STATE OF VERMONT
HOUSE COMMITTEE ON HEALTH CARE
PART 2

Re: Senate Bill 115
Date: 4/11/2007
Type: RX Drug Regulation

Committee Members:

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

CD No: 07-131/T1

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PROCEEDINGS

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CD131/TRACK 1

ATTENDEE: So we have a prescription drug bill in front of us, and I'm not sure whether we asked you to come or you asked us to come, but I know there are at least a few things in there that affect you or you might be --

MS. MOFFATT: As related to the health department, right. And again, for the record, Sharon Moffatt, acting commissioner of health.

We did testify on the Senate side in support of this bill. We had recommended, and I believe the language moved forward correctly, in regards to the education of providers in terms of detailing, if you will. And I don't know if this committee has heard any testimony from the AHEC, from Liz Cody, but they actually, for several years, through funding that we provide to them, actually provide that detailing work. And actually, probably Representative Chen knows maybe as much about that particular detailing.

But this actually teaches docs how to learn how the drug salespeople actually

approach them and also just kind of how to work with a drug salesperson, how the information is used, et cetera.

So it's individual classes. They do them around the state. There's a team of about two trained physicians out of UVM that actually do this through AHEC (sic). Actually, they're one of the national models out there. I think, actually, originally the language indicated a need for further -- or for funding in that regard. And one of the things in talking with the AHEC that they recommended if they got further funding in this particular area, what they would do is they would have a second team. They have one team that kind of has a hard time getting to all the particular priors.

Our experience and AHEC's experience is generally providers want to do it in small groups. They don't want to do it in a large group, because they have some particular questions around how they're approached or areas specific to prescribing that they want to talk out in a smaller group. So that would be one of the particular recommendations.

The other thing, and I apologize I don't

have it right in my hands, we had actually provided a letter to the Senate in terms of the area of the budgets that were similar, very similar to what you have from Josh here. We can make sure that you also have that for your records and all. Again, I believe everything we recommended in that actually followed the bill and is in the bill as we recommended.

Again, overall, just significantly support this bill. It's critically important as we go forward, and we worked a lot with Madeline and the medical society to assure that we'll continue to work on this in a unified way. I think that is, overall, our area of concern, that as we move forward, that we continue to recognize the critical importance of prescription drugs and the educational part of it.

And I will tell you, just an aside from the health department's experiences, many of our serious substance abuse related mortalities in the state are not from diverted -- are not from drugs that are considered street drugs but are actually diverted prescriptions. We're seeing more and more of that in the

investigations at our chief medical examiner's office. So again, a bill like this I think helps significantly to work towards supporting our providers and our citizens of Vermont in terms of protecting their health in the best way possible.

I'd be happy to answer particular questions, but overall --

ATTENDEE: Two questions. What's the attendance at these anti-detailing sessions? Is it required? Is it voluntarily?

MS. MOFFATT: The way it's worked to date, it's voluntarily. Usually what happens, AHEC actually gets calls from a provider group that's interested, maybe a practice group that's interested. That's the way it's worked to date. They find that the numbers are generally four to six, that that's the number that works the best.

And again, because the individual provider, prescribing provider actually wants to ask particular detailed questions about how -- you know, for example, a geriatric (sic), a generic choice, I'm sorry. That was another room I was in today. I'm sorry.

ATTENDEE: It's all right.
MS. MOFFATT: At least I've not started talking poultry to you yet.
ATTENDEE: Is that inspected or uninspected?
MS. MOFFATT: Hopefully not. Anyway, I'm sorry to divert the discussion there.
ATTENDEE: As a follow-up to that, you indicated that there was a second team would be needed. I would assume that there's a lot of demand for this kind of thing.
MS. MOFFATT: Well, and that's actually, I think, what AHEC suggested as we were working with them on the language in the bill. There was originally some appropriation to fund that. What I had informed the Senate committee, that there was already a model in place. It wasn't that we had to go out and find a new model to actually create. We had one in our own state. So as one raising the level of awareness in that. But if appropriation was made in that area, that that is how the money would be spent, to have a double -- you know, so you'd have essentially two teams, and you'd have better coverage around the state.

ATTENDEE: One other question (inaudible). We heard testimony a short while ago about the commissioner of health may issue a declaration of the health condition or diseases prevalent in Vermont. We heard some -- a recommendation that this is a highly subjective issue for the commissioner of health to make this determination. And the recommendation was to look at a list of diseases, if you will, from the CDC.
Would you -- have you thought about that?
MS. MOFFATT: Yes, actually myself and -- our medical director, Don Swartz, and I have already talked in that regard. What a model we would see very similar to is actually how we determine some of the formularies for HIV/AIDS treatment. Essentially, there's -- recommendations are made anytime a new drug comes on the market specific to the prevention of HIV/AIDS. For example, we go through and determine with a panel how to make that determination. We see the similar model but using (inaudible) a diseased based place.
Also, I think you're perhaps aware of how we set the communicable diseases that are

reportable in our state, which is also by statute.
Actually, if you go on our website you'll see that every year we actually go in and look at what are the reportable diseases that are communicable. Rather than the health commissioner just making those choices we actually pull a team, an advisory team together that includes, in this particular situation, the infectious disease docs around the state, Kemper Alston of UVM and actually a court law (sic) come together. They look at the recommendations of what the diseases are, any new emerging, any hot spot areas, like is the east versus the west coast having more of an incidence around a particular disease. And then we put it on a reportable list.
So that's essentially very similar to the model that we would see moving out here, using existing data but also using state experts to advise the commissioner on what those reportable diseases would be.
ATTENDEE: Okay. So what I'm hearing is this language is okay with you?
MS. MOFFATT: That language works given

the model of how we would apply. We're comfortable with that.
ATTENDEE: I'm just sort of having trouble. I'm hearing what you're saying, but it's not connecting yet in my brain, sort of how this would work. And Patty and I or a couple of us had had questions earlier on of -- because at one point or another this section of the bill was really -- was more confined to Katrina type situations. And now it seems, the way it's been presented to us, less confined to catastrophe sort of situations and more opened up, at least in theory.
And I guess my question to you is what types of situations, conditions, diseases do you contemplate that you would more forward with under this language, and how are you -- how are you connecting a particular condition or disease with the pricing of a pharmaceutical associated with the treatment of disease?
MS. MOFFATT: Let me -- let me --
ATTENDEE: I mean, where is the data connection there, is the second part of my question.
MS. MOFFATT: Okay. Let me see if I can

answer all those different kind of intersecting points, because your questions are (inaudible) around.

I mean, let me back up and say, first of all, one of the things we're doing even now as this bill moves forward is we're actually surveying other states and other state models to see how they've done it. And we've looked in particularly and talked to equate with -- Oregon is one model that we looked at and considered in terms of doing that. I think the other key point, as I indicated, is we'd have a critical advisory team to speak to the Katrina versus some other public emergency.

Let me give you one example. We, for right now, have been struggling about whether sarcoidosis -- what should we do in the area of sarcoidosis. As we're defining -- you know, uncovering that in Bennington and finding the incidents, well, we started exploring sarcoidosis across the state, where are the hot spots, whatever, what are the treatment areas that need to be addressed, and then what do we need to do in regards to addressing sarcoidosis.

So that's an example just of an emerging issue that presents itself, that until we started investigating didn't even know the incidence in our own state around.

So that's not a Katrina event, but it's potentially a Katrina-like event where you'd determine a new or a new emerging -- it's not even a new disease, but a clustering that you didn't -- weren't aware of before.

And then the data point to the formal --

ATTENDEE: Let me ask, though, before you're through with that. So I could read into this language testimony we've received about the epidemic proportion of increased incidence of obesity as a serious public health threat.

MS. MOFFATT: Um-hmm.

ATTENDEE: And, you know, so -- and obesity leads to Type II diabetes and the incident of that is -- so therefore is that the kind of thing that you would be looking at, and would you then, as part of your determination, look at the drugs that are used for diabetes?

MS. MOFFATT: Related drugs. That would be one -- that's an interesting example that we would certainly consider. I think what we

would want to do is -- let me say stay open to rather than mandate, but actually do the research of what that actually determines.

And actually, I think obesity is a perfect one, because it's in terms of hypertension and the hypertension-related drugs that you'd be looking at; the diabetes, the hyperlipidemia, issues that you'd also be looking at. So yes, it potentially could be.

But again, I think -- and let me just say, if there's concern about if the language is too open, I mean, I could offer you some suggestions on, you know, that it's advisory, and that it isn't at the whim of whatever one person defines as a public health emergency. I think that, if we look back to the intent of this drug is -- I'm sorry, this bill - it's the end of the day here - that what we're really trying to do is make sure that we're looking at the best prescribing and most economical ways for our Vermonters to have safe access to formal areas as they exist. Would you --

ATTENDEE: I'm not trying to give you a particular signal on whether I think it's too open or too closed. And I think, actually,

different people on the committee probably think different things about that. But I'm just trying to be clear about what's actually in front of us here and what -- and how you might interpret the language here, because it is sort of a broad language.

And -- okay. I'm not sure we -- we haven't really spent enough time on this section to really understand what's going on. There's this loose language at the beginning, but then it only kicks in if there's this pretty substantial issue with the pricing of drugs associated with that serious public health threat, as you determined it.

MS. MOFFATT: If you would like, what I could do is follow up with a memo and give you some further examples and some of the actual draw that we're looking at from other states as models of how they've approached some of this, if that would be useful.

ATTENDEE: I think that's -- that was my question. How would this work, how do you envision it working, what are the situations you might see that you'd use it in?

ATTENDEE: And possibly even talk about

your -- any advisory group that would -- this is so -- in my view, so open-ended that it's no, really, (inaudible) protection for gross use of power, if you will. That's not the right word, but you know what I'm saying.

MS. MOFFATT: So I could follow up with a memo and then give you some suggesting language of how we'd use an advisory around this. I think what we would want to consider is are there some currently existing advisors that we can use rather than create a new advisory. I think we're trying to be mindful of that process also.

I think the challenge on this one is sometimes it could be a communicable disease, but we already have the communicable disease reporting structure and all. But I think, to the Representative's point, you know, something like obesity could really put your arms around a whole lot of areas. So --

ATTENDEE: Maybe you couldn't.

ATTENDEE: So to speak.

ATTENDEE: Maybe you couldn't.

MS. MOFFATT: Well, depending if you had -- how much you were paying for stomach

stapling. But we won't go there today either, will we?

ATTENDEE: Did you want to --

ATTENDEE: Yeah. Yeah, I just had another question. We've heard some testimony about the data mining issue and that if we prohibited it here in Vermont and other states did, then that kind of aggregated mine data wouldn't be available, and that it potentially would impact the public health based on not having that link to prescriber -- prescriber/prescription data, i.e., the FDA or something like that.

I just wondered if you had any thoughts about if that would be a problem, from your perspective.

MS. MOFFATT: We've been supportive of the position that the medical society has taken in this area. I thinks it's an area that we do have to be mindful of in terms of the full ramifications of that. I -- mostly I think some of the other work that we have going on in the state with our prescription drug monitoring program that's getting up and going, that aspect of it, and also the chronic information system that we have going up, which will

actually work with the -- some of the work that Vital is doing in terms of bringing in that prescription information more at the provider level point of decision making, I think we've got some important tools already in place in Vermont that would prevent more that -- the downside of what you're suggesting there. But certainly we want to stay open to considering that for a while.

ATTENDEE: In the introduction, when you were just now talking, you were talking about the benefits of the bill. And you said something which I didn't pick up at all in the bill, where you said that the substance abuse problem in Vermont and other places is largely diverted prescription drugs. And you said and the bill will help this.

How would the bill help this? I don't read this and think that. So can you tell me?

MS. MOFFATT: I think from the anti-detailing workshops or classes is one way you're actually giving providers hands-on support in terms of how they're making those prescription choices.

Let me give you an example. And this is a

stretch, but I can see this being an opportunity that exists within the education that AHEC provides. Several years ago we had, in one area of the state, several physicians were being approached by individuals wanting prescription drugs, actually demanding them, would approach physicians out in the parking lot and all. And, actually, they called the health department in terms of how do we deal with this, because individuals were essentially going doctor shopping and whatever.

And in that situation, actually, we worked with our colleagues in New York State to help resolve that. In addition, we brought in Dr. Todd Mandell, who's a behavioral addictionist, who actually worked with that provider practice to help them actually learn how to say no to individuals that were seeking different choices of drug, and also how to intersect with the public safety area.

That's the kind of thing -- I mean, it happened through one particular event. They found their way to the health department and we resolved it. With more of the formal education by AHEC, you could get at that. I mean, that

happened because we had a provider, uncomfortable, approached us. What we don't know happens out there is how many providers are uncomfortable, wouldn't necessarily come forward to us or the medical practice board or other venues, but would be comfortable in a smaller setting, in an anti-detailing class to actually talk that through. So that's one type of example where I see the benefits of this going beyond just the pure, are we -- the pure purposes of or the immediate purposes, I should say, of the bill as it's written.

ATTENDEE: Yeah, but we've done a lot of work on Medicaid and stuff about doctor shopping and not allowing patients to go from one doctor to the next to get OxyContin prescriptions and stuff. And that's basically what you're talking about, is OxyContin. And I think, you know, that's kind of a stretch to say that -- that the anti-detailing part of the bill is going to help with the drug abuse that's going on in the state, you know, abusing a prescription drug.

I mean, that's all in -- in the computer software that we've developed and put in place

to catch these patients going -- and the insurance companies have done the same thing, you know, to catch these patients going from doctor to doctor to doctor for OxyContin. What you're not going to affect are the robberies for OxyContin, and there's no bill that's going to affect that.

MS. MOFFATT: Right. Right. But I think this bill, in combination with the prescription drug monitoring program that we have going on, the CCIS (sic), the Vital work, all of those, I think it's all of those tools coming together that better inform.

ATTENDEE: Well, I definitely think educating doctors is, you know. But that goes way beyond this bill. They should have been educated years ago about what was going on with OxyContin.

MS. MOFFATT: That's what I think actually us continuing to support AHEC in their work, with them being tied with the College of Medicine is critically important. And then actually having Vermont doctors out there educating Vermont doctors is critical. And let me just say, it's beyond just the physician

prescribing. It's, you know -- we need other individuals, nurse practitioners, et cetera, that have -- are prescribing, and also all of those individuals I think benefit as related to this bill.

ATTENDEE: Thank you.

ATTENDEE: Thank you very much.

MS. MOFFATT: Thank you.

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 07-131/T1, the House Committee on Health Care, Wednesday, April 11, 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

STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: Friday, April 13, 2007

Type of Committee Meeting: Standard

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

CD No: 07 - 132/T1 and 135/T1

PROCEEDINGS

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CD 132/TRACK 1

REPRESENTATIVE MAIER: Hi, Sharon.

ATTENDEE 1: Good morning. This is very low.

MS. TREAT: Well, do you want me to try to pump up the volume here?

ATTENDEE 1: There we go.

REPRESENTATIVE MAIER: Hi, Sharon. This is Steve Maier. Good morning, how are you?

MS. TREAT: Hi, Steve. Should I say Representative Maier?

REPRESENTATIVE MAIER: Well, that -- each one is fine. I didn't say Representative Treat so --

MS. TREAT: Well, I wear many hats.

REPRESENTATIVE MAIER: Are you feeling better?

MS. TREAT: Somewhat. But I've been trying to do this for I don't know how many weeks now, so I -- I very much would like to so --

REPRESENTATIVE MAIER: Great.

MS. TREAT: -- might as well.

REPRESENTATIVE MAIER: I know you have -- I think we have you for maybe 45 minutes or so.

MS. TREAT: Yeah, yeah. I've got committee including my own data mining bill.

REPRESENTATIVE MAIER: Okay.

MS. TREAT: So I'll tell you how that's going. So what -- I have some comments. I don't know how you want to structure this. I do -- you know, have looked at the Senate Bill and I do have some specific comments on that. I don't know if you're looking at that specifically.

REPRESENTATIVE MAIER: Yes, we are, and we're -- we're -- I think by the time we're done today, we'll -- we'll sort of have taken -- I hope to take temperature of the committee on a number of provisions but -- so I don't know -- I don't have sort of a formal idea of what the pressure points are for us but -- but I know they certainly do include the data mining and the unconscionable pricing sections. I don't know for sure which -- whether there are other sections that we're going to need to -- feel like we need to dive into more but I -- I think there are -- you know, a majority of the sections are probably less controversial around the building and this Committee but the bill is certainly too are attracting more attention here.

MS. TREAT: Okay. Well, let me -- I actually have some comments on the less controversial things as well which are more about drafting suggestions and -- and -- and just some kind of things that I don't think will be controversial but you might want to take a look at. So my thinking was why don't I kind of go through those kind of quickly at the beginning so I get them done and I don't not get to them and then delve into the more -- more needy aspects and -- and the parts that might be, to -- to deftly put it, pressure points for the Committee.

REPRESENTATIVE MAIER: Okay.

MS. TREAT: Okay?

REPRESENTATIVE MAIER: Thank you.

MS. TREAT: Just starting on the Consumer Fraud sections, you know, at the very end of the Senate Bill, one comment is that the provision in there that actually mirrors the language in Maine that focuses on misleading

direct consumer advertising, since then we have gotten some comments from people who are really experts in the field saying, you know, why is this limited to DCT advertising. There's no reason why you shouldn't also be taking a look at or preventing misleading statements from being made in the advertising that goes to doctors and other health professionals.

So I know that when Maine did -- it was the first state to do it, it was really kind of moving the FDA regulations by reference into Maine law and then giving a cause of action to go after those and I don't know if you want to look at that other section. But you might want to take a look at that because, you know, irritating as DCT advertising is and as much of a concern as it is, there's actually a lot more of the advertising and marketing that goes directly to physicians and other prescribers --

REPRESENTATIVE MAIER: What's --

MS. TREAT: -- and much that has been found to be misleading and there's a lot of issues around that as well.

So that's one thing in that section. Another comment I have is on the Part D

marketing part. This was actually a bill that I put together this year. It's gone through a number of revisions which have made it a better bill including banning door to door solicitation of Part D policies. And I have e-mailed to your staff the version of this bill that has now passed the House and Senate and is going to the Governor. There might be one slight change in terms of the effective date from the version I sent you but otherwise it's the same. And you might want to take a look at that.

The other thing I would suggest, which is not in that language but I think it should be, is there's no prohibition against class marketing different kinds of Medicare products with Part D. And actually a lot of the reports on this of real problems have occurred with cross marketing of Medicare Advantage products with Part D prescription drug policies and basically with consumers getting totally confused about it, signing up for insurance products that they don't need and potentially can't even take advantage of because they're not -- there's no providers in their areas

that -- that actually are part of the network, that are part of these plans.

And I have those reports if you don't have them but you might want to take a look at that. And I'll just say that I was called by the staff of the Senate Committee on Aging about my bill and he said it's the first in the nation. He's investigating. This is going on all around the country so this is a big issue. So I just wanted to pass that along.

REPRESENTATIVE MAIER: Okay. So why didn't you include that in your bill?

MS. TREAT: Well, I mean, basically this bill came originally from the Insurance Bureau and they weren't really comfortable with that and the insurance agents didn't like it and so like many things it's a compromise. And in our particular Committee I would just say that the insurance agents pulled a lot of -- have a lot of impact on several Committee members and there was a goal of having a unanimous report so that's what we got. And it's a good step, you know.

But I -- from what I have read, it really appears that there's as much of a problem with

this cross marketing of the other Medicare products so you just might want to take a look at that. And if you don't have this report, I have -- I can e-mail it. That was a national report but it came out of a California office while looking at this problem.

REPRESENTATIVE MAIER: Do we have that report, Robin?

MS. LUNGE: I can get it if we don't. I have a lot of reports so I have to check. I don't know off the top of my head.

REPRESENTATIVE MAIER: Oh, okay.

MS. LUNGE: I'll make sure we get it.

REPRESENTATIVE MAIER: Robin either has it or she'll contact you to get it.

MS. TREAT: Yes. I can find that easily.

Then I wanted to just make some comments on the price disclosure, the AWP certification provision. I'm not sure where that is on the bill. I'm probably -- it's in the beginning, section five of the bill. This --

MS. LUNGE: Page 10.

MS. TREAT: In my prior life some years ago we passed this. It was the first in the country to do this, and it came from really

conversations with our AG's office. I just want to stress again how important this is.

I was just meeting with the head of our health-care fraud unit, unit being two people, in the Maine AG's office and having a conversation about this and she says that this is incredibly important.

Basically this is the section that requires people with authority to sign off on what the pricing is. And, you know, there's been a lot of cases going against drug companies and also wholesalers, I think, for providing inaccurate pricing information and the state is supposed to be getting the best price. One thing that is a caveat is that, you know, there's a lot of discussion about moving from AWP pricing to other things and I just think it's very important that as you go -- if you go ahead with this, which I strongly urge you to do, that you make sure that the language is flexible enough to include changes of terminology that may come down the pike, you know, in the next year or so. So -- and I know your staff is very capable of doing that kind of thing. So that was just my quick comment on

that.
So can I leap to the data mining issue?
REPRESENTATIVE MAIER: Okay.
MS. TREAT: I don't know, you know, what's been said to your Committee but I've been going through this pretty -- in a great deal of detail with the Maine legislature that's working on this right now. We had actually three -- four different bills to regulate data mining and, you know, I just thought there might be -- I don't know what questions you might have but --
REPRESENTATIVE MAIER: I have a question for you.
MS. TREAT: Yeah.
REPRESENTATIVE MAIER: One of the -- one of the big arguments by the data mining companies is that if we cut off their ability to sell this information for commercial purposes, that they'll then just stop doing it and that data won't be available for other purposes that we might all agree are important, and my concern about that argument at least in Vermont's case and I think also in Maine's case is that we're actually already well under way

in creating databases that produce that same information. And we had testimony from our own insurance department about our multipayer database and their work in collaborating with what's been going on in Maine for several years related to that. So I guess I would just invite you to comment about what has been going on in Maine and whether it's your experience there in Maine that you are actually able to provide the data for research and for oversight and some of those other purposes that are important.
MS. TREAT: Yeah. Well, that's actually quite an interesting question because the Maine Health Data Organization, which I think is what you're referring to, came and testified about this bill. They were very comfortable with it. If it goes forward, they're -- they're supportive of it. They just wanted to make sure that they still had access to the information that they're getting now, and they do. There would be no change in it. And so we -- in a way we already have that function going on quite apart from the data mining companies and what they do.

And there's actually efforts to make this go online and do a lot of really neat -- neat things with it. Yeah. I would just say about that particular statement from the companies that they would no longer collect information, period, that I think that falls into the category of a threat and I don't think it's borne out by the evidence elsewhere.
You may not be aware of it but there are a number of Canadian provinces that do not allow prescribers' specific information to be -- you know, it shields that information just like this legislation does and, you know, I doubt very much there's been a problem. There's been no evidence of that in any of the research.
And, you know, I would further say that the argument they made in Maine -- and I don't know if they made it in your state -- was that safety would be compromised by them not being able to get the specific data because they couldn't get out safety recall.
ATTENDEE 1: Yes.
MS. TREAT: And I would like to draw your attention to a letter that was sent to the Maine legislature by Dr. Benjamin Shaeffer

(phonetic). And he's a cardiologist in Maine. And he specifically addressed that point with a letter that came to the Committee after the testimony at the hearing and said that there's a lot of channels for safety data to be provided to prescribers and they include but are not limited to the FDA, Center for Drug Evaluation and Research, mass media, pharmacies, PDM as, you know -- and he also -- and AMA and other places. But he said specifically that he thought that, you know, this whole point didn't really make a lot of sense anyway because the -- you know, if a doctor is going to do that -- first of all, well, let me just read you what he says as opposed to paraphrasing it. He says.
"Furthermore, the reasoning behind the pharmaceutical industry's suggested restriction of targeted safety warnings only to physicians that prescribe a drug is flawed."
They were basically saying, you know, we can't get the warnings out to the doctors who prescribe it most and therefore there's a flaw.
Dr. Shaeffer continues,

"If this was truly physicians' choice of information source, he who prescribes the medication for the first time or not that often would put his patients at risk. We are not alone when we say that our primary information on any given drug comes from less biased data, medical journals and FDA warning.

"In addition, this type of prescribing data is rarely used for purposes that benefit the public due to proprietary nature of this data and the high prices charged."

And I sent that letter to your staff. The other point I'd like to make is that in terms of reasons to pass this legislation and sticking with the kind of health and safety thought here -- we had quite detailed testimony from Drs. Jerry Ahorn (phonetic) and Erin Casselheim (phonetic). And I don't know if you have a copy of that, if they submitted testimony in Vermont, but it went into lot of detail about this issue and the fact that from a public health standpoint limiting the amount

of information about specific prescriber pattern was a positive thing for promoting better medical prescribing and public health issues. And they submitted testimony -- again, I can get that to you if you don't have it -- which says that essentially it has encouraged the prescribing of drugs that may not be as safe and it -- they gave some very specific examples of that, including you know, the well-known example of Vioxx. But they've actually done some pretty serious academic studies on this issue. And I'll just read a little bit about one of them they've done. They said,

"We have recently published an analysis of the adverse effect of marketing for the cardiac medication Nesiritide or NATRECOR. It was approved for treatment of acute exacerbations of congestive heart failure in 2001 despite the fact that the manufacturer had not adequately studied its side effect profile. The product was immediately promoted through a cadre of detailers in individual meetings with

cardiologists. Sales of the drug reached 400 million in 2004 but its use decreased dramatically in 2005 when it was found to be associated with (inaudible), kidney disease and death. The study showed these adverse effects were largely based on data available to the manufacturer when the drug was first approved but were not featured prominently in the marketing campaign."

So -- and they have a lot more information in this testimony but the basic point being that there really is -- you know, there's certainly a link to additional spending that's associated with this targeted detailing that is made possible by the prescriber specific data, but it is also an issue about public health and that it allows for these very targeted campaigns to shift prescribers to alternatives that are (inaudible) not safer and in fact may be risky.

And I also want to make one further point about this that we have been really getting into in Maine, which is the fact that, you know, if the people are saying to you that the

AMA opt-out really works, at least in our state -- and I don't know if this is the case in Vermont -- but I think it's somewhat the case.

First of all, a lot of the prescribers have nothing to do with the AMA. We have nurse practitioners, physician assistants, dentists. We even have naturopaths that can prescribe certain things. None of these folks are in any way connected with the AMA, they're not part of that network, they don't know -- and they're not really even covered necessarily by that database, yet they are marketed to by detailers using -- who can get specific information about them which doesn't necessarily talk of the AMA.

So aside from issues around opt-in and opt-out, whether it works, the whole system of -- of relying on a private association to police them through a voluntary mechanism that doesn't cover most or many, many of the prescribers, it's just kind of doomed to failure and so, you know, I just wanted to pass that along as well.

So that's about what I have to say on data mining. And, you know, I guess I'll open up to

questions before I turn to any other issue.
No questions?
REPRESENTATIVE MAIER: We got one.
ATTENDEE 2: In terms of this opt-out process, even if the people don't belong to the -- the AMA, they can still opt out. Right?
MS. TREAT: Well, I don't know what they're opting out of. The AMA system is about its own data which then gets -- about the specific doctors, which then gets linked up to the data coming from pharmacies and other sources of information about the actual prescription. And there's no -- I mean, if you want to rely on that, you're going to -- you know, if you're interested in opt-in or opt-out that -- instead of like a straight-out ban on this, what you really have to do is create a little mini bureaucracy. And this is something that one of the Senators on the Committee in Maine is looking at very seriously. But you have to create an independent place for that to work.
She's looking at doing it through the licensing of prescribers and the various licensing boards, of which there are four or

five would do it at the time that you're doing, you know, registration every year or your licensing fee -- paying your licensing fees and going through that process, you would have to get information and make a decision there and that information would then go to the aforementioned Maine Health Data Organization which would then, you know, be -- be where all these people that use it would have to go to find out who's opted in and opted out. Now, that's something that's being batted around in -- in Maine and the Committee is going to be talking about this today on whether to go with that or to go with a straight-out ban.
But if you're going to do it, you really have to have something like that plus some kind of enforcement mechanism, for example, tying violations of that to your Consumer Fraud Act because otherwise it's completely unenforceable, it doesn't cover a lot of the prescribers and you certainly don't want -- I was in negotiations, in quotations marks, with the pharmaceutical industry and the data mining industry about this whole thing, and they said, well, you know, we would certainly help, you

know, get information out to all these people about the availability of this law.
I don't think you really want to be relying on people that have a vested, you know, stake in -- in something not happening to be getting that information out. So, you know, if you're going to do that, then you've got to come up with a funding source which you can certainly, you know, put a fee on the drug industry or the data mining industry to fund it. But if you're going to do that, you know, do it effectively. I mean, relying on the AMA system is -- is not doing it and it's -- it's allowing for this private entity to be its own mechanism and it doesn't work now and it doesn't cover, you know, a lot of the people who are involved in this.
ATTENDEE 2: Okay. I've got a follow-up question now. We're talking about the violations and the Consumer Fraud Act and so on and having somebody with a -- with a designated private interest in this trying to watch dog them. I just want to -- for the record I want in my own mind -- I think I know the answer but I -- I would like to make sure it's for the

record. What do you do for a living?
MS. TREAT: What do I do for a living?
ATTENDEE 2: Right.
MS. TREAT: I'm an attorney and I'm Executive Director of the National Legislative Association of Prescription Drug Prices which is why I think I'm testifying today because my organization is made up of legislators. We're funded by state legislatures including the Vermont legislature who pays dues to us. And I'm available to help legislators figure out what our -- you know, what the issues are around prescription drugs and help with testimony and drafting bills.
ATTENDEE 2: Okay. Thank you.
REPRESENTATIVE MAIER: Pat.
REPRESENTATIVE O'DONNELL: How many states are -- are part of your organization now?
MS. TREAT: Well, I mean, there's kind of two ways to look at it. We have -- we have about 10 states that sort of formally sign up and where the Speaker of the House and the Senate President appoints specific people to -- to be on our board.
And then we also have another seven or

eight states that are represented through what we call associate members that independently join themselves. And so in our -- so we have, you know, members from -- heavily in the Northeast because it was really started by the Vermont, Maine and New Hampshire legislatures so they've been the most (inaudible) in it, but we have a lot in the Northeast but then we also have Alaska, Hawaii, Colorado, Arizona, Oklahoma, you know, all over the place.

REPRESENTATIVE O'DONNELL: So how many states fund your organization?

MS. TREAT: Four states fund it. And then, you know, we also have gotten some funding from other sources. You know, we charge for our meetings and things like that.

REPRESENTATIVE O'DONNELL: Thank you.

MS. TREAT: You're welcome.

And so would you like me to go on to any of the other issues?

REPRESENTATIVE MAIER: We have another question from Harry Chen.

REPRESENTATIVE CHEN: Hi, Sharon.

MS. TREAT: Hi.

REPRESENTATIVE CHEN: Just -- I guess I'd

like you to talk a little bit more on what -- really, the area that I have some degree of discomfort with this -- with this issue is about if this data wasn't available, the sky wouldn't -- wouldn't fall in.

MS. TREAT: Yeah.

REPRESENTATIVE MAIER: And that's, you know, just for people like -- we have a letter from Elliot Fisher of Dartmouth who works with Jack Wenberg (phonetic), you know, that he's concerned about that this data -- the lack of availability of this data would affect what he -- he's able to do.

MS. TREAT: Well, I just don't believe it and I guess I think better than -- you know, I can just tell you what people who I think are really experts on this have said. I mean, you can't find anyone who is a more, I think, unimpeachable source than Dr. Jerry Ahorn. And the materials that he provided to us certainly don't support that claim.

And, you know, I just -- in our state where we -- we had -- the Maine Health Data Organization, I mean, they -- they had kind of technical concerns about how the language was

drafted in -- in the bill that was presented here but once they were assured it wasn't going to, you know, affect what they do and how they use the information, they were fine with it.

REPRESENTATIVE MAIER: So how -- how do the -- how -- we have written testimony from Dr. Ahorn but -- and I think we've looked at it briefly but remind us what he or other people say, how do they get access? Where do they get their data from?

MS. TREAT: I know he got a lot of it from the Medicaid databases. Let me just see. You know, I have to kind of speed read through this. Let me just see if he specifically -- I know that they didn't get it from the same sources though and, you know --

REPRESENTATIVE MAIER: But the general -- the general part of the testimony is they get it from other places and it's not a problem.

MS. TREAT: That's right. And -- and I think that the basic premise to that this data will no longer be available is flawed with to begin with, because the fact of the matter is these people use this data for writing purposes. Keep in mind that even under the

straight-out ban in New Hampshire and it's proposed in the Vermont legislation and the Maine legislation and, by the way, also in Nevada and Texas where it's moving ahead and in New York where it's being readied to be kind of unveiled so we don't know how it will go there, but under all of those bills which are the most stringent that are out there, and the New Hampshire law, aggregate data is still -- you know, the data is still collected and aggregate data is still used for marking purposes. It just can't be used at this sort of micro level. So they will still be able to get a huge amount of information about what the prescribing patterns are, you know, in a given area, in a given state, in a given practice.

