do a conference call at noon. I'm really the only one that has the code. So I just need to have Lauren go to get that set up.

THE CHAIR: Is that okay?

LAUREN: Yeah.

MS. LUNGE: So you just dial this number, and then you dial in (inaudible).

LAUREN: Oh, sure.



MS. LUNGE: Thanks.

LAUREN: Uh-huh.

MS. LUNGE: Okay. PBM regulations, Section 7, this would establish a new chapter in Title 18 which would regulate pharmacy benefit managers. Section 9471 starts out with definition. You can see that the definition of health insurer is a broad definition, and it's broader than what we typically think of as an insurer. So it would also include self-insured employers, and the state and Medicaid, and that you can see on Lines 1 through 9 of Page 15.

THE CHAIR: Question here. Yes?

FEMALE REPRESENTATIVE: Robin, does B pull in the association plans like the small groups are?

MS. LUNGE: I think association plans are in 9402, which is referred to on Line 20 of Page 14, but I will look and check.

FEMALE REPRESENTATIVE: Okay.

MS. LUNGE: But I think they're in there, but I'll double check just to make sure.

FEMALE REPRESENTATIVE: Thanks.

MS. LUNGE: There's a definition for pharmacy benefit management on Line 12 of Page 15, which is an arrangement for the procurement of drugs at a

negotiated rate (inaudible) within this state of beneficiaries, the administration or management of a drug benefit provided by a health plan, or any of the following services: The mail service pharmacy, claims process (inaudible), network management, payment of claims, clinical formulary development --

FEMALE REPRESENTATIVE: (Inaudible).

MS. LUNGE: -- rebates, contracting an administration, certain patient compliance, therapeutic intervention, the generic substitution program. These are benefit management programs. So then a PBM is an entity that forms those services, and what includes a person or entity in a contractual or employment relationship with the entity.

So the next section of the bill outlines really what's regulated. And as you can see there were changes in Subsection A, which I'll just mention. In Subsection A, as it came out of Senate finance, the first thing that finance in their list of required practices is that it's a certain duty of care. So this is how careful the PBM would interact -- be when interacting with their clients. And Senate Finance went with a fiduciary level of



care, although they didn't use the term "fiduciary." So that would be really the skill care --

THE CHAIR: Where are you now?

MS. LUNGE: I'm on Line 12 --

THE CHAIR: Line 12?

MS. LUNGE: -- Page 16 in the strike-out language. So I just wanted to highlight the fiduciary duties. So it is this care skill producing a diligence under the circumstances for (inaudible) a prudent PBM in a like capacity is familiar with similar matters would use when conducting their business. In Senate Health and Welfare they decided that they would rather require a lower duty of care, but which is still higher than your normal contract duty. And this language you see on the top of Page 17, starting on Line 1, is the language from a Vermont Court case which defined the duty of care between an insurance agent and that agent's customers. So that is the duty to be -- to perform their duties with reasonable care and diligence and be fair and truthful under the circumstance then prevailing that a PBM asking in like capacity is familiar with such matters would use in doing their business.



THE CHAIR: And this may also put in this CMS contract unless it provides otherwise?

MS. LUNGE: Yes, thank you.

THE CHAIR: You need to tell me about that.

MS. LUNGE: That's a good point. That was in both versions of the bill as it came out of finance and Senate Health and Welfare. So what the Senate decided to do was to allow the PBM and the customer to contract around these duties. So what I should have said in the beginning is that this -- this bill, in it's original form, was modeled on a Maine law which was under litigation and went through several court cases, and recently the Maine law was upheld. They're starting to implement it now, but that all happened in the last few months, so they're not really fully up and running.

Similarly there was also a similar law passed in D.C. that also was sued and was in court, and the D.C. Court recently just went with the Maine decision, so both of those court cases were found in favor of the state or district.

THE CHAIR: And did they use for a standard this same --

MS. LUNGE: For Maine -- I think both of them -- I should check the D.C., but I know that Maine



leaves the fiduciary standard, and they used the term fiduciary as well. And they did not have the "unless the contract provided otherwise" language. They would require it as a duty. So I think Senate Finance and Senate Health and Welfare heard a lot of testimony about these types of transactions and felt like they were comfortable letting people contract around it in the marketplace. That's not how the other laws were structured.

So each of these duties that I'm about to go through, that we already started with including the duty of care, if the PBM and the client decide they don't want to do that, they can contract around it. So it's a default provision unless the contract specifically says, "our duty of care is X." Okay?

FEMALE REPRESENTATIVE: Is there some reason why that would desirable?

MS. LUNGE: Why Senate -- why does Senate find that desirable, or --

FEMALE REPRESENTATIVE: Why it's found desirable contracting around the standard?

MS. LUNGE: I think you'll hear that from the pharmacy benefit managers that feel like it's a very competitive marketplace, and that in their dealings with their customers, they think their

dealing with sophisticated customers who know what their options are, and that it's better to just let the market kind of run out the details of the contract. That may not have been -- I don't want to put words in anybody's mouth, but that's sort of my summary of what I heard.

THE CHAIR: We will get the change to hear from others. Can you --

MS. LUNGE: Do you want to do the duties real quick?

THE CHAIR: But what -- can you -- I have two competing thoughts, one is that I have this question about what's the different duty? You know, what's really the difference? But I would also like you to use -- because I don't know when we're going to be able to get you back to walk through the rest of the bill, and we're going to have people this afternoon, I think, focusing first and foremost on the data mining sections. I want to make sure that you walk us through that before you leave for lunch.

MS. LUNGE: Okay.

THE CHAIR: Although they may have other things that they're interested in. If you know that Julie has other things to talk with us about to, maybe



you could --

MS. LUNGE: She'll probably want to --

THE CHAIR: -- run us through --

MS. LUNGE: -- go through this also.

THE CHAIR: -- this one.

MS. LUNGE: Yeah. So let me just run through this in a little bit higher level then, so that we can give you more of an overview.

THE CHAIR: Okay.

MS. LUNGE: So there is basically -- a (inaudible) duty is 1-6 on Page 17 and 18, one is the duty of care, two is to provide this certain financial and utilization information, three is notice of getting conflicts of interest or policies that would prevent a conflict of interest. That's three on Page 18. Four is some rules about substitutions of drugs. Five is disclosure of certain volume based discounts that the PBM gets. Six is disclosure to the health insurance, all financial of terms and arrangements between the PBM and the manufacturer. And again, there are -- all some of the -- a lot of the disclosure requirements have confidentiality requirements as well to protect kind of a trade secret or business interest information. So that's really the gist of that



section.

The next section talks about enforcement. It's jointly with the A.G. and BISHEA. In fact, that BISHEA has sole enforcement over PBMs who are dealing with health insurers in the traditional sense of the word, not in the broader sense of this section.

And then Section 8 on the bottom of 21, that separate registration of PBM, is doing this as a pilot projects currently, so this would roll it out statewide. And then there's some audit provisions which would require PBMs to allow audits for administrative services only contracts, which I -- basically an administrative services only contract is something where the PBM is just administering the benefits. They're passing through any rebates, et cetera.

THE CHAIR: I mean this replacement language on 23 and 24 is the consensus language?

MS. LUNGE: Let me see 24. Yes, I think it is consensus language. It was the Senate Health and Welfare version. They -- mostly it was clarifying, although it was not entirely clear whether the Senate Finance version, they meant to require every PBM to offer this type of contract. In the Senate



language you could interpret it to mean that every PBM had to offer an administrative services only option. The Health and Welfare version, that's not a requirement, but they have to notify people that that type of contract generally is available in the marketplace, and whether or not they specifically offer it or not.

Section 9 is really a technical provision, so I'm going to skip that. 10 and 11, I believe, organize things to make it a little better than -- there's a bunch of language in Title 33 that has nothing to do with Medicaid, so it really shouldn't be there, so I would remove that.

Section 12, this is the evidence based evidence education program, and maybe I'll come back to this. This is the counter-detailing program. I'll come back to it so we can go through the data mining.

So the data mining, or the prescription drug data confidentiality section starts on Page 27. And there were basically three different versions of language on this area. The first language, which was in the Senate Finance version is modeled on New Hampshire. New Hampshire is currently in litigation on this issue, although a decision is

expected from the first court to hear the case, I think, really any day now, April. The court (inaudible) the decision, so the Judge may say April, and then take as long as 18 --

THE CHAIR: Federal Court, or --

MS. LUNGE: I believe it's the Federal District level court in New Hampshire. It's the first -- it hasn't been appealed yet, so this will be the first --

THE CHAIR: But not state courts. It's Federal court?

MS. LUNGE: I believe so, yes. So what this section would do is --

THE CHAIR: Are you still talking about the one that's crossed out?

MS. LUNGE: Yeah, the one that's -- the one that's crossed out is also the version that passed.

FEMALE REPRESENTATIVE: Oh, that's (inaudible).

FEMALE REPRESENTATIVE: Uh-huh, that's the Senate.

MS. LUNGE: Yes, it's a little confusing. But -- so the crossed out version is what ended up happening, because, I think, it was offered as a consortium by Senator McDonald after Senate Health and Welfare --



THE CHAIR: You're not actually looking at the language that the Senate Health and Welfare voted out? That's not anywhere in here?

MS. LUNGE: Senate Health and Welfare -- you are correct. Senate Health and Welfare, they basically put in a study. Their language said, "(inaudible) counsel, let us know when the New Hampshire case is resolved. We are really interested to know what happened, and if the State of New Hampshire has any data that's easily available, please bring that too." So that's what Senate of Health and Welfare did.

