STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: April 20, 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 - 148/Track 2

Esquire Job No. 887529

PROCEEDINGS

- - -

REPRESENTATIVE MAIER: Steve, we had asked some questions about the section -- there's -- there's -- there's a fee in here and it's pretty clear how much -- it's on page 41 of our Bill and there was a suggestion made I think by Olga to change the way this fee would be charged. And we asked Steve to take a look at that and I think he's ready to talk to us about that.

MR. KAPPEL: Yes, I am.

REPRESENTATIVE MAIER: Welcome.

MR. KAPPEL: Good morning.

ATTENDEE 1: Good morning.

ATTENDEE 3: Good morning.

ATTENDEE 2: Good morning.

ATTENDEE 4: What happened to the picture of the hat?

REPRESENTATIVE MAIER: It's behind that one.

MR. KAPPEL: No it's well hidden. It's still there, though.

ATTENDEE 4: Oh, there it is. Thank you.

MR. KAPPEL: I'm so glad that's a once in

a lifetime event.

FEMALE ATTENDEE 1: You could make it happen again.

MR. KAPPEL: Only on request.

As was mentioned, I was asked to take a look at the fee in the Bill and at Olga's recommended change. As I walk my way through this, two questions you might want to keep in mind. Question number one is how much money do you really want to raise and question number two is how do you want to allocate the costs?

FEMALE ATTENDEE 1: I'm sorry, I couldn't hear the second.

MR. KAPPEL: How do you want to allocate the costs?

FEMALE ATTENDEE 1: Thank you.

FEMALE ATTENDEE 2: The cost of raising the money?

MR. KAPPEL: The amount you collect from the various manufacturers.

The way the current language is structured, it's a thousand dollar fee on each manufacturer whose drugs are paid by Medicaid or the various other state pharmacy programs. What that leads to is kind of a complicated --

seemingly simple but actually complicated question of what's a manufacturer. And it's defined currently in the statute that requires the reporting of marketing activities but if you look at the Attorney General's report, you can start understanding how complicated it actually is because in different parts of the report they talk about 68 or possibly 93 different manufacturers, 83; 91 different manufacturers if you count each of the Johnson & Johnson subsidiaries, and then another 23 who reported but didn't actually have any marketing expenditures. So you have anywhere from 68 to 114 manufacturers under that definition. So it's kinds of a hard one to have to actually implement.

What Olga is proposing is to move from that to what's called the NDC labeler code. NDC is a very well structured system of identifying pharmaceuticals and it's a three-part code. The first part --

ATTENDEE 1: NDC?

MR. KAPPEL: National Drug Council, Commission, something.

ATTENDEE 1: Okay.

MR. KAPPEL: But the FDC actually assigned -- FDA, Food Drug Administration, actually assigns the NDC code -- I love this stuff -- and it's a three-part code. The first part identifies a labeler. The second part is the specific drug. The third part is the dosage size. And what Olga is recommending is that you use that first part, the labeler code, as the basis of the assessment.

What that does that's a little different from the previous definition of manufacturer is it will get to different subsidiaries, it will also get to partnerships because each one of those will have a different NDC. So if two companies get together to market a specific drug, that will have its own code. So that's the way of structuring that they recommend.

The second part of their proposal is rather than have a flat fee to have it as a percent of sales basically, and they recommend half of a percent.

Let's see. According to the data they have from the first quarter of 2007, that will raise about $429,000. So I think you may have heard numbers in the 70,000 range previously.

Taking this approach at that suggested level raises a whole lot more money. So one of the things you may want to think about this is if you move to this do you want to use that half percent number or do you want to use something else. What I've got to help you with that decision --

ATTENDEE 1: What if it were like five percent?

MR. KAPPEL: If it were like five percent, you may be able to solve the Medicaid budget problem.

ATTENDEE 1: That would be between 4 $5 million?

MR. KAPPEL: Yep. You're talking about a base of somewhere around $120 million in sales. So two handouts.

ATTENDEE 1: Are these --

FEMALE ATTENDEE 1: You said that, before you move on, a base of $120 million in sales, sales of prescription --

MR. KAPPEL: Prescription drugs paid for by Medicaid or VHAP or other pharmacy programs.

FEMALE ATTENDEE 1: So paid for by state sponsored programs?

MR. KAPPEL: Yep.

ATTENDEE 2: The 425 K (sic) was just for the first quarter?

MR. KAPPEL: That would be the full year at a half a percent.

ATTENDEE 2: Oh, full year, okay. Based upon the first quarter?

MR. KAPPEL: Yep.

FEMALE ATTENDEE 1: And, I'm sorry, what was the dollar amount that --

MR. KAPPEL: 429,000.