The way the Maine law legislation is written is they just can't kind of reverse engineer to get that data.

And, you know, another comment on the AMA program, it's kind of a joke because, you know, the industry and the AMA admit that that information still can be used by just one level up from that detailer. And I have all kinds of information, you know, establishing that point

because when I met last on -- I think it was Monday -- about this issue with all of the opponents and the head of our medical association who has not supported the bill unlike what's going on in Vermont and Maine -- and I don't really know why -- but he was completely unaware of the fact that the AMA opt-out still made the information available to the industry and to, you know, the data mining companies -- the pharmaceutical and data mining companies, he didn't realize that. And so, you know, we got him information on some of it from -- from people in your state.

So I just, you know -- but I think that if you have concerns about that particular issue, it would make sense to, you know, ask them specific questions to -- to people like Dr. Ahorn.

And certainly Dr. Shaeffer in Maine has concluded that it -- you know, it doesn't concern him and he's a cardiologist.

But, you know, this is the latest argument. We hadn't really heard that argument before and this is like a new thing that has been raised by the opponents as why legislators

should vote against it, and I don't think it has merit from everything I've seen.

But, again, you know, I would, you know, go to some of these folks that are -- that are experts -- and certainly Dr. Ahorn has done a lot of studies of these issues -- and find out, you know, specifically what he relied on for that.

REPRESENTATIVE CHEN: Thank you.

REPRESENTATIVE MAIER: Ginny.

REPRESENTATIVE MILKEY: Hi, Sharon. This is Ginny Milkey.

MS. TREAT: Hi.

REPRESENTATIVE MILKEY: Yesterday one of the people that testified mentioned that -- I asked the question was anybody licensing detailers and he said that there were several states that there were proposals that I guess most of them weren't unveiled yet but he said West Virginia was, and I wonder if you knew anything about that. I also wonder if it's Delegate Morgan that's doing it.

MS. TREAT: Well, I know that there was a bill in West Virginia that did not pass a couple of years ago.

REPRESENTATIVE MILKEY: Uh-huh.

MS. TREAT: And that bill was, as legislators always do, copied by Senator Maile (phonetic) in Maine and it didn't pass in Maine either. And the opposition was really -- and it was a license -- to provide basically CLE requirements and make sure that the detailers have some kind of background. There's no detailer registration that I'm aware of that has passed anywhere.

I do think that there's something pending in Massachusetts that would do that. I'd have to double-check that but I'm pretty sure that that is part of a major marketing and disclosure and gift ban bill that's pending there.

REPRESENTATIVE MILKEY: Are you looking at that in Maine again or --

MS. TREAT: No, we're not because it -- you know, it was just kind of basically creamed. The whole room was filled up with detailers wearing, you know, buttons saying, you know, Down with whatever the bill was. And -- and it went to a committee that probably wasn't the better committee to -- to listen to

because it had -- it didn't have anything to do with health. So --

REPRESENTATIVE MILKEY: Do you think it has any merit?

MS. TREAT: Yeah. I mean, I think it's one approach. I -- I guess one of the things we're looking at here is to start promoting an academic detailing program that would provide a wealth of information and -- and say, you know, those detailers, they can go off, they are who they are, they're sales representatives, they're not really -- you know, they're not academics. I mean, a lot of them are cheerleaders and we know this. So that's -- that's about marketing. Let them go do their thing.

REPRESENTATIVE MILKEY: Okay.

MS. TREAT: Let's protect prescriber information and limit it in ways so that they're not, you know, giving away gifts and they're not using a prescriber's specific data, and let's set up a separate system that has reliable information and qualified people providing that information. I mean, the problem there is you have to come up with some

money to fund that but I think there's a lot of interest in doing something like that like Pennsylvania is doing, approaching from that angle and saying we won't mess with -- you know, let marketers be marketers. And instead of pretending that that is really the best way of getting information and regulating them and turning them into something they're not, let's set up something that's a better way of getting medical information out to prescribers.

REPRESENTATIVE MILKEY: And then just a quick follow-up. Do any states have them registered?

MS. TREAT: I don't think so.

REPRESENTATIVE MILKEY: Okay.

MS. TREAT: I mean, I think that Maine bill was just to register them. It wasn't really -- you know, it was register and have some kind of basic requirements but I can double-check if there's anything that's passed this year that I'm not yet aware of.

REPRESENTATIVE MILKEY: Okay. Thanks.

MS. TREAT: Yep. So I only have like a couple of minutes and I did want to touch on a couple of other topics.

REPRESENTATIVE MAIER: Okay.

MS. TREAT: So I just wanted -- on the unconscionable pricing, I just wanted to mention I had a conversation with Shawn Flynn (phonetic) yesterday and I would just say -- just to find out what he testified on so that I wouldn't repeat anything that he did.

I did want to mention that I agree with his suggestion that the legislation include some kind of objective criteria about, you know, when there's this service major health issue that the pricing provisions could come to play. I think that makes it a better bill from a legal perspective in terms of, you know, if there's challenges to it in any way because it's always better to have objective standards than some subjective standard that doesn't have any criteria behind it. And I think that you could come up with, you know, an appropriate list.

I know that you've all been really (inaudible) around the country in terms of focusing on chronic illness and certainly there are areas there where the drugs are extremely expensive. And, for example, you know,

diabetes where there's no alternative to brand named insulin, that would be an example. But I don't think that the -- the conditions that you might want to look at are limited to that because certainly some of the more blatant examples of overpricing haven't gone into the chronic disease category. So, for example, you know, A.I.D.S. drugs and -- and, you know, flu drugs are examples of that.

So that's just sort of -- you know, if you're interested in going in that direction, that's a specific comment on that.

REPRESENTATIVE MAIER: Can you comment, Sharon, on are you -- do you have a bill -- are you trying to do this in Maine or what other states are trying to do this right now?

MS. TREAT: You know, I would have to get back to you on what other states are doing. Maine is not. I mean, it's just kind of like how many bills could we carry. I think it's something they should do but we're not doing it this year in any event.

There may be some other states out there focusing on this. You know, I don't know. I have to do a little research and I could get

back to you on that point and see where else it might be pending.

I think Houston was thinking about this in parts of the legislation in the previous year. And this is, you know, a complex area. I mean, there's certainly laws out there, the Wisconsin law that has a book, there's a lot of unconscionable pricing laws that are very, very narrow and focus only on, you know, if there's a major hurricane or something like that. If you're interested in having a broader base approach, you know, obviously there's the D.C. law, there's the Wisconsin law and I think there may be some other bills pending but I -- I would have to really take a quick -- do a little quick research on that, get back to you on that.

REPRESENTATIVE MAIER: So because of the commerce clause issues in the -- the D.C. law --

MS. TREAT: Uh-huh.

REPRESENTATIVE MAIER: -- we tried to -- our -- our legislative counsel has -- has drafted this in such a way as to limit it to transactions in -- inside of Vermont.

MS. TREAT: Right. It should also include wholesalers. I don't think it does. And that's -- actually, some of the issues around unconscionable pricing has -- has been a problem with wholesalers and -- and that includes like repackagers. You know, that -- that's sort of an issue that people don't know about too much, but like a lot of drugs get repackaged and put into different kinds of, you know, like the special blitzer package for -- for drugs but doesn't -- one per week kind of thing and that's where you can see, you know, a lot of price markups as well. But I know that one of these overpricing -- well, there's been a lot of litigation about overpricing and things like that, and wholesalers are part of that. And they -- I believe they are in the state.

I would also say about the commerce clause stuff, you know, that D.C. law I would not recommend as a model. And your bill does not follow it really as a model because it had a lot of things in it that raised questions that weren't very -- was the best drafting.

You know, there certainly are commerce

clause issues with anything states do and (inaudible) one of the toughest ones, but I do think that that particular -- you know, as they say, you know, bad facts make bad law and I think that particular bill wasn't drafted the way like I would have wanted to draft it. And what you have is a much more surgical approach to it.

REPRESENTATIVE MAIER: So what would -- I guess the concern that I have heard expressed about this is if it's truly limited because it has to be to Vermont only, we have only a single wholesaler in the state who is very concerned about it and the argument he presents which seems -- which seems legitimate to me is that his -- the -- the companies -- the manufacturers would just -- would just direct their product through a wholesaler somewhere else and the product, it would still -- it would still be in Vermont, it would just not go through the Vermont business --

MS. TREAT: Uh-huh.

REPRESENTATIVE MAIER: -- at that higher price even if it was an unconscionable price.

MS. TREAT: You know -- well, you know, I

guess that remains to be seen and maybe you don't want to wait and find out.

These are certainly the same kinds of claims that were made with pretty much everything we've passed.

I mean, when Maine passed the PBM law, we were told that PBMs would leave the state. That was a complete lie. When, you know, Maine passed the Maine RX, the same thing was that no one would participate, they will leave the state, we won't sell our drugs to the state. And even though we only have 1.2 million people, though -- you know, we're a little bigger than you guys -- but (inaudible) market that did not happen. You know, I -- I guess you need to evaluate whether that's an empty threat or not.

And I guess the other thing I would suggest -- I mean, I put my head together with Shawn again who's really focused on this more from the legal perspective of whether that is more narrowly drafted than it needs to be legally.

Again, because the case law on this is based on I think very poorly drafted

legislation so, you know, that -- I think, you know, I'd be willing to have a conversation with Shawn and just see if he had any additional thoughts on that. But I -- I just -- I do think there's a lot of threatening that goes on, whether it's we won't collect any data under the data mining, you know, law, so the sky will fall, or we won't sell drugs to your state and -- and I'm not sure how much merit there is to that.

REPRESENTATIVE MAIER: I have one last question and I know you need to go.

MS. TREAT: Yeah.

REPRESENTATIVE MAIER: Quick question from Harry.

REPRESENTATIVE CHEN: Sharon, given some of these concerns on how narrow we made this bill, if we were to broaden it in terms of its criteria for the public health threat, do you think there'd be any benefit in -- in doing it more rather than as a legal action then do it more as kind of shining light on it, so here are the drugs in Vermont that meet the criteria for unconscionable prices and publish it as a report every year?

MS. TREAT: Well, reports are fine but you know where they go; they go in a file cabinet somewhere with all those other reports.

I mean, you know, now that I'm back in the legislature, it's unbelievable the amount of paperwork I get and I guess, you know, it's not a bad thing to do but I'm not sure, you know -- I'm not sure it accomplishes very much unless you want to put some funding into really, you know, doing some kind of a campaign on it.

I mean, what really gets people's attention is hitting them in their pocketbooks and, you know, I do think there's some -- there's stuff going on here that's really worth paying attention to.

I mean, I know that there were like a dozen state governors that went to the FDA and said, you know, you have to come up with a system for licensing generics for these biologics like insulin because this is killing the states. And you have a situation where you have something that's a monopoly situation where basically, you know, they can charge as much as the market will bear, and I -- I think there's a strong policy as well as a legal

argument for taking some kind of action.

My legal advice -- and I think it's good policy as well -- is to do it in a way that is very targeted that focuses on particular situations. My thinking in part is not only where the drug price is particularly high but where, you know, you have, you know, kind of life or death implications of lack of availability of that drug, for example, or humongous implications with the state budget like the insulin case. And that's a life and death situation as well. I mean, these are life-preserving, -saving drugs. I think it's -- it's a targeted -- you know, there's a lot of policy behind it and I'm just not sure a report saying these drugs are really expensive -- there's been an awful lot of reports on this, you know, and I think there are organizations that have a lot more P.R. stuff behind them to get that news out than the Vermont legislature but, you know, I'm not big on reports but that's me.

Can I just say one thing about the PBM section and then I have to go? You know, the Senate Bill has all this great language about

PBMs. That, of course, is entirely voluntary and, you know, I would just say that -- and especially what I find very odd is that someone can go in and just kind of waive a duty of due care which from a legal point of view, I mean, I don't even think -- that's kind of against public policy in the first place. You know, when you go to law school, you learn all those things that are waivers against public policy. And I -- I don't really understand that.

I think if there's one thing you do, you -- you put in a fiduciary duty in there which covers things like major conflicts of interest, kickbacks. I mean, these are things that just should not be allowed and they're subject of all types of litigation that your state and mine have been involved with over the last 10 years. And now that -- you know, there's three big PBMs, there's other ones out there, and they have different models of -- of doing business, many of them, and many of them will comply with these standards that you have in there but that's just my suggestion. I don't really understand, you know, a waiver of like a duty, a duty of due care, a duty not to

have significant conflicts of interest.

You know, as an attorney, if I have those kinds of conflicts of interest, it's not okay to have my client just say, oh, I don't really care that, you know, Sharon is representing someone on the complete opposite side of the issue from me. I mean, I can't do it because it -- it's understood that I can't do a good job of representing both. And yet we have a system with PBMs that builds that in and allows it and -- and covers it up. And so, you know, I think that language is all great, all completely waivable so it sounds like it's more like a public education piece than anything else. So that's just my two cents on that.

REPRESENTATIVE MAIER: Could you -- could you comment briefly on -- when we heard from PB -- we heard from Medco and Express Scripts and they both either said explicitly or certainly implied that they no longer write business in Maine because of your law and that PBMs --

MS. TREAT: Well, I think that they're --

REPRESENTATIVE MAIER: You said a little while ago that PBM said they would leave and

that was a lie, I think was your word.
MS. TREAT: Well, yeah, I mean, because I think they're saying this in every state in the country except Maine. Well, see, because there's -- the pharmacists put in a PBM bill in Maine, I think not realizing we already had one, but it has some provisions that aren't in the Maine law right now so we're going to have a hearing on that. So that will be interesting to see what they say at that hearing. But the thing to remember is that these companies were not -- by and large they were not doing business in Maine before the law. Very few people had -- you know, companies or plans had PBMs. And in this state the vast majority of the market is controlled by one company, by one company only, Anthem Blue Cross and Blue Shield which has its own PBM. So -- and of course that PBM is not, you know, going out of business or leaving the state.
I checked into this with state employees which went self-insured around the time of this law passing and so I wanted to check with them, you know, did they get bids under the law. And they said they got multiple bids from various

PBMs. They rejected most of them because they wanted their pharmacy benefits bundled with the rest of their health-care, which is what Anthem offered.
So, you know, Medco may not have business in the state. I don't know that it ever did and I'm not at all clear because, I mean, I checked into this with Anthem to find out what percentage of the market they control. I don't have those figures with me but it's a huge percentage. I mean, it's a problem we have with our health-care market. It has nothing to do with the PBM law. It's the subject of another -- it's another issue that we're dealing with but that's -- that's the reality. I don't think it has anything to do with that law.
REPRESENTATIVE MAIER: You have a question.
ATTENDEE 4: Where's the law in your state that you're trying to get through right now, what's happening to it?
MS. TREAT: We have a work session today and so I don't really know. As I said earlier, there -- I know that one of the Senators on the

Committee is interested in passing something but it would be more along the lines of an opt-in or an opt-in that was independently run through the Maine Health Safety -- the Health Data Organization and the licensing board, and I don't know where the rest of the Committee is. So, you know, I'll find out. I'll know more by the end of the day. And then we have a week's vacation so, you know, they'll probably resolve it today, I think in that Committee, so I'll know better then. Okay?
So I have to actually leave but if you have additional questions you want to e-mail to me or any of the reports that I mentioned, I'd be happy to get them back to you as soon as I could.
REPRESENTATIVE MAIER: Are you around next week or are you going away?
MS. TREAT: Well, I'm not going on vacation but I'm not going to be in my office. I set up all my business meetings for that week so I'm traveling. However, I always have e-mail and I have my own cell phone so if you do want to get in touch with me, I'm sure I can find some time to -- to, you know, talk.

REPRESENTATIVE MAIER: One last comment.
ATTENDEE 3: Thank you. Sharon, could you do us a favor? When -- when you find out whether Medco and Express Scripts actually did business in Maine, would you send that information to us because I'm going to ask the same question of the people (static noise).
MS. TREAT: You mean did they do business before we passed the PBM law, that question?
ATTENDEE 3: Yes.
MS. TREAT: Okay. I'll try to find out. Finding out absent of information sometimes is hard but, you know, well, I'll see what I can find out, you know, because I mean, I've gotten a lot of states calling us and saying this is what's being said and it just doesn't ring true.
ATTENDEE 3: That's -- that's exactly what is bothering me. I heard one -- one side and now the other side.
MS. TREAT: Yeah.
ATTENDEE 3: There's got to be a record somewhere of business either being done or not being done.
MS. TREAT: Yeah. Well, I mean, see one

of the issues here at -- at a minimum, you know, states are at least making sure that these companies are registered because unless you have that, you don't actually know -- since they're not regulated, if they're not registered, you don't know if they're operating in the state or not. So we wouldn't even have that record unless they were registered as a PTA or something and according to our insurance bureau, because I was talking to them about this issue yesterday, they said only one company was registered as a TPA because it qualified but the other PBMs aren't. So I'm not sure how you find that out, you know, without -- I mean, I just don't know.

And since most of the marketplace has been controlled by Anthem that has its own PBM -- well, companies aren't -- they don't contract with Anthem for the health benefits but not the pharmacy benefits generally. I -- I asked that question and a very small percentage don't combine the two.

So, you know, I'll look into it as much as I can but I'm not sure that the answer is -- you know, we can find that answer out because

we have no way of knowing. You know, these are private contracts.

ATTENDEE 3: I thought maybe that organization that you work with may be able to.

MS. TREAT: Well, that's me.

ATTENDEE 3: Oh, that's only you?

MS. TREAT: Pretty much. So, I mean, I -- I do what I can but the fact is it's not like there's a list anywhere you can go find.

ATTENDEE 3: Okay.

MS. TREAT: But, you know, as I said, I'll see what I can find out.

ATTENDEE 3: All right. Okay. Thank you.

MS. TREAT: Sure, okay.

REPRESENTATIVE MAIER: Thank you, Sharon.

(On CD 132 from 50 minutes to the end too much static to be transcribed.)

CD 135/TRACK 1

ATTENDEE 1: Who's that -- I'm confused as to what we're talking about leaving in and taking out anymore.

REPRESENTATIVE MAIER: Okay. Well, I think what we just decided is on the bottom of page 16, the very bottom, the last two lines is to leave it in as written. So we have -- we

have a "unless the contract provides otherwise provision." We may move the sections around a little bit too just so that it's clear to the reader in the packet here that the first thing is there is a notice that happens.

My next question, if you can do this in two minutes, is to get a quick sense because then we have this call, is this standard related to the duty of fiduciary or duty of care, whatever we want to call that here. So it seems to me there are at least a couple of options here. One would be to keep it the way it is. The other would be to adopt a stronger fiduciary standard. I'm wondering what people feel about that.

ATTENDEE 3: What would it look like if -- do we have language that's fiduciary or is it the one --

MS. LUNGE: Yes. If you look where it's crossed out on page 16, "still prudence and diligence under the circumstances that -- prevailing that a prudent PDM acting in a like capacity and familiar with such matters.

ATTENDEE 1: Of a like character.

MS. LUNGE: And this was also -- one is

the language in Maine except Maine also uses the actual term fiduciary which --

REPRESENTATIVE MAIER: But Maine does not have "unless the contract provides."

MS. LUNGE: No, no. And one of the issues that Sharon raised that I thought I might mention to the judiciary is Committee -- I mean staff, Eric and Michelle, is because a duty of care is usually something a court would apply to a dispute in a contract situation. So I don't know if that's usually the kind of thing that you contract like -- that you include in your contract. I think it's usually the kind of thing a court would apply.

ATTENDEE 1: What she was saying is that this language, the way it's written, that it says --

MS. LUNGE: You can contract around it, right.

ATTENDEE 1: That you can waive --

MS. LUNGE: Right, but it's usually a legal duty. It's not like a contract term so it seems a little -- but I don't know. So I want to talk to the judiciary people just to get a sense of that because I really didn't

think about that before but --
REPRESENTATIVE MAIER: Well, understand what we're saying here. In A we sort of just decided -- I'm not -- I'm not holding anybody to anything here today because we're not voting today. But I mean what we just semi decided was to keep A, which means that everything that follows is waivable.
ATTENDEE 1: Right.
REPRESENTATIVE MAIER: So then the question is --
MS. LUNGE: My question is, can you legally waive a legal duty and if you can -- is it then even a duty if it's waivable?
ATTENDEE 1: Right, right.
MS. LUNGE: So I'm -- I'm posing a legal question to myself.
REPRESENTATIVE MAIER: And is that question -- is that question the same for you whether it's -- you understand the finance version or the current version?
MS. LUNGE: Yes, because I think one is substantively different than two through six, because two through six are terms that you -- about disclosure and notification as opposed to

the duty of care that a court would impose on a party to a lawsuit when looking at their contract.
ATTENDEE 1: So, in other words, one should be statute -- I mean, it should be the standard that applies legally rather than the contracts can do it or not.
MS. LUNGE: I think that's my understanding of what a duty of care is but I just want to check, you know, with some of my colleagues.
ATTENDEE 5: Take one out and then have A applied to two through six. Is that --
MS. LUNGE: Or to decide you don't want to touch one or, you know -- I don't know.
ATTENDEE 1: If there is a standard already that covers these kinds of things, it might be one or the other and we might not need to (inaudible).
MS. LUNGE: I think -- go ahead. I'm sorry to muddy the waters but that -- I -- that just -- I hadn't really thought about that from a -- you know, that legal question before today so --
REPRESENTATIVE MAIER: I think that's what

uncomfortable to me is that we're saying that you should be a good guy but you can have a contract that says --
ATTENDEE 1: Yeah, that you don't have to be a good guy, yeah, that's a strange.
REPRESENTATIVE MAIER: And if we think you should be a good guy, not to be sexist or anything, or good woman, but you can have --
ATTENDEE 1: Yeah.
MS. LUNGE: The good company because there really is --
REPRESENTATIVE MAIER: And then part of the things they can waive is all the -- the rest of it if they wanted the rest of it, but we still believe that they should have a certain standard they should live up to. So I would say leave in -- I'd be happy with the lower standard and then have the contract apply to the specific notice.
ATTENDEE 5: Well, I would like to know what the standard is before I decide whether I want it to be lower or not.
MS. LUNGE: I think the current standard would be the contract standard.
ATTENDEE 4: Okay. I have a problem with

the time here because, Chuck --
ATTENDEE 7: I don't know if this is very helpful but, you know, when we're talking about parties in a contract relationship, the way the courts are going to look at their rights and responsibilities first and primarily is they're going to look at the contract and see what that says.
Now, there's lots of times in the course of a performance of a contract where issues come up that aren't specifically addressed in the document itself. And in all contracts, the courts will imply a covenant of good faith and fair dealing. And that's basically what they say, you know. And then what that actually means depends on the given facts and circumstances of the case but there's an obligation in performing a contract to treat the other party in good faith and in a fair manner. That's a given.
And then there's also an obligation to perform the contract in a non-negligent way, it can't be negligent. So I just throw that out there as something that you can rest assured is always going to be the case in the context of

parties dealing with each other in contractual contracts.
REPRESENTATIVE MILKEY: And when it's the higher stand, is it written to statute that proclaims that it's a the higher standard --
REPRESENTATIVE MAIER: I'm sorry, you're just going to have to hold on to that question because I'm worried about the doctor we have at 1:30 and I won't want to lose her.
REPRESENTATIVE MILKEY: Oh, Okay. I'm sorry.
REPRESENTATIVE MAIER: Hold on to your thought.
DR. BOERNER: Hello.
REPRESENTATIVE LERICHE: Dr. Boerner?
DR. BOERNER: Yes.
REPRESENTATIVE LERICHE: Thank you. This is the House Health Care Committee. I will transfer it over to Chairman Steven Maier.
DR. BOERNER: Hello.
REPRESENTATIVE MAIER: Hello, Dr. Boerner, how are you today?
DR. BOERNER: Very well. Thank you.
REPRESENTATIVE MAIER: We're here talking about a -- a -- a bill that's in front of us,

S115, which is a bill that contains a number of different provisions related to transparency and privacy of certain pharmaceutical information and a few other things as well. One -- one of the provisions in front of us relates to what is at least euphemistically referred to as data mining. And I understand you have something -- an experience related to that that you could relate to us that we'd be interested in hearing.
If you could do that, that would be great. Maybe you can just start and tell us a little bit about yourself and where you practice and that sort of thing.
DR. BOERNER: Okay. I am that dreaded thing, I'm a flatlander. I practiced in Boston for 20 years and then moved six years ago to my weekend Vermont house in Reading, Vermont, and took a job with Lane and Nice (phonetic) Associates in Springfield.
Dr. Lane expanded his practice into New Hampshire and he put a satellite in Claremont and I'm the doctor in Claremont. So although I feel like a Vermonter, I practice mostly in New Hampshire unless I'm covering the E.R. near

Springfield Hospital. So that's my story, that's who I am.
And I was particularly delighted to be practicing in New Hampshire when the ability of pharmaceutical companies to harass me became terminated.
Basically, when a doctor prescribes for a patient, you would like to think that the doctor takes the best drug for you and hopefully that's what the doctor can do. But the first thing they have to look at is, oh, what's your insurance? So we have to look at a list of drugs that their insurance will allow them to have. So that's the first painful thing that a doctor has to do when they're making a drug -- a decision to put a patient on a drug.
And then you can -- if you check the list, you write the prescription. If it's a drug plan -- even if a patient is begging you, please don't make me -- put me in the third tier drugs, you know, that kind of stuff, so it's a pain in the derriere any way to do prescribing these days. It's no longer what's the best thing for the patient. It's what

their health plan will let you do for them.
So on top of that comes the layer of insanity that the drug rep -- these are the people paid by the drug companies to detail the doctors. A good rep is absolutely invaluable because when you're in the hinterlands, where are you going to get your information about what's going on with drugs? It's the drug rep.
They'll come in and they say, we have a new drug, you know, X drug does this, our drug does X plus Y, so you can see why it's a good idea for your patients. You know, you can learn from them. And oftentimes -- and they'll help you out. They'll say, you've had trouble with this. Well, put a artificial tear in the eye before you use it and then they won't have stinging. Little things, they can help, and they're useful. And most hopefully for us they bring samples of their drugs so that when you want to put somebody on a medicine, you don't tell somebody, particularly if they have no insurance, here, go spend $100 for this bottle of drugs and oops, two drops of it, you're allergic to it, well, I'm sorry about that. We don't have to put patients in that bind. We

just give a sample drop. It works, it doesn't work and no one can order it.

It is disgusting and really demeaning when a drug rep can say, well, you say nice things to my face but I know you're not using my product. Hello. They're in my office and they're accusing me of lying. Lovely.

They -- the drug rep will say, well, I know what you're doing and why aren't you using my product? I'm a five-foot four lady. Some of these drug reps, you know, they can -- it's intimidating, why aren't you, bah, bah, bah, bah, bah. It's -- it's another layer of the horror of practicing medicine these days and it shouldn't be that way. Nobody should be -- it's bad enough the health plans, you know, finding out what we do, everything that we do. And -- and the health plan that's paying for the health, I can understand they can say all right, we're paying for the drugs, we don't want you to use XY and Z. I don't like it. I can understand that.

But to have drug reps coming in and telling me that I'm not doing what they want me to do and they can prove it is nasty. It's --

anyway, so I'm really glad I got a chance to tell you this because it's not the way it should be. And nobody should be making money off of what I'm doing except me.

Any questions?

REPRESENTATIVE MAIER: Yeah, we have a question here from Dr. Chen.

REPRESENTATIVE CHEN: Doctor, I wonder if you could tell us a couple things. What is -- is this something that happens rarely, occasionally? You know, how often does it happen or did it happen? I know it probably happens less because you're practicing in New Hampshire.

DR. BOERNER: Well, yeah, because reps don't come up here.

In Boston I mean, you've got hot and cold running reps, there's always somebody there. If we ran out of a sample, I could have it within a day or two. Up here it's a week or two. It's just different.

How often does it happen? That's a hard question because I don't, you know, make a little mental note of when it happens. I guess I make a note of which reps are more obnoxious

than others. How often does it happen? Well, it's always there behind what they're saying when they say, well, you will try it, won't you? And I'll be checking up next week. You know, it's like always there.

REPRESENTATIVE CHEN: And then the other question is what every -- one of the counters to this is you can always say no. I mean, you could always say you don't want to see them.

DR. BOERNER: But, you know, you do want their samples, you know, so it's a -- I do need their samples. And I will tell you guys that when this thing came out with New Hampshire, the outcome, the largest ophthalmic pharmaceutical company in the world withdrew all their reps from New Hampshire. So I said, kick yourself in the foot, how do they expect me to ever use their drugs if they do that? And so we have no samples for Norcome (phonetic) anymore. I mean is that stupid? How stupid is that? You know, they piss -- they can't follow up on whether their rep is doing a good job because their rep is doing a good job if I prescribe the expensive drug -- the new expensive drugs.

They do not give their rep any credit if I use drugs that have been out there for a long time that are cheaper, by the way.

REPRESENTATIVE MAIER: Bill.

ATTENDEE GIBB: Bill Gibb from Burlington. Doctor, if you -- probably two questions. Because you're in a more remote area in New Hampshire, is that one of the reasons you're not being harassed by detailers?

DR. BOERNER: They don't -- they don't get out there much.

ATTENDEE GIBB: For that reason because you're in hinterlands or because there's something that the New Hampshire legislature enacted that they're --

DR. BOERNER: Oh, oh, before this bill they would come infrequently because it's a lot of gas to come out and see us in Claremont and when you can be a rep in Boston and there are doctors under every parking meter --

ATTENDEE GIBB: So there was legislation that curtailed --

DR. BOERNER: Well, what the legislation did, now let me make this clear, is one of the major companies said, if we can't keep track of

what you're doing, we won't give you any samples. So basically they're just going to hurt the patients by not giving out samples. I don't know how long that's going to last but that was their real tit for tat.
ATTENDEE GIBB: My other question -- it's my only question --
DR. BOERNER: May I finish with that? There are other drugs to use, so they're just hurting themselves.
ATTENDEE GIBB: My other question is, if the detailers didn't show up in your office, how else would you find out similar or parallel information?
DR. BOERNER: At meetings.
ATTENDEE GIBB: At meetings and you would --
DR. BOERNER: Meetings, talking to colleagues. There's a lot of information that go on at meetings and stuff right now.
ATTENDEE GIBB: And you have the time to do that?
DR. BOERNER: I do. Now that I'm working up here, I'm not crazy.
ATTENDEE GIBB: Thank you.

DR. BOERNER: I mean, working up here is wonderful because you do have -- the way it's set up, I have more time to take more care of my patients.
The overhead for a practice in Boston, I mean, my front desk people made 18.50 an hour. My technician was $25 an hour. And I know it's nowhere near that up here. I mean, the rent for my office in Boston was close to $9,000 a month, you know, so everything is less expensive up here so I don't have to see quite as many patients to make overhead. But that's not what you're asking about. You're asking about the drugs.
ATTENDEE 3: If you didn't have the samples --
DR. BOERNER: What would I do? I'd used another company's drugs.
ATTENDEE 3: How hard would it be just to have a container of the different drugs there and use them, you know?
MS. LUNGE: You can't do that.
ATTENDEE 3: You can't do that?
DR. BOERNER: Yeah.
ATTENDEE 1: Not unless you're a pharmacy.

DR. BOERNER: Who pays for it?
ATTENDEE 6: I think you have to be licensed as a pharmacist to have a dispensary in your office.
DR. BOERNER: Yeah. You can't give out drugs as a doctor because you're not a pharmacy. At least you couldn't in Massachusetts.
REPRESENTATIVE MAIER: Learn something new every day.
Ginny.
REPRESENTATIVE MILKEY: No, he asked the question.
REPRESENTATIVE MAIER: All right. Other questions?
ATTENDEE GIBB: How do you feel about your prescription patterns being sold to -- to commercial outfits?
DR. BOERNER: It makes me very, very angry.
ATTENDEE GIBB: Like how?
DR. BOERNER: Like how angry?
ATTENDEE GIBB: Yeah.
DR. BOERNER: Get me a pharmaceutical. It's not -- it's another hassle of practicing

medicine. It's bad enough that Medicare is following everything we do. The health plans are following and telling you what to do. And then the pharmaceutical companies are going to check up on what you're doing. Hello. It's -- it's very unpleasant. I don't like being watched like that.
REPRESENTATIVE MAIER: Topper.
REPRESENTATIVE McFAUN: Doctor, this is Topper McFaun.
What if the information that the -- the company had was being used for research, how would you feel about it then?
DR. BOERNER: What kind of research -- that's just only what they know. It's not research who's using what. That's -- that's -- that's business. You see it's -- at least in ophthalmology there are several different drugs in every class of drugs. So the fact that one -- one company doesn't want to come to New Hampshire just cuts off their nose to spite their face.
REPRESENTATIVE McFAUN: I'm not talking about a company coming or going. I'm talking about the information that they --

DR. BOERNER: But that information to me, who's using what, that's not research. That's research for their bottom line. That's not research to make patients' care better. Who's buying what does not make patients' care better. It's not research. They want to call it that because it sounds really good.