There is a third version which was -- is being referred to as the opt-in version. So let me start with the first -- the Senate Finance version was regulated records, meaning records in Vermont, either that -- either a prescription by a doctor in Vermont, or a prescription dispensed in Vermont that was trying to be targeted to just Vermont information, that that information could not be used for commercial purposes, and there's a definition of commercial purposes, and then there are some clarifying exceptions. But it was targeted really towards the marketing and advertising and that type of -- or looking at your



detailing sales force to see how they're doing selling drugs to a prescriber. So that's what the original version did.

But the other competing version, which you also don't have in front of you, which is called the opt-in version, said to the marketer "when you go to visit the doctor, you have to disclose to them that you have this information about their prescribing pattern." And if that doctor wants, they can opt into a program that "you, the drug company, facilitates" which would say that they didn't want their information to be used. Oh, wait, I got that backwards. That they could opt into having their information used, I believe, is the way it was written. So it implies that the information was confidential unless the doctor gave a specific provision for it to be used.

THE CHAIR: And did that get passed anywhere, or that was just sort of out there?

MS. LUNGE: That was in an amend -- no, that was just sort of out there.

THE CHAIR: Okay.

MS. LUNGE: I don't think that there were any amendments filed on that version.

MALE REPRESENTATIVE: (Inaudible) understand



that. The sole -- the opt-in -- I mean the opt-out is not anywhere in this bill now?

MS. LUNGE: Correct.

THE CHAIR: It was broken up and (inaudible)?

MS. LUNGE: Right.

FEMALE REPRESENTATIVE: So they're just (inaudible) marketing?

THE CHAIR: I'm sure we'll hear about different ideas here as we go along.

MALE REPRESENTATIVE: Okay.

MS. LUNGE: Now, the version that passed was the strongest most prospective version for doctors.

THE CHAIR: Okay. We're just -- right. It already has had a torture --

MS. LUNGE: Right.

THE CHAIR: -- process. So some of this questioning is to sort of figure out the process which at this point is sort of interesting, but almost irrelevant to -- because what we have in front of us in our different -- depending on how we feel about this, we may want to go somewhere else, and there are at least a couple of options -- there are three different options, I guess, that we know about --

MS. LUNGE: Yeah

THE CHAIR: -- or (inaudible) that have already been drafted by somebody or other for a -- that basically could live with this, but I think --
MS. LUNGE: I have them all in the system --
THE CHAIR: -- the first -- the first --
MS. LUNGE: -- so I can get them out.
THE CHAIR: -- idea is to at least understand what's in front of us.
MALE REPRESENTATIVE: Yeah, I guess I would say can you go on with what this actually does?
MS. LUNGE: Yeah.
MALE REPRESENTATIVE: And what --
MS. LUNGE: Sure.
MALE REPRESENTATIVE: Okay.
MS. LUNGE: So what this actually does is -- and maybe we'll begin with the language on Page 31 --
THE CHAIR: So is it literally the language on 30 -- I mean is the (inaudible) language literally exactly the same as the crossed out language?
MS. LUNGE: Yes. Yes.
THE CHAIR: Okay.
MS. LUNGE: And the reason why it was done that way is because of (inaudible) at the Senate office, and how like (inaudible).



MALE REPRESENTATIVE: I have another question now, Steve. This is the one that's under litigation?
THE CHAIR: Yeah.
MS. LUNGE: Yeah.
MALE REPRESENTATIVE: Okay. Why -- I guess I'm going to ask the question. You don't have to answer it. Why are we going here now if some states already did a litigation about it? Why would we want to do it? Why wouldn't we want to wait until after we find out how their court case comes out, and then pursue it?
MS. LUNGE: Well, I think that's what sort of Senate Health and Welfare's view was, which is why they put in a study and status. So, I think, it depends on --
MALE REPRESENTATIVE: Okay. Well, we'll talk about that later on, I'm sure.
THE CHAIR: Right, you'll have other opinions about that as well. I mean the other --
MS. LUNGE: I mean I will say, I did look at the court case, and I did try -- and to the extent that the reasons for the -- the legal reasons that were articulated, I did work on improving the language to correct that. So, for example, one of



the problems with the New Hampshire bill is it never said that it was only regulating records in New Hampshire, so that's why I added this definition of regulated records that made it clear it was just Vermont doctors, and just Vermont pharmacy information. So that whole issue then is off the table, because it's clear in our version that we are not trying to regulate records that -- from New Hampshire and New Hampshire doctors. We're only looking at Vermont doctors, or Vermont prescription information.
THE CHAIR: I guess what I ask the committee to do is try to understand the issue at the end here --
MALE REPRESENTATIVE: Right.
THE CHAIR: -- and then we can gauge our level of interest and how far we want to go with this, and I think there are options at different levels here. And depending on how concerned or not we are about the issue, but let's at least understand the issue, and what's in front of us, and then we can go from there.
MS. LUNGE: So the general issue is that they're -- and I can't remember if we talked about this, so stop if I'm getting into too big



(inaudible) here. But there are companies whose business it is to take prescriber number, which they can purchase from the AMA, and match that with prescription information, which you can purchase from pharmacies or other companies, and match them up, and then sell that matched data to drug manufacturers who can then look at a particular doctor and see "oh, you know, this doctor seems very open to prescribing new drugs, you might want to go visit them," or, you know, whatever, just looking at the particular doctor's prescribing pattern.
So what this bill would do would be to make that information on the pharmacy record side -- because we can't really control what the (inaudible) has -- confidential for commercial purposes. So that information, at least in theory, can still be used for research purposes, or non-commercial reasons, and that definition is on Page 31, Line 1621 where its commercial purpose includes advertising, marketing promotions, or any activities tend to be used, or is used to influence sales or market share of the pharmaceutical companies, et cetera. So the --
THE CHAIR: What kinds of things then would

still be --
MS. LUNGE: Allowed?
THE CHAIR: -- allowed?
MS. LUNGE: So --
THE CHAIR: What kind of things that tend to happen would still be allowed?
MS. LUNGE: Well, -- and this is where my knowledge of the industry is a little weak. But, for instance, if there's a researcher who purchases this information, for example, that researcher could still purchase the information for research purposes. So the researcher could find out the prescribing patterns of the Vermont doctors as part of -- if they needed that for their medical research, or pharmaceutical research, or something like that. But what it would prohibit is that the detailer, or the salesperson from the drug company who's coming to the doctor's office, that they would not have that information available in targeting their sales. So that's sort what it's trying to distinguish between.
You'll hear lots of testimony about whether or not there's a market for the information by researchers, et cetera.
MALE REPRESENTATIVE: So this would not



prohibit a company merging those two things?
MS. LUNGE: No.
MALE REPRESENTATIVE: That wouldn't happen. But it would prohibit a drug company using that information in marketing in Vermont?
MS. LUNGE: Yes.
MALE REPRESENTATIVE: Okay.
FEMALE REPRESENTATIVE: Let me just ask something quickly. How long has this been in practice?
MS. LUNGE: It just passed New Hampshire last year --
FEMALE REPRESENTATIVE: Oh, I'm sorry, let me back up.
MS. LUNGE: Oh, oh, you meant the --
FEMALE REPRESENTATIVE: The --
MS. LUNGE: I don't know. That would be --
FEMALE REPRESENTATIVE: Is this like the --
THE CHAIR: Is this the madness to mining, or is this -- we'll have later this afternoon, we'll have somebody from the company on a conference call, I think.
FEMALE REPRESENTATIVE: Okay.
THE CHAIR: Is that okay, Lauren? Did you get that conference call request?



LAUREN: Uh-huh, I did.
MS. LUNGE: So you could see the prohibitions on Page 32, Line 8, the insurer, self-insured employer, or electronic transmission intermedially, which is the company I was prescribing, pharmacy, et cetera, did not like this transaction for the use of records pertaining to patient, or prescriber identifiable data for any commercial purpose.
So in that contract to transfer or sell the information, the purpose would need to be delineated. So if it was for a research purpose, the contract would say that this is for research purposes, and then it wouldn't violate the section.
MALE REPRESENTATIVE: Do you happen to know how -- this is just a question -- how the AMA can use my information when I'm not a member?
MS. LUNGE: I don't know. I mean I don't know where they get the information, or how they get the information. I mean it must be a public record.
MALE REPRESENTATIVE: Okay.
THE CHAIR: Can we have at least something else added to on this section? Can you spend a minute-and-a-half on the unconscionable pricing section --
MS. LUNGE: Yes.



THE CHAIR: -- leading up to the little ones as far as we have been hearing about?
MS. LUNGE: Yes. So the unconscionable pricing sections final version starts on Page 38. This section is based on -- roughly based on (inaudible) law that passed through D.C. and is currently in litigation. There are some differences between this version and what passed through the Senate and the D.C. law, one of which is our (inaudible) is narrower in terms of the drugs that would be targeted, but I'll get into that detail when we get there.
So this basically sets up a process in which the A.G.'s office could bring a manufacturer to court in order to claim that that manufacturer is charging an unconscionable price, and I'll get to what is an unconscionable price in a minute. I just want to do an overview of the process. The way the process is set up is that the commissioner of health first has to declare that there is a public health threat, and that's outlined on Page 39. And you can see in B, starting on Line 12, there are six different factors that the commissioner would consider when declaring that a condition or disease is a serious public health

threat. Now, this is broader than just like an epidemic type of threat, so you can -- it's broad enough that it could encompass such things as breast cancer where the drug is extremely expensive, or a really wide spread chronic disease like heart disease, or something like that, if that particular disease was very wide spread in this state. So you can see that commissioner looks at the number of Vermonters, the cost to the state, the cost of the drugs, or similar drugs used to treat that condition, whether the drug is a necessary treatment for that condition, whether consumers can afford the drugs, and other factors that the commissioner determines.