ATTENDEE 2: 29 --

MR. KAPPEL: Oops, let me back up.

If you use the by code flat fee -- I'm sorry to confuse things a little -- that's 429,000. If you use the half a percent, it's 554,000.

ATTENDEE 3: So the way it's written in the Bill, it's not 70,000?

MR. KAPPEL: The Bill is not -- I could not tell from the Bill what you meant by manufacturer.

ATTENDEE 3: Oh, I see. If it's a flat fee but it's using this code thing.

MR. KAPPEL: Using the NDC code instead of

the definition that's used in the reporting Bill, it would change from about 70 or 80,000 to about 429,000.

ATTENDEE 4: Boy, am I glad we asked you to come in here this morning.

MR. KAPPEL: It's -- it's -- someone who comes in and says there's really a whole lot more money on the table than you thought.

ATTENDEE 5: That was easy.

MR. KAPPEL: The chart is basically -- I took the information that Olga collected and sorted it top down in terms of who would pay under the half a percent model, and what's striking is the top 16 pharmacies would pay half of this assessment.

ATTENDEE 2: Pharmacies.

MR. KAPPEL: Pharmaceutical manufacturers.

FEMALE ATTENDEE 1: Or the labels -- the labelers.

MR. KAPPEL: Yeah, the labelers. So the top 16 distinct NDC codes, about $279,000. But what you can see, like a whole lot of other things in health-care there's a couple of big guys and then lots and lots and lots and lots of little guys. So one of the other advantages

to the way Olga is suggesting you do this is the little guys who actually have a thousand dollars worth of sales in a year wouldn't be required to pay a thousand dollar fee.

FEMALE ATTENDEE 1: What do you mean? So if they pay a thousand or less --

MR. KAPPEL: Well, if you say it's a flat thousand dollar fee for each NDC code, there may be labelers who pay more in that fee than they actually collect in revenue from the state whereas if you say, it's going to be a fixed percent of their sales, the burden then falls proportionately on the big guys and the little guys.

FEMALE ATTENDEE 1: And how many separate and distinct labeler codes did you find --

MR. KAPPEL: 429.

FEMALE ATTENDEE 1: And that was for this year?

MR. KAPPEL: Yeah.

ATTENDEE 3: Steve, all of this could be done on a computer, just put a program in, and the computer would do all this stuff like that?

MR. KAPPEL: Which stuff?

ATTENDEE 3: With the figure, the

.5 percent.
MR. KAPPEL: Sure.
REPRESENTATIVE MAIER: Where does this come from?
MR. KAPPEL: This comes from --
REPRESENTATIVE MAIER: It doesn't look like your -- your spreadsheet. Is this somebody else's spreadsheet?
FEMALE ATTENDEE 1: There's no color on it.
MR. KAPPEL: Yeah, I know it's kind of subdued.
The original data came from Amrug (phonetic) at Ova (phonetic). So what she did was went into their claims system for calendar -- first quarter of calendar '07 and just accumulated claims payments by these NDC codes.
ATTENDEE 3: You were about to follow up with something else I asked about. Remember, I said all done on a computer program and just push a button and it's -- all the figures are kicked out.
MR. KAPPEL: Yeah. What I was going to suggest if you want to pursue it is we actually

have this spreadsheet with us today. So if you want to explore either different percents than the half a percent or if you want to explore things like truncating so anyone's fee who would be less than $100 wouldn't pay, we can do that right now.
And as a for-instance on that one, if you look at the box on top, if you say anybody whose fee is less than $100 doesn't have to pay it, you only reduce your revenue from 554,000 to 550,000. So there's lots of opportunities like that to make this simpler, easier to administer without losing a whole lot of revenue.
ATTENDEE 3: Okay. Good.
FEMALE ATTENDEE 1: So the filter was you took out less that 100.
MR. KAPPEL: Yep.
FEMALE ATTENDEE 1: And then this chart shows the -- this would be the labeler codes and this would be the revenue.
MR. KAPPEL: Yes. This is -- I just took all of the reports, put them in order of how much the fee would be. And then the big guy, GlaxcoWellcome is that 42,000 and then it

tapers off really fast.
ATTENDEE 1: This column over here confused me but this is a cumulative?
MR. KAPPEL: Cumulative percent.
REPRESENTATIVE CHEN: Question.
REPRESENTATIVE MAIER: Yeah, Harry.
REPRESENTATIVE CHEN: This may be too late to do something like this but if I asked you how many -- well, I don't know if it's possible -- generic prescriptions are written -- new generic prescription are written in Vermont that are -- you know, instead of -- you know, you give them a one week supply of -- a card worth one week's supply of a generic prescription, that would -- again, a generic sample -- essentially a generic sample at a physician's office so I don't know how to get at how much that is but maybe we can just do some, make them up and --
MR. KAPPEL: I'm trying to catch up because it's sort of a different way --
REPRESENTATIVE CHEN: No, no, I don't think you can come up with what it is but we could determine --
FEMALE ATTENDEE 1: Let the center