Research is when you try a drug and you find out whether or not it works.

REPRESENTATIVE McFAUN: That's what I was talking about.

DR. BOERNER: But that's not -- that's not my practice. That's not what I -- that's not what I'm prescribing. They don't get the data on whether or not it works. They just get the data whether or not it went in their pocketbook.

REPRESENTATIVE McFAUN: Well, if -- if you were prescribing a certain drop and you were doing it continuously, would -- would that not mean that at least in your practice it was a good drug to be using?

DR. BOERNER: As I said, it could be just that's what the health plan tells me I can use. It's not -- no, it's not research in any way,

shape or form.

REPRESENTATIVE McFAUN: Okay. Thank you.

DR. BOERNER: It's a prescribing pattern that is as much due to what insurance the patient has as to what works.

I can't tell you the number of times I've had to try drugs that don't work on a patient, they have to come back, that one doesn't work, no, that one doesn't work. Then I have to write a letter to the insurance company and ask them to use a noncovered drug because the other drugs don't work. So the insurance companies pay for several office visits.

REPRESENTATIVE McFAUN: That's exactly what I'm talking about.

DR. BOERNER: Yeah, but that's the drug company. That's -- I mean, that's the health-care company, it's not the drug company.

REPRESENTATIVE McFAUN: If you see 15 people in a day, they're not all on the same plan, you know, and if you continually want to use a particular drug --

DR. BOERNER: And they're not all on the same plan you said? I couldn't hear you.

REPRESENTATIVE McFAUN: If they were not,

right.

DR. BOERNER: So you have all different plans, uh-huh.

REPRESENTATIVE McFAUN: And you want to use a particular drug because a person -- they all have a similar problem, wouldn't that be good to know?

DR. BOERNER: No, because you don't know whether or not it works. All you know is it's been prescribed. Just because it's prescribed doesn't mean it works.

REPRESENTATIVE McFAUN: Why would you keep prescribing it then?

DR. BOERNER: You could -- you could -- I can try it. You -- if -- you come in with glaucoma for instance.

REPRESENTATIVE McFAUN: Right.

DR. BOERNER: All right. 15 people come in with glaucoma. I put them on -- on Drug A. I put them all on Drug A because it's the cheapest drug available.

REPRESENTATIVE McFAUN: Or because you had samples.

DR. BOERNER: Yeah. Samples is a good primary drug. I put everybody -- I put 15 of

them on Drug A and then they come back and half of them it didn't work in. So I put another half on Drug B and half of those didn't work in. So I put them on Drug C. So all you know is, oh, she -- that first drug, it really works good because she prescribed it 15 times. What you don't see is that it didn't work seven and a half of those times. Don't you see?

REPRESENTATIVE McFAUN: I see that and I see the other side, too.

DR. BOERNER: Yeah. It's -- it does not do anything for quality of care. It does not do anything -- all it is is how many times you've prescribed it.

REPRESENTATIVE McFAUN: Okay. Thank you.

REPRESENTATIVE MAIER: Yeah, Harry.

REPRESENTATIVE CHEN: Doctor, we've heard that -- that some of the prescriber identified information is used to -- by drug companies to notify people of problems related to drugs. Do you feel that your ability --

DR. BOERNER: No, that's done by the pharmacist -- the pharmacies and the health plans.

REPRESENTATIVE CHEN: So you don't think

that that's a problem.
DR. BOERNER: The pharmacy -- the pharmacy catches that. You get -- the pharmacy will call you and say, your lady, she's already on X, you can't do Y. And I go thank you.
Did she tell you she's allergic to this?
I go, no.
REPRESENTATIVE McFAUN: But what about things that are you know, like FDA notices or things like that of drugs that are -- you know, that maybe indications have changed --
DR. BOERNER: Well, that comes out to me, I get those all the time. They're mailed to me by the companies even for drugs I don't particularly use. I get that. The government -- FDA is real good about sending letters out.
REPRESENTATIVE McFAUN: Okay.
ATTENDEE 5: So it isn't just limited to the ones you prescribe?
DR. BOERNER: No. I can get warning drugs about other things -- warnings letters about other drugs. Like when this -- there's a problem with Glimepiride came out, that they -- they notified me and I don't ever prescribe

Glimepiride. That's -- an internist practice, prescribed for diabetes.
REPRESENTATIVE MAIER: All right, Dr. Boerner. Thank you very much for your time and your information.
DR. BOERNER: Please, please, it's a wonderful, wonderful, wonderful idea to not be spying on doctors and having the reps come back and make us feel guilty for not doing what they want us to do.
Thank you for your attention. Thank you for taking this up. I really appreciate it. Have a great weekend.
REPRESENTATIVE MAIER: All right. Thank you.
DR. BOERNER: Bye-bye.
ATTENDEE 4: I'm glad she waffles.
REPRESENTATIVE CHEN: Again, I wish she weren't so shy.
ATTENDEE 7: Is this a common story that we would hear from a bunch of physicians?
REPRESENTATIVE MAIER: That's what I was going -- I was going to ask Harry the same question.
REPRESENTATIVE CHEN: Well, obviously, you

hear some. The -- the husband of the person introduced in New Hampshire was getting harassed by -- again, I don't because I don't talk to them.
ATTENDEE 1: I have --
MS. LUNGE: My physician has a sign on the door that says no detailers because she's told me she feels their information is inaccurate. She won't let them in the front door.
ATTENDEE 2: Well, that equates to what salespeople do. They give whatever information that will sell their product, not necessarily accurate information.
ATTENDEE 1: The tragedy about this is the withholding of samples. If I can't get your -- your good information, I'm not going to give you my samples, because I know our pediatrician uses samples a lot either to start somebody on a Saturday night when they need -- you know, they need to start and they can't get to the pharmacy until Monday or people who can't afford the medicine can get their whole course of it free because he's got enough samples.
ATTENDEE 4: The Vermont Medical Society, you know, has been pushing this provision

because we heard from our -- from the (inaudible) in New Hampshire. None of the folks from New Hampshire have said they can't get the samples. My sense is from her testimony it was one company that just kind of abandoned the New Hampshire market. I think they're more the exception than the rule. But we've heard a lot of comments to support, from New Hampshire physicians, none of them have said the samples have dried up.
And, in fact, I'm -- I don't know if Madeline mentioned it in her testimony but two weeks from now I'm supposed to speak at a conference in Washington D.C. of pharmaceutical detailers who are trying to figure out how to have effective marketing absent this -- this physician specific information. So, you know, I -- it sounds like for her it was one company and presumably the other companies continued to visit her and provide the samples. And it's the first time that I've heard they are no longer getting samples from one company in New Hampshire.
REPRESENTATIVE MAIER: Okay, Ginny.
REPRESENTATIVE MILKEY: It seems to me if

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these companies via their reps weren't trying to hoodwinked doctors some of the time that, you know, if they actually were selling -- were -- were doing the educating that needs to get done, being honest about the side effects of who should, shouldn't use them, then maybe they won't be in this boat. But I think like they've dug their own graves here and it's just -- you know, how do you get a whole industry that has a lot of good things to offer to be honest and not try to peddle the stuff that really doesn't do much for people. And it's harmful just to make money. I think to me that's what the underlying problem is and I don't know if we can address that but this certainly would relieve physicians --

ATTENDEE 3: I don't think there's any expectation that drug companies aren't going to continue to send detailers to physicians' offices. It's just one company that was arbitrary --

REPRESENTATIVE MILKEY: Yeah. So maybe we'll actually be doing a service.

REPRESENTATIVE McFAUN: Well, you know, I have to say this. Let's look at the flip side

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of it. We know from all of us being around this table for years -- and, remember, before I make these statements I'm not sticking up for anybody but there's two sides to this. We know that drug companies provide drugs to people at a very, very reduced cost and sometimes nothing for -- for people who need help.

We also know that they go into physicians' offices and they give the drugs for nothing so they can start people on a drug. So it isn't -- I just want to -- let's -- let's keep the playing field.

There's some good things they do, too.

REPRESENTATIVE MILKEY: I said that, too. I said there was a lot of good stuff to offer and it gets muddied (inaudible). But it's great to give samples. Plainly there are good resources. But, you know -- and they can continue to do that but, you know, until we get honest information on clinical trials that didn't show the drug was safe yet or that showed that it had problems in all these areas and they sit on that information -- I know they do that. That's --

REPRESENTATIVE McFAUN: When I read

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those -- what I get with my pills, there's enough stuff in there --

REPRESENTATIVE MILKEY: Yeah, but those drugs are licensed. You know all the ones that got licensed, they didn't have all of the risks, you know.

ATTENDEE 3: And I will finish by saying I think the price is too high and we ought to do something about it.

REPRESENTATIVE MAIER: I think -- it's 3:00 on Friday afternoon. I think we have obviously a number of outstanding questions still on the table.

REPRESENTATIVE MILKEY: Can I ask a question, the question I had from before?

REPRESENTATIVE MAIER: Sure.

REPRESENTATIVE MILKEY: It was just -- when we were talking about the reasonable care and diligence standard being what's applied across the board and you had mentioned that there are situations such as the retirement funds and some others had been mentioned, and I was just curious, are those -- are those -- are those treated as fiduciary duty because it's specified in some statute or because that's a

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common practice of treating them or because it's federal law or something?

ATTENDEE 7: Historically that has all developed over time by court decision in the absence of statute. When ERISA was enacted, they adopted the fiduciary duty by statute, but if you read the cases, the courts say all of the law that has been developed over the ages applies in ERISA even if it was a different statute. So it's out there as what's called common law or case law but in certain instances that has been affirmatively enacted as a statute, too.

REPRESENTATIVE MILKEY: Thank you.

REPRESENTATIVE MAIER: I think I'm going to call it a day -- call it a week. Thank you all for a lot of attention on this. I know -- I know there's still work we need to do on this. I think I can see the light at the end of the tunnel. I think we're focusing on -- some things are becoming clearer at least for me and at least for my sense of where this Committee is headed.

Tuesday, just to remind the Committee, we're doing -- Tuesday we're doing naturopaths

in the morning and prescription drugs in the afternoon.
ATTENDEE 1: Do we have the scheduling?
REPRESENTATIVE MAIER: No, not yet. So at 2:30 on Tuesday we're going to continue this, essentially, what we've been doing with Robin. And we'll go through the rest of the bill and we'll have perhaps a more involved conversation that we need to have more on the data mining stuff, a little more on that and certainly the unconscionable pricing section and go through the rest of the Bill. Hopefully, we'll be able to do that in that almost two hours we have Tuesday afternoon.
Then for Wednesday and Thursday, we'll switch. We'll do RX in the morning so we can continue on with that.
And we will be working on getting some additional witnesses. Hilde and I -- several of us wanted to hear from Elliot Fisher. I've asked to see if we can't get Dr. Jerry Ahorn that we keep hearing about and then a couple of other people that we're working on. So we'll plug them in Tuesday and Thursday -- Wednesday and Thursday mornings if we can; otherwise,

we'll just keep working on -- on the language of the Bill and see how far we can get.
MS. LUNGE: So when is your target -- do you have a target date for when you will (inaudible.)
REPRESENTATIVE MAIER: At the end of the next week will be the timetable -- but when it's ready.
MS. LUNGE: Right. Right.
REPRESENTATIVE MAIER: And then in the afternoon Wednesday and Thursday we have other testimony on -- I have to remember. Do you have it?
ATTENDEE 1: Health insurance and reimbursement --
REPRESENTATIVE McFAUN: What is that naturopath?
REPRESENTATIVE MAIER: Okay. Have a good week. Thank you.
- - - - -

CERTIFICATE

THE STATE OF FLORIDA,)
COUNTY OF BROWARD.)

I, Dona J. Wong, Notary Public, Certified Shorthand Reporter and Registered Professional Reporter do hereby certify that I was authorized to and did transcribe the foregoing proceedings from CD and that the transcript is a true record.
Dated this 12th day of August 2007.

Dona J. Wong, RPR, CSR
My Commission # DD 002741
Expires May 16, 2009

STATE OF VERMONT

STANDARD COMMITTEE MEETING

RE: SENATE BILL 115, RX DRUGS

DATE: Friday, April 13, 2007

TYPE OF COMMITTEE MEETING: Standard

COMMITTEE MEMBERS:

Rep. Steven Maier, Chair Rep. Henry Chen, Vice□chair
Rep. Francis McFaun Rep. Sarah Copeland□Hanzas
Rep. William Keogh Rep. Lucy Leriche, Clerk

Rep. Virginia Milkey Rep. Pat O'Donnell
Rep. Hilde Ojibway Rep. Scott Wheeler
Rep. John Zenie

CD NO: 07□133/T1, T2, T3
CD NO: 07□134/T1, T2

PROCEEDINGS

CD 133/TRACK 1

ATTENDEE 1: (Inaudible) I found the three different documents that Sharon Treat mentioned (inaudible) now, or we can do it (inaudible).

CHAIRMAN MAIER: Let's wait.

ATTENDEE 2: That's okay. I'll get it (inaudible)

CHAIRMAN MAIER: So, this is Court 2. I guess Robin will be back in a little bit but □□

ATTENDEE 3: Oh, all right. Well, that's great.

CHAIRMAN MAIER: Kathy had to reschedule from some other day this week and here she is.

MS. CALLAGHAN: Hi.

ATTENDEE 4: Oh, perfect.

MS. CALLAGHAN: Thank you for your patience with all of this. Is there a mike?

CHAIRMAN MAIER: There's one in the middle of the table.

MS. CALLAGHAN: Oh, that does it? Okay.

ATTENDEE 5: Yes, that's it.

CHAIRMAN MAIER: Do we need to elevate it?

MS. CALLAGHAN: No, no. I was looking for □□

ATTENDEE 6: Is it on?

ATTENDEE 7: It's picking up fine now.

MS. CALLAGHAN: Oh, okay.

ATTENDEE 8: That one died.

MS. CALLAGHAN: Oh, I've got you. Okay. Great. For the record I'm Kathy Callaghan and I'm the director of the State Employee Health Fund. And I wanted to take the opportunity today while you are still taking testimony on this bill, to offer some information about our plan. And I thought this information would be helpful as you consider S □115.

This is essentially the same testimony that I gave to a Senate Finance Committee on February 6th. And I used the front and back of the paper.

ATTENDEE 9: Oh, you're good.

MS. CALLAGHAN: I just want that to be noted.

CHAIRMAN MAIER: Narrow margins and □

MS. CALLAGHAN: Narrow margins and maximizing everything we can.

ATTENDEE 10: Yes. That's (inaudible).

MS. CALLAGHAN: All right. The Senate Finance Committee asked me to come in earlier this year and their question was: How is it working? Can you quantify any savings, anything else you think the committee should know about the prescription drug plan, and is there any other information you would like to share. So I prepared some information. I will walk through it and I'm happy to take any questions.

Some facts about the State Employees Prescription Drug Plan. There are currently approximately 22,400 members, and this includes the state employees and the retirees and their covered dependents.

Our plan is a calendar year plan and in calendar µ06 plan members filled 333,457 prescriptions for a total cost of $21.1 million. And of this total, 140,225 were for brand named drugs and that cohort cost $16 million. The remaining 193,232 were for generic drugs and those costs $5.1 million. Quite a difference.

Through our plan design we maximized generic utilization. We negotiated with the union a long time ago a mandatory generic substitution provision so that unless it is medically contraindicated a generic is dispensed. The plan currently uses a Pharmacy Benefits Manager, or a PBM, called Express Scripts. Express Scripts is a commercial PBM covering approximately 50 million lives nationwide. And through Express Scripts the plan provides prescription drug coverage through both retail pharmacies and also mail order home delivery.

Retail pharmacists in Vermont and nationally contract with Express Scripts to provide retail drugs and then Express Scripts provides mail service prescriptions through its own mail service pharmacy. The mail service home delivery component is especially appreciated in our case because we have over 3,000 retiree members, and this allows them to get prescriptions in the mailbox rather than having to go out in the snow and what not.

Express Scripts obtains and passes along to the state manufacturer pharmaceutical discounts based on a drug's Average Wholesale Price of AWP. The discounts vary between Express Scripts retail network and their mail order pharmacy. Mail order discounts are generally deeper discounts.

In our current contract with Express Scripts we negotiated the following discount levels. At retail, for brand named drugs, we get average wholesale price, minus 16 percent, plus $1.20 dispensing fee. For generics we get average wholesale price minus 51.5 percent, plus the $1.20 dispensing fee. Through mail order home delivery you can see that the discounts are deeper at minus 24 percent for brands and there are no dispensing fees, and then generics are minus 54.5 percent with no dispensing fees.

ATTENDEE 11: May I ask a question?

CHAIRMAN MAIER: Yes.

ATTENDEE 12: Kathy, I remember from previous days in this building AWP stood for Ain't What's Paid.

MS. CALLAGHAN: Well, not in this plan, I guess.
ATTENDEE 13: Well, I mean, you □
ATTENDEE 14: Well, it is in this plan because it is a minus 24 percent, 54 percent, 16 percent.
ATTENDEE 15: It's a basic □□ I just question the credibility of Express Scripts in the situation when they are using an artificial number so much to issue you a discount, issue the (inaudible) discount. It's an artificial number.
MS. CALLAGHAN: Okay.
ATTENDEE 16: So when you may be getting a good deal, you may not be getting. Maybe they are not □ Express Scripts is not passing along all of the advantages of bulk purchasing.
MS. CALLAGHAN: Okay.
ATTENDEE 17: That's all I'm saying and I just raise that issue.

MS. CALLAGHAN: Sure. No, I would like to address that. I have no doubt that they are not passing along all that they could be passing along because the very nature of pharmaceutical pricing is a shell game at best.
ATTENDEE 18: Yes.
MS. CALLAGHAN: I don't know if you've heard testimony before I came in. I'm sure you probably have.
The commercial PBM's all use this very same basis. It is average wholesale price as determined by First Data Bank. There's been some recent controversy about First Data and it is possible there is a lawsuit pending. And what the suit suggests is that First Data was favoring a particular drug manufacturer over others. And as a result of that, and in settlement of that it is our belief that AWP as we know it is no longer

going to be the standard by which pricing is set. And we think that the industry is going to move as a whole to another form of pricing.
That doesn't say that AWP isn't workable right now but it is on the chopping block. Okay?
ATTENDEE 19: We will see what the substitute looks like, but go ahead. I just have a problem with the credibility of that process. Go ahead.
ATTENDEE 20: And I'm surprised that you have a better, that you somehow got a better deal than our Medicaid Program.
MS. CALLAGHAN: We do.
ATTENDEE 21: And does that include the other □□ Medicaid gets like two discounts.
ATTENDEE 22: Oh, that's right. The supplemental rebate.
ATTENDEE 23: They get the federal discount.
MS. CALLAGHAN: That's correct and we don't get a supplemental discount. I believe the Medicaid supplemental is only on certain drugs and in certain quantities. I don't think it is a wholesale overall two□tiered system.
ATTENDEE 24: Right.
REPRESENTATIVE COPELAND□HANZAS: May I ask a question?
CHAIR MAIER: Sure, Sarah.
REPRESENTATIVE COPELAND□HANZAS: We've been told that Medicaid can't be used to leverage better prices for other Vermonters.
MS. CALLAGHAN: Uh□huh.
REPRESENTATIVE COPELAND□HANZAS: But is there any reason that if this [illegible]ly [illegible]omething better than Medicaid, that Medicaid couldn't get prices through the State Employees?

MS. CALLAGHAN: Yeah, there is. CMS is the □□ the Centers for Medicare and Medicaid □□ is the agency that controls Medicaid. And I guess the real question might be: Could the Sate Employees Plan and Medicaid combine to get as good or better than what we are getting now because clearly we're getting equal to or better.
The CMS would run the show. They would have to approve whoever was selected as a vendor. The State Employees Plan would have to align itself with CMS in a number of different ways, as we understand it now. And those include CMS would determine the formulary. There's different payment methodologies going back and forth.
REPRESENTATIVE COPELAND□HANZAS: CMS determines the Medicaid Primary
MS. CALLAGHAN: As I understand it, that's correct.

ATTENDEE 25: Well, when Josh was in □□
MS. CALLAGHAN: They would have to file a formulary with CMS.
ATTENDEE 26: It was open.
ATTENDEE 27: When Josh was in here the other day he said it was open and they have to □□ and that there is a preferred □□
REPRESENTATIVE COPELAND□HANZAS: It was open but there is preferred □□
MS. CALLAGHAN: Preferred.
ATTENDEE 28: But just by the very virtue of it, having to be open, I can imagine that would increase the cost for that.
MS. CALLAGHAN: Because we have a global commitment, you're saying?
ATTENDEE 29: No. The drug formulary is not □□ it's not the same drug formulary for every state.
MS. CALLAGHAN: That's correct.
ATTENDEE 30: That's developed in Baltimore. It's developed by the Vermont

□□
ATTENDEE 31: Yes.
ATTENDEE 32: □□ Vermont Medicaid Office.
MS. CALLAGHAN: That's correct.
ATTENDEE 33: But not the National CMS; the actual formulary itself.
MS. CALLAGHAN: Okay. Maybe I wasn't making myself clear. I think □□ what I think would have to happen is that we couldn't have a joint □□ we couldn't go in with Medicaid and say we want our own separate formulary. I think we would have to adhere to theirs.
REPRESENTATIVE COPELAND□HANZAS: And what they said was that supposedly they are the □□ because of the federal discount they say that they are the cheapest price.
MS. CALLAGHAN: Federal is the limit.
ATTENDEE 34: And that they cannot legally □□ Medicaid cannot legally be used to leverage that same price for otehr non□Medicaid.
MS. CALLAGHAN: That's correct.
ATTENDEE 35: That was the limitation they had.
ATTENDEE 36: So they can't go that and you don't want to go that, in the Medicaid direction.
MS. CALLAGHAN: Well, we don't know, you know. What we want to do is explore every possibility and see what the best financial arrangement is for the state, period.

At the end of my testimony I talked about what the future is and basically we're going out to bid again in µ08. And when we do, like we did in µ05, we will solicit bids from Med Metrics, and any of the other not□for□profit PBM's and see if things have changed and there is a way that we could do this together.

So we are interested. I just think that there are in place right now some barriers but who knows how that is all going to shake out. So □□

ATTENDEE 37: Kathy, do you know □□ does a pharmaceutical company have an interest, a financial interest, in Express Scripts, to your knowledge?

MS. CALLAGHAN: To my knowledge they don't.

ATTENDEE 38: Does your □□ when you do an RFP, do you include that in your RFP whether that the PBM has to indicate whether or not a pharmaceutical company has an interest? Is that included in your RFP?

MS. CALLAGHAN: Yes.

ATTENDEE 39: Thank you.

MS. CALLAGHAN: And they all swear that they don't.

ATTENDEE 40: Thank you.

MS. CALLAGHAN: Okay. I'll just continue on with what we have for discounts.

I took our discount arrangement and I sent it over to Ann Rugg (phonetic) at Medicaid. Some of you may know Ann. She works with Josh. She confirmed that the comparison between ours and theirs is accurate.

I think another important thing to notice when we are talking about saving money is that the discounts at mail order are even deeper than the discounts at retail.

And on generics, the State's plan is getting comparable pricing to what Medicaid is getting. We pay no administrative fees to Express Scripts. Now, that's kind of a statement that, you know, in some ways is silly. But there are no specific administrative fees assessed. And there may be another plan.

ATTENDEE 41: They are not broken out.

ATTENDEE 42: (Inaudible) charges.

MS. CALLAGHAN: They are not broken out. They are all built in.

ATTENDEE 43: (Inaudible) grace.

MS. CALLAGHAN: And generally I think they make their money on the spread in the generic, the cost □□ between the cost of what they purchase the generic for and what they sell it out for.

But if you look at our pricing structure □□

ATTENDEE 44: You have a traditional PBM arrangement and not what someone described the other day as a PBA arrangement.

MS. CALLAGHAN: Correct.

ATTENDEE 45: Where □□ so they are getting □□ they are getting rebates on other things from manufacturers but there □□ so I guess my question is: Have you looked into any of these different arrangements whereby you would get all the rebates that they received from manufacturers for moving market share. It would come back to you and then rather than paying no administrative fees you would pay a standard fee and you would get whatever the rebates are.

MS. CALLAGHAN: We did. And when we went out to bid in 2005 we solicited bids from □□ we instructed our consultants to solicit bids from everybody. That included RIXAS (phonetic), it included NLARX, and all the not□for□profits that they could find and the profit □□ and the commercials they could find.

We got no bids back from any of the non□profits, including NLARX. And that was a little disappointing because we had been sort of going back and forth with Senator Reedy (phonetic) and Senator Rivers on how we should be looking at this. And we did, but they declined to bid.

And I, myself, gaining a better understanding of the difference between a

PBM, a PBA, and a fiscal agent. So I can't come to the table today and tell you that I know this very well. But the understanding I have to date is that they don't function the same way. And the problems that other states have had apparently in putting their plans together is that one set of services doesn't look like the other; the funding is different; the pricing is different; the formularies are different, et cetera, et cetera.

Now different is one thing and can different be overcome is really the place you want to be looking. So when we go out to bid next year we will have a better understanding of this and we will be looking in conjunction with S□115 to see what we can do.

It may be that adding the Medicaid lives to what we have already and with all the different ways that the peanuts in the cups are manipulated then prescription drug pricing may not result in lower pricing than we have now, and it might. It is □□ it makes buying a used car look like a walk in the park to try to get underneath pharmaceutical pricing.

And, Mr. Chair, to answer your question, we asked for transparent pricing and we asked for conventional pricing in our last bid. And invariably the transparent pricing was higher because all these pieces can be manipulated. So there we are. We save more money not □□

ATTENDEE 46: Not knowing.

MS. CALLAGHAN: I think transparency is a word that it kind of goes to a level and even beyond that it is non□transparent in the current world.

CHAIRMAN MAIER: Another question here.

MS. CALLAGHAN: Sure.

ATTENDEE 47: When you change plans, if you change vendors, or whatever you call it for the State employees.

MS. CALLAGHAN: Sure.

ATTENDEE 48: So they then have to go through what you go through when you join a family and you only get a month's prescription on maintenance drugs before you can get the three months that your plan allows. So every time you change you have to go through that? Or do they □□

MS. CALLAGHAN: The wait would be the same.

ATTENDEE 49: □□ get grandfathered, since they are already your employees?

MS. CALLAGHAN: Now that's a good question. That's a plan design question and I don't know. We haven't changed vendors in □□

ATTENDEE 50: It would be worth asking if you're going to change vendors because it is a nightmare.

MS. CALLAGHAN: Would they consider □□ they would have to receive all of the prior authorization material from the other one and they would have to □□

ATTENDEE 51: And just looking at your information, it is the plan that pays the difference for using a retail pharmacy versus the new owner one?

MS. CALLAGHAN: The pricing □□

ATTENDEE 52: Rather than the consumer. Rather than the State employees.

MS. CALLAGHAN: No, I don't think that's accurate. If you get a prescription at retail or at mail order and you are a state employee, you pay 20 percent of the cost and the plan pays 80 percent of the cost. And the reason we put in percentage co□pays is we realize that if he had put in □□ negotiated with the union flat dollar co□ pays, well, gee, you know, $10 doesn't go too far in year two, but then you would have to go back to the drawing board and negotiate, you know, another higher co□pay. And this way the percentage rides with pricing.

ATTENDEE 53: Just as an interesting thought for you to take back. I've

had a non□profit for twenty□four years and the local pharmacies put me back into
(inaudible) communities, the mail order companies but nothing into the state of Vermont.
MS. CALLAGHAN: Okay.
ATTENDEE 54: I appreciate that.

CHAIRMAN MAIER: Why don't we let her finish her testimony.
ATTENDEE 55: (Inaudible) pay and (inaudible).
MS. CALLAGHAN: Yes, yes. Let's see. I think I've already covered a couple of these points.
I wanted to talk about the renegotiating change to a PDL for a drug list
January 1st of last year. And the change essentially gave us a three□tiered system with a
lower co□pay for the member on the generic tier, the same co□pay for the member on the
middle tier, and then a higher co□pay on the non□preferred (inaudible) tier.
The results □□ and the purposes clearly were to (inaudible) numbers
purchasing (inaudible) based on this system, try to drive market share to preferred brands
resulting in greater rebates, which I'll address in a second, and (inaudible) a greater generic
utilization rate.
So members are happy because they paid 10 percent of their drug, if they
get a generic drug. We're happy because generic drugs are obviously far less costly.
The savings to our plan in 2006 were $2.8 million and that is based on an
overall drug span of $21.1 million. And what that means is that we would've spent $2.8
million more had we not negotiated the PBL plan and had left everything as it had been.
There was a higher generic fill rate. We got better rebates since with
the three□tier plan you can drive volume to the preferred tier and then the PBM gives you
better rebates. And we also got better overall discounts than we had had before.

ATTENDEE 56: Do you have any idea what the total drug span? Do you keep
track of □□ I don't know how you □□ I'm not sure how you do it, but in other words, there
are two possibilities when you save that money. One is that the drug companies are
getting less money because you're □□ you know, whatever. You are actually spending □□ you and
your employees are actually spending less money on prescription, on the same amount of
prescription drugs, you know, whatever the (inaudible).
MS. CALLAGHAN: Yeah, the same basic usage.
ATTENDEE 57: The other possibility is that for some there's □□ the
employees are paying more somehow through this changed cost sharing arrangement.
MS. CALLAGHAN: No. I understand your question and it is the former, not
the latter. The employees aren't paying more. In fact, the employees are paying less
because generic utilization is higher and now they are paying 10 percent where they used to
pay 20.
ATTENDEE 58: And they are paying 10 percent of the generic so they would
be paying 10 percent of a lower amount.
MS. CALLAGHAN: Of a lower amount.
ATTENDEE 59: A lower amount.
MS. CALLAGHAN: But they might've also □□ they might've also gotten a brand before
before that incentive was in there. And then they would pay 20 percent of a □□
ATTENDEE 60: Of a higher amount.
MS. CALLAGHAN: □□ higher amount and we would pay 80 percent of the higher
amount.
ATTENDEE 61: Okay. Thank you.

MS. CALLAGHAN: Okay. I'll just finish by saying that when we go out to

bid again for this plan in 2008 we will solicit bids from anyone who is viable □□ for
profit, not for profit, consortiums □□ just to see what the marketplace looks like. Our goal
is to save as much money as we can for the state and for the employees, so we will be
looking very closely at it. And that's all I have.
CHAIRMAN MAIER: I just want to □ I don't know. Maybe Robin can □□ she's
walking in the door there. The committee has been asking questions about NLARX, and what they
are, and who they are. I don't think this is technically correct. NLARX is a separate
non□profit organization. I believe what they were trying to do a few years back was
set up, was spin off a different organization that would become a non□profit PBM. And was
that □□ I don't think it was under the umbrella of NLARX as an organization.
ATTENDEE 62: No, it wasn't.
CHAIRMAN MAIER: So, it is not NLARX.
MS. CALLAGHAN: Okay.
CHAIRMAN MAIER: It's □□ and partly □□ it never got off the ground.
MS. CALLAGHAN: Never got off the ground. Yes. Okay. I □□
CHAIRMAN MAIER: So just because we've been hearing from NLARX in their
capacity as □□ in their staff capacity from that organization, they have no interest, never had
a specific interest officially and certainly at this point don't have any interest as a
PBM because it never □□
MS. CALLAGHAN: It never got off the ground. Okay. Yes. Thank you for
that clarification. I think that in µ05 when we were looking at them □□
CHAIRMAN MAIER: They had a different name. I don't know what the □□ that
non□profit had a different name for a while.
ATTENDEE 63: NLARX had a different name?
CHAIRMAN MAIER: No.

MS. CALLAGHAN: No.
CHAIRMAN MAIER: The PBM they were trying to □□
ATTENDEE 64: Yes, it did, and I □□ I don't remember what it was.
CHAIRMAN MAIER: And it would've been □□ if it had worked it would b ideal.
It would be a not□for□profit PBM.
ATTENDEE 65: And I'm wondering if you have particularly I guess this section of the bill that was maybe affecting most would be the pharmacy benefit managers
section. I'm just wondering if □□ I don't hear in giving your testimony any specific concerns
or problems with the bill (inaudible). And I'm wondering if you have any specific comments for us regarding this piece of legislation you just (inaudible)?
MS. CALLAGHAN: I don't have any specific comments with regard to any portion other than the joint purchasing pool which would be required by 2010. I have read the
rest of it. I think it is interesting and I would be interested to see how the PBM's
will react. And we're not the only state, certainly, that's pushing the PBM. So it's okay
with me.
ATTENDEE 66: So the joint purchasing pool, it's a may not a shall.
MS. CALLAGHAN: It's a may.
ATTENDEE 67: And so you're □□ there is time □□
MS. CALLAGHAN: Yes. We're interested in □□
ATTENDEE 68: You're interested in pursuing any way that you can save money.