FEMALE REPRESENTATIVE: So this isn't just like in the cases of Hurricane Katrina.

MS. LUNGE: Correct.

FEMALE REPRESENTATIVE: This is all of our chronic -- it could be all of our chronic (inaudible) that we talked in (inaudible)?

MS. LUNGE: It could, yes. Yeah, it's broad enough that it could, although it does require that affirmative step by the commissioner.

So if the commissioner's health words declare that a particular condition was a public health



threat, then you would go to looking at whether or not there was a unconscionable price. And you can see that the definition really of unconscionable price is set up in 26, and it's set up as a prima facie case, which means that the initial burden of the A.G. coming to court would be to show that the manufacturer's price of the drug in Vermont is over 30 percent higher than prices available to Federal agencies under the Federal supply schedule, The Healthy Vermonters Program, or the most favored purchase price which does have a definition that's linked back to Vermont in the definition section. And the thing about a prima facie case is that does allow the other side back in to say, "oh, no, it's not really unconscionable even though it's 35 percent higher because it was merely expensive to invent and develop our billable sales elsewhere which are restricted for the following reasons," so in the process there is a back and forth of information that the court would consider.

FEMALE REPRESENTATIVE: May I?

THE CHAIR: Yes.

FEMALE REPRESENTATIVE: So in this definition does Federal agencies -- does that mean 340 - the 340 D --



MS. LUNGE: It could.

FEMALE REPRESENTATIVE: -- pricing?

MS. LUNGE: Yes -- well, that's a good question, because it specifically references the Federal supply schedule which I think is higher than 340 D.

FEMALE REPRESENTATIVE: Yeah.

MS. LUNGE: No, I think it would just be the Federal agencies that use that Federal supply schedule, not the 340 D.

FEMALE REPRESENTATIVE: Not the 340 D?

MS. LUNGE: Yes, because I think that is a different pricing schedule.

MALE REPRESENTATIVE: What are the most favorite purchase prices today and (inaudible)?

MS. LUNGE: The most favorite purchase price is defined on Page 38, and it means the price offered to a seller -- by a seller to the most favorite purchaser in Vermont, and a purchaser and seller are both defined. So it would be basically the best price transaction in the state.

FEMALE REPRESENTATIVE: So they could --

MALE REPRESENTATIVE: But why wouldn't that be defined -- you know, it's a 340 D price, for example? Would that fall in under that?



FEMALE REPRESENTATIVE: No.

MS. LUNGE: I think it would depend on whether the Federal -- the seller would be someone -- any person who trades in drugs for resale to purchasers in this state. So I think in that case, I don't think there's a resale, so it would be excluded. I think that's a direct sale.

THE CHAIR: I think they have to --

MS. LUNGE: But I could be wrong.

THE CHAIR: I think they do it through a pharmacy (inaudible).

FEMALE REPRESENTATIVE: Okay.

THE CHAIR: (Inaudible).

FEMALE REPRESENTATIVE: Or do you do it through a pharmacy?

THE CHAIR: (Inaudible).

MS. LUNGE: So maybe. I mean it depends on the details of the market in this state, and I don't know those details.

THE CHAIR: All right. I think we're going to stop there unless, Robin, there is absolutely one other thing you could tell us before we break.

MS. LUNGE: Yep, the register defines how the (inaudible).

THE CHAIR: We're going to have to pick this up

as we go along, I think, if there are any in some of these other sections, but I think we've been able to touch the sections that we're going to hear about most from other folks.

FEMALE REPRESENTATIVE: Is there a restriction that we haven't talked about that deals with state enforcements of the MDA?

MS. LUNGE: Yeah.

FEMALE REPRESENTATIVE: Okay. Good.

MS. LUNGE: Yeah, that's --

FEMALE REPRESENTATIVE: Thank you.

MS. LUNGE: -- that's Section 17 on Page 43.

FEMALE REPRESENTATIVE: Great.

MS. LUNGE: You could (Inaudible).

THE CHAIR: Okay. We're -- we have --

(CD NO: 07-124/T1 and T2 were concluded.)



CERTIFICATE

THE STATE OF FLORIDA
COUNTY OF PALM BEACH

I, Vicki L. Lima, Professional Court Reporter and Notary Public in and for the State of Florida at Large, do hereby certify that I was authorized to and did listen to CD 07-124/T1 and T2, The House Committee on Health care, Tuesday, April 10, 2007 proceedings, and stenographically transcribed from said CDs the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 27th day of August, 2007.

_____
Vicki L. Lima, Court Reporter
Job #889733-G

STATE OF VERMONT

S.115 - Prescription Drugs, regulation

April 10, 2007

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PROCEEDINGS

CD125 Track 1

MS. MORGAN: Good afternoon. I'm Madeleine Morgan from the Vermont Medical Society. I'm here to talk you to about S-125, the Prescription Drug Bill.

As some of you know, VMS has been working on prescription drug issues for a long time, going back to about 2001 and 2002, when H-31 representative Koch's (ph.) bill sort of -- sort of started us working on this issue.

And I know that representative O'Donnell and Keogh (ph.) were around for that bill, which was the first bill that I created, the Medicaid Preferred Drug Use and the Drug Utilization Review Boards working on that, and the medical society was sort of nervous about how that was going to work out, and whether the drugs would continue to be available for their patients.

But it has turned out to be a good process and a good, I think, a good system also. In that bill, there was a counter detailing provision, which we're going to be talking about again today.



OVHA (ph) was required to set up a counter detailing program for physicians, which they never, I think they never had the funding to do. I mean, I think they thought it was an important thing to do, but they really with all the -- the low funding, they couldn't really accomplish that.

The other thing, H-31 was sort of a goal which is receding further and further into the distance, but a goal to create a single formulary for all the state plans for Medicaid, for the state employees, for workers' compensation, and this bill is kind of taking kind of, moving a bit further away from that, but it almost -- the thing that's really pushing that -- that goal further away from us is the Medicare prescription drug plans, because there's so many of them; all have different formulas, so that even if it were possible to get all the state pharmacies into one formula, we still would have the Medicare formulary, so that was sort of -- oh, the last thing was the mandatory gift marketing disclosures to the attorney general's office. And that was also another initiative that the



medical society sponsored back in 2002 and we're still sponsoring it.

And this is -- an op-ed that the current president of the medical -- Hugo --

UNIDENTIFIED: Doesn't matter.

MS. MORGAN: Okay. So the current president of the medical society had -- had published about this. An article came out in JAMA, Journal of the American Medical Association about the two states. It reviews the two states, Vermont and Minnesota, that had drug disclosure laws, and so this article is written in response to that and emphasizing our support for public disclosure and of gifts and payments to doctors; our support for eliminating, if it were constitutionally possible, the trade secret exception to that disclosure, and also in the last paragraph it talks about our support for -- for the prescription data confidentiality section that I'll be talking about, which is also in -- in S-113.

So that's just to give you some background because it does support transparency of physicians and their prescribing. The Medicaid



program has complete transparency of every prescription that a physician prescribes, and uses it, we think appropriately. When they see that somebody's prescribing too much or there are drug interactions, they contact the physician in an educational way and -- and about changing that.

We also last year supported the prescription monitoring program which the Department of Health is in the process of setting up, which requires pharmacies to report to the Department of Health all prescriptions of controlled substances, and then that information is available to doctors, to patients, and to the Commissioner of Health, and through the Commissioner of Health, to the Commissioner of Public Safety in certain limited exceptions, to check for misuse of drug prescription and possible diversions, so that's another thing we supported.

And we also supported the multi payer claims data base where BISHKA (ph.)is going to make a huge database of all the claims, including the prescription claims, so we think that there definitely is a place for

transparency, but when I get to section 13, we don't think that the way that it's currently being done now is a good way to do it, but before I get to section 13, I want to talk briefly about section 12.

This is the -- there is section as far as -- it's not conroversial and it's on page ... I think it's like --

UNIDENTIFIED ATTENDEE 2: Page 25.

MS. MORGAN: -- of the version that I had. This is the section about the evidence-based education program. And as I said before, originally OVHA had the job of creating an evidence-based prescribing program, and now it's being transferred to the Department of Health.

But an evidence-based prescribing program, or a counter-detailing program, or an academic detailing program, they're all basically the same thing, and they're an educational program for prescribers, physicians and/or prescribers built on the model, the effective model of the pharmaceutical manufacturing companies where the academic detailers go to the physician's office and talk to them about a particular



class of drugs, is the way they're doing it now.

So, this year the area health education centers program are focusing on depression drugs and antihypertensive drugs. Those are the two, I think -- pretty sure that they're doing this year, and so with this program, there's a ... I think it's a PharmD, Amanda Kennedy and an M.D., Rich Puckney, (ph.) who have created a team and they go to physicians offices or larger practices or hospital practices around lunch time or whatever time is convenient for the practice, and talk to them about these classes of drugs. And they have handouts like maybe little cards and things with short cuts for prescribing.

And so this is the kind of educational program that we think works well and that we support. AHEC has been running this -- this type of program 2005, 2006 and this is the third year in 2007, focusing on different classes of drugs. It's funded in part by settlements from lawsuits the Attorney General has had with the drug companies, and Julie Brill, when she gets here, could tell you more



about that.