detailers hand them out?
REPRESENTATIVE CHEN: Yeah, let the detailers hand them out or --
FEMALE ATTENDEE 1: (inaudible) detailers to hand out a certain percentage of generic samples for all the other ones --
ATTENDEE 1: No, I don't think we want (inaudible).
FEMALE ATTENDEE 1: Topper, could we roll that into your Bill?
REPRESENTATIVE CHEN: It might make it more attractive to some.
REPRESENTATIVE MAIER: The bell is ringing but I'd ask do people have -- I think it's pretty clear. We can talk about this later. We can refer to it now.
REPRESENTATIVE CHEN: Tiva Bar and Milo (phonetic) -- there's no bar in my language, generic.
ATTENDEE 2: Say that again, Harry.
MR. KAPPEL: The second one and the last one.
REPRESENTATIVE CHEN: The second one and the last one are generic -- companies that own generic drugs.

FEMALE ATTENDEE 1: Only?
MR. KAPPEL: Yeah.
ATTENDEE 3: Aren't you going in the direction of providing some financial incentives for issuance or sales for generic drugs? Is that where you're going?
REPRESENTATIVE CHEN: Yeah.
REPRESENTATIVE MAIER: Yeah, Scott.
REPRESENTATIVE WHEELER: Going over this I'm not certain if we talked about this is, do we know what percentage of doctors really don't sway towards generics? Like my doctor first -- the first thing he does is he -- anything I take is -- if there's a generic for it, that's it. You don't have -- I know, Dr. Chen, you have some insight but do you know if --
REPRESENTATIVE CHEN: I would probably say just from my own personal experience that probably 40 percent of people -- 40 -- at most 50 percent of the people use -- really are oriented towards generic prescribing.
ATTENDEE 2: Doctors or people?
REPRESENTATIVE CHEN: Doctors.
FEMALE ATTENDEE 1: Doctors are people, too. (Inaudible.)

FEMALE ATTENDEE 2: They must have a subsidiary. Right?
ATTENDEE 2: Doesn't the pharmacy --
MR. KAPPEL: Yeah, actually Pfizer shows up a couple of different times. There's Pfizer Laboratories, a division of Pfizer, Incorporated.
FEMALE ATTENDEE 1: It's just pricing that --
MR. KAPPEL: They're spread out.
FEMALE ATTENDEE 1: Okay.
MR. KAPPEL: So this is the trick of why manufacturers are not necessarily manufacturers.
FEMALE ATTENDEE 1: Yeah. Okay. Good. Thanks.
MR. KAPPEL: Harry, you were asking about (phonetic) Bar. Was that the third one?
REPRESENTATIVE CHEN: Yeah.
MR. KAPPEL: They're down around 900,000 in sales so they're not much further down the list but a little bit.
ATTENDEE 2: Isn't it in Vermont?
REPRESENTATIVE CHEN: Let -- can I just do -- let's do this -- this is -- so people

have heartburn. All right.
ATTENDEE 2: Yeah. Stand this way, that's how teachers do it like this; see, you lean like that.
REPRESENTATIVE CHEN: For heartburn there are drugs called PPI, proton pump inhibitors; they inhibit the pump that makes acid. All right. So there is drugs like Prevacid -- these are brand names -- Protonix and then there used to be a drug called Prilosec. Remember that a while ago?
FEMALE ATTENDEE 1: Yeah. They all have to start with PS.
REPRESENTATIVE CHEN: Prilosec is -- is now generic and is now over the counter so -- but these drugs are not over the counter. So -- so you can't -- well, I don't know, is Prilosec something is over the counter (inaudible).
FEMALE ATTENDEE 1: Yeah, I see the OTC ads.
REPRESENTATIVE CHEN: But let's say it wasn't even over the counter. So doesn't this -- this is the generic name of Prilosec. Let's just forget it's over the counter now.