MS. CALLAGHAN: Exactly, exactly. And it does say in the current language
to the extent practicable. And that's, you know, for a good reason because it may not be
at the end. But we are very interested. We were interested in trying to join RIXAS
last time if we could, but I don't know if you are familiar with that. That is a

purchasing pool in West Virginia. But at that time they were taking no new states so we weren't able to.

There are other purchasing pools we've learned across the country that charge you a fee to get in. So there's all kinds of interesting things going on. But, I mean, we keep our eye set on the service you have to have and the lowest possible price for the same thing in whatever way we can do it.

CHAIRMAN MAIER: Harry.

REPRESENTATIVE CHEN: I just have a general question. The dollar amounts you list like 140,000, 2.5 prescriptions cost $16 million. Is this total dollars or does it include the cost to the state holders?

MS. CALLAGHAN: No. It is total dollars.

REPRESENTATIVE CHEN: So it is member plus it is the cost sharing is included in that?

MS. CALLAGHAN: Yes, it is.

REPRESENTATIVE CHEN: Okay. And let me just throw out to you. If you do the math, brand name prescriptions average out to costing $114 and the generic prescription average out costing $26. And I'm just going to make a case that you should be paying people to do generics. You shouldn't □□ it should be □□ you would save money if you paid somebody ten bucks to have a generic prescription. I'm serious.

MS. CALLAGHAN: No. I get you.

REPRESENTATIVE CHEN: Right. Rather than the percentage. You know, agree with the percentage (inaudible).

ATTENDEE 69: I don't have any co□pay with generics.

REPRESENTATIVE CHEN: I think that it should be zero or actually paying them.

MS. CALLAGHAN: Well, we do have something in place that forces them.

ATTENDEE 70: Yeah, right.

MS. CALLAGHAN: At this point □□

ATTENDEE 71: If there is a generic for the drug he has to take it.

REPRESENTATIVE CHEN: Oh, yes. No, no, I understand that. But □□

ATTENDEE 72: (Inaudible) drugs that don't have generic.

MS. CALLAGHAN: Well, there are. I think we're maxed out. I could also give you this piece of information. I think we're maxed out at somewhere around

which is all of the □□ my understanding is, it is all of the drugs that have a generic equivalent. We are very □□ we are like 98, 99 percent maxed out to what we could be because we checked that out, too.

REPRESENTATIVE CHEN: I would like to go off line and talk to you.

MS. CALLAGHAN: Sure.

REPRESENTATIVE CHEN: Because I don't think you are. I mean, I think the mandatory is a good think but I think within a class. So, for instance, you have cholesterol drugs, Lipitor, and Zocor. Zocor is now generic.

MS. CALLAGHAN: Right.

REPRESENTATIVE CHEN: So if you write Zocor you get a generic Zocor, but if you write Lipitor you won't get a generic Zocor. You could use, for many people, the generic Zocor.

REPRESENTATIVE O'DONNELL: Is Zocor the only one that is generic?

REPRESENTATIVE CHEN: I think right now. There may be another one coming. So that □□ you know, that's □□ so, again, I think you would save money by actuall paying people.

MS. CALLAGHAN: I would love to talk with you off line. I just have one other comment and then I'll finish.

CHAIRMAN MAIER: John had another comment.

MS. CALLAGHAN: Oh, I'm sorry.

REPRESENTATIVE ZENIE: That's okay. It actually kind of piggybacks on this. I was curious. Can you tell me what the criteria is as to how someone is placed on the PDL, and specifically relative to preferred versus non□preferred? I mean, obviously cost is one factor but is there other factors that □□

MS. CALLAGHAN: Yes, there are. That work is done by the PBM, generally and they have a therapeutics and pricing in therapeutics committee that they use which is comprised of pharmacists, doctors, and folks who are not their employees. And they meet quarterly and then establish new PDL drugs on an annual basis.

Now, the PBM's have either an open formulary, a middle□of□the□road formulary, or a very restricted formulary. So depending upon what drug you are talking about it could land someplace else in a different formulary. But it is done by those experts and my understanding is those experts are not employees of the PBM?

REPRESENTATIVE ZENIE: Okay. So it is not each PBM that is developing their own formulary?

MS. CALLAGHAN: Yes, it is.

REPRESENTATIVE ZENIE: It is?

MS. CALLAGHAN: Yes. Within the PBM it is.

REPRESENTATIVE ZENIE: I don't understand that. Why would it be so different between PBM's?

CHAIRMAN MAIER: Because that's how they are making their money.

MS. CALLAGHAN: That's how they make money.

REPRESENTATIVE ZENIE: That's what I'm trying to get at.
MS. CALLAGHAN: The chair knows. He knows.
ATTENDEE 73: It has to do with making money, not with (inaudible).
REPRESENTATIVE ZENIE: I understand. I guess what I'm trying to get at □□
CHAIRMAN MAIER: They are trying to set up some sort of □ it sounds like
they are trying to set up some sort of firewall between their clinical group and the money
making part.
MS. CALLAGHAN: Yes, yes.
CHAIRMAN MAIER: But □□ and I don't have any reason to doubt that there is
□□ you know, that it is most □□ at least mostly valid. I haven't heard any complaints
particularly about □□ the complaints we hear about formularies are more like from doctors and, you
know, they're considered a thousand of them.
MS. CALLAGHAN: Yes.
CHAIRMAN MAIER: You never know (inaudible). I don't know if you've seen Harry in his □
□ he has a little □□ he can show you. He has a little (inaudible). He can show you □□
I don't know how many different formularies are on it. His isn't strong enough to have
them all.
REPRESENTATIVE CHEN: No. I couldn't fit them.
CHAIRMAN MAIER: It isn't big enough.
MS. CALLAGHAN: I believe you.

CHAIRMAN MAIER: He needs to get a new one.
MS. CALLAGHAN: Yes.
CHAIRMAN MAIER: But that's the complaint more than I hear about that there are inappropriate drugs, preferred drug things going on.

MS. CALLAGHAN: Right.
CHAIRMAN MAIER: The state □□ the Medicaid PDL is, like Kathy just suggested, it is done □□ it's staff, or the appointees to the drug utilization board are
physicians and pharmacists and □□
MS. CALLAGHAN: They develop it.
CHAIRMAN MAIER: And they make the decisions on therapeutic, on value of a
particular drug. But they do □□ it is an odd collaboration of therapeutic science and costs.
REPRESENTATIVE ZENIE: Well, that's what I'm trying to find out. Is cost
the overriding or the driving factor, the leveraging factor in where things are placed?
ATTENDEE 74: I don't think it is.
CHAIRMAN MAIER: Well, I think □□ and maybe Harry can help with it. think there are □□ there are classes of drugs □□ you know, there are a number of drugs in
many classes that are either completely equivalent or largely equivalent in their therapeutic value. So I think you have to meet that standard first.
REPRESENTATIVE ZENIE: Okay.
CHAIRMAN MAIER: And then you move on to a class negotiation and □□
MS. CALLAGHAN: Yes.
REPRESENTATIVE ZENIE: Well, I'm glad to hear that anyway.
MS. CALLAGHAN: It starts with □□ my understanding is it starts with a therapeutic look, cost aside. Then when the decisions are made about the therapeutic then it goes
to cost and then something may be thrown out or □□
ATTENDEE 75: And (inaudible) then the drug can (inaudible).
CHAIRMAN MAIER: But what she was (inaudible) at in terms of open or closed,
or middle. The Medicaid formulary is an open one in the sense that yes, there is □□
you go through the process of they are preferred things. But if □□ but there is an out,

essentially. A doctor can write, fill out a form, make a phone call, go through a process that
for his prior authorization to prescribe something that is not in the formulary or on the
preferred list.
MS. CALLAGHAN: We have the same thing in our plan.
CHAIRMAN MAIER: Maybe Robin can help clarify on this and then a couple of
more questions.
MS. LUNGE: I would just add that when you are thinking about the therapeutic stuff, though, remember that when the FDA approves the drug they are approving it
against the placebo, not against the other drugs in the class. So until more of that testing
is done between two drugs in one class, you may not know which one is therapeutically
better in relation to the other drugs in the class.
CHAIRMAN MAIER: Right. Okay.
REPRESENTATIVE ZENIE: I just wanted to make sure that that comparison is
being done before (inaudible) talking about, you know, where it is going to be placed.
Because, you know, that's got to be □□ in my mind, it's got to be the number one criteria.
MS. CALLAGHAN: Yes. I agree with you. I just wanted to go back to the
Zocor and Lipitor if I could and talk about the joys of labor negotiations, if I may.

We knew that Zocor was going generic and we wanted to take Lipitor off our
formulary. And so we □□ it was the first year, after the first year of the formulary,
so we proposed doing that. And it just made every bit of sense.
The union went sky high. There is language in our labor agreement that
says that we will mutually meet and discuss. It doesn't say that they have an absolute say
but they can take us to the Labor Board for a unfair labor practice, which is what they
were threatening to do.

There are something like 1857 state employees taking Lipitor. So had this
been a drug that 18 people were taking, or 200, we could've gotten it done. But there
was such a horrendous snafu. They had Lipitor experts on the phone who, of course worked
for Pfizer and it went on.
ATTENDEE 76: Well, under your (inaudible) policy they would be required
to □□
ATTENDEE 77: No. See, that's the whole issue. This generic, it's smoke
screen, this generic stuff.
MS. CALLAGHAN: Yes.
ATTENDEE 78: And the fact that everyone uses generics, if there is two □□
the same drug but generic literally □□
ATTENDEE 79: Oh, I see. Because Zocor has a generic and (inaudible).
MS. CALLAGHAN: Zocor had its generic. Lipitor doesn't.
ATTENDEE 80: All right.
MS. CALLAGHAN: Exactly.
REPRESENTATIVE CHEN: I'm going to just add to my □□
MS. CALLAGHAN: You and I □□
REPRESENTATIVE CHEN: (Inaudible) spend a few minutes (inaudible).
MS. CALLAGHAN: You and I should meet in the hall because if you've got a
good idea I'm interested.
REPRESENTATIVE CHEN: You'll never know. It's unlikely you will ever know
whether one is much better than the other because they're never going to do that study.
No one is ever going to take that study.
MS. CALLAGHAN: No. And the only study that was offered up was the Lipitor
study that said: You will have muscular problems if you use anything else. So there we

were.
MS. LUNGE: You know what, though? If you have ideas on that then we should get that addressed to Medicaid because that saves a lot of money in Medicaid.
ATTENDEE 81: Well, I'll tell you, Consumer Reports does do their own evaluation on drugs. It's not as clinically sound, probably. I mean, they look at cost, but also at side effects and other things relative to blood pressure medications and so on.
MS. CALLAGHAN: Yes.
ATTENDEE 82: I have two questions. When □□ and I think you have apparently answered my first one.
When these people on the other side of the firewall who decide, you know, which things work, are doing their work, do they have access to all of the studies or only the studies that each pharmaceutical company makes public that favors their drugs?
MS. CALLAGHAN: Well, I don't know what studies there would be.
ATTENDEE 83: (Inaudible) share their problems.

MS. CALLAGHAN: Well, let me back up. Let me back up a bit. Let me back up a bit. Because they are independent individuals, it is my understanding that it is their duty to look at all the studies.
ATTENDEE 84: But can they get them, I guess is my question.
MS. CALLAGHAN: Well, from leading medical schools and other NIH and □ □
ATTENDEE 85: I think that the answer is no because □□
MS. CALLAGHAN: Why wouldn't they be able to?
CHAIRMAN MAIER: Most of them they get.
MS. CALLAGHAN: Yeah. I □□
ATTENDEE 86: There are ones that are done when they contract, for

instance, with the universities to do research and it comes out unfavorable and they put the gag order on it.
MS. CALLAGHAN: Well, I guess my answer would be that I think they can get what they can get.
ATTENDEE 87: They can get what they can get.
MS. CALLAGHAN: Right.
ATTENDEE 88: So they are basically working with the same information that anybody else could get, which isn't necessarily all the information. Okay.
And my second question is: Going back to v□ I think □□
ATTENDEE 89: I love the conclusions that are drawn.
ATTENDEE 90: I know.
ATTENDEE 91: Going back to □□ I think earlier in the session we were talking about some other aspect of health care and the State employees plan is going to be tracking cat. amount as it unfolds. And I think that was in the context of the, you know, the language that talks about health care professionals that opens it up to other providers.
But my question on this is that is □□ will the plans for State employees in terms of chronic illnesses track cat. amount when it starts in the fall with the no co □pays for visits related to the chronic illness and no co□pays for the medications needed, you know, for the diabetes and □□
MS. CALLAGHAN: We're working on it.
ATTENDEE 92: So you are. You're aiming to (inaudible).
MS. CALLAGHAN: It's our intent because we are required under □□ the way I read □□ the way I read the legislation. We've had some meetings on that and some discussions. It's our intent to fully comply unless we are □□
CHAIRMAN MAIER: It's not the cat. amount; it's the blueprint.

MS. CALLAGHAN: Yeah.
ATTENDEE 93: I'm sorry.
MS. CALLAGHAN: It's not cat. amount; it's the blueprint.
ATTENDEE 94: The blueprint.
MS. CALLAGHAN: Yeah, you're right. Yeah, I was thinking blueprint.
REPRESENTATIVE O'DONNELL: I may need help for this because I'm not sure I'm phrasing this right. But we heard testimony from the Attorney General's Office that they felt this language was needed because □ □
CHAIRMAN MAIER: Which language?
MS. CALLAGHAN: Which language?

REPRESENTATIVE O'DONNELL: The PBM language. Because the insurance companies may be big enough to negotiate for themselves but there were □□ there were entities within the state of Vermont that they felt needed that protection and state employees was one of the ones.
Do you feel you need the AG's protection or do you feel that you are doing a good enough job □□ obviously by our Medicaid, the difference in Medicaid prices. But do you feel that you're doing a good enough job negotiating that you don't need anybody else's protection?
MS. CALLAGHAN: Well, I think it would depend on what □□
REPRESENTATIVE O'DONNELL: Did I phrase that right?
MS. CALLAGHAN: □□ part of the bill you're referring to. If □□ yeah. I'm not sure how to answer that.
We hire experts in the field to do our negotiating for us and these are consulting firms that have ex□PBMer's working for them. These are the □□ I swear. I can't help

it. These are the only people who know where the peanut is.
ATTENDEE 95: And if you didn't have an "in" or didn't have the budget to do, to hire somebody to negotiate for you, would you feel you were at a disadvantage?
MS. CALLAGHAN: Yes, sure. Yeah.
ATTENDEE 96: So this is kind of a necessary part of dealing with PBM's, that you have to have an insider to □□
MS. CALLAGHAN: Yes, it is, sure. And we save much more money than we otherwise could because it requires people who know what the □□ well, you know the story (inaudible) people know. This all may change as we go forward.
CHAIRMAN MAIER: Well, we were, I think, sort of □□ the committee has been excited this morning and I think we've hit you with questions that we have more generally than you □□ you just happen to receive because you were the one sitting in this chair.
MS. CALLAGHAN: You know, that's happened to me in Senate Health and Welfare, too.
CHAIRMAN MAIER: I'm not sure Kathy is the expert on PBM's or other things but it interesting to hear what □□
REPRESENTATIVE O'DONNELL: I think she's done a very good job answering the questions. You know, how many private employers □□
MS. CALLAGHAN: Thank you.
ATTENDEE 97: (Inaudible) interesting (inaudible).
ATTENDEE 98: And hire a consultant (inaudible).
ATTENDEE 99: Well, another thing I like about the labor relations is what you have for (inaudible), too, for the employees, and how that works.
Well, that's shifted recently but, you know, that's a nice way to, I don't know, crowd control the prices on an individual. And that's, of course, a nice

erage way of doing it.
MS. CALLAGHAN: Yeah. It's always interesting when we go into bargaining.
Yes.
ATTENDEE 100: Tell me □□ I mean, do you have any idea roughly how much
money you spend on these consultants to negotiate with the PBM? I just (inaudible).
MS. CALLAGHAN: I want to say $60,000.
ATTENDEE 101: That's $60,000 in administrative costs just kind of tucked into the system?
MS. CALLAGHAN: Yeah, yeah.
REPRESENTATIVE O'DONNELL: But it saves a lot of money.
MS. CALLAGHAN: It saves a tremendous amount of money.

ATTENDEE 102: I understand that.
REPRESENTATIVE O'DONNELL: It's worth it.
ATTENDEE 103: Yeah, yeah. Millions.
MS. CALLAGHAN: I mean, under today □□ in today's □□ it pays for itself
many, many, many times over.
ATTENDEE 104: But just thinking about access, about, you know, if we can
afford $60,000 to negotiate □□ you know, to hire somebody to □□
MS. CALLAGHAN: Well, that's true.
ATTENDEE 105: I mean, you have to be pretty large entity.
MS. CALLAGHAN: That's true. But, you know, I don't think that there are
many employers in Vermont who use PBM's either. What they do is they will get their drug
coverage through CIGNA who negotiates with its PBM, and Blue Cross who negotiates with RECEP (
phonetic).

REPRESENTATIVE O'DONNELL: (Inaudible) self□employed (inaudible).
MS. CALLAGHAN: So, we're large enough to be able to command market share
and do our own deal. And, by the way, both CIGNA and Blue Cross bid for our drug plan and
they were both significantly higher than Express Scripts. So when you take Express
Scripts and add $60,000 you're still doing a whole lot better than we would get through a
commercial.
ATTENDEE 106: And Express Scripts is a significantly bigger company, I
would guess?
MS. CALLAGHAN: They cover 50 million lives.
ATTENDEE 107: As compared to the other ones?
MS. CALLAGHAN: I think the others are smaller.
ATTENDEE 108: (Inaudible) Vermont.
ATTENDEE 109: That's just Vermont.
ATTENDEE 110: It's just Vermont.
ATTENDEE 111: (Inaudible) CIGNA.
MS. CALLAGHAN: Well, they use a RESTAT who probably is bigger than that
but I don't think they are as big as □□ there are only two or three big ones in the
commercial marketplace. Caremark just merged with CVS, Express Scripts, and I think it is MedCo.
ATTENDEE 112: Yeah. That's what we're talking about.
MS. CALLAGHAN: Yeah.
ATTENDEE 113: So we will see who becomes WalMart in the long run.
CHAIRMAN MAIER: Any other questions?
ATTENDEE 114: Yeah, right after here.
CHAIRMAN MAIER: Topper. Here it comes, baby.
MS. CALLAGHAN: Save the best for last.

ATTENDEE 115: Representative Leriche talked to you about is there any part
of this bill that concerns you. And you talked specifically about joining forces with
the other identities, to purchase to get a lower price.
MS. CALLAGHAN: Uh□huh.
ATTENDEE 116: Now, in that discussion the words "may" were used and the
words "shall" was not used.
MS. CALLAGHAN: That's right.

ATTENDEE 117: Except that it is "may" and not "shall." My reading of it
is, it is "shall" not "may." Now, if I'm wrong, correct me.
MS. CALLAGHAN: Okay.
REPRESENTATIVE O'DONNELL: What page are you on, Topper?
ATTENDEE 118: I'm on page six and seven.
ATTENDEE 119: That's the one where it says (inaudible).
ATTENDEE 120: Shall is (inaudible).
ATTENDEE 121: That's the "may." This is □ yeah.
MS. CALLAGHAN: Yes.
ATTENDEE 122: Practicable is "may" with a good reason. Shall try.
MS. CALLAGHAN: Shall. You're correct. It says shall. And shall do it to
the extent practicable and consistent with the purpose of the chapter.
CHAIRMAN MAIER: It also says shall on a voluntary basis.
MS. CALLAGHAN: Yes. We are going out to bid next year.
CHAIRMAN MAIER: But if you look at the language □□
ATTENDEE 123: This is coming from the Senate, right?
ATTENDEE 124: Why would we expect any (inaudible).

ATTENDEE 125: (Inaudible) more of a choice of participation in there.
MS. CALLAGHAN: To the extent practicable.
CHAIRMAN MAIER: That was to the (inaudible). Well, we will talk about
that with (inaudible).
ATTENDEE 126: I wanted to bring it up because I think it needs to be clarified.
MS. CALLAGHAN: Well, I think, when I was in the Senate testifying about
this the □□ Ann Cummings said that the extent practicable means that there is recognition
that there may be barriers to doing this and that we may not end up in the best place after
we □□ if we were forced to do it. So that's the reason why.
ATTENDEE 127: (Inaudible) really saying you shall get together and figure
out if there's a way you can do it that is beneficial.
MS. CALLAGHAN: Yes. That's the shall.
ATTENDEE 128: And (inaudible) cost more money.
MS. CALLAGHAN: That's right. That's the way we see it.
ATTENDEE 129: Yes. I think that's perfect.
MS. CALLAGHAN: Yes.
ATTENDEE 130: And if that isn't what the language means to you, you should (inaudible).
ATTENDEE 131: Is that how you understand it?
MS. CALLAGHAN: Yes, that is. Okay. Thank you very much.
CHAIRMAN MAIER: Thank you. I'm going □□
CD 133/TRACK 2
CHAIRMAN MAIER: (Inaudible) now is □□ I'm just trying to figure out. What
I would like to do before the day is over is walk through the bill with Robin and

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identify which areas of the bill we are either more or less comfortable with, needing more or less work from our standpoint. I'm quite sure that that will (inaudible) quick page, but, yeah, I think we're going to get into some discussion about it. I'm not sure that we can do □□ we will even be able to do that in the hour that we have here before lunch.

So I'm just □□ I am planning to come back this afternoon. And we also have □□ is it Marina? Is that right?

ATTENDEE 132: Maria.

CHAIRMAN MAIER: Maria Burns. Is that the last name?

MS. MITIGUY□BURNS: Mitiguy.

ATTENDEE 133: Maria.

CHAIRMAN MAIER: And so would you like to just testify?

MS. MITIGUY□BURNS: If time allows, that will be great, yeah.

CHAIRMAN MAIER: Because we could easily take all the rest of the morning with Robin. Would you like to go now or are you here through the whole □□ why don't we have you go now □□

MS. MITIGUY□BURNS: Okay.

CHAIRMAN MAIER: □□ unless you would rather wait until later? I don't know what your schedule is.

MS. MITIGUY□BURNS: Oh, I'm pretty open, I think, now, and I can □□ whatever works for you folks.

CHAIRMAN MAIER: Is that □□ are you

MS. LUNGE: I'm free all day except □□

CHAIRMAN MAIER: □□ flexible?

MS. LUNGE: Of course.

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CHAIRMAN MAIER: Let's do it that way.

CD 133/TRACK 3

CHAIRMAN MAIER: Do we all have a copy of this?

MS. MITIGUY□BURNS: Everyone has one.

CHAIRMAN MAIER: Okay. Burlington Drug is the most □□ only drug wholesaler. Maybe you could spend a minute or two explaining what that means □□

MS. MITIGUY□BURNS: Sure.

CHAIRMAN MAIER: □□ to be a drug wholesaler.

MS. MITIGUY□BURNS: Yes.

CHAIRMAN MAIER: And maybe you will come to the point in this letter and I think your primary interest in what's before us is with this section of (inaudible) that's being referred to as unconscionable pricing exception.

MS. MITIGUY□BURNS: Yes. Chapter 5, I believe it is. Well, good morning. My name is Maria Mitiguy□Burns and I work for Burlington Drug Company. We're a wholesale distributor that services Maine, Vermont, New Hampshire, New York, Massachusetts, Connecticut. We've been in business for 116 years. We're a family□owned business. We have about 150 employees and roughly 500 dependents. And we are a full□line wholesaler. We are considered regional and we distribute in the area I expressed. And we do everything from pharmaceuticals to health and beauty aids, the whole gamut.

And specifically I think □□ well, also as an aside, we also provide, being the only in□state wholesaler, a service to the state of Vermont. We do things such as stock excessive amount of Tamaflu for in case there is a pandemic. So having an in□state wholesaler is also a plus for anything that happens and also for distribution. We wouldn't be around as long as we had if we weren't one of the finest in the business. So, that aside.

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So essentially what we take issue with is not that you are researching and trying to find better pricing and we don't support high prices of pharmaceuticals, nor have we ever carried the manufactures call on protecting or defending pricing of products.

The issue we have is that we don't have control over it. And I think this is probably number two or three times that this type of legislation has surfaced. And as it gets closer and closer and narrower and narrower, the laser beam seems to be on Burlington Drug and we have really no impact on how to help you effect better pricing.

We can't say to the manufacturer, you know: "You need to lower your prices. " We are the distributor. As I said, we do an excellent job at it and most of the drugs in the U.S., I'm sure you all know, are through distribution. Probably 90□ some□odd percent.

So what we have a problem with is the part □□

ATTENDEE 134: What does that mean? I'm sorry. If I could just (inaudible).

ATTENDEE 135: Through distribution.

MS. MITIGUY□BURNS: Sure. Through distributors such as ourselves. There are obviously the big three, maybe now four. Cardinal AmeriSource. You've probably heard of them. Okay. McKesson. Doctor Chen may have them, Representative Chen.

ATTENDEE 136: They are large wholesalers?

MS. MITIGUY□BURNS: They are large wholesalers, yeah. And so we are considered a regional one.

ATTENDEE 137: Do you do Kenny Drugs, CMS? Do you do those chains?

MS. MITIGUY□BURNS: We do do some Kenny products, yes. They are considered a small chain.

We do everything from retail, to hospitals, to clinics, to mail order.

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There is, as another aside, a in□state mail order firm CN Middlebury, Vermont Mail Order, as well, as Marble Works Pharmacy. They are co□owned. And that will be determine inaudible) a little bit on what the woman was talking about earlier. So there are in□state mail order firm seats that could help the state of Vermont on pricing as well, that are very competitive.

So essentially what is at issue is there hasn't been any success. And I think the Attorney General's Office feels there could be but there is not law that can allow controlling of interstate trade.

And this particular or similar bill was tried in Washington D.C. in µ

it was struck from the court. The judge, I believe, called it absurd that you cannot
control or regulate interstate trade. So I guess that's where it is at.
It is going to allow out□of□state distributors to sell into Vermont and
not be affected, which I think we personally find unconscionable because we're the only
ones affected. So I apologize if I get, you know, upset over this but it seems to me that
it is unfair to Burlington Drug.
So I would've been up here sooner to take other questions and to have some
more communication but things prevented that. So I just wanted to touch base today and
see if anyone had any questions.
Again, we feel we are really the only ones affected by the legislation and
all of the out□of□state wholesalers, some of which I mentioned, will be able to sell
into the state and not be affected or held to the same restriction that we are.
And the □□ what was I going to say? I guess I forgot. So, if anyone has
any questions I can answer.
REPRESENTATIVE O'DONNELL: I'm Patty O'Donnell. I actually talked to □□ I
don't know what relationship □□

MS. MITIGUY□BURNS: Michael.
REPRESENTATIVE O'DONNELL: □□ Michael is to you.
MS. MITIGUY□BURNS: My cousin, yes.
REPRESENTATIVE O'DONNELL: Okay. When I talked to him he said something
about this contract with the manufacturers.
MS. MITIGUY□BURNS: Uh□huh.
REPRESENTATIVE O'DONNELL: And they have a clause that they can break that
contract within thirty days □□
MS. MITIGUY□BURNS: Yes.
REPRESENTATIVE O'DONNELL: □□ and what that would do. If you could explain
that to the committee.
MS. MITIGUY□BURNS: Sure. We enter into a partnership contract where they
will □□ they can basically stop doing business with us at any point in time.
CHAIRMAN MAIER: Who is "they"?
MS. MITIGUY□BURNS: I'm sorry. Manufacturers.
CHAIRMAN MAIER: Of?
MS. MITIGUY□BURNS: That we purchase from.
CHAIRMAN MAIER: Pharmaceutical manufacturers?
MS. MITIGUY□BURNS: Pharmaceutical manufacturers. I'm sorry. So they can
be out at any given moment at any time. And I don't even know that it would take thirty
days. But I think that there is a thirty□day clause.
We have had two manufacturers phone us. I just don't think that they are
going to, you know, be hindered or hurt by selling to Burlington Drug and they would just be,
you know, "Sorry, we're going to sell to Cardinal in Massachusetts and they will ship

into Vermont." And they will get around the law that way.
So it □□ if that answers your question.
REPRESENTATIVE O'DONNELL: What I'm trying to get at is they wouldn't □□
the manufacturers wouldn't lose a speck of Vermont business, but Burlington Drug Company
would lose it all?
MS. MITIGUY□BURNS: Yeah. But then there's also the potential, I believe,
that they □□ Vermont is like one□tenth of one percent of the entire national pharmaceutical
business. So they've said before, you know, it's not like Vermont is going to deter
them in their bottom line or whatever they make for profit. If they have trouble they may
not sell into Vermont. They may say, "If we're going to get lawsuits or we're going to . .
." but I can't speak for them. I can't make assumptions. But yes.
CHAIRMAN MAIER: Harry and then Sarah.
REPRESENTATIVE CHEN: It sounds like (inaudible) that one. And Robin can
actually correct this. That this law in □□ is she correct when she says this law will only
affect that one transaction between Burlington Drugs and □□
MS. LUNGE: I don't know because it's a factual question. And I don't know
the supply distribution (inaudible) change in enough factual detail that I feel like I
could answer that question.
REPRESENTATIVE CHEN: Okay. Because obviously that's an important question.

MS. LUNGE: Yes. But, I mean unless □□ I think you would really need to
find out the factual situation in order for that question to be answered. And then with
commerce (inaudible) and talking to Sam Berg, who I think is our staff expert on it, they are
very factually specific. But it is hard for us to give you an answer because it's going to

be □□ you know, it is not the kind of legal area that is clear and easy to predict. So
I'm not going to give you anything other than a wishy□washy answer. That's my answer.
You know, I can't.
REPRESENTATIVE CHEN: And therefore you won't be able to give us a different answer when □□
MS. LUNGE: Well, I don't think there are likely to be other markets that
are analogous to this market. So in order to give you an answer I would need to find
another case somewhere that has an analogous market and say: Well, this case found in this
market which looks like it is the same X, Y, and Z. And I just □□ I don't know that it is
going to exist out there.
MS. MITIGUY□BURNS: I do have it. I do have a 2005 Washington D.C. case
that it was the same thirty percent, the same must□meet.
MS. LUNGE: I've read that case and actually I addressed some of the issues
of that case in rewriting the legislation. So that □□ I mean, that is rough □□ it is
the same subject matter but it is not the same market and it is not the same words. So it
is just a □□ it is a hard area to legally predict.
CHAIRMAN MAIER: Sarah?
REPRESENTATIVE COPELAND□HANZAS: The contracts that Patty was referring to
that you said are severable within thirty days notice.
MS. MITIGUY□BURNS: Yes.
REPRESENTATIVE COPELAND□HANZAS: Does that include prices? When you sign
that contract with the manufacturer does that set a price for a particular period of time
on a particular drug?
MS. MITIGUY□BURNS: No. They set the prices. We don't have any □□ we can't say, you know, if they go up or down. I don't even □□ to be honest with you, I don't

even think price is written in there. It is more: You will hold it at certain temperatures; you will pay within thirty days; you might get two percent; there might be a rebate on this item that, you know, you pass on this item to your customer; you know, drop shipments, things of that nature.

It's not: We're going to sell you at this price, you know, for Lipitor. It doesn't really □□ it's more of a distribution agreement. If you □□ you know: You will have temperature monitoring for this particular product in your warehouse; you will meet DEA guidelines. Things of that nature.

REPRESENTATIVE COPELAND□HANZAS: So there wouldn't be any reason for a manufacturer to even weigh in on this section of the bill since their contract with you has nothing to do with price, and this is about unconscionable pricing.

MS. MITIGUY□BURNS: Well, what they will do is they wouldn't sell to us if they had to if the state of Vermont complied with that piece of the bill.

REPRESENTATIVE COPELAND□HANZAS: Okay.

ATTENDEE 138: Sell it to somebody else in other states?

MS. MITIGUY□BURNS: Right.

REPRESENTATIVE O'DONNELL: And ship it in.

MS. MITIGUY□BURNS: And ship it in.

ATTENDEE 139: And ship it in.

ATTENDEE 140: So the way this is written, my □□ tell me if I'm correct. That this only governs the transaction between the pharmaceutical industry and the wholesaler? Or pharmaceutical industry and it is the sale from a pharmaceutical company to whoever buys it from them, whether □□ generally a wholesaler, or □□

MS. LUNGE: The □□

ATTENDEE 141: That's kind of what my question was.