But I believe part of it was a Neurontin settlement, so funding that came from that settlement is being used to fund this educational program.

So we think it's entirely appropriate to transfer it from the OVHA to the Department of Health and have the area health education center program involved, have OVHA continue to be involved, have the A.G.'s office continue to be involved, and that's how it's designed in the version that passed the Senate.

There's also a provision that allows this program to contract or collaborate with other state programs and took out the name of the organ program.

There's also a program, I think in British Colombia, and there's a possibility that the AMA has this program that we're asking the -- the academic detailing program to look over to see whether that would be the type of program they might want to participate in, but it would be sort of through that program that education would be structured, and we would have confidence that it was evidence based and



valid.

So, we -- anyway, more on section 12, and I don't think it's a controversial section.

So now, turning to section 13, which is somewhat controversial. This is the confidentiality of prescription information section, and I think you're looking at the version that starts on page 31.

And this -- this was something that we really didn't know about until last year, when New Hampshire passed it. It's now law. The physicians in New England get together, the presidents of the Maine, Vermont, New Hampshire, Massachusetts, the New England Medical Societies, all get together and talk about what they're working on, and when the Vermont physicians at that meeting heard about the New Hampshire law, and really, I think, to some extent learned about this practice of using data to influence prescribing, they asked us to basically pass or to work to pass legislation similar to legislation enacted in New Hampshire.

And so we have a process with our membership, where we've adopted a resolution at

the annual meeting, and this is the resolution that we adopted that talks about why we think this is a problem, and then as a result, that we would work on passing legislation similar to the legislation in New Hampshire.

So ... I guess the next thing I want to do is talk about how this -- how this works. I think you've heard a little bit about it, and if you don't need this level of detail, you know, let me know, but the way we understand that it works is that the prescribing information by prescriber is sold to the data companies from the chain pharmacies, from the PBM's.

At the same time, the -- the American Medical Association sells the physician master file to the data companies, and they put them together and make -- a make a profile of the physicians prescribing. I think the number that the AMA uses is the the physicians continuing medical education number that they have for that, and they, I think the data companies like that number because it tends to be a more consistent number. A physician might change licenses from Vermont to New Hampshire,



might have a different license number, but anyway, this number would be a consistent number.

So they get these profiles, and then they use these profiles to influence the behavior of prescribers. So here's it -- this is how the companies does it. And what they do is, they use this data to encourage physicians to switch brands. And the way they seem to do it is, they segment the prescribers into different groups, and you can see on the second page in the top of the right-hand column, they have these five groups, one that's switched to a drug, one that's switched to another drug, one that switched to another product in the market, and they have not switching and using one drug, and not switching and not using the drug. So they segment the prescribers into their different classes.

Then they can target or customize the messages that they send to them. So, for example, if they know that one particular physician, once they prescribe a sample to someone keeps the -- keeps the patient on the sample and doesn't go to generics, then they'll



give that particular physician a lot of samples. Because that's the a way to influence that physician's prescribing behavior.

So -- and they have there, you know, I'm just beginning to find out about this, but so that seems to be the way that they do it, and then if you look at the third page, you can see how they're reporting how the market share of their particular drug is influenced by using this data, which is the inaudible) of this data mining, and there's lots of stuff.

If you look, there's three companies that I know of so far. I keep learning more and more about it, but there's three companies that are doing this data, and they have -- it's very interesting to look at their web sites.

One of them has a little video where the prescribers move around and get put into clumps and one clump gets more samples, and one clump gets more visits, and another clump gets less visits. And anyway, so it's kind of interesting, so that's sort of how it works.

And then the next question I'd like to try to answer is how we think it increases costs of prescription drugs. And the first way we think



it increases costs of prescription drugs is we think that -- that the drug companies are spending a lot of money on this. So, this may be sort of a backwards way to back into it but this is part -- from one of the data companies, IMS's annual report for 2005.

And one of their products is called their sales force effectiveness offering, and that's on -- page two, I guess, they describe it. And they define it as sales force effectiveness offerings are used principally by pharmaceutical manufacturers to measure forecast and optimize the effectiveness and efficiency of their sales representatives to target the marketing and sales efforts of sales forces, and to manage sales territories.

UNIDENTIFIED ATTENDEE 2: Where (inaudible) where are you reading from?

MS. MORGAN: I'm reading on, I think, the second page in --

UNIDENTIFIED ATTENDEE 2: Page 22.

MS. MORGAN: That's right. It's page 22, our products and services.

And then it says, sales force effectiveness offerings. And then the second

sentence sort of starts with this definition, their definition of what the sales force effectiveness offering is: Used by the pharmaceutical manufacturing companies to improve the efficiency of sales representatives, and also used by customers to compensate pharmaceutical sales forces. So that's their definition.

They divide this into three more products below, the sales territory reporting services, the prescription tracking reporting services, and this is the one that we're more interested in today, designed to monitor prescription activity, this is at the bottom of page 22. And to track the movement of pharmaceutical products out of retail channels.

And then they describe some of their products, their exponent service that monitors activity, their early view product, and then they have something called professional spears (sic.) that has the healthcare professional's names, addresses, organizational affiliations, license numbers, et cetera.

On the last page, they have their operating revenue by product line, and we can't



break it down any finer than this, but their sales force -- or at least I can't, I'm sure that they can -- their sales force effectiveness product revenue in 2005 was 847 million. And you can see it increases each year from 2003, 2004, 2005.

So -- so that drug companies are spending a lot of money on this product. We believe that it influences prescribing behavior to -- in a direction that would increase the prescriptions of more expensive brand drugs, and you know, Julie Brill, when she's coming is going to be bringing a paper from Jerry Avorn (ph.), who's a physician at Harvard, who has really studied how this influences prescribing behavior. So she's going to be talking about this.

And the -- the third piece that we have on the issue of costs, is a paper, or this is a press release from the AARP, that talks about how the brand -- the prices of brand name drugs are increasing at double the rate of inflation. They look at, I think, it was 200, they look at 200 of the most commonly used brand name drugs in 2006, and found that they -- the prices of



these drugs increased nearly twice the general rate of inflation. And that in contrast, the prices of generic drugs fell by two percent.

And you know, some of the drugs they were looking at increased four times the rate of general inflation. And then they say, Ambien led the pack of the 29.7 percentage increase in manufacturing price, and they have a couple of others that they mentioned.

So that's the third reason, or we think we see that the prices of brand name drugs are going up. We think that this -- this practice influences prescribing behavior and the drug companies are spending a lot of money on it. So that's as close as we can get to costs.

So ... what is the AMA opt out, and why do we not support that opt out?

The AMA opt out is something that the AMA created in response to seeing the New Hampshire law and other states that were thinking about or working on enacting prescription privacy laws. So the AMA adopted something called the Physician Data Restriction Program.

UNIDENTIFIED ATTENDEE 2: AMA is --



MS. MORGAN: Okay. The AMA is American Medical Association. It's the membership organization of all the physicians in the country. The Vermont Medical Society is the membership organization of physicians in Vermont.

UNIDENTIFIED ATTENDEE 2: What was the AMA's interest in this?

MS. MORGAN: Oh, okay. The AMA's interest in this is that they -- that they sell their physician master file to the data mining companies, which use the master file along with the prescription information to create the profiles of physicians prescribing behavior that are then sold to the manufacturing companies to influence prescribed behavior. So does that answer your question?

UNIDENTIFIED ATTENDEE 2: Yes (inaudible).

MS. MORGAN: Yes. And that's -- that's coming, but I think it's about $30 million a year. So it's a lot. And that also goes into the cost of prescription drugs.

UNIDENTIFIED ATTENDEE 1: And I think someone said this before about all the physicians, about what percentage of physicians

are members of the AMA?
MS. MORGAN: In Vermont, it's a small percentage of physicians. We think it's around five percent.
UNIDENTIFIED ATTENDEE 2: (Inaudible).
MS. MORGAN: No, no, of Vermont physicians. In Vermont, about two thirds of the physicians are members of the Vermont Medical Society, and we have one of the lowest memberships in the AMA in the country.
UNIDENTIFIED ATTENDEE 1: Only about five percent?
MS. MORGAN: Yeah, but nationwide, I don't know, but I think -- I think there are about 800,000 physicians, and I think -- well, I could probably -- why don't I just find out how many members the AMA has?
UNIDENTIFIED ATTENDEE 1: I'm just curious as a percentage of the whole physicians, you know.
MS. MORGAN: Yeah.
UNIDENTIFIED ATTENDEE 1: (Inaudible).
MS. MORGAN: Yeah.
UNIDENTIFIED ATTENDEE 3: -- does the AMA have -- somehow get all the data from the



members?
MS. MORGAN: Well, I think because of the continuing medical education, one of the things that the AMA does, you know, like when we offer a seminar, we usually go through a UBM to get the continuing medical education. But UBM has to be certified by the AMA as -- as knowing how to provide appropriate CME, so that they get the continuing medical education numbers for everybody. I don't know quite how that works. But ... I think they do.
UNIDENTIFIED ATTENDEE 1: So you're not sure that AMA even has the Vermont physicians numbers to pass on; is that what you're saying?
MS. MORGAN: Oh, no, I think they do. I think they have the numbers for every physician, because every physician has a continuing medical education number, 'cause they all have to do continuing medical education. And they keep that in the master file of all physicians, whether they're members of the AMA or not.
(Pause.)
So ... back to the AMA opt out, okay?
UNIDENTIFIED ATTENDEE 2: Yeah.