That confuses you. Omeprazole.
FEMALE ATTENDEE 1: Who comes up with these names?
ATTENDEE 1: These are all Latin people.
REPRESENTATIVE CHEN: So this -- this is where the generic law comes into place. So if I write a prescription -- and forget it's over the counter. If I write a prescription for Prilosec, they will give you omeprazole. That's why -- why we're 95 percent and that -- that's a no brainer.
The trick is, is that there is not -- again, what drug companies do when they release a drug is they compare all these drugs to sugar pills. That's all they do. And so when a FDA approval comes and says, this is better than a sugar pill for your acid, but very rarely do you ever see these studies of one against the other. And probably there is not a lot of difference between any one of these drugs and any other of these drugs.
So this is where generic detailing would help -- again forgetting it's over the counter -- would be to give a card that says because this drug is probably as good as this

drug for most people, for 90 percent of the people, to give a card that would encourage people to use this drug, again because this drug may cost, what, $15 versus $70 a month. So that's why this is -- so this is a -- this is the generic type issue.

ATTENDEE 2: No. So if a doctor writes a prescription for one of these --

REPRESENTATIVE CHEN: You can't put that.

ATTENDEE 3: Because there is no generic.

MR. KAPPEL: Because there is no generic because these are -- this is the monopoly.

ATTENDEE 3: But if there is a generic, the physician -- not the physician, the pharmacist would give you a generic. That happens to me all the time.

MR. KAPPEL: No, right. And that's fine, that's a no brainer. That's an easy one. That's what the law says. We do a good job of that.

This is where we don't do quite as good a job, because these are the things that are going to be in the doctor's office. There is going to be no sample of that in the doctor's office.

ATTENDEE 3: That's right.

FEMALE ATTENDEE 1: So -- so when it comes to generic, your pharmaceutical coverage no longer pays for it.

REPRESENTATIVE CHEN: No.

FEMALE ATTENDEE 1: What I meant to say --

REPRESENTATIVE CHEN: That's a confusing issue.

FEMALE ATTENDEE 1: But there are drugs that you can have over-the-counter versions but you can't get a strong one except by prescription.

ATTENDEE 2: You just double it.

FEMALE ATTENDEE 1: Like hydrocortisone.

REPRESENTATIVE CHEN: Oh, yeah. Well, that one you can.

FEMALE ATTENDEE 1: You can --

REPRESENTATIVE CHEN: But the problem is over the counter is actually 15 milligrams. We used to prescribe the prescription as 30 milligrams. It doesn't take a rocket scientist to know (inaudible).

ATTENDEE 3: Just like Claritin.

REPRESENTATIVE CHEN: Right, same thing, but that's again -- so this is what -- what

again all the marketing is try to get more (inaudible), and more Protonix. That's what marketing does and that's obviously what's -- you know, that's what's wonderful about America but the fact of the matter is that people -- people can do just as well with Omeprazole.

FEMALE ATTENDEE 1: So your brainstorming is, oh, gee, maybe there's money to get generics out and solve that problem?

REPRESENTATIVE CHEN: Well, to encourage more generic prescribing.

REPRESENTATIVE MAIER: Let's please come back at 10:30 sharp.

(Whereupon, the CD 148, Track 2 ends.)

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 listen to CD 07 - 148/Track 2, the House Committee on Health Care, Friday, April 20, 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 17th day of August 2007.

_____

Dona J. Wong, RPR, CSR
Esquire Job No. 887529

ESQUIRE DEPOSITION SERVICES

STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: April 20, 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 - 150/Track

Esquire Job No. 887980

PROCEEDINGS

- - -

Transcribed from: CD No: 07 - 150/Track 1

ATTENDEE: Here we go.

ATTENDEE: Where are we going?

ATTENDEE: Robin has a new draft, so let's have her hand that around, and she's going to -- she's not going to walk us through it, but she's just going to orient us to it or run us through it because I don't really want to do a walk-through first. If we have time before the end of the day, then we will do that so, you know, most of the -- most of the big pieces that we're going to talk about, she hasn't really done anything yet, but she'll explain that.

Actually, I think I already have that, yeah.

MS. LUNGE: Okay, so I did this as a strike-all amendment because I thought it would just be a little easier to read. The changes are in bold, so to look for changes, you can just sort of flip through until you start to see bold.

And what is in this draft are specific requests that you've -- that you've heard from different folks on all the sections, except the big three, PBMs, prescription drug confidentiality

and the unconscionable pricing.

I didn't do anything with those yet because I felt like I didn't have enough direction to know what way you were going to do so -- but some of the smaller issues or changes that were raised, I incorporated.

There's a couple of different places where there's a couple options because I wasn't exactly sure what you'd want to do, so we can go through it in more detail, but that's basically what's in and not in overall.

ATTENDEE: Let me just say in the last copy you gave us, a lot of stuff just simply had like cross-outs like that.

MS. LUNGE: Yes.

FEMALE ATTENDEE: So this time, that's like--

MS. LUNGE: All the cross-out is disappeared.

FEMALE ATTENDEE: Oh, you took that out. Okay.