MS. MITIGUY□BURNS: I mean, I sort of □□ I think, you know □□

MS. LUNGE: In the senate there was an amendment to add the term " manufacturer's price." And so the bill currently said □□

MS. MITIGUY□BURNS: Page 39 at line (inaudible).

MS. LUNGE: Once it gets to court the judge would look at the manufacturer's price of the drugs in Vermont being (inaudible) thirty percent more than these other three prices.

ATTENDEE 142: Okay. So the manufacturer's price is what the manufacturer charges to whatever the sale site is that they make their sale to.

MS. LUNDE: Right.

ATTENDEE 143: So a manufacturer of prescription drugs or its licensee, that would mean AmeriSource or Burlington Drugs, or □□

MS. LUNDE: I think licensed □□ my understanding of licensee would be if the manufacturer, for instance, gets a license for someone else to manufacture the drugs for a generic, for instance.

ATTENDEE 144: Okay.

MS. LUNDE: For generic drugs there's a bunch of different people who make them so □□

ATTENDEE 145: Okay.

MS. LUNDE: That's probably a bad example. But a licensee would be somebody whose license □□ who has a specific contact with a manufacturer to manufacture that drug under the manufacturer's patent.

CHAIRMAN MAIER: I'm sorry. I'm still not sure I'm clear. Does □□

MS. MITIGUY□BURNS: We are not a licensee.

CHAIRMAN MAIER: No, I am clear about that.

MS. MITIGUY□BURNS: Okay.

CHAIRMAN MAIER: But I'm not clear about whether in the case where a particular drug company decided to try to not go through Burlington Drug, go through some other wholesaler in Massachusetts or New York, or something, and then they ship it into Vermont, is there □□ is there any restriction that is written into the law here that would apply at the point of sale in Vermont or □□

MS. LUNGE: I think that the issue around that is whether or not a court would consider someone □□ that particular transaction as occurring in Vermont or in Massachusetts. That's the question that I can't answer. So, you know, that would be the subject of litigation and the court would decide whether or not they thought that transaction from the manufacturer or the wholesaler out of state to someone in Vermont where that would occur.

CHAIRMAN MAIER: That's the question that would be presented, could or would be presented to the court. And the way that it is written, would we □□ would it be written in such a way that we would □□

MS. LUNGE: Automatically □□

CHAIRMAN MAIER: □□ that we would be □□ that our law says that you can't do that, whether it is through Burlington, an in□state wholesaler or an out□of□ state wholesaler? Or is it written □□ not written that way?

MS. LUNGE: Well, we don't specify where the wholesaler is located. We say a manufacturer shall not sell in Vermont. So the question is: What does "sell in Vermont" mean? Could that include where the third (inaudible) the wholesaler, if there is a wholesaler in that transaction, is it selling in Vermont if you go from manufacturer to the

wholesaler out of state to Vermont where the final destination is Vermont?

ATTENDEE 146: How could that be considered? It is a separate transaction in Massachusetts. But then a Massachusetts distributor would turn around, a wholesaler, would turn around and sell in Vermont at a different price. I don't see how that could be considered in Vermont. But I'm not a lawyer, so, it is just □□

MS. LUNGE: I'm not a commerce lawyer.

ATTENDEE 147: No. For me it defies logic but then again these things aren't always based in □□

CHAIRMAN MAIER: Ms. Copeland□Hanzas snuck in there.

ATTENDEE 148: No. That's okay. My questions actually were □□ that's what I was trying to get clear on. This whole discussion, this is where I'm at. I guess what I'm trying to figure out is, I mean, it was □□ you drafted this more narrowly so that □□

MS. LUNGE: (Inaudible) specified where the transaction would take place. So that's one major difference.

ATTENDEE 149: And so that it wouldn't □□ so that in your mind it would be less likely to be a violation of the anti□trust?

MS. LUNGE: You mean commerce clause?

ATTENDEE 150: I mean commerce clause.

MS. LUNGE: The D.C. (inaudible) sued on it's □□ it's my understanding is it was sued on its face because it wasn't clear from just reading the bill that they were only looking at transactions in D.C. So that was one of the changes in the senate, was to make sure that when you read it, it was clear that you weren't meaning that you want to effect transactions to D.C., or New Hampshire, Maine, or □□

ATTENDEE 151: So we couldn't write this to protect Burlington Drug, for

example, from pharmaceutical companies trying to sell to them at an unconscionable [redacted]
[redacted]use as Maria is saying they could just sell to another distributor and get the Vermont market through another distributor and be able to get their unconscionable price from somebody else? I mean, is that the issue?

MS. LUNGE: I think that's the issue that □□

ATTENDEE 152: Yeah.

MS. LUNGE: I mean, I think □□ I don't know if you □□ no, really. I doesn't seem to me like you're asking me a legal question.

ATTENDEE 153: Yeah, I guess not.

MS. LUNGE: You're asking me a factual question that I don't know.

ATTENDEE 154: Okay. I am just trying to figure out if there is some way that the language, that we can craft the language so that Burlington Drug wouldn't be on the hook for something that's completely out of their control. If a pharmaceutical company wants to sell them drugs at an unconscionable price and they have □□ their choice of whether to purchase the drug and, you know, for their business or not purchase the drug, and lose the business to other distributors, I mean, I was just wondering if there □□ what we can do about that with this language.

MS. LUNGE: Well, I think, you know, I don't know what you can do because I think □□ you know, there is □□ if there are other sales into Vermont, too, you're going to have that same issue with anybody who is giving □□ who is in a contract with a manufacturer. So if the manufacturer is □□ I don't know who Fletcher Allen, for instance, where they get their drugs, if they get it from Burlington Drugs or if they get it directly from the manufacturer. You have □□ so if □□ you know, Burlington Drug is our only wholesaler but I don't know whether or not there are other entities in Vermont that are also in □□

you know, get their drugs directly from the manufacturer.

So it is not just Burlington. They might be the only wholesaler but there are other entities that are also impacted. So that is the other piece of what isn't really fleshed out in my mind, is in terms of our market, how our market compares to the national market, or other states. I don't know that actual information.

ATTENDEE 155: We need to allow our wholesalers to buy through other countries.

MS. MITIGUY□BURNS: Canada.

ATTENDEE 156: Yes.

MS. MITIGUY□BURNS: We've done that.

ATTENDEE 157: We could put that emergency provision in there.

MS. MITIGUY□BURNS: Just kind of touching what □□ is it Robin?

MS. LUNGE: Yes.

MS. MITIGUY□BURNS: □□ said. There are other people that buy direct from the state of Vermont but to be honest with you, it is small. So, I mean, there might be a Kenney's that has a warehouse in Vermont; there might be some other small purchasers that buy direct, so they will be affected. But I'll be honest with you, it might be only one or two percent of purchases. So it will affect others but I think the real question and I think, you know, in our studies and looking at other stuff that may not be exactly comparable as what you say because it's a different state, but it looks almost □□ it looks very similar □□ is the Washington case.

But the big issue, the $6 million question is that can you regulate interstate trade coming from, if you sell to Cardinal en masse and they ship into Vermont. And [redacted]e belief and the legal belief is that not. And I don't know that the Attorney [redacted]eneral's Office, to be frank with you, is being completely up front with that. And I feel that

Burlington Drug is being pushed and pawned in the middle based on something that really is not feasible.

And the other issue that came up is that perhaps we are being coerced or strong□armed by the manufacturers. I would point out that last year I sat in this committee and I was on the opposite spectrum of what the manufacturers wanted on a particular bill. So I don't think we've ever been □□ and that was the pedigree bill. So that has never been the issue.

As I said in the beginning, we don't carry their coal, but we also have no ability to sway them. So □□

CHAIRMAN MAIER: Sarah and then (inaudible).

REPRESENTATIVE COPELAND□HANZAS: So this section of the bill talks about serious public health threat. And you mentioned in your initial talk about the fact that you stockpile Tamaflu for the state of Vermont.

MS. MITIGUY□BURNS: Uh□huh.

REPRESENTATIVE COPELAND□HANZAS: Is that a contract that the state has that □□ or is that something that your customers asked you to keep a certain amount on hand?

MS. MITIGUY□BURNS: That is something that the state asked us to do. We do it for the state of Vermont, for the Department of Health.

ATTENDEE 158: Do you get paid for it?

MS. MITIGUY□BURNS: I think it is a nominal fee. I don't □□ to be honest again with you, I don't know the exact amount. But yes, there is a □□ yes.

REPRESENTATIVE COPELAND□HANZAS: So you stockpile that and you hold onto it and if nobody needs it at the end of the □ of its useful life, you □□

MS. MITIGUY□BURNS: Either destroy it. I doubt that the manufacturer in that particular instance would take it back. It has to be under refrigeration and it is, you know, not useful.

REPRESENTATIVE COPELAND□HANZAS: So you've been paid for that or you've taken a loss of that?

MS. MITIGUY□BURNS: I don't have their return policy in front of me. I'm sure we would get fully reimbursed on that particular situation.

CHAIRMAN MAIER: The state buys it and they are storing it at your place, or you've bought it □□

MS. MITIGUY□BURNS: We purchased it.

CHAIRMAN MAIER: □□ (inaudible) available?

MS. MITIGUY□BURNS: Yeah.

CHAIRMAN MAIER: Topper? I'm sorry. Do you have (inaudible).

ATTENDEE 159: I'm not quite □□ I'm not sure I understand that. You purchased it and nobody purchased it from you.

MS. MITIGUY□BURNS: Correct.

ATTENDEE 160: So you return it to the □□ or you destroy it and □□

MS. MITIGUY□BURNS: If it expires, will reimburse us.

ATTENDEE 161: □□ the manufacturer gives you your money back?

MS. MITIGUY□BURNS: Yes.

ATTENDEE 162: Okay. So in the case of a bird flu epidemic, if this were to kick in, what would be the loss to Burlington Drug? If you have a stockpile of this.

MS. MITIGUY□BURNS: In this particular instance what I was trying to point out was that we do provide a benefit to the state being in□state. In case there was an emergency or issue such as that, that has already been purchased. So I don't know, I mean, in

that particular case what the loss would be unless □□ unless the state of Vermont said, "
Now we're going to purchase it from you for thirty percent less," then we would be like, "
Well, we already bought it for . . ."
ATTENDEE 163: So you □□
MS. MITIGUY□BURNS: So we would lose if there was □□
ATTENDEE 164: You have it and you essentially bought it before the price (
inaudible) □□
MS. MITIGUY□BURNS: Months ago. Yeah, we keep it on hand.
ATTENDEE 165: □□ your price is set at that non□crisis price □□
MS. MITIGUY□BURNS: Right.
ATTENDEE 166: □□ then if □□

MS. MITIGUY□BURNS: We wouldn't go back to □□
ATTENDEE 167: □□ the United States gets into crisis mode you would already have the cheap stuff on hand. Right?
MS. MITIGUY□BURNS: The expensive stuff. We bought it at full price.
ATTENDEE 168: Right. No, but I □□
MS. MITIGUY□BURNS: If they said □□ the state said □□
ATTENDEE 169: □□ think it would get more expensive than that if we have an
epidemic.
MS. MITIGUY□BURNS: Yeah. But, I mean □□
ATTENDEE 170: I'm saying, if you had to buy more.
MS. MITIGUY□BURNS: Two issues, I think. Are you saying that if the state
said, "All right. Now sell it to us at thirty percent less," or are you just saying,
you know what I mean?

CHAIRMAN MAIER: She is saying the market is going to go up.
ATTENDEE 171: What I'm saying is the market is going to go up, you know,
the same way that heating fuel does in a very cold winter season. You know, the market is
going to go up because of demand. And so you are already going to be in a good
situation in Vermont because you have a stockpile of this that you can sell in a very tight
market.
MS. MITIGUY□BURNS: I don't think we would □□ no, because we wouldn't sell
it. We actually sell most of our product at cost□minus, believe it or not. So we
wouldn't say, "All right, state of Vermont, we're going to sell it to you for $4,000 more than
we paid for it." That would be unconscionable.
ATTENDEE 172: Well, I wasn't suggesting that you were going to turn the □□
MS. MITIGUY□BURNS: Right.
ATTENDEE 173: □□ that you were going to turn your prices up.
MS. MITIGUY□BURNS: Yeah.
ATTENDEE 174: I am just saying that compared to distributors outside of
Vermont, nobody would be able to tap into that market in a serious public health threat.
MS. MITIGUY□BURNS: Yeah.
ATTENDEE 175: You've got □□ you're holding the oil reserves so you're
doing a wonderful thing.
MS. MITIGUY□BURNS: Yeah. Okay. I see where you are □□ I was confused, I
guess.
ATTENDEE 176: You said something that I didn't understand and I guess I'll
come back to it unless I can □□
MS. MITIGUY□BURNS: Okay.
ATTENDEE 177: Robin, the very first paragraph on page thirty□nine, could

you just (inaudible) with that (inaudible)?
MS. LUNGE: The manufacturer or its licensee □□ and as we just talked
about a few minutes ago, the licensee would be someone with a license from the manufacturer
to make the drug; at least that's my understanding □□ shall not sell in Vermont □□ so
that's the connection to Vermont and that's where the interpretation of which transactions
means, sell in Vermont comes in □□ for an unconscionable price □□ and we get the definition
of unconscionable price □□
ATTENDEE 178: 30 percent above.

MS. LUNGE: Well, that's the prima facie case. So what that means is the
first look is thirty percent compared to the prices but then the manufacturers would have an
opportunity to come in with evidence to say: This drug is really expensive to invent,
or, you know, you can see those criteria on my thirty□five through the end of the page,
to come back to show that thirty percent isn't a reasonable price. So there's thirty
percent is the first target but there is an opportunity for the judge to consider whether or
not that is reasonable.
□□ of a prescription drug necessary to treat a serious public health
threat as provided for in the next section.
So none of this gets triggered without first the Commissioner of Health
declaration. So the process would have to go: Commissioner of Health looks at these factors,
looks at a particular condition or disease, looks at all these factors and first the
Commissioner of Health decides is there a serious public health threat and is there a need to kind
of trigger this law.
So presumably the Commissioner of Health would look at the price of the
drug and whether or not it is already affordable and so there's not really a need. The

first cut is the Commissioner deciding that there is a need to take a step based on a
serious public health threat.
ATTENDEE 179: That's the only thing, isn't it? Isn't that □□ isn't that
what this conscionable price section is about?
MS. LUNGE: Right. If the Commissioner decides this isn't really a serious
public health threat, or if the Commissioner decides: Well, this is a serious public
health threat but the drug is really cheap so it doesn't make sense to get anything else,
period, the end.
ATTENDEE 180: A $10 drug is selling for $13, for instance.
ATTENDEE 181: Yes. Right.
CHAIRMAN MAIER: Thank you. I have a question for Maria.
MS. MITIGUY□BURNS: Sure.
CHAIRMAN MAIER: And I don't know exactly how to ask it. But but I'm
wondering in your experience, you must have at least a gut sense, if not empirical sense, for
how often □□ not □□ you're not the expert in whether something is a serious health threat
or not. That's somebody else's thing. But how often does the price of a drug swing by
as much as 30 percent or more? Is that a rare occurrence, you know, from one week or one
month to the next sort of market driven or is it □□
MS. MITIGUY□BURNS: Thirty percent from the FSS schedule?
CHAIRMAN MAIER: Yes.
MS. MITIGUY□BURNS: Okay. You may be aware so stop me if I'm □□ there are
multi, multi prices on every drug, whether it is FSS □□ I don't know if you all are aware □□
or Veterans or Public Health Service, or Hospitals or Clinics, or retail, or what have
you. Retail pays about the highest. Mail order. So a manufacturer will have a
different price.

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You could have a drug that costs $1,000 and on the FSS it could be
9.
that's always been at issue. And we actually have to maintain that pricing
when we
sell to our customers. It's called a charge□back. And then we get reimbursed for
the
amount in between. We pay at full price.
So to answer your question, it's all over the board. There is a
multi□
price system in the country which □□ so yes, it could be many □□ you know, any
item,
especially if you are comparing it to the FSS because, as I said, that's about the
lowest,
Federal Supply Schedule.
ATTENDEE 182: Maria, what percent of your business is in Vermont, roughly?

MS. MITIGUY□BURNS: At this point in time □□ it varies, you know. It
depends □□ it's probably anywhere from 20 to 30 percent, yeah.
ATTENDEE 183: Thank you.
CD 134/TRACK 1
ATTENDEE 184: (Inaudible) disease is prevalent. We've already done
that
with diabetes, high blood pressure, obesity. So, you know, these are diseases
that the
Commissioner of Health has already □□ has already said, you know, are at dangerous
levels. So all
of the drugs for all of those diseases could be part of this, not just vaccines
that are
coming in for the pandemic flu.
MS. MITIGUY□BURNS: Right.
ATTENDEE 185: So you're talking probably the basis of their supply to
their customers.
MS. LUNGE: It's definitely broader than a pandemic flu. But I think
because the Commissioner is in Vermont and they are looking at conditions in
Vermont, I was
just trying □□ my point was only that I don't see how these drugs to New York, for
instance,

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percent of those drugs were purchased from Burlington Drug at whatever price abov

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would be affected, because that's not connected to the conditions in Vermont.
But
that was my only □□
ATTENDEE 186: Clarification. In that case then, in this example they
were
using of the drugs going into Burlington Drugs and going out to New York. If say

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or whatever was determined to be unconscionable, then who is on the □□ who is
actually
□□ who would the state be going after? The manufacturer or Burlington Drug, or
both?
MS. LUNGE: The manufacturer because it says the manufacturer shall
not
sell at (inaudible).
ATTENDEE 187: So it really wouldn't even affect Burlington Drug, then.
MS. MITIGUY□BURNS: No, it would.
MS. LUNGE: I think the issue is the effect on Burlington Drug's
supply.
MS. MITIGUY□BURNS: They wouldn't sell to us. They wouldn't want to
be
putting themselves in that situation.
ATTENDEE 188: Or they would say: We're only going to sell to you for
distribution in the other 60 to 70, 70 to 80 percent of your market you may not
distribute in
Vermont. Then how could they do that?
MS. MITIGUY□BURNS: No, they wouldn't sell to us at all. And that's
what I
was going to touch on is our □□ the percentage of our business may be 20 to 25
percent
in Vermont but they simply won't sell to us so we won't have supply. So even
though
we're only selling 20 percent of our business to Vermont we won't have supply to
even be in
business.
ATTENDEE 189: How do you know they won't?
MS. MITIGUY□BURNS: We've had two phone calls already.
ATTENDEE 190: Threats?

MS. MITIGUY□BURNS: No, not threats. We are trading partners and they want to know □□ they called about what is going on in Vermont. They are not threats at all. I've made that very clear already. They are not threats at all and I'm not defending a manufacturer, but that is part of the issue that we have in this letter that I think describes it very well.

We've always been very open and communicative with the state. We've come up many, many times over the years and we've informed on how the pricing works and all the multi levels. We've been more than willing to discuss and communicate. We are not threatened by manufacturers. It's simply that they wouldn't sell to us. So □□

ATTENDEE 191: It's Economics 101. They are not going to sell where they may end up with a lawsuit.

MS. MITIGUY□BURNS: Right.

ATTENDEE 192: Even with this (inaudible) are we on thin ice, Robin? Even with this □□ even if we pass this we would be on legal thin ice?

MS. LUNGE: It's not a legally□settled area. So, I mean, it □□

ATTENDEE 193: That's not what she means.

ATTENDEE 194: That's what I thought. That could clear the (inaudible).

ATTENDEE 195: You know, this reminds me (inaudible) talking about.

CHAIRMAN MAIER: She tried to blow as much □□

MS. LUNGE: If it was an easy answer I would give it to you.

CHAIRMAN MAIER: She tried to blow some cold air on it so the ice might be a little thicker. She doesn't know how much □□ how thick the ice is.

MS. LUNGE: Exactly.

ATTENDEE 196: It just reminds me of my days in Commerce when we were

discussing whether or not we were going to get rid of the usury laws for credit cards because they only applied to cards issued in Vermont. And anybody who wanted to could go get a card any place else and we had no jurisdiction. And it's not exactly the same thing but it just □□ you know, it brings back for me the frustration we had in dealing with banking issues around how little control we had because of interstate commerce. We just could never win those.

CHAIRMAN MAIER: John.

MR. ZENIE: Just a comment. This whole topic seems to reek of the same topic that you hear in public when we talk about price gas gouging and how do you protect against that. We're talking about drug price gouging and how do we protect against that. It's very similar.

MS. LUNGE: Yes.

MR. ZENIE: But the whole issue is very complex and it's not like you can say: No, you can't do that any more. It is □□ who are you pointing to.

CHAIRMAN MAIER: Scott and then (inaudible).

REPRESENTATIVE WHEELER: I don't know if I'm on the same vein as you but I think we're trying to tackle a nationwide issue on a statewide basis. And I'm sitting here and I'm thinking that we might just make things worse before we make it better. Well, not before. I think we're just going to make it worse because I'm sitting here and the one question that comes to my mind is I've been talking to □□ I'm already prescription □drug confused here now.

MS. MITIGUY□BURNS: There are drugs that will take care of that.

REPRESENTATIVE WHEELER: And, by the way, the □□

ATTENDEE 197: There are pharmaceutical labs that can help you with that.

REPRESENTATIVE WHEELER: My wife works in a pharmacy in the hospital. So

how did we get here? I can't even □□ I can't remember anymore how did we even get □□ why is this discussion going on? What happened □□

CHAIRMAN MAIER: (Inaudible) is a bill in front of us that has (inaudible).

REPRESENTATIVE WHEELER: All right. But where did the bill pop up out of and why? I'm just □□ being a history person I like to know history.

ATTENDEE 198: You don't have enough time, Scott.

REPRESENTATIVE WHEELER: Because I'm sitting here and I'm trying to □□ and I'm going back to my memory banks. Did I miss something? Did I not understand something? So how did we, in a minute or two thing, can somebody explain the need for this and how it all popped up? Did we have a crisis in the pharmaceuticals?

ATTENDEE 199: I was going to ask the same question.

ATTENDEE 200: Do we □□ money.

CHAIRMAN MAIER: I don't have an answer for that.

MS. LUNGE: And you haven't heard from the sponsors yet, so that's part of why you haven't, I think □□

ATTENDEE 201: I don't think this just popped up. This has been ongoing for years as the costs of health care have gone up and as the percentage of health care costs related to pharmaceuticals has gone up. And as that cost increases and at a huge rate.

CHAIRMAN MAIER: Was your question □□

REPRESENTATIVE WHEELER: I'm talking about on a state level □□ on a state □

ATTENDEE 202: He is wondering if there is some □□

ATTENDEE 203: A reaction to a □□

CHAIRMAN MAIER: Is your question specifically related to the section that we're talking about or are you talking about the whole bill?

REPRESENTATIVE WHEELER: Well, just about □□ well, this particular section.

CHAIRMAN MAIER: This is □□ you know, this is the first I've been through the conversation about unconscionable pricing. It's a relatively newer attempt on the (inaudible) you know, □□

MS. LUNGE: Well, yes and no because in S□288, which was a prescription drug bill, there was a prescription drug fair pricing board that actually looked at directly setting prices in a more aggressive way than what this section would do. So it is related in the sense that the state, for a number of years, has looked at different creative or legally unsettled ways to directly attack the prices of prescription drugs because it is a high cost area. And so in my mind, I sort of see it as starting in previously with this idea of having a pricing board. And it has kind of evolved over time where different states have done things and gotten sued to a more narrow approach. So that's kind of my historical knowledge, is that there have been other bills that have looked at the issue of drug pricing and tried to look at direct ways of addressing that. Not in this form but in a bigger □□

REPRESENTATIVE WHEELER: I guess my concern was just on a state level whether □□ whether it can be done on a state level versus a national level.

ATTENDEE 204: Well, some things can. I mean, the generic issue we've dealt with a lot on the state level but, you know, when □□

REPRESENTATIVE WHEELER: Generic drugs?

ATTENDEE 205: Yes. The □□

MR. WHEELER: I'm on the generic of Zocor and it cleaned out my arteries

just like that. And they (inaudible).

ATTENDEE 206: I mean, the issue □□ the problem that we continually face is that if there is a generic we can get people to use it, there's competition in that market and the prices are reasonable. When you're talking about name□brand drugs they are protected by patents, there is absolutely no competition, and they can get whatever the market will bear and it is □□ because it is such an increasing part of our health□care costs, you know, we're constantly trying to figure out: Well, okay, we've done the generic route but, you know, if you've got asthma, you've got other things, there's drugs that don't have generic equivalents and they cost a lot of money, and so what can we do. And so we're constantly scrambling to try to find other things we can do.

MR. WHEELER: Can we get George Bush in here to testify and we'll put that on a national level.

MS. LUNGE: Lauren will get right on it (inaudible).

REPRESENTATIVE O'DONNELL: All right. All right. Let's stop this conversation. (Inaudible) in the sandbox.

MR. WHEELER: So what would the governor's □□ I'm asking it quite serious. What is the □□

CHAIRMAN MAIER: You would go □□ you would get further in the governor's office than I would, Pat.

REPRESENTATIVE O'DONNELL: No, I don't think so. You've never seen how little I get up in the governor's office.

REPRESENTATIVE WHEELER: So what am I supposed to do with the governor, then?

CHAIRMAN MAIER: Maria?

MS. MITIGUY□BURNS: I was just going to make two points to what Scott said was we've often said in the past we thought it was a national issue. And that's not just to disregard the work trying to be done and the attention to the issue that needs to be drawn. But we've often said it really is a national issue.

And on the second □□ another aside on generics. What we've done, we're about the □□ I think we're the most competitive as a distributor for generics in the nation, even against Cardinal and Amerisource. And that's some of the way we compete. We've garnered the lowest prices because we've joined seventeen other wholesalers in the country. And that's one way we've tried to keep prices down and that's one way that we actually, you know, compete in our marketplace.

So there is □□ you're right. There is incredible ways to keep prices down, generics, and to force generics, which is one way to keep it.

CHAIRMAN MAIER: Harry?

REPRESENTATIVE CHEN: With legal uncertainties aside, certain □□ just ignore that second page. But the definition is the technical definition of unconscionable price. Do you have any comments on that since you know how the whole system works?

MS. MITIGUY□BURNS: The technical definition □□

REPRESENTATIVE CHEN: The definition in the bill.

MS. LUNGE: That's in our bill?

REPRESENTATIVE CHEN: You know, not □□ regardless of how we're going to use it, I was just wondering if you had any comment on that.

MS. MITIGUY□BURNS: Can you tell me exactly what section because □□

ATTENDEE 207: Page 39, right?

MS. MITIGUY□BURNS: 39? Because I don't think I have 39. I have up until 37.

CHAIRMAN MAIER: Prima facie case, that definition?

ATTENDEE 208: Yeah.

MS. MITIGUY□BURNS: Page 31?

REPRESENTATIVE CHEN: Is that the definition?

ATTENDEE 209: Section 15.

MS. MITIGUY□BURNS: I must have a □□ can I read yours.

ATTENDEE 210: It's on page □□

ATTENDEE 211: She's got it.

MS. MITIGUY□BURNS: I have a different □□ well, I think what you are asking me is do I think that that is unconscionable to have a 30 percent. Is that what you are saying?

REPRESENTATIVE CHEN: More than (inaudible).

MS. MITIGUY□BURNS: I mean, I guess where I'm coming from is whether I agree with it, whether Burlington Drug or not does, there's not anything we can do about it. I mean, as I said before, there's plenty of times when it can be 30 percent because FSS is the lowest.

REPRESENTATIVE CHEN: Right.

MS. MITIGUY□BURNS: So I'm not saying that □□

ATTENDEE 212: What does FSS mean?

MS. MITIGUY□BURNS: I'm sorry. Federal Supply Schedule.

ATTENDEE 213: So that's not the manufacturer's price or is it? I still haven't gotten that straight.

ATTENDEE 214: That's Federal Government (inaudible).

MS. MITIGUY□BURNS: That's what the (inaudible) negotiated.

MS. LUNGE: It's the manufacturer as compared to 30 percent more than (inaudible).

ATTENDEE 215: Oh, okay. All right.

MS. LUNGE: And the healthy □□ just for your information, the Healthy Vermonter's Price would be the Medicaid price. If that helps you frame that in the pricing scheme.

MS. MITIGUY□BURNS: Okay.

MS. LUNGE: And the most favored purchase price would be the best private market.

MS. MITIGUY□BURNS: So are you saying do I think it is unconscionable?

REPRESENTATIVE CHEN: Well, no. I mean, do □□ I was just wondering how many drugs would fit into this category?

MS. MITIGUY□BURNS: There could be □□ I don't know. I can't even really give you a percentage but, like I said before, there could be quite a few. The Federal Supply Schedule garners the lowest in the nation. You've □□ the bill has definitely chosen the lowest price here, I think, that's available, which is the FSS. So □□ and they contract for hundreds of items. I don't know if it's □□ I mean, I can't really give you a percentage. I could look into that.

REPRESENTATIVE CHEN: So it would be (inaudible)?

MS. MITIGUY□BURNS: It would what?

REPRESENTATIVE CHEN: (Inaudible).

MS. MITIGUY□BURNS: I can't really say.

REPRESENTATIVE CHEN: Okay.

MS. MITIGUY□BURNS: Honestly, I would hate to □□ I would hate to say

ATTENDEE 216: What we need to do is to get the Feds to treat this as a

regulated utility where they get guaranteed a profit that is a little bit above, you know, (inaudible).
REPRESENTATIVE O'DONNELL: And then let's have them work on health care when they're done.

ATTENDEE 217: They get a defined profit and that's it.
CHAIRMAN MAIER: Scott?
MR. WHEELER: When I hear about unconscionable pricing, the □□ is that also □□ because I know what the mark□up is in the hospital, which I find totally unconscionable. The mark□up is just extreme. My wife has gone over some of that with me and just said no. So what are we doing to address that unconscionable mark pricing because it can get there as low as you want.
ATTENDEE 218: But you're paying for □□ you're paying for all the security systems and procedures of everybody that handles that aspirin.
REPRESENTATIVE WHEELER: No.
ATTENDEE 219: (Inaudible) answer to □□
ATTENDEE 220: (Inaudible) the cost shift.
ATTENDEE 221: Well, yes, but the (inaudible)
ATTENDEE 222: And the cost shift.
ATTENDEE 223: Before you get to the cost shift the answer that you get is:
Well, it doesn't matter because the insurance company is just going to pay it.
ATTENDEE 224: Yeah, that's right.
ATTENDEE 225: Then you get to the cost shift.
ATTENDEE 226: Yeah. (Inaudible).
REPRESENTATIVE WHEELER: (Inaudible) has anything to do with the cost of

hospital care.
MS. MITIGUY□BURNS: The hospital pricing is one of the lowest when you're looking at the multi□tiered system.
ATTENDEES 227: (Inaudible).
REPRESENTATIVE WHEELER: For the drugs.
ATTENDEE 228: (Inaudible) the insurance company (static).
MS. MITIGUY□BURNS: Like we pay at full price and if we were to sell it to, say, Fletcher Allen, and we paid $100 for a drug and they get it for $19, we bill them $19 and then we bill the difference back to the manufacturer and get reimbursed like thirty days later. So it is □□ that's a whole other piece. We've been up here discussing that before, just people trying to understand the different price levels.
ATTENDEE 229: The hospital charges the hundred bucks (inaudible).
ATTENDEE 230: So you have money coming in and out and back and forth, and through all sorts of sources to you.
MS. MITIGUY□BURNS: We do wait. We do wait for □□ that's why we sell at such volume, to give you an idea. That's why we are □□ we've expanded a little bit over the year. We just expanded over into Connecticut and that's why it's in □□ that's why we do try □□
REPRESENTATIVE O'DONNELL: You have to do a lot of volume to keep your bottom line.
MS. MITIGUY□BURNS: Yes.
ATTENDEE 231: Lots of wheeling and dealing going on.
REPRESENTATIVE O'DONNELL: But any distributorship is different because it's the middleman. So they are always paying out, waiting for their money to come in. So a distributorship is a different □□

ATTENDEE 232: They are waiting for their money to come forward and backwards.
ATTENDEE 233: Right.
REPRESENTATIVE O'DONNELL: And so when a drug distributorship that's □□ who has more levels of pricing and craziness has got to be very (inaudible).
MS. MITIGUY□BURNS: We maintain a lot of contracts, you know, whether it is PHS, Public Health Service, or FSS, or, you know, Amerinet, or whatever the hospital contracts are, what have you. So you are right. Hospitals are one of the lowest in the price tier.
REPRESENTATIVE O'DONNELL: Highest charge and lowest paid.
MS. MITIGUY□BURNS: And I don't know that they pass it on. Some groups pass it on, like FSS. And PHS passes along because they are garnering it because they are health centers in rural areas, public health centers. So they are getting the price because they're in rural areas. So they usually pass it on.
REPRESENTATIVE O'DONNELL: That's another (inaudible) Topper. I'm just getting □□ I'm just getting you going. (Inaudible). It's lunch time.
ATTENDEE 234: That's not nice to do right before lunch.
REPRESENTATIVE O'DONNELL: And now I'm sitting here with my stomach growling. (Inaudible).
CHAIRMAN MAIER: What I would like to do is first thank you for (inaudible).