MS. MORGAN: So in July of 2006, the AMA created this physician data restriction program, or PADRP. As we understand it, less than one percent of physicians have signed up for this now. And what the AMA opt out does, is it would take the data away from the reps that go to see the physicians in their offices, but leave it available to the pharmaceutical manufacturing company for marketing, for compensation, for other purposes.
The rules of this program allow companies to retain access to the prescription data for most purposes, we think, and require companies to police their own sales forces. So it doesn't really stop all the influence from happening, it just stops one piece of it, which is the piece where the rep goes to visit the physician in their office. And what -- the -- what they say about this -- well anyway, they say if this program succeeds, the legislators will turn their attention elsewhere. And the industry can retain most of its most valuable data sources. So they're -- so they're sort of -- anyway, I'm not going to editorialize much.



The other reason we don't like the AMA opt out is that opt outs are generally not very effective. Opt ins are more effective. And it depends on which perspective you're looking at it, but from our perspective, an opt in would be more affective because a physician would have to know what was going on, and then choose to participate.
An opt out, you know, people don't even know the opt out is out there. We informed our members about the opt out. I think -- I don't know how many read our materials and -- and are really aware of it, but anyway, so that's the AMA opt out. And I have materials about that if you would like them.
The last thing I want to talk about is the lawsuit, the lawsuit in New Hampshire and should we wait? These companies are pretty litigous. I mean, I think everything that has been done in this area has been litigated. Some things have been struck down, some things have been upheld. I don't know what the batting average is, but there's -- there's, you know, some -- we've -- some cases have been lost, some have been won. If -- if it's struck

down, you can come back and adjust it.
The Attorney General was at our annual meeting when we presented this issue, we had the people from New Hampshire there before our membership voted on the resolution, and we had the Attorney General there, and the people from New Hampshire. We had somebody from the AMA also talking about their opt-out program.
What he said was, that, you know, he didn't really want to have a challenge or a lawsuit, but he signed on to support this -- this initiative, even knowing that it might be the subject of a lawsuit.
Now, in this article from Forbes, I have a copy of it somewhere. Here it is. Thanks.
What the prediction on the lawsuit in the last paragraph of this article from Forbes is that -- that an analyst from Bear Stearns, what they say here is that this analyst isn't buying IMS's free speech claim, the data company.
They make two claims. One was commerce clause and one was commercial free speech, like it's their freedom of speech to -- to use this data, mine this data. And so this analyst is saying, he isn't buying that free speech claim,



and his bet is that the drug data dealers will lose.
The other things I'd like to point out in this article in terms of the costs, in the second paragraph, they say the financial stakes are large for companies such as IMS, which brings in 400 million a year licensing this database. So there's another, getting a little bit closer to costs.
And then the American -- in the second to last paragraph, the American Medical Association makes 30 million a year licensing its doctor directory, but then it says, but a poll commission shows two thirds of the doctors oppose the spying.
So anyway, we would support keeping the legislation the way it is, the way it came over to you from the Senate, and then if we lose the lawsuit, then adjusting it and going to some other type of option.
And I'd be happy to answer questions.
UNIDENTIFIED ATTENDEE 2: (inaudible) I'm just going to make, just a comment (inaudible) I actually was never aware of this (inaudible) had I been aware (inaudible) without me knowing



it and all after sudden they know every drug I prescribe. This person comes knowing every drug I prescribe, how many I did this month, how many I did last month. I think that's outrageous. And I think that an opt out, I've already opted out but an opt-out clause is obviously a very weak (inaudible).
Can someone come in this morning and maybe I had to keep it on radar (inaudible) understand how I think made a comment, some of the language has been drafted in the bill to address at least some of the concerns that has been raised in (inaudible) just like, no more about that, (inaudible.)
MS. MORGAN: Okay, thank you.
(End of CD-125, Track 1.)

CD 125/TRACK 2
UNIDENTIFIED ATTENDEE 1: I don't know everyone in the room, and I don't know if



everybody else does. Introduce yourselves and who you represent. That would be very helpful to us to have you start.
MR. BERMS: Kevin Berms with PhRMA.
MS. GROGOWKI: Susan Grogowki, representing PhRMA.
MS. MORGAN: I'm sorry, Madeleine Morgan from the Vermont Medical Center.
MS. AARON: Stephanie Aaron. I'm here on behalf of (inaudible).
MR. MANTEL: My name is Jeff Mantel, I work for (inaudible) and I guess a number clients, d/b/a --
MS. BRILL: Whoa, whoa, I'm sorry, I didn't hear you.
Who are the clients?
MR. MANTEL: Pharmacies, local pharmacies, chain drug stores, d/b/a Dart and (inaudible) which does ... mail order advertising.
MS. BRILL: Thanks.
MR. SNIDER: Aaron Snider representative of (inaudible)
MR. GILBERT: Alan Gilbert from the American Civil Liberties Union.
MR. LUNGE: Robin Lunge, counsel

(inaudible.
(Inaudible) attorney with (inaudible) Sherman and Ellis on behalf of Express Scripts, a pharmacy benefit manager.
MR. KIMBELL: Steve Kimbell from Sherman Ellis. I'm here on behalf of IMS Health, which is one of the data companies whose business would be affected by this bill.
MS. SCHULTZ: Heather Schultz with William Schultz & Associates on behalf of Merck.
Thanks.
MS. BRILL: And I'm Julie Brill from the Attorney General's Office, and I specialize in Consumer Protection Antitrust and Tobacco matters and do a tremendous amount of work with respect to pharmaceutical companies.
So, I don't think at the beginning of this session we had a chance to come in here and talk to you about our overall perspective on pharmaceuticals, and that's sort of a shame but -- but we do a tremendous amount of work, and some of the materials that I'm going to pass out will describe some of that work, but not all of it.
I should start by saying, I have the



article that Marilyn passed up but I have it in color, if anybody wants it. Color. Color is sort of nice to look at sometimes, so do we don't we have a protocol as to how you pass things out? Okay. Some committees get very perturbed about that. (Inaudible.) I didn't say anything. I didn't say anything.
I thought I'd give you an overview of our perspective with respect to general pharmaceutical issues. However, I haven't heard the testimony that you've heard so far today, and if you don't want that, and you want to go right to the bill, I'm really here to help you understand the issues and why we support this bill, and why we want to see the provisions enacted.
So Steve, do you have a preference? Would you like me to do just to what I was planning to do and did you want to just ask questions?
MR. KIMBELL: Do what you were planning to do (Inaudible.)
MS. BRILL: That sounds great, or if you feel like you've heard it all, or whatever, that sounds great. I'll leave this here in case anybody in the audience would like a color



copy.
(Inaudible.)
MS. BRILL: Oh, sorry Harry. Let her have one of the colors. This is not mine because this is black and white.
Oh, back to Madeleine, okay? Thank you.
We issued a report in 2005 when my boss, Bill Sorrell, was the president of the National Association of Attorneys General, and this report was on pharmaceutical pricing. It's a great report but it's very long, and although I have a lot of materials for you, I don't have that because it is, you know, over 50 pages. But it is available online, and I would be, if people are interested in it, I would be more than happy to print it out and bring it.
What it outlines, is to a certain extent outlines the amounts of money that is spent on marketing to doctors, the amount of money that's spent on marketing to consumers and to a certain extent what some of the theories and concerns are with respect to what happens in the marketplace as a result of this marketing.
You know, we all see the direct to consumer advertisements on T.V. you know, the



Lunestra butterfly, and we think that we may have a view as whether or not that is affecting prescription behavior.
But the extent to which pharmaceutical companies advertise to consumers is tremendous -- by the extent to which they market to doctors. It's probably on the scale of about 20 or 30 to one in terms of dollars that are spent. It is just a huge, huge amounts are going to marketing to doctors.
Now, some of the dollars, there are arguments about how to put these dollars in which buckets, because there's a big debate about free samples.
Free samples are a huge amount of what's spent by pharmaceutical companies, and some people consider that a form of marketing, because once you get a consumer on a prescription with free samples, then they usually have to start paying for it.
On the other hand, a lot of doctors really like free samples because they have patients who can't afford any drugs, and so there's a debate about that. But even if you take away the free sample bucket, there's huge amounts

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spent on marketing to doctors. There's huge amounts spent on detailing, and you probably have heard about what detailing is at this point, right? When a sales rep goes in and actually tries to meet with a doctor or meet with a prescriber (Inaudible.)

You know, that's a really good question. I'm sure there is a good answer to that. I can give you my guess. My guess is because they're supposed to be providing details about the specific benefits of the product. That's, you know, they often actually -- one of the whistle blowers in the Neurontin case, which was a huge case that our office was very involved in nationally, he was someone who was supposedly a medical liaison who met with doctors. He actually wasn't a doctor. He had like a biology degree.

But, Warner-Lambert, which is now a subsidiary of Pfizer, asked him to pose as a doctor and to go and talk to people with the details of Neurontin, which is an anti-epileptic drug. So I think it's because they're posing as sort of a medical -- I don't want to say, "posing", sometimes posing. Often

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actually are doctors for giving out information about the details of the product.

And I saw, Harry, you've nodded. If you disagree with anything I'm saying, let me know. That's my understanding of why they're called, why it's called detailing.

MR. CHEN: (Inaudible.) It comes up around this building, so why don't just outlaw all this --

MS. BRILL: First Amendment.

MR. CHEN: I don't understand why --

MS. BRILL: The First Amendment. To give you the two-second answer (Inaudible.)