MS. LUNGE: I didn't, but it's done automatically in the office.

FEMALE ATTENDEE: Except what had been crossed out, but was actually --

MS. LUNGE: The version that you got was the version from the Clerk's office, and they

hand-strike things.

FEMALE ATTENDEE: Okay. Okay.

MS. LUNGE: And then my office gets their hand-stricken and actually, you know, corrects it in a Word document, so you have the corrected version with my amendments, and my amendments are in bold.

FEMALE ATTENDEE: Okay.

ATTENDEE: Corrected version as passed by the Senate.

MS. LUNGE: Yeah, with your amendments from the discussion here.

FEMALE ATTENDEE: Okay, so -- well, we'll find out like when we get to page 4, you can explain.

MS. LUNGE: And I can, you know, when we go through it later today, I'll explain where it came from and stuff like that.

FEMALE ATTENDEE: Okay. All right. Thanks.

ATTENDEE: Okay, so what I'd like to do first, as I said before, is to just sort of create, you know, over the next half hour or 45 minutes or so, each of us sort of weigh in on where we stand on the -- the both larger pieces and see if we can't -- see where we are and

whether we're of enough consensus already to give Robin direction over the weekend or identify if we're not what further information we need. Let's go around the table. I'll start with Lucy. Do you have a question?

ATTENDEE: No.

REPRESENTATIVE LERICHE: I am fine with -- obviously, very quick.

I'm fine with everything in this Bill except for the unconscionable pricing section. I just feel like -- that feels like a bit of a can of worms to me, and so if we decide to do it as a Committee, I guess I would say there may be a more restrictive version of it, so I feel very strongly that we need to keep the data mining section for a lot of reasons, which I don't think I need to go into.

And the PBM section, I think that -- I'm good with the PBM section, and I could definitely be convinced to make that even a little stronger than it already is so that's...

ATTENDEE: Thank you.

ATTENDEE: In what way would you want it stronger?

REPRESENTATIVE LERICHE: Well, I think this

hole question of saying okay, PBMs, you agree to
t in good faith and with the -- I forgot your
term of art that we were using, the duties of
acting with these duties, but you can -- we can
waive those duties, like you don't really have to
do that.
ATTENDEE: Uh-huh.
REPRESENTATIVE LERICHE: So I mean, that
could, in my mind --
ATTENDEE: That's a little waffling.
REPRESENTATIVE LERICHE: Yeah. I mean, I
think in my mind, I think that could be -- that
could be stronger, and I would say that doing
something a little more akin to what they did in
Maine, but I also, you know, am here to work with
the Committee, and hopefully, you know, hear what
you all have to say.
I mean, you know, I'm not -- I'm not putting
a stake in the ground with that. That's just --
just my general feeling about it.
FEMALE ATTENDEE: Fabulous. Well said.
ATTENDEE: Sarah?
REPRESENATIVE COPELAND-HANZAS: I'm starting
to feel real comfortable with the Bill, but as
Lucy said, I do still have some questions about

the unconscionable pricing section.
I think that I would feel more inclined to --
to restrict that to more of a national disaster
emergency sort of situation, as opposed to a
general health threat I guess but, you know,
again, I'm -- I'm willing to work through that and
see where everybody else's comfort level is as
well.
And as far as the PBM section, you know, I
think it's right on. I feel that -- that -- that
they should be held to a standard, and so I'm
hoping that we can spend some more time working --
looking at that section and just decide as a
Committee where -- where we think that ought to
fall, but otherwise, I think it's -- I think it's
looking good. We've taken a lot of testimony. I
think it will be -- it's a great Bill. It's
getting there.
FEMALE ATTENDEE: With the pricing, I don't
want it in there at all because the reason I feel
that way is I feel like if it can't be excellent
that we shouldn't do it at all and because there
is so many questions, I just don't think in two
days, we can produce something that's excellent,
so that's why I'd take it out.

But the data mining, and I told Steve this,
although it can complicate matters a little bit, I
would prefer to see instead of -- well, writing
the wording, and I don't know how it would be
said, but not to say that -- I don't know how to
say this, but that you could only get the data if
doctors opted in, and I know that complicates it,
but the reason I would prefer to see it that way
is I think people can say, as I think companies
have, Well, you're putting us out of business,
you're bad for Vermont business.
In fact, I think it's their own business
practices that put them in this situation, and I
think that by forcing that, for doctors to have to
say, Yeah, sure, you can have my data, that will
put them out of business, and it won't put us
between -- you know, it sort of does, but I think
it's -- it's their own practices that when they're
put out in the light of day and by opting in, it
forces, it really forces it out there.
Well, I feel by us saying it's illegal just
puts like a lid on it and kind of hides it, and I
would like it as flushed out as possible.
That's why I want -- and also, again, it's
not -- it's not the legislature putting private