MS. MITIGUY□BURNS: Thank you very much. I appreciate it. I wasn't on today so v□
CHAIRMAN MAIER: (Inaudible) notice.

MS. MITIGUY□BURNS: Thanks a lot.
CHAIRMAN MAIER: (Inaudible) understand how this works.
MS. MITIGUY□BURNS: Feel free to call if you have any questions.
CHAIRMAN MAIER: So can we please come back at 1:00 and we will see we can put a couple of hours in on this before we head out for the weekend. And we'll sit down with Robin and we will try to figure out how we want to proceed with some of these sections and we will □□
CD 134/TRACK 2
CHAIRMAN MAIER: Let's see if we can't start to get our way through the bill as we talk about □□ the goal is not perfection today. Our goal is □□ in terms of words or whatever. Our goal is how are we □□ what are we thinking in a general way, what more information would we need about a section or if we don't like a section all together can we □□ are we □□ can we get rid of it. That's what I would like see how far we can get with that sort of a conversation today.
And then particularly with those things where we need more information, and that will give both Lauren and Robin something to work with going into next week.
MS. LUNGE: Cool.
CHAIRMAN MAIER: Okay.
MS. LUNGE: Okay.
CHAIRMAN MAIER: So if you can sort of give us a brief summary of each section again and then we can □□

MS. LUNGE: Sure. Section 1, which actually starts on page two, is the Pharmacy Best Practices and Cost Control Program in OVA. So this is the section that has the statewide PDL language that's being struck. That starts page two to three and then moves to the

Purchasing Pool concept. It also has the FQHP language in it and also strikes language about the counter detailing program which later in the bill is moved to the Department of Health.

CHAIRMAN MAIER: Okay. So this was the section that took out the language on the statewide PDL?

MS. LUNGE: Yes.

CHAIRMAN MAIER: We broke that up on the board. We were □□ we wanted to know why it didn't work. We had some testimony from OVA about why it didn't work.

MS. LUNGE: Uh□huh.

CHAIRMAN MAIER: And I guess maybe I suggest our general reaction is maybe sadness but in a little □□ to a sense □□ you know, in some sense. I mean, it would be great if it could work but I'm not sure I disagree with them that it's hard to make it work. Are there other □□ other talk about that part of it?

What OVA said seemed reasonably persuasive to me is all I was saying. But I □□

ATTENDEE 235: I agree. That sounds like it would be much too large a problem. I mean, if our goal is to get this bill out and then, you know, fairly soon, I would think, you know, within (inaudible).

ATTENDEE 236: Right. The (inaudible) is structural and (inaudible) permittable.

ATTENDEE 237: So what are you saying? Take this out?

CHAIRMAN MAIER: No, leave it in.

ATTENDEE 238: It's okay (inaudible) because it says impracticable.

CHAIRMAN MAIER: Because we can't □ yes, not practicable.

ATTENDEE 239: Okay. I agree with that.

MS. LUNGE: And OVA did have two suggested changes but both of them are in the senate version of the bill.

CHAIRMAN MAIER: Okay.

MS. LUNGE: So, I can clarify it. Maybe they just missed them, but (inaudible) was added □□ that was one suggestion □□ and then they suggested adding language about getting CMS approval, which I did add, although I didn't write it exactly the same way that they suggested. But it is in there so I think that was just an oversight.

CHAIRMAN MAIER: Okay. Can you tell me a little bit more about the □□ on page five now, the change to the FQHC section?

MS. LUNGE: Yes.

CHAIRMAN MAIER: On □□ and I'll just □□ I note from past experience that this committee feels much smarter □□ has historically felt much more positively about FQHC's than the Senate Health and Welfare Committee. So with that background I just have a little red flag that went up that suggested I want to understand whether this is □ □ is this, indeed, something that is taking something significant away from FQHC's or not? That's sort of where I'm probing here.

MS. LUNGE: Uh□huh. Well, I think that the language, the original language, the plan to encourage, was really sort of, I think, drafted with the concept that you would want more people to be moving and you think FQHC's regardless of income level, et cetera. And because of the senate's discomfort with, I think for some people it was FQHC's; with other people it was just having □□ encouraging people to move from a current doctor.

They modified that language so it would be more general information and not necessarily a plan to kind of think about how to move people there into those entities. So I think □□

ATTENDEE 240: is doing this again, (inaudible)?

MS. LUNGE: It's OVA.

ATTENDEE 241: OVA is doing (inaudible)?

MS. LUNGE: Yes. Yes. And I think what OVA had □□ OVA prefers to take it out, I thought. Take them out, themselves out, at which point I don't think that it makes sense to overdo it, but □□

REPRESENTATIVE O'DONNELL: A note here that says (inaudible) sees better prices, better prices.

ATTENDEE 242: New pricing and the (inaudible) financing plan.

ATTENDEE 243: (Inaudible) supplemental.

ATTENDEE 244: Because of the supplemental rebates so they didn't want to be telling their Medicaid patients (inaudible) pharmacy benefits when they could get them cheaper.

MS. LUNGE: Right.

ATTENDEE 245: It's cheaper to (inaudible) the Health Department, if anything. Because they (inaudible) the ones that do all the (inaudible) grants.

ATTENDEE 246: Can I say something?

CHAIRMAN MAIER: Uh□huh.

ATTENDEE 247: I know that one of the reasons one person has given me about concerns about FQHC's is that the physicians at FQHC's (inaudible) get slighter higher reimbursement rate than Medicaid pays primary care physicians in other settings. And there's a question of whether that is being fair to other physicians who take a lot of Medicaid patients and don't get paid as much. So that's one reason I know that there is some concern about the FQHC.

All this makes sense when we are talking about pharmaceuticals. Unless

we're going to try to get more doctors moving their practices under the auspices of FQHC's, why would you want to be encouraging people to leave their primary care physicians I mean, this is a question I have. ATTENDEE 248: Yes. That was a concern.

ATTENDEE 249: And I guess that □□ I mean, that's kind of what I heard in the rationale for doing this. But it just doesn't □□ in terms of the big picture of health care, unless our aim is to get all of those PCP's to move to the FQHC's where they have a 340□B drug pricing, then why would you be doing this? I mean, it seems a little disjointed. And I (inaudible).

ATTENDEE 250: A suggestion that I might have is, because who are the people we want to go to (inaudible). You know, that's my question.

ATTENDEE 251: Maybe people that don't have a choice.

ATTENDEE 252: People who don't have a choice, or don't have prescription drug insurance. Those are the people that really, in my mind, we should target (inaudible).

That might be a way to modify this.

MS. LUNGE: Although if people who don't have prescription drug insurance are below 300 percent of poverty they can get the Healthy Vermonter's card which gives you the Medicaid price which, if Joshua's figures are accurate, would be lower than the 340 □B price, at which point □□

ATTENDEE 253: I thought they had to cancel that program.

ATTENDEE 254: The Medicaid card program.

MS. LUNGE: No.

ATTENDEE 255: I was confused with that (inaudible).

MS. LUNGE: Yes, they □□ it was □□

ATTENDEE 256: I was confused with that testimony, too. They said □□

ATTENDEE 257: I thought they said □□
ATTENDEE 258: It sounded like more □□
ATTENDEE 259: □□ got taken to court and told they couldn't do that because they were leveraging better prices for people who □□
MS. LUNGE: Well, we were, but then Maine built on our experience and Maine passed a law which was upheld. And our changes were modeled on Maine. So (inaudible) I was going to touch base with them about that to try to understand exactly what the issue was, which part of it.
ATTENDEE 260: So we aren't doing it.
MS. LUNGE: We are doing it up to 300 percent of Federal poverty right now, and 400 for □□
ATTENDEE 261: There was a hassle factor with the waiver or something. Something to do with the waiver.
MS. LUNGE: And that was connected to the whole litigation back and forth between Maine and Vermont. When we □□ we changed it to require a waiver before the Maine litigation was finished because based on our court case it seemed like we needed a waiver. But then Maine was litigated and found favorably and they didn't need a waiver. So it's been kind of like court case language, court case language, court case language. So, it's a little confusing. But I will definitely touch base with them about that to try and clarify what that issue with Healthy Vermonters program exactly is.
But on FQHC's then □□ just back to that. I'm sorry. I sort of brought us on a tangent.
MR. WHEELER: Where did this come from?
MS. LUNGE: It was in □□ it's been around for a long time. It was in S□288, which was four years ago now, originally. And it was pre sort of the initiative that

you did in the last few years (inaudible) FQHC's. So it's an older concept.
ATTENDEE 262: I think at some point I would like to suggest something. If we are going to □□ I would like to keep something in but it would clearly have to be in the Health Department.
ATTENDEE 263: The Health Department and then focus it on □□
REPRESENTATIVE O'DONNELL: Just the way you said it like we really picked this (inaudible) but I want to keep something in because I'm having a hard time about it.
ATTENDEE 264: Something focuses it on other populations that would (inaudible) probably (inaudible).
ATTENDEE 265: Who is going to want to use it. Why do you want to □□
CHAIRMAN MAIER: Well, Paul had something that □□
ATTENDEE 266: Well, just a little information point behind Robin's most (inaudible) comment. It sounds like this language was around before the initiatives allowing the state to get the supplemental rebates.
MS. LUNGE: The Healthy Vermonter language or the FQHC language?
ATTENDEE 267: The FQHC language.
MS. LUNGE: No, I don't think so. We were getting supplemental □□ we've been getting supplemental rebates for a while.
ATTENDEE 268: Okay. It is certainly not □□ okay. I stand corrected.
CHAIRMAN MAIER: All right, Robin. Is that a little bit of (inaudible) □□

MS. LUNGE: Yes.
CHAIRMAN MAIER: □□ sort of general direction and maybe bring us back something that will look a little bit different (inaudible).
MS. LUNGE: Sure. And I just also wanted to mention that in Feb Division □

□ I'm sorry. We are not quite there yet. I have a technical correction that I need to make so I just wanted make you aware of that so you're not surprised when it shows up.
CHAIRMAN MAIER: And you've made note of all the OVA recommendations?
MS. LUNGE: Yes.
CHAIRMAN MAIER: So you will flag them for us when we come to them?
MS. LUNGE: Yes.
CHAIRMAN MAIER: As we get closer to the bill.
MS. LUNGE: Yes, I can do that. Okay. So the next section in this to discuss is six to seven. This is the language on the purchasing consortium. I mean, this is the language that you were discussing earlier with Kathy Callaghan about the shall be offered on a voluntary basis the mandatory participation by 2010 to the extent practicable. So I don't know if you □□ you probably don't want to get into the details necessarily of discussing that now but □□
CHAIRMAN MAIER: Well, let's □□ I mean, let's give it a couple of minutes and then we'll at least have whether the explanation that we received, how people feel about that. And I'll look at Topper first since he brought it up. Are you comfortable with the language the way it is now or do you think we need to work on it some more?
ATTENDEE 269: I guess I don't understand it. It is confusing to me when it says mandatory may. It is like this language in there that one (inaudible) the other. I just read it again trying to figure it out. So I guess I'm still (inaudible).
CHAIRMAN MAIER: What I heard Robin and Kathy say, and it's sort of □□ the way they are interpreting it is, it's sort of a □□ it's a mandate for them to □□
MS. LUNGE: It's a mandate for OVA to offer it.
CHAIRMAN MAIER: □□ for them to talk to each other and figure out whether it makes sense to do it. And then you could □□ we could try to ask Robin to draft

language that said that instead, you know, that directs them to □□ I don't know how it might be different but □□ or we can just accept her □□
MS. LUNGE: But □□
CHAIRMAN MAIER: It seems like a □□ it seems like a good thing to do if there is benefit to be had, but if □□
MS. LUNGE: The mandate is on OVA offering to be the person kind of administering the joint purchasing consortium. The voluntary basis is for the other people to 2008. So it tells OVA: You need to work on this joint purchasing consortium. It says to the state employees and Workers' Comp, et cetera, et cetera: This is voluntary for you until 2010. And then to the extent that it is doable, or practical, then you should do it; it is mandatory unless you have a really good reason not to.
ATTENDEE 270: And does mandatory mean everybody mean everybody?
MS. LUNGE: Mandatory for state or publically□funded purchasers, administered or subsidized purchasers. So not mandatory for private insurers.
ATTENDEE 271: But they can join if they want?
MS. LUNGE: They can join if they want.

ATTENDEE 272: And the Workers' Comp? Whose Workers' Comp? Everybody's Workers' Comp has to do this?
MS. LUNGE: I think □□ I guess my question is, is Workers' Comp □□ I don't know that much about Workers' Comp. Is it publically funded, administered or subsidized?
6305: Well, I think if it's □□ if it is the state Workers' Comp program it would be □□ in the (inaudible) cities and towns is a self□insured Workers' Comp program. And so I would imagine that they are outside of □□ that that would be an employer□ offered benefit, so it would be ERISA.

MS. LUNGE: Uh□huh.
ATTENDEE 273: But it is just it says Workers' Comp and it is not
ear to
me if it is saying that it is going to be Workers' Comp for state employees, or
Workers'
Comp for (inaudible).
MS. LUNGE: So that could (inaudible).
ATTENDEE 274: Yes. It says □□
ATTENDEE 275: Well, it could be cities and counties, too. It says
publically funded.
ATTENDEE 276: Any other state or publically□funded purchaser of
prescription drugs.
MS. LUNGE: So that's something that needs to be (inaudible) out, is
who.
It needs work.
ATTENDEE 277: So I guess what it is trying to say is for any Workers'
Comp
things in this list of things, that they have to □□ for the health insurance part
of it
(inaudible).
MS. LUNGE: For the drug purchasing part of it?
ATTENDEE 278: Yes. But I don't know if the League of Cities and
Towns,
it's □□ I don't know how that counts because it's all those employers who happen
to be
towns self□insuring together.
MS. LUNGE: I mean, I think you could decide, you know. I don't know.
I
mean, it is not something (inaudible).
ATTENDEE 279: I don't know if I have the ability to regulate that.
ATTENDEE 280: (Inaudible) Workers' Comp is not subject to ERISA.
ATTENDEE 281: No, it is not.
ATTENDEE 282: It's not. It is state regulated.

ATTENDEE 283: Oh, it's not?
ATTENDEE 284: Put them all in. It can't hurt.
ATTENDEE 285: Then everybody □□
ATTENDEE 286: And a further point of clarification. There is a state
mandated fee schedule and their pharmaceutical costs aren't covered under that
state mandated
fee schedule. At least it sets a ceiling for pharmaceuticals and other medical
procedures.
So they can cut a better deal but there is a cap as to what they are obligated
to pay.

ATTENDEE 287: So the insurance companies providing the Workers' Comp
coverage can do whatever they want. That's all they are going to get paid.
ATTENDEE 288: No. It's the pharmacies who have □□ basically
pharmacies
can only get a certain amount for the drugs. It is a □□ it uses a (inaudible)
price plus
a dispensing fee. The insurance companies can negotiate a lower fee but there is
a v□
ATTENDEE 289: But they have to use that formulary?

ATTENDEE 290: There is not a formulary but there is a ceiling on what
the
insurance company has to pay.
ATTENDEE 291: (Inaudible) make sense to keep them in here if they can
achieve some (inaudible) from purchasing (inaudible).
ATTENDEE 292: I don't see why not.
ATTENDEE 293: Didn't she say (Inaudible) same price as the Medicaid,
though?
ATTENDEE 294: I don't know.
ATTENDEE 295: She did but I don't know if she was including the (
naudible
).

ATTENDEE 296: I think we've had conflicting (inaudible).
REPRESENTATIVE O'DONNELL: Yes. Didn't she say she □□ they were to
get □□
the state employees, through their PBM, already get better pricing than Medicaid?
MS. LUNGE: They can't, legally anyway. Medicaid is supposed to have
the
best price in the state so □□
REPRESENTATIVE O'DONNELL: But she did say that.
MS. LUNGE: Well □□
ATTENDEE 297: She wrote it. She (inaudible) said it.
MS. LUNGE: Well, that would violate several Medicaid laws □□
ATTENDEE 298: That's what I thought. That's exactly what I thought.
MS. LUNGE: □□ because Medicaid is supposed to get the best price.
So it
□□
ATTENDEE 299: And she said that □□ I don't think she said that (
inaudible).

ATTENDEE 300: She sent it to Ann Rugg and she concurred.
ATTENDEE 301: She sent it to who?
ATTENDEE 302: Ann Rugg at OVA.
ATTENDEE 303: I think it must not have included the supplement.
MS. LUNGE: Well, I don't think the best price includes the
supplemental
rebate either under federal law, so □□ I'll double check that but I thought the
best price
was before the rebate. I'll ask (inaudible) probably knows off the top of his
head so I
can check with him (inaudible).
ATTENDEE 304: (Inaudible) remembers that stuff.
MS. LUNGE: Yeah.
ATTENDEE 305: He remembers everything in such fine detail.

MS. LUNGE: True.

CHAIRMAN MAIER: Okay.

MS. LUNGE: Okay. So the technical correction is on page seven, line

□21.

Before C□1 it should say "subdivision."
CHAIRMAN MAIER: I don't know about that.
MS. LUNGE: We can do it now or we will do it later, but we're going to do it.
ATTENDEE 306: Which one are you on?
MS. LUNGE: Technical correction, page seven, lines 20□21. So, in this section, in F□1 it talks about evidence based refers to the definition in Title 18, adds a couple of other criteria. And then there was discussion of □□ then there is □□ directing over the (inaudible) additional information from entities doing clinical comparisons.
ATTENDEE 307: Robin go back to the previous page. Did you want to □□ on page nineteen, at page seven, the reference is to the OVA director. Did we feel one that needed clarification of who that was?

MS. LUNGE: No. Because in that whole section director is defined as the director of OVA so you don't need to repeat it.
ATTENDEE 308: Okay. I had that note and (inaudible).
ATTENDEE 309: So you are on F□1 on page seven, did you say?
MS. LUNGE: F□6, I think, on page seven, nineteen □□

line nineteen. We define director □□
ATTENDEE 310: No, no.
MS. LUNGE: I'm sorry.

ATTENDEE 311: Before that question was asked were you talking about □□ you were talking about F□1?
MS. LUNGE: The subdivision addition?
ATTENDEE 312: Before you said that you said something about the evidence space.
MS. LUNGE: Yes, F□1.
ATTENDEE 313: Okay. Well I didn't □□ I wanted to say something before we moved on to something else.
MS. LUNGE: Okay.
ATTENDEE 314: And it's just that if this does what I think it does, this seems to me to be one of the most important pieces of this bill. Because □□
ATTENDEE 315: (Inaudible) chocolate?
ATTENDEE 316: Here, take the big one.
CHAIRMAN MAIER: Where did this come from?
ATTENDEE 317: (Inaudible)
MS. LUNGE: This came from me.
ATTENDEE 318: A little devil. The one in red.
ATTENDEE 319: My biggest concern in this whole □□ one of my biggest concerns in this whole thing is the misinformation that gets given to prescribers and the public about safety and efficacy of pharmaceuticals. And the studies that are published or the misleading comparisons that are done, is this going to address that?
MS. LUNGE: This addresses how OVA does the preferred drug list.
ATTENDEE 320: Yes, and they will be able to □□
MS. LUNGE: It doesn't address □□
ATTENDEE 321: □□ do your best to get back all that information in □□

MS. LUNGE: Not □□ information that's not public, you mean? Is this related to your □□
ATTENDEE 322: The studies. Is there something we need to add to this bill to get at the studies that have □□ that are gagged by the □□
MS. LUNGE: I don't think we can do that.
ATTENDEE 323: We can't? I thought the Attorney General's Office said we could.
MS. LUNGE: If they □□ if two parties have a contract saying that one party won't talk about something, I'm not sure how we can countermand that unless it's in Vermont.
REPRESENTATIVE O'DONNELL: It's not my state. It's not our state.
ATTENDEE 324: But it's illegal (inaudible) contract.

CHAIRMAN MAIER: They said that we could do it potentially. I'm not sure if (inaudible).
MS. LUNGE: Okay. I didn't hear that testimony.
CHAIRMAN MAIER: Having a clinical study registered.
MS. LUNGE: Oh. All right. This isn't □□
CHAIRMAN MAIER: This doesn't address that?
MS. LUNGE: Doesn't address a clinical trial's registry. We did have a clinical trials bill, I thought.
ATTENDEE 325: Cancer.
MS. LUNGE: Was it for cancer? (Inaudible) handled that so I don't recall the details.
CHAIRMAN MAIER: (Inaudible) somebody else doing clinical trials?

MS. LUNGE: Yeah, Maine. Maine has those. Yes, that legislation isn't in this bill.
ATTENDEE 326: Oh, it's up on the board. Clinical trial registry.
CHAIRMAN MAIER: Is that something you want to come back to?
ATTENDEE 327: Yeah, absolutely.
CHAIRMAN MAIER: Or we could just find the main bill and (inaudible) easy to (inaudible).
ATTENDEE 328: I think the more light we shine on what is going on in this industry the safer and more effective drugs people will have. And that's what my goal is. (Inaudible) safe (inaudible).
CHAIRMAN MAIER: Are you okay with moving on to the next question?
ATTENDEE 329: Yes.
CHAIRMAN MAIER: On this section two. Is that where we are at.
MS. LUNGE: Yes.
CHAIRMAN MAIER: So you've stricken this Oregon language?
MS. LUNGE: Yes.
CHAIRMAN MAIER: Regardless of whether or not that language is in there, do we □□ what do we mean when we say shall seek assistance from? Does that mean we are going to □□ we're going to □□ what does that mean? How does the Oregon health thing work? Does it □□ do you pay something to become a member of it?
MS. LUNGE: There are □□ it has two different stages. You can pay to become a member of it, which allows you to get earlier access to the research and information, or if you don't □□ you can still get access to the information without paying. It's just there is a time lag. And I don't know how long a lag but there is testimony in the senate that it □□ I think the Department of Health looked into it and there was something

like a $300,000 cost for a three□year period to join and participate in the
arch at an
arlier stage before it was public but that wasn't funded. So I think in this instance it
would be seeking assistance that we could get for free because we didn't fund them paying to
join anything.
CHAIRMAN MAIER: Okay. Well □□
MS. LUNGE: So they can get the information from Oregon for free.
CHAIRMAN MAIER: I would be, I guess, at a different point in time might be
interested in understanding what the difference is between a member and a non□ member
and what the time is and, I mean, I'm not prepared to add $300,000 to this bill. But □□
MS. LUNGE: Well, I wonder, maybe □□

CHAIRMAN MAIER: But maybe □□
MS. LUNGE: I was going to say maybe Lauren can contact somebody from there
and they could give us a call and just give you some brief confirmation about it.
CHAIRMAN MAIER: Or it came up at a web site or something. I mean, I am
not going to do anything with the information now.
MS. LUNGE: Okay.
CHAIRMAN MAIER: So I would □□ let's focus on other things. But I just □□
at some point over the summer or next year or something I would like to understand what
the □□ maybe it's just □□
MS. LUNGE: Well, I can let □□
CHAIRMAN MAIER: Ask for them to report in to us about how well it's gone
over the □□ what they've been able to get for free.
MS. LUNGE: Yes.
CHAIRMAN MAIER: And I think we want the information but at this stage of

the game on this bill, in this session, (inaudible) $300,000 to ask for it. So I would
need to have been asking for that with justification much earlier in the process.
ATTENDEE 330: Are you picking a number out of the air?
CHAIRMAN MAIER: No. That's what she said.
ATTENDEE 331: Oh, that's (inaudible). Okay. I didn't hear that.
MS. LUNGE: No, no. The Department of Health came in with that. I think
that was the figure they came in. That's off the top of my head. I can double check my
notes.
ATTENDEE 332: Okay.
CHAIRMAN MAIER: Allen?
ATTENDEE 333: Steve, I used to work for the guy who is involved in this.
He was the Chief of Staff for former Governor Kissoffer (phonetic) who is now □□ was an
M.D. and is now associated with this. And I called him about a year ago and he basically
said the contribution was to help support the program, but everything they had was on the
web site.
CHAIRMAN MAIER: Everything they had what?
ATTENDEE 334: Everything they have is on their web site.
MS. LUNGE: Right. But don't □□ Department of Health got information
saying that you got something extra when you signed up. They made □□ their testimony was
that you've got earlier access to the information. So □□
CHAIRMAN MAIER: (Inaudible) access before it is supposed to go on the web
site?
MS. LUNGE: Right.
CHAIRMAN MAIER: Okay.
ATTENDEE 335: Steve, let me ask a question before we go. Did we agree

that on this statewide preferred drug list, did we actually agree that that was something
that we were going to pursue?
CHAIRMAN MAIER: No. We agreed to leave it the way it was in the bill
which was they were striking the language that had not been implemented for several years
now that called for OVA to try to set up a statewide PDL.
ATTENDEE 336: That's what I thought.

CHAIRMAN MAIER: And so the bill, as it came over from the Senate, had
stricken that language out of the statute. And we just said we wanted to take some testimony
on why OVA wanted to take it out, why it wasn't working for them. And I think the
committee has sounded persuasive enough not to want to change what the Senate did which was to
remove that language.
ATTENDEE 337: Okay. That's what I thought, just exactly what you said.
But maybe I'm confused on this bill that we have. Does not line 25 □□
CHAIRMAN MAIER: What page are you on?
ATTENDEE 338: On page seven. And then you go over to the next page.
Whereby technical (inaudible) for the (inaudible) development (inaudible) and evidence based
education program establishes (inaudible).
MS. LUNGE: The preferred drug list referenced there is the OVA preferred
drug list or the Medicaid preferred drug list.
ATTENDEE 339: This is a new section.
MS. LUNGE: So earlier in that section we modified the statewide PDL language to be just an OVA Medicaid PDL.
ATTENDEE 340: That answers my question. Thank you.
MS. LUNGE: You're welcome. Okay. Three, section three is the

pharmaceutical marketer disclosures. This is current law that the AG's office will get information
on marketing that's done in Vermont by pharmaceutical companies. And this adds language
that would allow the AG to share the information with the Department of Health and the
Office of Vermont Health Access. And both of those entities would keep the information
confidential which actually means that there is a technical correction on line twelve. We should
add OVA as well as Department of Health there.
CHAIRMAN MAIER: Okay. Are we □□ what are we □□ any comments or questions
about this section, concerns, praise?
ATTENDEE 341: All set.
ATTENDEE 342: Does this sequence stuff, by the Attorney General, does that
(inaudible) anything back here on the Attorney General could do certain things. Maybe
it was the price (inaudible). Wasn't that what it was?
CHAIRMAN MAIER: Yeah.
ATTENDEE 343: Serious public health. That had to do with that unconscionable (inaudible).
MS. LUNGE: The information referred to in Section Three is the marketing
disclosure. So it doesn't have to do with the pricing of drugs. It has to do with how much drug
companies are spending on marketing in the state. So they would disclose gifts to
doctors, you know, basically the kinds of things that the detailers would bring to the office.
If they are bringing □□ if it's under $25 they don't have to disclose it, but gifts
over $25 they would disclose. But □□
ATTENDEE 344: It's like what we have for anything over $5 for us.
MS. LUNGE: Right.
ATTENDEE 345: Why different standard.
ATTENDEE 346: It's just (inaudible) Department of Health.

MS. LUNGE: So did that answer your question, Topper?
ATTENDEE 347: Thanks.

MS. LUNGE: Yes. And then four is the same issue, the marketing disclosures. And it adds □□ these are a list of exemptions. So currently unrestricted grants for continuing medical education does not have to be disclosed. By striking that we would have it be disclosed. And then there is some provisions in (D) about exactly what had to be disclosed.
Okay. Page 10. Price disclosure and certification. This is the section that has the manufacturer's prescription drugs for disclosing to OVA, the prices of the drugs that OVA buys, and there are three prices set up in the statutes: Average manufacture's price, best price, and the price that a wholesaler in the state pays the manufacturer to purchase the drug to give OVA pricing points.
It also requires that a summary of the methodology for the price be disclosed and that the information doesn't have to be disclosed until after it has been disclosed to the feds.
Then in (D) there is a requirement that the president, CEO, or designated employee certify the reported prices. Again, all this information is confidential and OVA keeps it confidential and the AG can enforce the provision and (inaudible) the consumer product.
ATTENDEE 348 : What's the penalty for falsification of that report?
MS. LUNGE: You asked that before and I don't know yet. I □□ because that would be □□ there's no special penalty put into this section of statutes so that would be whatever □□ if that's already a crime it would continue to be a crime.
ATTENDEE 349: Okay.

MS. LUNGE: But I don't know. I meant to actually ask the judiciary folks about that but I don't □□ without (inaudible).
ATTENDEE 350: But it's covered somewhere.
MS. LUNGE: I don't know if it is covered because I don't know what our crime □□ if that's a crime in Vermont or not. So I'll try to find out but it's not my area of expertise.
ATTENDEE 351: Thank you.
MS. LUNGE: Certainly it sounded like it is in Maine from what Sharon Treat said this morning about the main AG liking that provision.
CHAIRMAN MAIER: Harry?
REPRESENTATIVE CHEN: We heard something about trying to put in some flexibility.
MS. LUNGE: Yes.
REPRESENTATIVE CHEN: You heard that?
MS. LUNGE: Yes. I heard Sharon's testimony that it would be good to put in some flexibility in case the federal law □□
REPRESENTATIVE CHEN: Changes in terms of the nomenclature (inaudible).
MS. LUNGE: So I can work on that.
REPRESENTATIVE CHEN: Okay.
Attendee 352: Boy, (inaudible) in that. Must've been doing something else.
CHAIRMAN MAIER: Okay. Any other questions or comments on this section?
ATTENDEE 353: I guess I don't understand what □□ were you just talking about (F) when you said you weren't sure if it was illegal or □□
MS. LUNGE: No. I was talking about (D).

ATTENDEE 354: Okay. But so □□
MS. LUNGE: (F) says that the AG can enforce it under the consumer product.
ATTENDEE 355: Which is civil.
MS. LUNGE: Which is a civil.
ATTENDEE 356: Okay.

MS. LUNGE: And my interpretation of the question was is it a criminal matter if you falsely report something. And it might be. I don't know. I just don't know.
ATTENDEE 357: Robin, I'm sorry for yelling out to you. That's okay. I don't always see you.
Is there anything that we have to worry about legally about this section?
MS. LUNGE: Patty had asked that question and I was also going to double check on that because it was my impression that Maine this up and running for sometime, which is what it sounded like.
ATTENDEE 358: If I sit here and do this you will see this thing gone. (Inaudible)
ATTENDEE 359: There we go.
CHAIRMAN MAIER: Oh, yeah. That was better.
ATTENDEE 360: It's winding up. Watch out. Just a little more chocolate and we'll see where we can go.
MS. LUNGE: I don't think this question has been challenged in Maine but I'm just going to double check that.
ATTENDEE 361: Okay.
MS. LUNGE: Because it is a certification of in□state prices to the in □ state entity, so I don't □□ I don't think there is like a (inaudible) problem with it but

I'm going to double check that as part of my to□do list.
ATTENDEE 362: Topper, don't go making eyes because that mirror is right in front of me.
CHAIRMAN MAIER: All right. Sorry.
MS. LUNGE: That's okay. Healthy Vermonters, I'm going to double check with OVA on their comments to try and sort that out as to whether or not they thought there were problems or what exactly is going on there.
The main intent behind this section was to expand this program from 300 to 350 percent of FPL for □□
CHAIRMAN MAIER: And to simply (inaudible).
MS. LUNGE: And to simplify current law in terms of taking out an additional eligibility category. So if it does other things than that I just need to understand them with OVA.
The next section is the PBM regulation section. And this establishes the □□ this is the part which said unless the contract provides otherwise the PBM would provide the following six things.
The first is a duty of care; second is disclosure of financial and utilization information; the third is notice of any conflicts of interest; the fourth is specific information to the health insurer about drug substitutions; the fifth is whether or not the PBM gets the sales volume, the volume of sales discount, and whether or not that is passed through to the insurer; and then six is disclosure as financial terms and arrangements between the PBM and the drug manufacturer.
ATTENDEE 363: What page are you on?
CHAIRMAN MAIER: Page eighteen.
ATTENDEE 364: Number (inaudible) on page □□ yes.

MS. LUNGE: And you've heard lots of testimony on this section, mostly think in terms of in or out more than specific language (inaudible), I think.

ATTENDEE 365: And all these, the unless contract provides applies to all of them?

MS. LUNGE: Yes. Because it is in subdivision (A) on line □□ page sixteen, line twenty□one. It's a number (inaudible).

ATTENDEE 366: And this is so □□ Sharon Treat this morning said □□ it's kind of like she felt pretty strongly that he should not be (inaudible) the duty of care (inaudible) of that.