Well, with respect to marketing, with respect to advertising, that would be particularly difficult. You know, to say no more ads on television, no more ads on -- on magazines, there actually used to be the FDA, you may -- for those of who are of a certain age, we may remember that there used to not be ads on television with respect to pharmaceutical products. And that was because the FDA had a regulation that said, if you're going to advertise a product, you have to tell all, tell about all of its risks in addition to

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all of its benefits. And there was never enough room in the television ad to outline all the risks.

I mean, you know, you look at a label for a drug, you know, the insert for a drug, if you're taking anything, especially as a maintenance drug, if you actually read that material, you'll see there's lot of information there.

Well what the FDA did, and I forget the date, it was around '80 or '85 or so, it was before, I believe it was before 1990, what the FDA did is, it said, okay, we're going to allow that risk information to appear in a linked media or medium. So that you could have a television ad that said, for details, see our ad in House and Garden, or Ladies Home Journal, or whatever, and so that allowed companies to advertise in a way that would talk about all the benefits, but the risk information be mostly contained in some other media (Inaudible.)

UNIDENTIFIED ATTENDEE: But the negative side effects about when it first came out, I can remember thinking, well, who -- I mean, who

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would ever buy this drug, you know, who would ever buy this (Inaudible.)

MS. BRILL: Well, I think to a certain extent we're numb to it. I think to a certain extent, you know, it is important information for people to understand that if they are going to take, you know, a drug that maybe is for an optional illness, if you had something that's a condition that may or may not really require medication, it's certainly important that they understand this, that there are risks any time you're talking a pharmaceutical.

Typically speaking, there are some risks. Sometimes the risks are low compared to your condition, and it's certainly worth it on a risk benefit basis, but sometimes if the condition is, you know, you have trouble sleeping at night, or you have a little bit of anxiety in a big room, those kinds of things, you may decide it's not worth it.

But, I do think that, you know, and we actually back in 2005 when we did this project and we wrote this report, we had a big meeting in Chicago where we brought in national experts on pharmaceutical issues, and that issue was

raised.
The issue you're raising, Steve, whether could we just ban advertising? And Dan Abrams, who was the former chief counsel for the FDA was there, and he said: Listen, you guys can talk all you want, but you'll never be able to do that. You'll just never be able to do that. You can try to restrict it. You can try to make it more so that it is not deceptive, so that it is not misleading, cetera, but to just ban it -- we are one of the only countries -- there's two countries in the world, I'm sure you've heard this, United States and New Zealand are the only two countries in the world that allow advertising to the consumers. Every other country in the world bans it, does not allow it, but most countries do not have the First Amendment that they have to deal with.
So, that was a long-winded story. That was long winded --
MR. MINBELL: Okay.
MS. BRILL: -of what your question was.
So, with respect to the marketing issue, and with respect to the prescription privacy piece of this bill, we feel very strongly that



this is good provision and that we would like to see it in this bill. We feel that it's important to try to come up with effective ways to ... to stop the huge amounts of money that are being spent, or to try to effectively counter them, and there are provisions in this bill that deal with counter detailing.
You've probably heard those outlined, but we will never ever as a state, or as regulators, will never be able to spend the kind of money that the manufacturers spend. I mean we're talking about $70 billion a year, which is actually the figure that is out there, in terms of marketing to doctors. We can't match that. We can try to be as effective as we can with the money that we have, but it's just an imbalanced situation. So that's one of the reasons why we need to be thinking creatively with respect to trying to damp down on all the detail that's going on.
Someone mentioned, I think it was you, Mary, you mentioned the concern about the opt out. We do not believe the opt out would be effective at all. And it was interesting, because actually, Steve's client testified in



the Senate, and I don't know if you'll have him testify here, but he was quite clear in the Senate when he said: Look, we can use the AMA number as the linking to link to the prescription data.
Did you all understand how this data works? They need to be able to link the prescription data that they're getting from the pharmacies with the doctor, because they get, you know, depersonalized information, but it's often linked, there's some kind of number or identifier that they need to be able to link that with the doctor, and often link it with the doctor's, you know, specialty. They don't need the AMA number at all.
IMS said in the Senate finance committee they could use the state licensing number. They could really -- they could use any number, as long as it's clear that the number will link it to the physician.
So, we're really concerned that the opt out is a red herring, you know, everyone's saying they can, -- advertisers opt out and everyone can opt out. And it all will be fine, I think, if every doctor in the nation opted



out of the AMA system, IMS and Verifipan which ph.) is one of the AMA's competitors, and other entities would simply move to using some other kind of identifier.
So, opt out we think is completely ineffective. If you want to talk about another option, we actually have -- did you discuss the opt in with them?
MS. MORGAN: Not really, no.
MS. BRILL: I think -- I mean there's a possibility of thinking about a opt in, if you really do want to go with some other solution. An opt in would probably eliminate some of the constitutional concerns that have been debated in the New Hampshire case going to your question earlier about how, you know, how could we avoid some of those issues. But we don't know where the New Hampshire court was going to come out, so maybe what New Hampshire has done is going to be fine.
But an opt in, where basically what that would mean is, rather than saying we don't want to be part of your system, we're going to opt out, instead the doctors would be saying -- you can't use our data unless we give you

permission. That's what an opt in is.
And one of the reasons why we'd like the opt in, in addition to perhaps eliminating some of the constitutional issues, is Vermont actually has a very strong history or a strong view that, basically speaking, in consumer areas and in other areas, we do prefer opt in over opt out. And generally, I remember some of the debates.
UNIDENTIFIED ATTENDEE: Oh, yeah.
MS. BRILL: -- House Commerce committee on credit reporting. Very similar issue again, talking about data and data mining and that kind of thing. And the House Commerce committee back 15, I want to say 15 years ago, it was really a long time ago, became the first in the nation to say that before a creditor, a credit grantor, like a bank or a car loan firm or whatever, could look at your credit report, they would have to receive the consumer's permission here in Vermont, and say so, and there have been other areas like financial privacy where we have opt in rather than opt out, and that's a strong vein running through our legal jurisprudence here in Vermont. So we



think the opt in, again if you want to move away from something that is a ban on using this for commercial purposes, that would be something to consider.
I do have a letter from Jerry Avorn. You may know who he is. He wrote this book, he's one of the nation's leading physicians on evidence-based medicine. He's at Harvard. This book is called, Fearful Medicines, the Benefits, Risks And Costs of Prescription Drugs. He was one of the witnesses in the New Hampshire case regarding the prescription privacy provision. And he has written a letter to you actually, Steve, which I thought I would pass out supporting this provision.
So should I just pass that out? I do have, I think I have some extra copies for people who may want it, but I can also e-mail to anybody who doesn't have it. Actually, I should just ... (Inaudible.)
MS. BRILL: Actually, Aaron Kesselheim is one of his associates and he and Jerry wrote this, and they have joint appointments at Harvard Medical School and Brigham and Women's Hospital, which is one of the nations leading



hospitals, and rather than go through, I thought I would just let you know that they feel very strongly that this kind of provision which would ban the commercial use of this data, allowing it for all other uses, research, all other uses it would be allowed for, but the commercial use, that is for the detailing purpose, they think it would effectively lower prescription drug prices. And that's what they testified to in New Hampshire and that's what they're saying here in this statement to you.
Jerry is a very busy guy, but he's also very amenable, and you know, if you wanted to speak with either of them on the phone, I have a feeling you could probably get them on the phone to talk to them directly. I don't have extra copies of this book. But I'm more than happy to loan it out. It's one of my faves, okay?
So I thought I would talk a little bit about the gift reporting issue.
UNIDENTIFIED ATTENDEE: (Inaudible.) Excuse me.
Is this -- does he get at the cost by (inaudible) making the case that this data



mining actually -- that the data out there is (Inaudible.) patterns -- I mean if we have whole industries --
MS. BRILL: Right, right.
UNIDENTIFIED ATTENDEE -- suggest that, but is there independent data, is that sort of where they're coming from?
MS. BRILL: I actually -- now that I've moved along, let me just take a quick look. I don't remember if they cite data. I mean, obviously, it's a very difficult thing to try to generate data, but let's just take a really quick look.
UNIDENTIFIED ATTENDEE: (Inaudible.)
MS. BRILL: They talk about the amounts that are spent. They do cite some data about, for instance, 60 percent of physicians named commercial sources, such as detailers as most influential in their first decision to prescribe a drug, that's footnote six.
And then footnote five also is another study that they're citing, so yes, I believe they are citing specific studies. I have not read the studies, but I can do that for you if that's of interest (Inaudible).

I'm kind of sitting here today, you know, you hang around in a building long enough and you start to feel like deja vu. There's a lot of what's being discussed here today that I remember from a discussion from six years ago. And we've done a lot of work on PDL's and formularies and all of that other stuff. So no matter how much detailing is done within a doctor's office, when that patient goes to the pharmacy, their insurance is only going to cover what's on the pharmacy, no matter what the doctor has given them.

The only work that the state can do with respect to PDL's is, my understanding is to affect Medicaid.

UNIDENTIFIED ATTENDEE: Except for everybody's insurance, I mean the insurance --

MS. BRILL: Sure.

UNIDENTIFIED ATTENDEE -- carriers in the state hire their own PDL's. I can watch 500 commercials and go -- in fact, I've had it happen in my own family, when our PDL has changed. The doctor has prescribed my husband's medicine. January 1st comes along, his PDL has changed. It doesn't matter what



commercials he's watching, doesn't matter what the doctor has done with him as a patient. Our PDL changes, he can't have that medicine any more.