companies out of business. It's the private
businesses putting themselves out of business
because they were unethical I think in how they
went about their business to start with. That's
why I would like the opt in, even though it
complicates matters, and with the PBMs, I think
it's fine because I don't buy the argument that
anyone dealing with the PBM is so sharp that they
won't have the wool pulled over their eyes. I
don't buy it, so I would rather have a higher
level of accountability.
ATTENDEE: On the pricing, I agree. I would
love to see it go into some global area, talking
about the state getting ripped off in a lot of
different categories of consumer fraud or
whatever, rather than just this one issue, I mean
if we have a state of emergency.
The other reason that's bad is the way we
discern even to find out if we got ripped off
won't be until like a year after it happens, so
it's not like we're going to save money right
away. It's going to be like -- we're going to
have to spend it anyway because we won't know what
the fair market value, or whatever the term is,
that we're comparing it against until sometime

later on, so it's an afterthought.
It's much too complex for what we want to do.
I agree with everything that's been said by Lucy and others about the PBMs. I really want to see more transparency as to what the contracts are including.
I also would agree with making that change that they shall put that information in if others would agree with that. I think it could be a little bit stronger. I really want it to be very transparent as to what's in the contract and that everybody, all participants, understand what that is.
The data mining, I'm definitely for, and I'm not worried about IMS going out of business. This isn't going to put them out of business. Right now, they're more worried about the trend of where it's going, and it's going to be years before that would ever happen, that I think what it's going to do is elevate the attention of them and us towards the whole issue of counter-detailing, and that's what we're really trying to get at.
The point is not to put IMS out of business. The point is we need help to discern what we need to do to help detailers be more of a contribution

to the -- to the pharmaceutical business rather than a detraction and a cost, and so this just elevates that discussion in a -- in a way that's not going to put anybody out of business.
It's just going to raise the flag and say, okay, we've had enough, so we're going to try to look at something different, so I'm for it.
ATTENDEE: When you say you're for it, you mean you're for --
ATTENDEE: I'm for keeping it in.
ATTENDEE: Oh, okay.
ATTENDEE: The way it is.
ATTENDEE: Okay.
ATTENDEE: I think -- I think I agree with a little bit of everybody.
Unconscionable pricing hasn't -- nobody showed me any reason that we should have that, and I'm not ready for even hypotheticals, what if.
It's just -- that doesn't interest me, but like everybody else, I would work with them.
The data mining, I find that one to be a struggle. I understand -- I understand both views.
I felt like I ping-pong ball back and forth. I would listen to one person and say yep, I agree

with them.
I guess on that one, I'd have to think about that one over the weekend because it's a little bit -- I haven't -- I haven't firmed up my thought.
If you asked me to vote on it right now, I would probably -- no. 50/50. The ball is in the middle.
ATTENDEE: I got a coin.
ATTENDEE: Okay. Bill?
ATTENDEE: I think unconscionable pricing can go, and I like the data mining.
I'd like to hear a little bit more. Patty brought up the point about fiduciary responsibility and contract responsibility. I'd like a little bit more discussion about that, but (inaudible) unconscionable pricing's got to go, and we've heard a lot of testimony on keeping the data mining in.
That's it.
ATTENDEE: The PBM language is okay with me. I already stated the unconscionable pricing has to go.
I'm torn between waiting until litigation is completed on the data mining, between that and

listening to doctors talk about how much they dislike it, and so I'm still thinking about that, but I guess if I had to vote today, it would be a toss-up on that one, but that's how I feel about the PBM, how I feel about the pricing, and I'm still trying to make up my mind on data mining.
I don't like the activity, the way I'm hearing it's going on. It affects doctors, so I'm listening very carefully to what they have to say.
ATTENDEE: I would say -- I mean, I think there is a lot of good things in this Bill. I'm going to make a comment on the PBM second.
I guess I'm really uncomfortable with -- with the contract, the being able to contract out of anything. That's just -- to me, it's like saying this is what we think people should do, but we don't mean it.
FEMALE ATTENDEE: Yeah.
ATTENDEE: So I would -- I would like to see at least the first number 1 pulled out, as an expectation of health agencies.
ATTENDEE: What page and line are you looking at?
ATTENDEE: On the bottom of page 15.
ATTENDEE: I'm okay with everything else

being contracted out, but I think the way that they relate to their customers, that we believe that this should have a different standard then. I think that we should say we do, period.
FEMALE ATTENDEE: So that phrase Harry -- just so I'm sure.
ATTENDEE: Sure.
FEMALE ATTENDEE: So you're saying take out that phrase, "Unless the contract provides otherwise"?
ATTENDEE: No. I would -- what I would do is pull -- I would recommend that we pull number 1 out.
ATTENDEE: B-1?
ATTENDEE: Number 1 out by itself.
FEMALE ATTENDEE: So what I would probably do is--
ATTENDEE: And then wherever, wherever -- is it 1 and 2, or is it 1?
ATTENDEE: B-1.
FEMALE ATTENDEE: It's -- 1 is the duty, B-1.
ATTENDEE: I'd pull the duty out.
FEMALE ATTENDEE: Right.
ATTENDEE: And then put everything else as it is, but "unless the contract provides."