CHAIRMAN MAIER: And the standard again is of an insurance agent and a customer?

MS. LUNGE: Yes.

CHAIRMAN MAIER: And what is the fiduciary? What is the example of a fiduciary standard?

MS. LUNGE: It is a higher standard □□ I'm trying to think of a good example.

CHAIRMAN MAIER: Is it like a bank?

MS. LUNGE: Yeah, like a bank. That's a good example. A bank is a fiduciary for your money so it means that they have a high level of responsibility, sort of, in terms of their dealings with you.

ATTENDEE 367: Mr. Chairman (inaudible) with Express Scripts. Usually a fiduciary duty applies in a situation where somebody has given somebody else some money.

For instance, like the State Employees Retirement Board. They have a fiduciary duty to manage the assets for the benefit of the members so they should make prudent

investment decisions and things like that. And we would argue that fiduciary duty really isn't applicable to the relationship, or shouldn't be applicable to the relationship between a PBM and one of its customers because that's a different type of transaction. That's a transaction for services, or a middle man (inaudible).

CHAIRMAN MAIER: And can you distinguish for us then, this was considered to be a step less fiduciary, or something. A lower standard.

MS. LUNGE: Yes. Then this is considered to be a lower standard than a fiduciary (inaudible).

CHAIRMAN MAIER: What is a regular contract? Whatever is there.

MS. LUNGE: I don't remember the magic words but it is basically to □□ you would assume both parties are knowing and have their own interest at heart. So it's a lesser standard than this. So there's no duty owed from one contracting party to the other. You assume two willing parties going at it to come to the best terms that they can come to.

ATTENDEE 368: From their own interest?

MS. LUNGE: From their own interest, yes.

CHAIRMAN MAIER: John and □□

MR. ZENIE: Correct me if I'm mistaken. I interpret this (inaudible) materials more like you promise to do, have good behavior.

MS. LUNGE: Uh□huh.

MR. ZENIE: And what Sharon was saying, we should make it a little bit stronger and have maybe some financial motivation for good behavior. Is that what she was saying?

MS. LUNGE: I didn't hear all of her testimony this morning, unfortunately, because I had to come in and out.

MR. ZENIE: Okay. Well, I just wrote down, you know, waiving a duty of due care that's bad, and that there should be fiduciary language to require the behavior. That was my notes.

CHAIRMAN MAIER: And that really comes out to this, the (A), which is the unless the contract provides.

MS. LUNGE: Yeah.

CHAIRMAN MAIER: I mean, that's something that we need to have a discussion about.

ATTENDEE 369: And basically everything after this is moot. They don't have to have to put it in our contract.

ATTENDEE 370: Right.

MS. LUNGE: And one thing that Paul remind me of is that ERISA also has a fiduciary duty.

ATTENDEE 371: So the whole linchpin of the ERISA framework which deals with all employee□offered benefit plans is the employer is the fiduciary to the employee. And, you know, it's a different kind of model but that's the real core.

CHAIRMAN MAIER: How does that play out in the context of a health insurance plan?

ATTENDEE 372: Well, the employer in an ERISA situation, in all employer□ sponsored health benefits, including health insurance, the employer is contracting with the insurance company. Most of your work deals with the regulation of the insurance company but the employer, under federal law, is never relieved of his or her fiduciary responsibility to the employees. And if there were □□ if a grievance was brought under ERISA th employer would be subject to that fiduciary standard.

ATTENDEE 373: Just humor me for a minute. So is the leap that I would make there correct that under ERISA then the contributions that my employer make on my behalf for health insurance coverage would be considered my money in essence? Do you see where I'm going with that?

ATTENDEE 374: And this is why I brought it up (inaudible)

ATTENDEE 375: What is the fiduciary, where does it come from?

ATTENDEE 376: Well, it's basically that the employer is making decisions in the best interest of the employee. So that the monetary exchange may be coming up in some instances, but not in all instances. And I think the core concept of fiduciary responsibility, as Robin articulated, that you're acting in the best interest of the other party.

ATTENDEE 377: So the difference here would be if it's the fiduciary responsibility then the PBM would be required to act in the best interest of the employer or health plan whereas this standard would be that they act in their own best interest. Did I get that right?

MS. LUNGE: Well, under this standard they would □□

ATTENDEE 378: They've made agreements.

MS. LUNGE: They would still have a higher, a slightly higher duty than in a contract situation where they were only acting in their best interest. With this standard it is higher than that. They would have to □□ I think that it could be interpreted that they would have to disclose enough information that something wouldn't be misleading, for example. That they □□ it's not entirely relying that the other side completely has all the information they might need.

So it's □□ it's not □□ I would say it's a little bit higher than what you described. So it's not entirely their own self□interest. They have to sort of judge if how

they're acting, is that also going to meet the reasonable care and diligence and be fair and truthful under the circumstances.

ATTENDEE 379: So if this were a fiduciary standard how much farther beyond that □□

MS. LUNGE: Well, you know, it's □□

ATTENDEE 380: □□ would you go?

MS. LUNGE: Well, it's not sort of a linear measure so it's □□ I mean, I think as Paul said □□

ATTENDEE 381: Yeah. I was trying to (inaudible).

MS. LUNGE: I know. It's hard to kind of □□

ATTENDEE 382: I understand it under that circumstances because, you know, we've all read about the employers that took □□ the occasional employer that took □□ big companies that took employee money that was paid in and matched by the employer, whatever person, for health insurance benefits and used it for some other purpose so people were left without insurance.

MS. LUNGE: Uh□huh.

ATTENDEE 383: So I understand through this example. But I'm just trying to put this in the perspective of what we've heard in terms of these are sophisticated entities and then, you know, the head of the State Employee Benefits Plans was here today saying that, you know, they rely on the people they contract with to get the best deal and they really don't know that much about how all of this stuff works. And I think once the program is set up do they keep the consultants, or are they on their own? And a large employer would be in the same position, I would think. So I don't know. I'm trying to get a grasp of it so it really does make sense.

MS. LUNGE: Yes. And there's not really a clear □□ I mean, I □□ the

fiduciary language is the language that's in the Maine and the D.C. laws. And Maine really just got up and running because it was in litigation.

ATTENDEE 384: Uh□huh.

MS. LUNGE: And so it's not like I can give you an example, really, that v yeah.

CHAIRMAN MAIER: So let me □□

ATTENDEE 385: Inaudible) these out (inaudible).

CHAIRMAN MAIER: Yes. I would like to take our temperature here but I think □□ I think we need to have a conversation about (A) before we do that. So what □□ because how □□ to a certain extent how □□ whether we are strong, medium or neutral in number one (inaudible) affected whether or not we have the beginning clause in (A).

ATTENDEE 386: Yeah.

CHAIRMAN MAIER: I mean, you have to □□

ATTENDEE 387: (Inaudible) says it is contractor.

ATTENDEE 388: So who is going to do this? Who is going to do one, two, three, four, five, six.

MS. O'DONNELL: Only the people whose paid consultants have told them that they must.

ATTENDEE 389: Well, they would insist on those things in their contract.

ATTENDEE 390: I mean, we've clearly gotten the message from the PBM's that they don't like this so they don't have to agree with it. That's the □□

CHAIRMAN MAIER: Bill first and then □□

ATTENDEE 391: Mr. Chairman, when it is appropriate I would like to talk about the in inner□play between Section 7 and 8 and how it looks at the agreement between

the PBM and the health insurance. I think it might answer a lot of these questions or maybe allay some of the uncertainties about who is, you know, gaining or losing a perceived advantage based on the (inaudible) part of Section 7.

If I may, for example, in subsection (B) at the bottom of page 19 it talks about □□ it talks about that it shall provide notice to the health insurer that the terms in (A) may be included in the contract.

So it presupposes, we're pre□contract at this point. And the first thing that happens when □□ and as we heard from, I think, Mr. Hardy at Medco, the insurer said about the RFP thing, "Here's what I want for my beneficiary." The PBM's then would have to come back and say, "Okay. Don't forget, you have a right to (A) if you want it. And if you want these things we're going to respond □□ you know, we're going to respond to your RFP with perhaps a different model of pricing and pass reducing, all those other things that Mr. Hardy talked about. But if you □□ but we don't have to do that. So you health insurer decide if you want these in your initial RFP or not."

ATTENDEE 392: Only in the state of Vermont?

ATTENDEE 393: Right. And so we have to, first of all, give them notice that these are out here. This was more to allay the concerns about the little employer out there who may not know that they could get (A) one through six. So we had to say to them, "Don't forget, you get (A) one through six in this contract if you want it."

CHAIRMAN MAIER: So, this isn't nothing, this whole section, now that we're here. You're trying to show us that there is a notice requirement here.

ATTENDEE 394: We're telling them, if you want to put it in your RFP and you want us to bid on this business, you know, you can do that. We can also choose not to contract with you at that pre□contract stage. Okay?

CHAIRMAN MAIER: Uh□huh.

ATTENDEE 395: And then under Section 8 it talks about audit requirements. This gets at Representative Milkey's concern, I think, about, how do we follow up on if you're doing this stuff or not. And that's fine. You know, Section 8, starting on page 23 is how the senate addressed at least administrative service only contracts in auditing those. Because many of the RFP's that are out there in the (inaudible) agreements with (inaudible) have audit rights. That □□ they're out there in the RFP's though so that the PBM □□

CHAIRMAN MAIER: I hate this jargon. I'm so sorry.

ATTENDEE 396: The (inaudible). The next thing it will be (inaudible).

ATTENDEE 397: We're with you so far.

ATTENDEE 398: A total of maximum daily (inaudible). No, that's across the hall. So I might be exceeding my twelve maximum daily (inaudible) that chocolate.

So what was crafted in the senate was an attempt to have the transparency that someone would want in an administrative services contract if v□ and have all the parties to a potential contract with the PBM aware of that up front and say □□ so that my client can knowingly bid on it and price their product accordingly, and so that the smaller employer □□ (inaudible) what's a small employer these days, it's really not (inaudible) Smith World Headquarters in Northdale with three employees.

But in any event, the PBM has to give notice that you could get (A) one through six. And at that point if you want to go then to your RFP and get a bid on it, put it in there. If you don't, you're bound by regular contract law and whatever audit and penalty provision you might put in to your RFP. So it is driven by the health insurer and not by the PBM. But we have an affirmative obligation to say, "Have you thought about (A) one through six?" We've got to do that no matter what.

ATTENDEE 399: And it was possible that those consultants would also [redacted]ntion it?
ATTENDEE 400: Yes. They probably wouldn't earn their $60,000 if they didn't.
ATTENDEE 401: (Inaudible) picture.
ATTENDEE 402: It helps.
CHAIRMAN MAIER: Thank you.
ATTENDEE 403: Did I answer the process with □□
ATTENDEE 404: Bill hit it right on the head as far as what I was going to say. The only thing I would say additionally is that I think (A) is important because without it it's a one□size□fits□all contract. And I think the parties that Ms. Callaghan and the representatives from the PBM's have described a situation where everybody doesn't necessarily want a one□size□fits□all.
ATTENDEE 405: Well, given that this is optional, is there any reason why we couldn't have (inaudible) standards as an option, the fiduciary and (inaudible)?
MS. LUNGE: The only complication with that is that it does say unless the contract provides otherwise. So it sort of sets up the standard if the contract is silent. So if you had two □ □
ATTENDEE 406: Two standards which would □□
ATTENDEE 407: Yes.
MS. LUNGE: It would be confusing as to which would control if the contract was silent.
ATTENDEE 408: Since it's optional I would think that we would want people to know that they could have a stronger one because the PBM's would be letting them know that there is a less strong and they could have it like (inaudible).

ATTENDEE 409: But the consultant would be letting them know that the □□
ATTENDEE 410: Well, the consultant would let them know that.
ATTENDEE 411: Right. And I think the Attorney General's Office testified that they are concerned about small groups but the state employees testified the (inaudible), whatever they are, testified that they hired consultants who were former PBM employees that know all the ins and outs and they don't feel they need this protection. And there aren't any □□ I mean, there's no small shops like mine that are getting their prescription drugs from PBM's. We're getting our prescriptions through MBP.
ATTENDEE 412: No. But there are employers who have 400, 500, 600 that are doing self□insured. And they may be mostly doing them through the insurance company contracting with an administrator. But □□
ATTENDEE 413: I don't think there's anybody that's just (inaudible).
CHAIRMAN MAIER: I would like to ask □□ did you have □□
ATTENDEE 414: No.
CHAIRMAN MAIER: Okay. What I think I would like to ask the committee □□ John, did you want to (inaudible).

MR. HOLLARD (phonetic): Well, I don't □ I do, just a □ □ on behalf of MBP, John Hollard. In our view we do obtain the transparency that we need through the negotiating process with these PBM's. So this language that is in the bill as passed by the House was sufficient for us in terms of obtaining that information. These are generally transactions between very large sophisticated [redacted]entities [redacted]o we're able to waive that and we certainly are comfortable with that language.
CHAIRMAN MAIER: The way it is now?
MR. HOLLARD: The way it is now. We don't think □□ I mean, we are able to obtain these things currently just through the negotiating process.
CHAIRMAN MAIER: Well, let me first ask the committee, we could just go around, or □□ about the (inaudible) in (A). How do you feel about the (inaudible)?
(End of CD transcription.)

STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: April 17, 2007

Type of Committee Meeting: Standard

Committee Members:

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

CD No: "04/17/07, #1 c"
(Made from CDs 136, 137 and 138)
Tracks 1 and 2

PROCEEDINGS

(Start of Track 1 from CD labeled 4/17/07 #1c, made from CDs 136, 137, and 138.)

ATTENDEE: Prescription drugs.

MS. LUNGE: That's what we're doing.

ATTENDEE: You didn't happen to mark where we ended, did you?

MS. LUNGE: Well, I think what we did was talk about PBMs and then skip ahead to the data mining stuff and then skip ahead again to the unconscionable pricing, so there -- I think we could go back to page 25 and talk a little bit about evidence based and then move forward and sort of skip over the two big chunks we already did.

Does that make sense?

I think we were -- we kind of ended in the -- let me see. Where are my notes?

FEMALE ATTENDEE: What's the last graph? (inaudible).

MS. LUNGE: It's the Bill as passed.

FEMALE ATTENDEE: (Inaudible).

ATTENDEE: It doesn't actually say that, or

does it?

FEMALE ATTENDEE: On the front.

ATTENDEE: Oh, yeah, it does.

ATTENDEE: But in the middle of it, it said Bill introduced (inaudible).

FEMALE ATTENDEE: Mine said Bill is introduced on the whole thing.

ATTENDEE: Go to the very front.

FEMALE ATTENDEE: Oh, (inaudible).

FEMALE ATTENDEE: Page 25.

MS. LUNGE: Yeah. I have a star there, and that says "come back," so I think it means we skipped it.

ATTENDEE: And just to remind the committee, what we're trying to do is take a temperature here. This is your last chance to raise a question or concern on that section, but what I'm trying to get to is if no one has a particular question on this section, I'm going to assume that we're more generally okay with it than if you were raising questions or more serious concerns at this point. I'm trying to narrow the field here.

MS. LUNGE: So I think we did finish the PBM section, so unless anybody else remembers differently, I think that's right.

ATTENDEE: We had questions to come back to it though, right?

MS. LUNGE: Yeah.

ATTENDEE: We were going to talk about the standard, right?

MS. LUNGE: Right.

ATTENDEE: And whether --

MS. LUNGE: We were going to come back to that issue later and then --

ATTENDEE: Which one now?

MS. LUNGE: That was on page 17, the standard. We had -- I think that was our last discussion maybe.

ATTENDEE: Oh yeah, right.

MS. LUNGE: We were in the middle of addition we finished kind of --

ATTENDEE: Fiduciary versus --

FEMALE ATTENDEE: Are we back to drugs?

ATTENDEE: Where does that --

FEMALE ATTENDEE: Contracts.

ATTENDEE: Contract versus -- what's the other one?

FEMALE ATTENDEE: Private contracts.

MS. LUNGE: Fiduciary versus the contract versus the in between that's set in case law.

ATTENDEE: The one we're at now.

MS. LUNGE: Right.

ATTENDEE: Insurance agent.

MS. LUNGE: Right, exactly so -- and I think we had kind of gone over these six duties already that are listed on Pages 18 and 19 and the notice provision.

What I don't remember is if we did talk very much about the enforcement provision starting on page 21.

FEMALE ATTENDEE: I don't have any notes on that.

MS. LUNGE: So maybe that's where we kind of left off.

So just a little summary, this section is the enforcement provision for the PBM section and the part -- there are two different PBM sections.

This is enforcement for the requirement that the PBMs give notice that those six duties could be contained in a contract, but they didn't have to be -- they can be contracted around, so this would be enforcement if the PBM didn't give that notice that that was possible.

And so the enforcement section is split between BISHCA and the AG's office and provides

basically that the two agencies, BISHCA and the AG's, would share enforcement, that there would be a right of action that the AG could bring under the Consumer Fraud Act, and -- but, excuse me, that the Commissioner of BISHCA would have the same exclusive authority to investigate, examine or otherwise enforce this chapter when it's a PBM connect -- who has a contractual relationship with a traditional health insurer.

So you may remember we talked that in this section generally, the health insurer definition is broader than what we normally think of as a health insurer and would include a self-insured employer.

In this section, the term health insurer means what you usually think of as a health insurer, MVP, Blue Cross, Cigna.

So BISHCA would have exclusive jurisdiction over those relationships, and then BISHCA and AG would share over other types.

Section 8 is this --

ATTENDEE: Yeah, I had a question. We also talked about perhaps reordering this so that it would -- that it doesn't start off with "unless the contract provides otherwise."

MS. LUNGE: Right.

ATTENDEE: Just to kind of provide, you know, that this is what we think there should be -- they should have the ability to have this notice stuff.

FEMALE ATTENDEE: That's right.

MS. LUNGE: Uh-huh.

ATTENDEE: And then later on, if you needed to, but I'm not sure it's not redundant to have that and to have what's on page 19 when you have "may" there.

Isn't that the same?

MS. LUNGE: Where on page 19?

ATTENDEE: Page 20.

MS. LUNGE: Oh, I'm sorry.

ATTENDEE: No, page 19, line 19, starting there.

MS. LUNGE: I think you mean --

ATTENDEE: Is that saying the same thing twice, when you say "may be included in the contract"?

MS. LUNGE: No, because what this provision says is that they shall provide notice that those things may be in the contract, but it doesn't require that those things are in the contract unless otherwise stated.

But I think that it would make sense to make this B an A and make the current A, B so that you understand really what's happening before you get into the --

ATTENDEE: The process, right, okay.

ATTENDEE: On page 21.

MS. LUNGE: Yes.

ATTENDEE: That enforcement section.

MS. LUNGE: Yes.

ATTENDEE: Is my memory right on this one? BISHCA is okay with all of this?

MS. LUNGE: Yes. This language was compromise language between BISHCA and the AG's office.

ATTENDEE: This italicized language?

MS. LUNGE: Yep.

ATTENDEE: Thank you.

ATTENDEE: And I also wrote in the margin that I think one of the -- Brian Quigley, (phonetic) somebody from one of the PBMs was raising ERISA concerns about this section.

MS. LUNGE: Yes, and Maria is looking into it, so we should have an answer on that one soon.

ATTENDEE: Can you at least state the question that we believe she is looking into?

MS. LUNGE: I think what she's looking into is whether or not -- and she had exchanged e-mails with Brian Quigley directly, so she may have gotten further clarification, so I should probably check in with her, but I think what she's looking at is whether there's actually any part of this enforcement that would violate the ERISA enforcement because ERISA has specific enforcement, but my understanding is that the ERISA enforcement applies to individuals' privacy protection through the plan information that like you or I would have, and the reading I have of this enforcement section and combined with the rest of this section is that we're not talking about individuals like you or I enforcing because we're not in a contract with the PBM.

So the person who would have the enforcement, like the plaintiff, would be the health plan or the employer, not the employee of the employer or the subscriber to the health plan, so I don't think they cover the same people, but I'll have -- once I have a chance to check back with Maria on that to see how she is doing on looking into that...

ATTENDEE: Is the other thing she's going to

check on or someone's going to check on, Is the AG involvement necessary? There are other laws that might be in effect right now that cover this?
MS. LUNGE: Well, I know that --
ATTENDEE: The one that was mentioned was the Department of -- I think it was the Department of Labor, but I don't remember for sure.
MS. LUNGE: Hum. I guess I would ask you to ask the AG's Office if they think they need it.
ATTENDEE: Well, she was in here testifying.
MS. LUNGE: Right, and she's coming back I think later this week but....
ATTENDEE: I don't think there was any --
MS. LUNGE: They certainly want it so...
ATTENDEE: Yeah, that's what I thought.
MS. LUNGE: So whether or not it's necessary, you know, I guess the question would be whether or not there's current -- this currently would fall under our Consumer Fraud Act, and I could talk to, you know, Sam Burr, (phonetic) who probably knows that better than I do to see if he has a read on that, but really, it's the AG's Office who would know whether or not -- because they're the ones doing the cases, not us, so, you know, we can kind of look at the statutes and give a read, but we

aren't in front of the judges, so we don't know.
ATTENDEE: Yeah. Let me just state what my -- my concern is, at least the way I (inaudible).
MS. LUNGE: Uh-huh.
ATTENDEE: If the -- if the Commissioner of Health didn't agree on something, it wouldn't matter. The Attorney General's Office would just say, you know, go ahead.
MS. LUNGE: That's not this section. That's the unconscionable pricing section.
ATTENDEE: Oh, that's right. Okay. Excuse me.
MS. LUNGE: No, that's okay.
FEMALE ATTENDEE: My notes say there's protection, Department of Labor and contract law according to the person who objected to -- just what you were saying, the enforcement.
ATTENDEE: Yeah.
MS. LUNGE: In terms of current enforcement.
FEMALE ATTENDEE: Yeah.
MS. LUNGE: You can enforce a contract under contract law.
FEMALE ATTENDEE: It was the Department of Labor also.

MS. LUNGE: You get different remedies than under Consumer Fraud Act.
FEMALE ATTENDEE: Right. Yeah, I was just -- but I remembered that. I had written that down as what somebody said.
MS. LUNGE: I see. Thank you.
FEMALE ATTENDEE: Not something I'm saying I know.
MS. LUNGE: Section 8, 9421-A directs the Commissioner of BISHCA to register PBMs. On page 23, subsection B --
ATTENDEE: Didn't we hear that that's not necessary?
MS. LUNGE: There is currently a pilot project under the multi-payor database, and so for the purposes of the multi-payor database, registration is happening.
If for some reason, I think you decide to change what's going on with the multi-payor database and registration was not involved in that, then this would give you a stand-alone provision, so I think it's cleaner if you want to register for the purposes of registering to have that separate from the multi-payor database statute because right now, it's specifically

linked for that purpose. And we could probably take it out of the multi-payor database, this section of the statute if you wanted.
ATTENDEE: Is this authoritatively different about the registration that we're following if it were to happen here, and what's happening in -- already happening?
MS. LUNGE: I don't think so because it's not very specific here so I think they're doing now would be fine.
ATTENDEE: Okay.
MS. LUNGE: And I don't think it was very specific in the multi-payor database section either, but I will also double check that in case my memory is faulty.
It's more just legally speaking, I think there's an argument that registering -- if the language is in the multi-payor database statute, if for some reason, you decided not to do the multi-payor database, the registration would also go away because it's linked specifically to that project, as opposed to general regulation.
ATTENDEE: And are there -- we've got to go through that, but presumably, there may be parts of this section that may ask for or at least imply

that we would use information associated with the registration for purposes other than just the multi-payor database, or is that not an issue?

MS. LUNGE: The way this is set up is just set up as a regulatory requirement so it's not specifically used in B or C, that information.

ATTENDEE: Okay.

MS. LUNGE: Okay? So in fee, which the amended version is on page 23, this requires PBMs to notify health insurers when the PBM provides a quote to that insurer in response to an IFR -- in response to an RFP, that a quotation for an administrative services only contract with full pass-through of any negotiated prices, et cetera, is generally available, and also whether or not that particular PBM offers that type of contract.

The quotes for an administrative services only contract, if that's what they were offering, would include a reasonable fee payable to the insurer by the insurer -- excuse me, to the PBM, to be -- to include a competitive profit for the PBM, but this section is not meant to require a PBM to offer that type of contract if they don't already choose to do that.

So again, it's -- it's basically notice to

someone that here's another option you have in terms of a different type of contract. We do -- we could provide you with that or we don't do it, so you'd have to look elsewhere. That's the gist.

ATTENDEE: How is this language different than what's crossed out?

MS. LUNGE: In the -- the way it came out of Senate Finance, it wasn't clear whether or not they intended that every PBM offer an admin services contract, so this clarified whether or not that was the case.

ATTENDEE: It's very similar.

MS. LUNGE: Other than that, it was very similar, yeah.

So then also, C-1 requires that for an administrative services contract, a PBM would allow access by the health insurer party to that same contract, to financial and contractual information necessary to do an audit.

And then A on the bottom of 23 through C on the top of page 24 are the types of things that they could look at in an audit:

A. The full pass-through of negotiated drug prices and fees.

B. Again, this is in that specific contract

that that health insurer has, so they wouldn't be getting other peoples' information, just their own in relation to their own contract.

B. Full pass-through of all financial remuneration associated with drugs dispensed again to people of beneficiaries of that health plan, and,

C. Any other verifications relating to pricing arrangements and activities of the PBM required by that specific contract, if that's required by the Commissioner of BISHCA.

D is a bill-back provision, and this is the provision that you heard from OVHA that they would like to not have their PBM stuff billed back to the PBM because they're concerned it would be passed through to Medicaid, and I think BISHCA has said they're okay with that.

There was some confusion about that, but I verified with them that they're okay with it so...

ATTENDEE: In this section, is there any discretion for the Commissioner to close any potential loophole in this contractual arrangement if there's found some way where these pass-throughs are somehow not fully revealed for whatever reason?

MS. LUNGE: So what is -- basically, what is the enforcement for the audit?

ATTENDEE: Yeah. Is there any discretionary enforcement on the part of the Commissioner?

MS. LUNGE: There's no specific enforcement outlined in this section, but to the extent -- and I'd have to double check BISHCA's general enforcement, but they do have general enforcement authority over the folks that they regulate, so I think that there is probably some enforcement through that process.

Exactly what that would be, I'm not sure.

ATTENDEE: Okay, but if it's general, I'm okay with that.

ATTENDEE: Okay, thank you.

MS. LUNGE: I'll -- I had that on my list of things to do, to check BISHCA's general enforcement.

ATTENDEE: Does this audit requirement only apply to administrative -- I'm just trying to understand --

MS. LUNGE: Why?

ATTENDEE: I guess, why? Why -- why is this here, and why is this -- it almost seems like a new era of regulation for just this one particular

kind of contract.
MS. LUNGE: Right. Well, the testimony in -- it was less clear. In fact, the way it was written as they came out of Senate Health and Welfare, it could have been interpreted to apply more broadly.
It had some specific language about -- like A and B were specific, that they meant administrative services only contracts, but C was broader and could have been applied to other types of contracts, but the testimony -- there was competing testimony in Senate Health and Welfare about whether or not admin only contracts were the type of contracts that you really need to audit for, and I think Senate Health and Welfare decided that they were most concerned about making sure people could audit in that type of contract, so -- but there are some sort of pros and cons from different folks about -- about that.
ATTENDEE: (inaudible) by design, the other kinds of contracts, by design.
MS. LUNGE: That you get "X" amount regardless of what --
ATTENDEE: Right. They're keeping all that other stuff in themselves.

MS. LUNGE: Right.
ATTENDEE: And in one case, we heard they weren't charging any fees at all because they were --
ATTENDEE: They were making money elsewhere.
MS. LUNGE: Right, from the rebates or something.
ATTENDEE: You just decide how you want to do business.
MS. LUNGE: Right. I think that was the basic back and forth.
ATTENDEE: And are there many of these contracts around?
MS. LUNGE: I don't know, actually.
FEMALE ATTENDEE: I need to move the oranges for the resting place of the phone, like you usually put it here.
FEMALE ATTENDEE: You could put it on top of the apples.
FEMALE ATTENDEE: Can I ask one more question?
MS. LUNGE: Sure.
ATTENDEE: It's going to be a fruity discussion.
FEMALE ATTENDEE: Robin, on page 24, line I

think 8 and 9 --
MS. LUNGE: Uh-huh.
FEMALE ATTENDEE: -- this is just kind of a catch-all for anything that might be required by the Commissioner?
MS. LUNGE: It has to be something that's relating to your specific contract, but it would give the Commissioner some other opportunities through rule to say okay, here's some other ways to audit these types of contracts.
If that specific thing wasn't in your contract, then obviously, you wouldn't audit for it but...
FEMALE ATTENDEE: Okay.
MS. LUNGE: But yes, it's kind of a catch-all.
FEMALE ATTENDEE: Okay.
MS. LUNGE: Should I try and just finish this section because we're almost done?
So D is the bill-back.
E is a general just rule-making provision for the Commissioner.
And then F has some definitions. It uses our standard -- one of our standard definitions for insurer, one of our standard definitions for

health plan. PBM was defined in the previous section and Pharmacy Benefit Manager, management and manager as defined in the previous section of the Bill.
And then Section 9 is a technical provision which would state when the PBM provisions would apply to contracts in existence and as they come into creation, so that just clarifies for folks when they have to start complying with it.
ATTENDEE: Okay. You can stay there if you want.
MS. LUNGE: Sure.
ATTENDEE: Just as Lauren is getting this set up, just to orient the Committee again, this is Elliot Fisher.
He's a researcher at Dartmouth, has done work with Dr. Jack Wenberg (phonetic) there, as much as his own work, and this Committee has heard from him-- it's hard for me to remember how many times he's been in the Committee room here and some other places I've seen him, and he's a pretty well-known health policy researcher, and he wrote a letter that's copied in the materials that Steve Kimball (phonetic) gave us, expressing some concern against, against the data mining sections,

concern about losing access to the data producers, but I'm sure he'll tell us.

FEMALE ATTENDEE: What section is that in? I'm sorry.

ATTENDEE: Section 3.

FEMALE ATTENDEE: Thank you.

FEMALE ATTENDEE: Thank you very much.

(Speaker phone call placed.)

DR. FISHER: Hi, it's Eliott Fisher.

MS. STAR: Dr. Fisher, hello. This is Lauren Star of the House Health Care Committee.

DR. FISHER: Hi.

MS. STAR: Thank you, and I will pass you over to Representative Steve Maier, the Committee Chair.

REPRESENTATIVE MAIER: Hi, Elliot, how are you?

DR. FISHER: I'm well, Representative Maier, how are you?

REPRESENTATIVE MAIER: We're doing well here today.

Thank you for joining us, taking time out of your schedule.

DR. FISHER: I'm happy to do it. Wish I could be there. It's more fun to look at you all

and be able to say "hi" and have a chat, but I couldn't get up there.

REPRESENTATIVE MAIER: We have all of our Committee members here. Maybe I'll ask them to introduce themselves, and we also have a pretty cool Committee room of other interested folks. But I understand you would like to talk with us about the data mining sections of the Bill.

DR. FISHER: I'm happy to try to answer questions or give you a little bit of my own opinion about my concerns about that section.

REPRESENTATIVE MAIER: Let me have the Committee just introduce themselves.

REPRESENTATIVE CHEN: Hi, Elliot, Harry Chen here.

REPRESENTATIVE LERICHE: Lucy Leriche.

REPRESENTATIVE COPELAND-HANZAS: Sarah Copeland-Hanzas.

REPRSENTATIVE OJIBWAY: Hilda Ojibway.

REPRESENTATIVE ZENIE: John Zenie.

REPRESENTATIVE WHEELER: Scott Wheeler.

REPRESENTATIVE O'DONNELL: Patty O'Donnell.

REPRESENTATIVE KEOUGH: Bill Keough from Burlington.

REPRESENTATIVE MILKEY: Ginny Milkey

REPRESENTATIVE McFAUN: Robert McFaun.

REPRESENTATIVE MAIER: All right, so we have a copy in front of us of the letter that you wrote, I guess it's to me, but I think at Steve Kimball's request or something along that line, and then you also had either testified or submitted testimony on the Senate side.

So maybe if you could just summarize what you said there or more generally what your concerns are about this.

DR. FISHER: Yeah. Let me start by being very clear so that you're aware of any -- any potential conflicts of interest that you may -- or perceived conflicts of interest.

First, I have spoken with folks from IMS at various points over the last several years when I learned of a Canadian atlas of prescribing that was prepared by researchers at the University of British Columbia with whom I've done work in the past, and more recently, on a project that is not related to prescribing, but is related to understanding physician groups throughout the United States.

We are using some data that we obtained from an IMS subsidiary that tries to figure out which

physicians are members of which groups.