MS. BRILL: Usually, most -- most pharmacies today have a preferred, and then a sort of -- they're tiered. In other words, it can be, you know, the cheapest drug in terms of co-pay, and then there might be a second layer where the co-pay's a little bit higher, and then there might be something called pre-authorization, which would require that before you can get the drug, there needs to be some kind of communication between the insurance company and the doctor.

It doesn't mean that it's going to be unavailable, it may be slightly more expensive to the consumer, and it certainly will be more expensive to the plan. But, it does not mean that it's unavailable. That's typically speaking the way most plans are run.

UNIDENTIFIED ATTENDEE: You're right but for most cases the plan will say if you want this drug you're paying for it out of your pocket.



MS. BRILL: Again, I don't -- sometimes that's the case. Usually, it's a higher co-pay. It depends on the drug. I mean we could -- there are clearly going to be --

UNIDENTIFIED ATTENDEE: Talk back and forth for hours.

MS. BRILL: There are clearly going to be some drugs for which the plan will say, no, you know, you're on your own there. I once tried to get some wrinkle cream for my wrinkles over here, and the ESI said, sorry, you've got to be a teenager who, you know, has acne, before we are going to give that to you. So yes, there are going to be those kinds of situations.

But typically speaking, if it's a condition that you know that's a real condition, but you're just talking about a branded drug, for instance, that may be more expensive, that the pharmacy benefit manager or whomever doesn't haven't the relationship with such, that they're getting it more cheaply, or it's been PDL, typically it's just going to be more expensive to the consumer, not unavailable.

UNIDENTIFIED ATTENDEE: Well --



MS. BRILL: It's hard to generalize about these things, because it's hard to get so many drugs.

UNIDENTIFIED ATTENDEE: My personal experience, it has been, you want this drug, you pay for the drug. And if, you know, I just kind of like it, if I'm willing to pay for that drug, and they're foolish enough to do that, then there's only so much we can legislate.

MS. BRILL: Well, I'm not going to disagree there are those circumstances, but I don't think that that is the entire ... picture with respect to pharmaceuticals. There are many, many, many insurance carriers that have lots of branded drugs when there are generics available on their PDL's, available to their consumers. Sometimes at the lowest -- fee tier, that's the most favorable to consumers.

Even though there's a generic available, they're going to have, you know, Lipitor, even though Zocar is there. I mean, now talking about statins and high cholesterol drugs, a class where there are lots of branded drugs, even though there are generics that are available. And those are the kind of

maintenance drugs that people are on for their entire lives. And they can be quite expensive. So it's hard to generalize, you really have to talk about it class by class I have found over the years.

UNIDENTIFIED ATTENDEE: (Inaudible.) Class formulary and there are those other you have to take (inaudible).

MS. BRILL: And so it depends on your insurance carrier. If that's Blue Cross Blue Shield perspective, again you know, I'd be more than happy to talk to in detail about what your husband was experiencing, but it may have more to do with a particular carrier that he has.

UNIDENTIFIED ATTENDEE: But my point is the pharmacies drive for the most part, the uses of drugs in the state. We have a very high percentage of generic drugs that are sold in the state, very, very high, because the insurances demand them, and it's not only Medicaid and Medicare, it's the insurances. So I guess I really don't understand. A lot of what we're saying in this bill just doesn't make a whole lot of sense to me. I don't see where he's going to save money because the



insurance companies are going to demand a certain behavior from the people.

MS. BRILL: It's sort of a catch 22, though. Insurance companies are responding to the consumers, and from an insurance, from a pharmacy benefit managers consumer as an employer, typically speaking, the employer sets up a pharmacy plan. And if the employer says, look I want my employees happy here, I'm not trying to squeeze them, I want it to be cost effective, but I want them to have Lipitor and not just have to go to a generic statin, that's what the pharmacy benefit manager is going to set up.

I think that most pharmacies are more similar to what Harry was talking about, than perhaps what your husband was experiencing, where they set up a plan that has choices for consumers, such that again, things are not unavailable, they just might be slightly more expensive to the consumer. That's how the pharmacies work.

UNIDENTIFIED ATTENDEE: (Inaudible.)

MS. BRILL: It's hard to generalize. There are certain cases where generic drugs



cost less than $10 (inaudible) brand name drug might cost something in the hundreds of dollars.

UNIDENTIFIED ATTENDEE: Oh, yeah, the difference in the prices between generic and brand name drugs is (Inaudible.)

MS. BRILL: We have been looking a lot at those differences. And we're hoping very soon to get our web site on line, which will actually allow consumers to compare those prices at retail. We've had some technical issues that we've been dealing with, mostly computer capacity, because we expect the consumers will really like seeing this information.

But other states have these web sites -- a few other states, not a lot, but a few -- and we are working to get that online.

But I've looked at the data and again you're right. And as I said, it's hard to generalize about this industry because it really is a class-by-class category, I find. But in many categories, I found exactly what you're saying, Steve, that there are huge disparities in price (inaudible) $5 or $10,



(inaudible) then have a $25 co-pay (inaudible)

UNIDENTIFIED ATTENDEE: (Inaudible.)

UNIDENTIFIED ATTENDEE 1: And that's where you get a savings demonstrated, working backwards and say, (inaudible) community typical. You guys are just talking about there's a (inaudible) it's a 20 percent 40 percent, and if there is something on non-preferred 40 percent of the cost, but if my physician says I need the one that's -- then it gets charged as the preferred drug, and so the physician, and I've not had any circumstances, in my experience with respect to the non-generic, ever got the rate of a generic, either if there were (inaudible) if the physician is convinced that the non -- drug which likely has a higher cost, and it would be the preferred drug (inaudible.)

UNIDENTIFIED ATTENDEE: I guess it depends (inaudible) aspect that that would be convinced that the other one was better, would allow them to feel (inaudible).

MS. BRILL: Right.

UNIDENTIFIED ATTENDEE: This one, and it costs more, and then because the doctor said,

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yes, many, not all, but many plans to charge that one, the prefer charge, so this clearly to me couldn't (inaudible).

MS. BRILL: Absolutely. And you know, I think you take a look at what Jerry had to say, Jerry Avorn again, they cite studies of doctors who claim, or who it appears it, you know, this kind of activity, this detailing activity does affect their prescription patterns to put it into (inaudible).

I don't know if they do that, but we can ask (inaudible) got about 900,000 out of this settlement. Or maybe it was -- it could have been ... maybe it was 600,000, I'm sorry. I could get that figure for you, but we also had a fund where we were able to (inaudible) grants to researchers who were doing counter detailing programs, and two grants did go to local researchers. One went to UBN for about 400,000 and the other went to Dartmouth again for about 400,000.

So, we are trying to work on counter detailing issues, counter detailing being using evidence-based medicine, or trying to tell doctors, you know, you might be marketed to use

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a product in a particular way because it has all bells and whistles, and could do wonderful things for your patients. But if we look at the studies, the studies don't demonstrate an effectiveness for some of those uses. That's really what the counter detailing programs are trying to do.

So, even though I told you it's very difficult to try to counter the huge amounts of money that are being spent by the manufacturers on marketing, I didn't want you to think that we weren't trying. So this is an effort where we are trying. There are some provisions in S-115 as passed by the Senate that also focus on counter detailing, and you guys have probably already talked about that.

UNIDENTIFIED ATTENDEE: Excuse me, may I ask a question. I know it's off the topic, but okay so I'm here about this and (inaudible).

Well, you know, are comparable practices occurring in for medical equipment, you know, just taking it to another level, so they're doing the same thing; they're getting the insurance records from hospitals and areas and then they go in and they push equipment?

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MS. BRILL: I'm not prepared to tell you today that I'm aware that it is happening, but that's a great question. And it's something that is definitely on our radar screen. I'm not trying to obfuscate, I just -- I can't say yes, but I'm not going to say no, either. I don't know.

UNIDENTIFIED ATTENDEE: If I could make by pushing drugs, I'd certainly be pushing equipment too.

MS. BRILL: I think it's a great question. We have under investigation one medical device ... manufacturer. And it's my first foray into the medical device field, so it's a whole new horizon. I won't be surprised but I'm just not ready to say that yes, it is happening, because I'd rather be giving you information based on data than my supposition.

I thought I'd talk a little bit about our gift reporting law, but because that's trying to do some of this work in the sense of bringing to light payments that are being made to Vermont doctors. And I did want to pass out for you, here it is, our latest gift disclosure report, which actually has some really

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interesting information in it.

UNIDENTIFIED ATTENDEE: I asked about that this morning.

MS. BRILL: Oh, did you? Great. I knew you had asked for it. No, I didn't know.

UNIDENTIFIED ATTENDEE: One page report.

MS. BRILL: No, no, we --

UNIDENTIFIED ATTENDEE: Is this the report?

MS. BRILL: No, no, no. We get -- we get over 10,000 lines of data that we have to analyze, but we have a deadline of April 1st. We didn't want to send it on April Fool's Day, so we did send it to you April 2nd. But that's just to satisfy the legislative requirement to get you something by April 2nd. We will probably get this year's report out in May, possibly June, because we have a tremendous amount of data to go through.

UNIDENTIFIED ATTENDEE: This is last year's?

MS. BRILL: This is last year's report, and you'll see some of the really interesting things that -- the things that I think are interesting. If you look, for instance on page

seven, you'll see that with respect to the specialties, these are self reported specialties that are receiving the most amount of money. First comes psychiatry with 15 recipients receiving an average of $20,000. Again that's an average. You've got (inaudible).

And most of that is going to be for consulting fees, things like that, where they are, you know, on some kind of speaker's bureau or whatever, with the pharmaceutical manufacturers, offering advice or something like that.