FEMALE ATTENDEE: So we could make 1 a complete sentence and make it B, and then renumber B to C and renumber 2 to 1, et cetera.
ATTENDEE: The way I look at it is this. You will be on good behavior, but if you contract, you cannot be on good behavior. That's the way I view it.
FEMALE ATTENDEE: Yeah.
ATTENDEE: Or you don't have to be on good behavior.
FEMALE ATTENDEE: You don't have to be on good behavior.
ATTENDEE: You don't have to be.
ATTENDEE: So we think they should be --
FEMALE ATTENDEE: You can contract out of (inaudible) -- yeah.
ATTENDEE: So you would strike 1, B-1?
ATTENDEE: No, no, no. I'm saying bring it forward.
ATTENDEE: Bring it forward.
ATTENDEE: So that it's not subordinate to the introductory clause on B.
ATTENDEE: Oh, I see.
ATTENDEE: Okay, you can't waive it.
FEMALE ATTENDEE: So it stands it alone. It

cannot be waived.
ATTENDEE: I think that there should be -- this duty should be what they -- how they relate to their customers.
ATTENDEE: Okay.
ATTENDEE: Period, and then some of the other things, I think they can contract out.
They don't want to see all the -- all the transparency things they can contract out of that. They don't want to see where all the money goes and...
ATTENDEE: Okay, all right.
FEMALE ATTENDEE: Great.
ATTENDEE: And that puts a little more teeth to this, and I'm, you know, and I'd like to talk a little more about the level of the duty, but I think I would be -- if we pull it out, I would be more comfortable with it at this level versus the fiduciary.
In terms of the unconscionable pricing, I also agree that the way it is now, it's unworkable. As I say, I'm a little sad that it's gone.
FEMALE ATTENDEE: Yeah.
ATTENDEE: Mostly because I'd love to know --

the pricing, the way pricing is, it's so complex.
I mean, we have no idea what we're paying and if it's a reasonable price or not, and the beauty of this is that we would get to the bottom of it.
FEMALE ATTENDEE: Uh-huh.
ATTENDEE: So I really mourn the fact that we won't have that, but I understand that in many ways, it's (inaudible) so that's why what I see here, I may even try to see if there's another way to accomplish something that might be short of the actual court case, but I'm not there yet.
In terms of the confidentiality, what I would -- what I would ask people to do, call their doctors this weekend. Ask them. Say, you know, you've got the -- you have this testimony. Say, Do you know that your drug company, you know, that your -- that whoever comes to your office knows what prescription you wrote last week and how many? Is this something you want them to have?
And, you know, I can't imagine that the doctor's going to say oh, yeah, I love this. I would love for them to have it.
So I mean, I just throw that out so -- so I'm comfortable with the way it is.
ATTENDEE: That's a good idea. I already

e-mailed my doctor. He's on vacation though, vacation week.
ATTENDEE: Yeah. I can't imagine that doctors would like that.
FEMALE ATTENDEE: It's probably one of those bonuses he got from the detailer.
ATTENDEE: That's right.
FEMALE ATTENDEE: A speaking engagement.
FEMALE ATTENDEE: Yeah, speaking in Miami.
ATTENDEE: So I mean, I think as much as anything, I would object, I object to it just strictly on the privacy issue, plus all the other issues related to (inaudible.)
FEMALE ATTENDEE: Can I just follow-up with that?
I would say I really don't think that IMS or any other company's going to go out of business based on what we --
ATTENDEE: Oh, no.
FEMALE ATTENDEE: No, I didn't mean it that way.
I was just saying it as I just suggested the opt in as a compromise for people who felt they're uncomfortable having it in there and also for people who were pro-business, it would say, you