We're doing some research for the Common Law Fund that has us trying to look at the quality and costs of care within the United States and how -- whether physicians are in one-person, two-person or a hundred-person, multi-specialty group practices, whether that makes a difference in terms of the quality and costs of care.

So we are -- you should be aware that we are using some data that is owned by a subsidiary, that's from a company that's a subsidiary of IMS and that I have thought about in, you know, in the context of the Dartmouth atlas of health care, developing a Dartmouth atlas of prescription drugs within the United States which could be done with the kinds of data that is prepared by -- maintained by IMS, so that's the -- you should understand my comments in that context.

So my concern about the Bill that's before you all is that by precluding the commercial use of aggregated data, it will make it harder for us to understand trends and patterns of practice related to prescription drugs.

One of my earlier studies that reported on the overuse -- the potential overuse of drugs for

ADHD was based on prescription reporting maintained by -- put together by a data aggregator similar to IMS.

So that's -- the concern would be that by restricting the commercial use, you would eliminate the kinds of population-based research that can be carried out doing that.

Now, it may be worth doing if the public interest in preventing detailing, prescription drug detailing to physicians is more important, and that's a judgment that you all will have to make.

My concern about this Bill is I'm not sure that as I understand the Bill, it actually is likely to reduce detailing of physicians or the amount of time that the drug companies are trying to get to physicians.

Rather, it will change the information that they have to target physicians, but it won't necessarily reduce the degree to which pharmaceutical company representatives are in physicians' offices, the use of gifts or other inducements to prescribe inappropriately through the use of samples.

So that's -- that's the question I would -- I

would ask you all to think about.

So that would be my initial statement, Representative Maier, and I'm happy to answer questions.

REPRESENTATIVE MAIER: All right. Thank you very much.

Patty O'Donnell?

REPRESENTATIVE O'DONNELL: Yes, thank you for making yourself available to us today.

We heard testimony that a lot of the information that you receive -- that you receive to calculate could be gotten from Medicare and Medicaid.

Is there a difference in the quality of the information that you receive from them and the quality of the information you receive from like an IMS?

DR. FISHER: Medicare right now does not provide -- Medicare, which is the program for the over 65, does not now make accessible the prescription drug data that's under the Medicare Part B program.

We are in discussions with Medicare, and there's legislation pending in the Senate, I believe, the U.S. Senate that would require CMS to

release that data, but under the original MMA (phonetic) date, we don't get it.

Private insurance companies do provide detailed claim level prescription drug data that can be used for many of the kinds of things, the kinds of post-marketing surveillance or epidemiologic studies that we have done.

But when the patients of the private data and of the Medicaid data -- is that it has to be put together from multiple different sources, so that although -- for instance, Wellpoint I believe has the largest population-based coverage in the United States, it still covers, you know, a very small fraction of the total population, so the advantage of a -- you know, until we develop comprehensive population-based claims data systems for the under 65 that can be combined with the over 65 and bring in the prescription drugs, the IMS data provides the only sort of comprehensive population-based window, I believe.

So within Vermont, you will have within, we hope a couple of years when BISHCA gets contracts set up for the all-payor database, you will have for the under 65 population data on prescription drugs, but that would -- if you stop the

commercial access to prescription drug data within Vermont, it makes any national analyses likely to have some holes, as we will now have in New Hampshire. You know, it's not a huge hole, as you know.

Does that answer your question?

REPRESENTATIVE O'DONNELL: Yes, thank you

REPRESENTATIVE MAIER: Yeah, John?

REPRESENTATIVE ZENIE: Elliot, this is John Zenie.

I'm trying to get my arms around this idea of the fact -- I have an IT background, and I understand data very well, and I understand how data can be collected, and then it can be dispersed based upon a need to know; in other words, that data is only as valuable as those that want to use it and where it's going to go to.

And if this -- if this data is no longer used for commercial use does this make this data invaluable to the rest in the way of research, even though the data would still be there, but only for research purposes?

MR. FISHER: I think, you know, I think if the data is still there, the likely -- it's not clear to me, and I don't know the answer to this,

it's not clear to me that in the absence of the commercial uses that it's -- this is clearly very valuable information to phRMA, I believe, and it's probably not only about how they detail and try to change physicians' behavior, but overall understanding the impact of all of their activities.

So the concern would be that precluding any of its commercial uses would mean it basically doesn't get collected, and then we -- you might hope that someone else would set up a research database but, you know, we've got three states now that are trying to do this, and Maine is the farthest along of anyone in the country, and so it's going to be a while, I'm afraid, before we have comprehensive data sets for the rest of the country.

REPRESENTATIVE ZENIE: I'm a little confused by that. You make it sound like there is two different sets of data that's needed for research versus on commercial use, and I guess -- but then we say if we take away the commercial use, then there won't be any research data.

MR. FISHER: Well, I guess what I'm -- what I don't know, would IMS still collect the data from

the PBMs and try to put it together into a clean manageable database that's acceptable to researchers if they couldn't also market it to phRMA? And that, I don't know the answer to. That, they'll have to tell you.

REPRESENTATIVE ZENIE: Right. I don't think you would know the answer. I'm just saying I think there is a certain value left if there's no commercial value, that there is still value left, and I'm not sure where it would come from but --

MR. FISHER: Oh, I think there's tremendous value.

REPRESENTATIVE ZENIE: Right.

MR. FISHER: I mean, I think for -- I mean, I've been calling for comprehensive regional and national databases to allow us to monitor population health and health outcomes in health care for years, so yes, it would be tremendously valuable, but -- but it will require the public sector to come to support it if it's for research purposes because -- I mean, NIH funding is now flat.

We're only -- it's a very small percentage of grants that are being awarded, so there's great concern that the adequacy of funding research

dollars to support the development of databases isn't there right now. Maybe it will be for health care performance measurement in the next few years, but it's not there yet.

REPRESENTATIVE ZENIE: Thank you.

ATTENDEE: Harry?

REPRESENTATIVE CHEN: Elliot, I guess I mean, sitting where we're sitting, I mean, we're really asking --

DR. FISHER: I'm sorry?

REPRESENTATIVE CHEN: This is Harry.

MR. FISHER: Yeah.

REPRESENTATIVE CHEN: We're asking the question, to what extent is this data causing some of the problems that you're seeing in terms of inappropriate prescribing and things of that sort? And if that is the case, then, you know, is there-- can we make a more compelling case to, you know, banning the use of this data for commercial purposes in -- in the hopes of trying to reduce the cost, in the hopes of trying to reduce the inappropriate prescribing?

MR. FISHER: Well, I -- I think that's exactly the right question.

I'm very concerned about the behavior of the

pharmaceutical companies. If I could do away with direct consumer advertising, I would. If I could do away with physician detailing, I would.

I think the recent articles about the public release of the transparency of physician performance -- of payments by pharmaceutical companies to physicians which, you know, on which Vermont is one of the two states that tries to do this, but still protects the data much more so than Minnesota does, um, I -- I think we ought to do everything we can to reduce the influence of the pharmaceutical industry on physicians' prescribing practices.

What I don't know is whether -- and I'm actually concerned about whether this Bill is the correct vehicle to do -- the section on banning data mining essentially, is that the right approach to reducing the influence of the pharmaceutical industry on physician prescribing?

And I would bet that a more direct approach would be to say let's -- let's keep the pharmaceutical industry out of the physician's office as follows and, you know, the physicians could sign up for, you know, not to be contacted, and we could get rid of samples, and we could

get-- I think there would be other approaches that might be more direct because I bet this will lead to -- I would hypothesize that there will still be detailing, but it will be less accurate and more sort of shotgun.

And the detailing is the problem for me, not the, you know, not specifically how they're doing it, although maybe -- Harry, you could be right. It could be that this'll make it so ineffective that they stop doing it, but I doubt it.

REPRESENTATIVE CHEN: Thanks.

ATTENDEE: I have the most --

MR. FISHER: Recent calculation on how much they're spending on every one of us?

ATTENDEE: No.

MR. FISHER: It's relatively high.

FEMALE ATTENDEE: (inaudible) $13,000.

REPRESENTATIVE MAIER: Elliot, this is Steve. I think we've heard -- I forget where I've heard, but somebody I think suggested that the price tag to get access to the data from companies like IMS is pretty high.

Can you -- is that -- I'm not sure, from what you said before, whether you've actually used data from them or not, and can you comment about how

accessible it is from the standpoint of cost or price for researchers?

I mean, what sort of a budget do you have there?

MR. FISHER: Well, I have not tried to purchase the pharmaceutical -- the data on the pharmaceutical stuff, so -- so that, I can't, I can't speak to, and because this IMS subsidiary has an interest in having this physician data used for performance measurement by others, they have been giving us this data to use for this particular research project with Common Law.

So I think the question, the question that really needs to be posed back to IMS -- I actually will say that I do know that the prices charged to a -- I think they were Rand investigators for IMS data were rather high, were steep, and they were being charged I think the same price as the pharmaceutical firms would have been paying.

So I think it would be a fair question to-- I mean, I think IMS is vulnerable on this one to the extent that they -- that they do not have a sort of public, you know, a public sector price where, you know, BISHCA could buy the -- could get access to it for feedback as well, and I think that they

should be pressured to do that, in fact, that if this is felt to have public value, that there should be some -- some -- I mean, I would be worried myself if the data became inaccessible to researchers because of its high cost, and then I'd be happy to shut it down.

But I don't -- my sense is that they're -- in my conversations with them about the potential of the atlas, they were talking about setting a price that would be affordable for us and not, you know, not in the kinds of realms that we would not have been able to do with our -- with our grant funding.

REPRESENTATIVE MAIER: Is $50,000 a lot or a little in your world?

MR. FISHER: $50,000? That's a lot. So that-- I mean, we pay -- the purchase of Medicare data, well, it's a lot or a little. It depends, it depends whether our grants are going well or not going well.

I don't know whether that's a fair answer, but we get Medicare, who normally charges most research organizations, you know, $50,000 to $100,000 a year for the data that we've been getting, gives it to us because of our

population-based public reporting.

So we do not pay CMS for their data, although most others do.

We would expect -- for some data, we pay up to 10,000. We purchase the AMA data, and that's in the sort of $5,000 per year to $10,000 for sort of copyrighted material to a more commercial organization, and that is what I would hope to be paying for IMS data. 10 to 20 or something per year would seem more -- depending on if it's readily available, and I mean, we'd have -- we would pay -- for special production runs, we still have to pay -- we still pay Medicare. It depends if it's a routine data request. But 50 seems like a lot.

REPRESENTATIVE MAIER: Bill Keough?

REPRESENTATIVE KEOUGH: Yes. How well known in the medical profession is this opt out capability for doctors to opt out of this program?

MR. FISHER: I really can't speak to that. I-- I had heard of it. I think when there was -- I believe there -- and Harry may remember this better than I, there was an article I think in the New England Journal about California's physicians working in this area, you know, on this concern.

I think the opt out -- I mean, I would like all physicians to opt out of their detailing.

We finally managed I think Dartmouth Hitchcock to stop letting the prescription drug folks in to deal with the -- to be with the residents, to bring lunch, but it's only recently.

REPRESENTATIVE KEOUGH: Thank you.

REPRESENTATIVE MAIER: Hilda?

REPRESENTATIVE OJIBWAY: Dr. Fisher, you said again it sounds like, you know, you want to reduce influence, and you said consider alternatives, but let's say that some of these alternatives you talked about were all implemented.

Then why would they continue to do the research? Because it's like you're closing the door one way or the other.

I don't know if I'm being clear about this, but --

MR. FISHER: Yeah. No, I could --

REPRSENTATIVE OJIBWAY: So I don't -- I understand, you know, the idea that just be direct about it, but it seems like if -- if -- I don't see how the other one would work.

MR. FISHER: Uh-huh.

REPRSENTATIVE OJIBWAY: How it would -- how

it would really stop -- would -- would decrease the amount of influence.

I mean, maybe you have a -- maybe I just didn't kind of get what you were talking at. I didn't see how -- how it would work.

MR. FISHER: Well, I mean some of this is -- gosh, I don't know.

I mean, I've only -- you know, it's only when this, when lightning struck the second time in a state that I actually lived in, you know, New Hampshire, that I started worrying about this, and I think one of the questions we should all ask ourselves is, you know, what's the best way forward, and how should we put something together, and can we do it in the next week or two? Because I think you're asking a very good question.

How can we have this -- is the data resource that IMS has put together valuable?

If you block the commercial use for -- and will this -- would it have an adverse -- would they stop collecting it?

If it's all commercial uses, I worry they might. If it's -- if it could be so narrowly framed so that they can't use it for detailing, maybe less, maybe less so. So I guess I'm not

answering your question very clearly but...

REPRSENTATIVE OJIBWAY: Well, it's sort of the same thing Harry was saying. I guess it's just -- and you laughed when you started. You said, you know, that's for us to figure out, but it's -- it's looking at, well, the costs of having this influence or increased cost of insurance and inappropriate prescribing, so that's a bad public health issue, and then on the other hand, we're hearing that well, but if you don't have that ability to have the detailers go out, then there's no incentive to collect the data, and that's a -- that will have a bad impact on public health, so either way, we're hearing it.

MR. FISHER: Although I, you know -- if you guys could shut down the detailing, I'd give up the IMS data.

You know, I guess, I guess some of this is I think we're -- we're in a period in health care where we're trying to improve our data systems, and Vermont is at the forefront of that with your -- with the efforts you made to support BISHCA's creation of an all-payor database.

We're not there yet in terms of the kinds of performance measures that we'd like to be able to

put in place.

I -- I think it's possible that the data collected by IMS could be used as a, you know, for public reporting on rates of generic prescription, rates of high-cost drug use, overuse of, you know, the latest anti-psychotic medications for patients with schizophrenia.

You know, there's a lot of those -- I believe that the data they put together, and I haven't -- you know, we've talked about doing an atlas.

I believe that that could be used to improve health care until we get the kinds of measures that we really need, which are from all-payor databases and the Medicare data with prescription drug data, but I don't see the public sector in the next year or two nationwide stepping forward.

So I'm -- this is where I really -- you know, on the question, Should we stop it now, and if you decide to, I don't think it'll -- I don't -- I think it will make it harder to do, you know, an atlas of prescription drugs.

I can't promise you we'd do it even if, you know, in the -- in the very near term, but I worry that would it be in the public interest to try to come up with a direct -- what you're -- I guess

what you're asking is if we stop detailing, would they stop, would the pharmaceutical industry stop paying to collect the IMS data?
Is that correct?
REPRESENTATIVE OJIBWAY: So if every doctor-- yeah, because I mean, one of the arguments is well, the doctors can just turn away the reps now. There's no need for a law like this.
MR. FISHER: Right. Well, and I wish they would, and I'm not sure that this law is going to reduce the numbers of detailers visiting physicians. That's my -- one of my fears about this, so that -- because I think what we're doing-- what it seems to me is we're -- we're guessing that this might change their practice somehow, but I'm not -- with known -- and -- and we're guessing that then it would make it no longer useful for IMS.
I wonder if we're ready to act at this point.
I mean, if I had access to the Medicare Part D data, if we had -- or if IMS decided in its wisdom to produce, you know, state-level reports to help states understand prescribing in their local communities, would we be in a different place?

It's something that you should -- that's -- I'm -- my concern about the Bill is that you're moving into something where I really don't know what the -- what the impact will be, so I'm not sure I can be helpful.
REPRESENTATIVE MAIER: John?
MR. FISHER: Or have been helpful.
REPRESENTATIVE ZENIE: Actually, this is John Zenie again, Dr. Fisher. You're being very helpful to me anyway. I know that. I think to others too, as I see heads nod, and you're helping me to brainstorm some different ideas than what's in this Bill, so I find it very useful.
And my latest brainstorm is if this was feasible, whether or not the research community could basically hire IMS to maintain a database for which the research community controls access to the database; in other words, basically, pay IMS to continue doing what they're doing and that the research community maintain control over access and the use of the database.
I don't know whether that's even a plausible thing. How much money would IMS want for that kind of service? I don't know.
MR. FISHER: I think, I mean the little I

know about -- the little I know about how IMS assembles the data and their sources, my guess is the research community couldn't afford to -- to pay for it.
REPRESENTATIVE ZENIE: Well, we're paying for it one way or the other, right? I mean, that's just a matter of how you want to pay for it I guess.
MR. FISHER: Yeah, that's certainly true, but I -- you know, as I look at -- as we try to figure out how Congress is going to fix this physician payment schedule for next year, you know, and -- pay for S chips, (phonetic), I don't see increased funding for -- for the maintenance of a federal database, you know, federal support for a database of prescription drugs. I don't think that's very high on their list.
REPRESENTATIVE ZENIE: Could I take your answer as saying if we could find the money, yes, that might be a good idea?
MR. FISHER: I mean, I think if -- if -- I guess I wouldn't -- if we could find the money, I wouldn't put it only into the pharmaceutical stuff.
I would put it into the kinds -- I'd have

every state doing the kinds of population-based data systems that you're talking about here or that BISHCA's already starting to move forward on contracting, putting implementation on for the all-payor database in Vermont, which will include prescription drugs for as many -- you know, for those who are enrolled and have it, as I understand it, have drug coverage.
So I think the question -- a question would be whether that's in the short term something that you can expect and whether -- you know, and that, I can't predict.
REPRESENTATIVE ZENIE: Okay.
MR. FISHER: Because I don't think -- I don't see a lot of excellent resources floating around to pay IMS to maintain this database without some support from the pharmaceutical industry which needs to understand trends in -- you know, which, you know, trends in overall drug use, sales of drugs, you know, where they're going as much as it does to understand individual physician prescribing, I believe.
I think there are a lot of other uses besides individual prescribing which would not be of great use to the research community. But that's

something you'll have to ask IMS, you know, that IMS would have to testify to.

REPRESENTATIVE ZENIE: Sure, and also to the pharmaceuticals to find out, you know, in our own minds, is there an aggregate-type thing that we could still provide to the pharmaceuticals that they would still find of some value, not to necessarily help detailers as much as just seeing trends and analysis in a global way, rather than a doctor-by-doctor basis?

MR. FISHER: Right. I bet there are -- I mean, I hear you -- I hear the Committee trying to do some creative work around how can we meet the public interest in maintaining access to important and valuable data that can be used to understand the performance of a delivery system and reduce the impact of the pharmaceutical -- adverse impact of the pharmaceutical industry on physician prescribing.

REPRESENTATIVE ZENIE: Correct.

MR. FISHER: And I think those are -- I agree with both of those goals. I don't -- I worry that I can't come up with the right answer to that, or we may have a hard time as a community coming up with that in the next month or two.

REPRESENTATIVE ZENIE: All right.

MR. FISHER: Or whatever your time frame is for this Bill, so the question -- you know, a question then is is this something you should, you know, we should all think about further? And that's -- I think that's really where my testimony to the Senate Committee was.

You know, it seems like we're rushing something here, so I think there's some -- some challenges that we should work through.

REPRESENTATIVE MAIER: Okay. I think -- I think -- well, I don't see any more questions, so thank you very much, and I'm sure we'll cross paths sometime soon.

MR. FISHER: Yeah. I'm happy to help you. Good luck with your deliberations. I -- you know, you're doing God's work.

REPRESENTATIVE MAIER: Really?

MR. FISHER: I remember being on the School Board. You guys have the hard job. All right. Thanks a lot.

REPRESENTATIVE MAIER: It could be worse. We could be on a School Board.

ATTENDEE: Thank you.

(Start of Track 2 from CD labeled 4/17/07 #1c, made from CDs 136, 137, and 138.)

MS. LUNGE: Sections 10 and 11, which are on page 25 are technical sections.

ATTENDEE: Did you do Section 9?

MS. LUNGE: Yes. Section 9 is a technical section about when the PBM regulation would apply to contracts.

ATTENDEE: Okay.

MS. LUNGE: Section 10 and 11 work on reordering some stuff we currently have in statute and changes our current chapter on generic drugs to more generally a prescription drug cost containment and then moves the generic drugs, all that language into a subchapter of subchapter 1, and part of the reason to do that is to have a logical place to put some of the stuff we're going to go through, and also, right now, in Title 33, there are some provisions in the Medicaid chapter which have nothing to do with Medicaid, and so I wanted to move them over to this title where they would make a little bit more sense and you could actually find them if you were looking for them.

So substantively, Section 12 adds a subchapter 2, evidence-based education program, or as it's also been called, the counter-detailing

program.

4621 has definitions. The Department is the Department of Health.

There's a definition for "evidence-based" at the bottom of page 25, which is based on criteria and guidelines that reflect high-quality, cost-effective care.

"The methodology used to determine such guidelines shall meet recognized standards for systematic evaluation of all available research and shall be free from conflicts of interest.

"Consideration of the best available scientific evidence does not preclude consideration of experimental or investigational treatment or services under a clinical investigation approved by a institutional review board."

Section 4622 talks a little bit about the program, and it charges the Department of Health in collaboration with the AG, UVM, AHEC area health center program and the Office of Vermont Health Access to establish an evidence-based prescription drug education program for health care professionals, and that would be designed to provide information and education on therapeutic

and cost-effective utilization of drugs to physicians, pharmacists and other professionals who prescribe drugs, prescribe and dispense drugs.

"The Department may collaborate with other states in establishing this program."

And that was specifically included because there was some testimony that prescription policy choices, which is a policy organization affiliated with NLARX (phonetic) may be working with Maine, Vermont and New Hampshire to do a regional program which would save a little money because all the programs could use the same materials and develop common things like that.

Also, Pennsylvania, does have an evidence-based education program, which I think is affiliated with their Medicaid, so they've been developing some materials as well.

"The Department of Health shall request information and collaboration from physicians, pharmacists, private insurers, hospitals, PBMs, the Drug Utilization Review Board, medical schools, the AG, and any other programs providing an evidence-based education program to prescribers on on prescription drugs and developing and maintaining the program.

"The Department may contract for technical and clinical support in the development and administration of the program by entities conducting independent research into effectiveness."

And you can see this reference to the Oregon program was struck by the committees as well so that there was no specific program mentioned.

"D. The Department of Health and AG shall collaborate in reviewing the marketing activities of the pharmaceutical manufacturing companies in Vermont in determining appropriate funding sources for the program, including awards from suits brought by the AG against the manufacturers," which is the current funding for the AHEC program I think.

FEMALE ATTENDEE: You've said this already, but could you just please remind me of the amount of money that you just mentioned that funds this program? Do you remember?

MS. LUNGE: I actually don't know that I know that.

FEMALE ATTENDEE: I thought somebody told us.

MS. LUNGE: I don't think I know --

FEMALE ATTENDEE: Okay.

MS. LUNGE: -- how much AHEC is currently operating on. It could be the Department of Health mentioned that, but I don't recall off the top of my head.

FEMALE ATTENDEE: Okay. I'll look at my notes.

ATTENDEE: The money was going to come from the settlement.

MS. LUNGE: I think it currently -- AHEC is currently getting some money.

ATTENDEE: Some money.

MS. LUNGE: From a settlement through a grant by the AG's Office, but I don't know the amount. Okay?

ATTENDEE: A hundred thousand pops into my head. I have no reason to think that that's actually true, other than I just -- I shouldn't have said it out loud, but that's the number that popped into my head.

FEMALE ATTENDEE: The part that I asked -- you know, I'm just trying to get a sense of say the state of Vermont spends a hundred thousand and has four employees working on this, and then if you could quantify how much is on the detailing, so there's -- it's kind of so lopsided, it's

ridiculous, isn't it? Well, I mean just within the state. I was just trying to get a sense for--

FEMALE ATTENDEE: David and Goliath kind of?

FEMALE ATTENDEE: Yeah, but I just -- that's my impression, but I don't have anything quantified. I just (inaudible).

FEMALE ATTENDEE: Never mind.

MS. LUNGE: I can't recall if AHEC is coming later this week, but I can certainly e-mail someone there and try and find out the specifics of the amount of money.

ATTENDEE: I think that would (inaudible).

FEMALE ATTENDEE: It's me against the NFL defensive line, isn't it?

FEMALE ATTENDEE: It is.

FEMALE ATTENDEE: That's what I thought.

FEMALE ATTENDEE: I hope you've been pumping iron, honey.

MS. LUNGE: So the next section is Section 13, which was the data mining section you were just hearing about, and -- so should I go through this again?

It seemed like we kind of went through it, so I don't know.

ATTENDEE: Yeah.

ATTENDEE: Not line by line.
MS. LUNGE: Okay.
ATTENDEE: I think we need -- I need to be clear exactly what this does.
MS. LUNGE: Okay.
ATTENDEE: And I'm not (inaudible).
MS. LUNGE: Well, you did ask me at one point for the language from the other versions, and I do have that with me as well. I don't know if it makes sense to do that now or wait until we get through the rest of the Bill and then come back to that or what, but I do have it when you're ready for it.
So -- well, so this Section 4631, A is basically just a finding intent section.
B, I think the two most important definitions in this section, one is commercial purpose, which shall include advertising, marketing, promotion or any activity that is intended to be used or is used to influence sales or the market share of a pharmaceutical product, influence or evaluate the prescribing behavior of an individual health care professional market prescription drugs to patients or evaluate the effectiveness of a professional detailing force.

So that's, that's how we define commercial use.
ATTENDEE: So -- so it's to evaluate the prescribing behavior of an individual health care provider, so in that just, you know, just taking what Eliott Fisher does, that would include that?
MS. LUNGE: It potentially could, although we also -- there's some clarifying language in D, which excludes certain things, including research purposes, so I think you have to read this section in conjunction with the rest of the text too to kind of get the full picture, but I think you're right, that just those words taken alone potentially could.
ATTENDEE: Right, okay.
MS. LUNGE: Although you could -- I think you could if you wanted to say something like evaluate the prescribing behavior for the purpose of influencing, and that would narrow that down too because I think the intent was certainly not to sort of affect the research evaluation part.
So the other important definition is on page 32, line 5, and that is regulated records, which means information or documentation from a prescription written by a prescriber doing

business in Vermont or a prescription dispensed in Vermont, and so that's the definition where we narrow the information that we're talking about to just Vermont-based information.
ATTENDEE: Where are we again?
MS. LUNGE: This is on page 32, lines 5 through 7.
ATTENDEE: Okay.
FEMALE ATTENDEE: And one of the reasons you did that was in response to the lawsuit which was an interstate commerce?
MS. LUNGE: Yes, because my understanding -- the New Hampshire law didn't specify that, you know, what records they were talking about very clearly, so it didn't have a definition like this which tried to be very specific, that we were just looking at Vermont-based data.
FEMALE ATTENDEE: Doing business in Vermont, just refresh my memory on mail order pharmacies, do they have to be registered or something? Are they considered doing business in Vermont, or is it --
MS. LUNGE: That's a good question. They are-- I don't know if it's registered or licensed. I think it might be registered, and let me just

double check on that. I would think that would be since we're regulating them, I think they're considered to be doing business in Vermont, but I'll just double check with the Commerce people to make sure that --
FEMALE ATTENDEE: Okay.
MS. LUNGE: -- that that is accurate.
ATTENDEE: Could I -- could I go up a few levels, and could you help us -- help me review what -- I got confused about where the firewall gets put up if we pass language such as this, and there was this conversation going on. I forget whether you were in the room about, you know, does the information from -- from an IMS have any -- does it still go to the pharmaceutical company and then the firewall is set up, you know, somewhere between, you know, pharmaceutical companies and --
FEMALE ATTENDEE: Detailers.
ATTENDEE: And somewhere down and then the detailer?
MS. LUNGE: The firewall for this program, the way it's written in this version is between the pharmacy or the entity or the doctor, whoever has the records in Vermont and IMS.
FEMALE ATTENDEE: You're thinking about the

AMA firewall.
MS. LUNGE: The AMA firewall is within the pharmaceutical manufacturers.
ATTENDEE: Oh, that's under the opt out.
ATTENDEE: Yeah, that's the opt out.
MS. LUNGE: That's under the opt out.
ATTENDEE: Okay. Thank you.
ATTENDEE: What if we took out collection on all these, you know, 5 and 6 and 7? Well, how would that change it?
MS. LUNGE: 5 and 6 and 7 on page --
ATTENDEE: 32.
MS. LUNGE: 32.
ATTENDEE: Because it's that collection which is what's --
MS. LUNGE: Line 28.
ATTENDEE: 28.
ATTENDEE: -- creating the firewall at the pharmacy level.
MS. LUNGE: Well, line 28 is an exclusion, so line 28 says the collection for the prescription drug, so Chapter 84-A or 9410 are Vermont laws, so this actually authorizes BISHCA to collect the information for the multi-payor database. This is the exception, so we wouldn't change anything

there.
If we changed anything, it would be in C.
ATTENDEE: C, yes.
MS. LUNGE: On lines 8 through 12 because there is the prohibition.
ATTENDEE: Okay.
MS. LUNGE: This says, "The insurer, a self-insured employer, an electronic transmission intermediary," which would be someone like IMS, a pharmacy or other similar entity, "shall not license, transfer, use or sell regulated records which include prescription information containing patient identifiable or prescriber identifiable data for any commercial purpose."
So it's saying that the health insurer or the pharmacy or IMS, it doesn't prohibit them from licensing, transferring, using or selling the regulated records for a different purpose, but it would prohibit it from the commercial purpose, which refers back to our definition.
FEMALE ATTENDEE: Your definition of commercial purpose.
ATTENDEE: Okay.
FEMALE ATTENDEE: Does it become a commercial purpose because IMS intends to sell the data?

MS. LUNGE: If they intend to sell the data for advertising, marketing --
FEMALE ATTENDEE: Okay.
MS. LUNGE: -- promotion or any activity that is intended to be used or is used to influence sales or market share, but they can still sell it for other reasons.
FEMALE ATTENDEE: Okay.
MS. LUNGE: So -- and then D is supposed to clarify again specific situations that have come up where people were worried about it.
So it doesn't apply to the license, transfer, use or sale of regulated records for the purposes of pharmacy reimbursement, formulary compliance, patient care management, utilization review or health care research.
It doesn't apply to dispensing prescription drugs to the patient.
It doesn't apply to transmission of the information between a prescriber and the pharmacy or between pharmacies that may occur in the event a pharmacy's ownership is changed or transferred.
It doesn't apply to care management, educational communications provided to a patient -- and then there's a list of those kinds

of things, or to, you know, recall or patient safety notices or to clinical trials.
It doesn't apply to using the data for the multi-payor database, the -- what's the name of that program? It was S-90 last year, but it's the program, the electronic prescription drug monitoring program by the Department of Health where they're looking for misuse of regulated drugs, and Chapter 84 is our other regulation of prescription drugs that we have in terms of collecting information in Vermont. It's about regulated records, so I think it's like the narcotics and stuff, so it doesn't apply to those things.
It doesn't apply to collection or transmission of prescription information to a Vermont or federal law enforcement officer engaged in his official duties as otherwise provided for by law.
It also doesn't apply to the commercial use of the data if the data does not identify a person and there's no reasonable basis to believe that the data provided could be used to identify a person. And person in that sense means health care professional as well as, you know, a patient.

So that means IMS could still sell the data to a phRMA if it didn't identify the prescriber.

So for instance, they could say here's statewide data on your sales of this particular product.

FEMALE ATTENDEE: Or data for all prescribers in zip code 05401.

MS. LUNGE: Unless there was only one prescriber in that zip code, and then I think that could be used to identify the prescriber, but if there were -- let's say it was a primary care doc, and there were a bunch of them, then yes.

FEMALE ATTENDEE: Uh-huh.

FEMALE ATTENDEE: So they couldn't include-- if they do transmit this -- this data, these data, they couldn't include the prescriber numbers with it?

MS. LUNGE: Correct.

FEMALE ATTENDEE: Because that could be used.

MS. LUNGE: Right.

FEMALE ATTENDEE: In conjunction with the AMA to identify it.

MS. LUNGE: Right.

ATTENDEE: But it seems to me they can -- well, they -- let's just say on this company, I'm

a data mining company, and I go to CVS Pharmacy, and I say I want your Vermont data. If you have a contract with this CVS pharmacy, not to -- not to uses it for commercial purposes, then you could collect it.

MS. LUNGE: Yes. Yes.

ATTENDEE: So it can be collected, it's just that the supposition is that it wouldn't be collected because it's not financially --

FEMALE ATTENDEE: Right.

FEMALE ATTENDEE: Who's going to pay for it?

ATTENDEE: -- profitable.

FEMALE ATTENDEE: Right.

MS. LUNGE: Right, correct.

ATTENDEE: Or...

MS. LUNGE: Yes, that's correct.

FEMALE ATTENDEE: They're all still going to be there. They're just not going to get it nicely arranged, potentially.

(Track 2 ended there.)

CERTIFICATE

STATE OF FLORIDA
COUNTY OF BROWARD

I, Katherine Milam, Registered Professional Reporter, State of Florida at large, certify that I was authorized to and did stenographically report the foregoing proceedings and that the transcript is a true and complete record of my stenographic notes.

Dated this 26th day of August 2007.

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Katherine Milam, RPR