UNIDENTIFIED ATTENDEE: (Inaudible.) Patient related.

MS. BRILL: What do you mean, patient related?

UNIDENTIFIED ATTENDEE: Well dealing with the patient (inaudible) than consulting (inaudible).

MS. BRILL: Well, I want to make sure I'm understanding your question, Bill. There are, there is a practice where it's called preceptorships, where companies will pay a doctor in order to actually sit in on their



visit with the patient. Is that what you're referring to?

UNIDENTIFIED ATTENDEE: No, no.

MS. BRILL: Okay, sorry.

UNIDENTIFIED ATTENDEE: My question, this is not patient related.

MS. BRILL: Oh, it is not? Correct, I'm sorry.

UNIDENTIFIED ATTENDEE: These are typically speaking gifts that have been reported, or payments that have been reported by the manufacturers with respect to payments they're making to doctors.

MS. BRILL: Okay.

UNIDENTIFIED ATTENDEE: Yes, and it's not free samples, for instance. Free samples are excluded. There are a whole -- several categories of payments or -- or monies that are flowing that are not, that do not have to be reported. Free samples is one of those. (Inaudible.) So again, when it's in here, these are ... it is not any kind of (inaudible) this is actually financial payments.

MS. BRILL: Correct. It could be -- not with these amounts, but some of the things that



are required to be reported might be books or other large items that are for educational purposes. Those do have to be reported, but when you're talking about this kind of money on average, you're pretty much talking about consulting fees.

UNIDENTIFIED ATTENDEE: (Inaudible.) A lot of these just aren't doctors that go give (inaudible) to other doctors.

MS. BRILL: That could be too. Trips is definitely a part of what needs to be reported, but with the amounts, for instance, with psychiatry?

UNIDENTIFIED ATTENDEE: (Inaudible.) Julie, when a company says that something is trade secret, is it just automatically considered so? Does anybody make a ruling on that?

MS. BRILL: Well, we, and there was an article that JAMA, you guys here about that? I actually was on the phone with the lead author of that article. Joe Ross is his name. He's in Mt. Sinai.

UNIDENTIFIED ATTENDEE: (Inaudible.)

MS. BRILL: JAMA, oh, I'm so sorry. The



Journal of the American Medical Association is what JAMA is. And I would be happy, if you haven't seen their article, I'd be happy to bring it in. I know you've seen it, Harry. But ...

UNIDENTIFIED ATTENDEE: (Inaudible.)

MS. BRILL: Say that again?

UNIDENTIFIED ATTENDEE: In a nutshell.

MS. BRILL: In a nutshell. You know what, let me just -- let me just pull it out, because basically they're saying a number of things. They're comparing, not just -- actually, I don't think I have it with me. They're comparing Vermont and Minnesota and Minnesota's law is really archaic. Nothing's online. There's no analysis, there's no report that they produce. It's just, come and look at it, and it's a stack of sheets that get filed. Very unorganized. And many of the recommendations that they make are actually defined to help a state like Minnesota, but they, the authorities are very concerned about the trade secret issue, and they said that they can't get complete data because of the trade secret issue.

And my conversation with him was: Well, did you ever consider why we have the trade secret provision in our law?

And he said: No, you know, we're public health people, we're not lawyers.

And I said: Well, that's okay, I'm a lawyer, so I'll tell you why.

And really, the problem is that, you know, we wanted our law to not be subject to constitutional challenge. We wanted it to be effective and to be up and running as soon as possible. And we were concerned that had we not had some provision allowing them to declare trade secrets, that we would have been subject to a takings challenge which is what Massachusetts was subjected to.

UNIDENTIFIED ATTENDEE: How do you --

MS. BRILL: Yeah.

UNIDENTIFIED ATTENDEE: I understand the trade secret.

MS. BRILL: Okay.

UNIDENTIFIED ATTENDEE: (Inaudible).

MS. BRILL: But who examines it?

UNIDENTIFIED ATTENDEE: (Inaudible). How does a state government claim things are



confidential, but occasionally judges will say, I'll decide that. And then suddenly all this information goes to the requesting entity, and I just wondered if anybody is looking at these and saying, you know, and they're claiming the case of the state agencies (inaudible). I'm wondering if this isn't going on with trade secrets that maybe makes a fair *determination and I'm not -- I'm not looking to get trade secrets.

MS. BRILL: I understand what you're saying.

UNIDENTIFIED ATTENDEE: Competitors.

MS. BRILL: (inaudible) we actually have a fairly broad law as to that trade secrets (inaudible) is broader than elsewhere. There was litigation over this issue, and just as you described, as soon as you know this was threatened to be examined by a judge, suddenly -- well, it was actually litigation against our office, and we said, you know, we're happy to give this information, but you've claimed it was a trade secret, you got to bring in the pharmaceutical manufacturers. So 35 manufacturers were brought into this



litigation. And as they were ... in the process of negotiating and trying to figure out, well, did all of this information have to be considered trade secret, many of them have now settled with Public Citizen. Public Citizen is the group that sued, and it's a national consumer organization. And so most of the information is now flowing.

UNIDENTIFIED ATTENDEE 1: And this was because a judge said.

MS. BRILL: It was the threat of a judge looking at it. It never got that far. It never got that far.

UNIDENTIFIED ATTENDEE: Yes, same thing.

MS. BRILL: Yeah. So it's very similar to the phenomenon you're describing.

UNIDENTIFIED ATTENDEE: (Inaudible). Well, actually, the judge saw it ...

MS. BRILL: Proportionately, it's on order of 60 to 70 percent prior to this litigation. I don't know what it is this year.

UNIDENTIFIED ATTENDEE: (Inaudible). You think it would be?

MS. BRILL: I think so. We are also going to change our database. This was a lot -- and



maybe you and I can have a separate conversation about all the details in the JAMA article.

There was a lot in there that they were just misinformed about our law and what it does, but we are going to try to change our reporting forms so that each piece of information would have to be declared a trade secret. In other words, they can't say, well, the whole gift is a trade secret. They'd have to say, well it is name of the recipient, it is the amount, it is the purpose, because we opt (inaudible) as Joe said. That was his term, and I think it's a good one. So we're -- that's what we're aiming for with respect to the gift report.

So this approach, the gift approach is the sunshine approach. It is not about being the practice at this time. It could still continue, but it's trying to shed light on what's happening with respect to the public.

We do issue this report, the JAMA again, the Journal of American Medical Association. In their article they seemed to be saying, well, Vermont never tells anyone what the

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results of all this data is. And I'd said, now, have you looked at our report online, you know, it's a 50-page thing. He said, yeah, yeah. I was really talking about Minnesota there, okay. Whatever.

So, we do really make an effort to try to get this information out to the public. And we do actually issue a press release when this goes out. Sometimes, you know, the press picks it up and sometimes they don't, but every year we do put this online, and the previous reports are available as well.

There was one really good suggestion I thought in the JAMA article, which is the one suggestion I really liked, was to increase the penalties in the event of a violation, which would have required, which Joe Rosen and his co-authors were saying, you should have an ultimate penalty, the inability of a pharmaceutical manufacturer to sell to the state's Medicaid program. They would be banned from selling to the state if they violate the law.

There are other federal laws that have that as a penalty, and I thought, wow, that's a

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great idea. So, I did think there was some good things in this article.

Before we move off of this whole detailing section and marketing section, I don't -- have you heard yet from OVHA? Okay.

As you may know, OVHA has has a tremendous amount of data as well, and it also potentially identifiable by prescriber. OVHA is concerned that if this passes, its database will become the next target for use for marketing. And OVHA and Ann Rug and I have come up with language to try to ensure that OVHA's information is also appropriately prevented from use for commercial marketing purposes. And I'm sorry, I don't have that language here right now, but I can easily get it for you. Robin I know has it. And it sort of got lost in the sauce over on in the Senate side. I don't think anyone objected to it. I just, it didn't get put forward in the right way at the right time. We'd very much like to see that added to this bill if you're going to do anything in this area.

So we can get you that language, but you can imagine Medicaid prescriptions now are just

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a huge, huge amount of the overall prescribing in Vermont, and if someone just has Medicaid prescription data identifiable by a doctor, they can do largely the same thing that they would be doing through IMS.

All right. And that's a concern. We share that concern. So we'd like to see that added as well. Okay?

Let's see. Having said that, we would like, we think, one of the things that will make this marketing report more effective for you all to understand what is the effect of these kinds of gifts and payments and what not. We would like to link this to prescribing patterns.

We don't want to disclose individual's names, but we would very much like to be able to say, people who have received gifts, you know, tend to prescribe more for the ... brands that are being sold by the companies that have given them gifts. So we would like to see OVHA's data in order to make our gift report more interesting and effective for you. So you can see the exact kind of link that you're talking about.

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Is there a link between the payment that's made to a doctor and their prescription patterns? So that's in the language that we created that we'd like you to see the OVHA language.

Okay. I was going to talk a little bit about evidence-based medicine.

(End of CD-125, Track 2.)

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CERTIFICATE

STATE OF FLORIDA )
COUNTY OF ORANGE )

I, Richard Castillo, Notary Public, Certified Shorthand Reporter and Registered Professional Reporter, do hereby certify that I was authorized to and did listen to CD125, Tracks One and Two, S.115 -- Prescription Drugs, regulation, April 10, 2007 proceedings and stenographically transcribed from said CD the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this ___ day of August, 2007.

_____

Richard Castillo, Registered Diplomate Reporter