know -- that's all I'm suggesting.
ATTENDEE: According to Dr. Landry, only two people would -- or two percent would opt in.
FEMALE ATTENDEE: Right.
ATTENDEE: If his numbers are correct, right? Out of a hundred, only two of them would opt in.
FEMALE ATTENDEE: Right. It's choosing a method of death.
ATTENDEE: They wouldn't be able to use the data.
ATTENDEE: Right.
ATTENDEE: All that data is there.
ATTENDEE: Yeah.
ATTENDEE: Okay?
ATTENDEE: Yeah.
ATTENDEE: And it's in a usable form, especially in a state like Vermont which has what, between Medicaid, NDC and Blue Cross, that's what, 75 percent or 80 percent of the population right there, without (inaudible).
FEMALE ATTENDEE: Yeah. There's a very good chance that we'll be getting Medicare data at some point down the line.
ATTENDEE: How does Mr. Chair feel?
ATTENDEE: Perhaps not too surprisingly, I'm

pretty much in agreement with what many of you have said, and more in particular, with what Harry was saying in terms of some of the details on this section.
I think I'd like to -- to look at -- look at the PBM language more or less as Harry suggested, and I think we need to -- maybe we can have a little bit of a conversation more today along the lines of what Bill asked for, just can we talk to Robin about what does it mean, fiduciary? And how does that, how is -- this language that we see in front of us is a little bit of a step down from that, and I need to understand that a little better before I'm ready to sign on to one versus the other.
I agree on the unconscionable pricing. I don't think that it -- I might like to have a conversation along the lines of what Sarah suggested again with Robin to understand a little more about what did it look like and how would it work, and if it was really more of a Katrina-type situation only, and how much effort would it take to -- administrative effort sort of and how it -- you know, does that actually work, or does it also not work?

I'm worried about throwing it all away and yet -- and yet, I'm also worried about whether it would work.
And I feel pretty strongly about the data mining, for all the reasons that you suggested, and I would just reemphasize, I've said a few times -- Harry mentioned it briefly, I think the data is largely already available and will be even more available in the course of the next year or so -- so for the other purposes for which we and others want to be able to use it for, I think it-- we've already taken steps in that direction, the multi-payor database.
And through our Medicaid program, for example, we track -- we heard from Dr. Landry this morning, we track prescribing patterns in terms of their safety and utilization issues, and we contact physicians, if necessary, in a reasonable and private sort of way, and I think -- I think we already do or could begin to do the kinds of things that we all want and I think we all would agree we want to have happen so...
ATTENDEE: On the Katrina thing, I think it might well be a separate item, rather than try to do it with this Bill because there's so many

ramifications to that, so many checks and balances that I think it might be necessary to do that, which we don't have in the current draft.

ATTENDEE: Well, maybe we could dispose of that quickly if Robin could just talk to us a little bit about that particular -- because there was a form of that somewhere at one point or another, right?

MS. LUNGE: Yeah.

ATTENDEE: Can you talk about how that would have worked?

MS. LUNGE: Sure.

ATTENDEE: And do we need to create a sort of a whole bureaucracy just to do that and...

MS. LUNGE: Sure. Why don't I hand out -- the Senate Health and Welfare version isn't exactly a Katrina thing, but it's -- well, let me start broadly.

So there's two different ways to do it.

What Senate Health and Welfare did was keep the basic structure of that section intact, but narrow the serious public health threat so it wouldn't apply in very many situations, except for like epidemics, and that language is -- the considerations for what would be the public health

threat in that version is tailored to sort of an epidemic that you would use prescription drugs to treat, so it's not tailored to the Katrina situation. It's tailored to an epidemic situation that you would use the drugs to treat the epidemic.

ATTENDEE: Sounds more like a crisis.

MS. LUNGE: But a crisis situation.

ATTENDEE: Bird flu or something.

MS. LUNGE: Exactly.

ATTENDEE: Anthrax.

MS. LUNGE: Exactly, something, some sort of quickly-moving kind of communicable type disease is kind of what they had in mind.

So that's the version that I have here handy.

Some other states do have, and I don't have the language kind of easily available, so I wouldn't be able to get that to you probably until the end of the day or next week, they have broader laws for price gauging generally, and their price gauging laws generally could include prescription drugs as one of the types of goods or services that could be -- that you're prohibited from price gauging.

And price gauging laws usually have a list of

triggering events, such as a Katrina or a hurricane or a snowstorm or a, you know, weather-related or natural disaster related.

So they're usually quite narrow, like a market disruption is the term that's often used, meaning that something happens that disrupts the market, and you don't get to the price gauging trigger until the market is disrupted, so if you had a big Katrina, but there is no problem delivering the drugs, you don't get there. Okay?

So the trigger in that case is a market disruption, and then usually, there is a comparison of the price before and after the market disruption and a decision about whether or not there's been price gauging.

And I can't recall sort of the process of that, and I think it's -- I think some states do it as a -- the Governor can declare, and other states might have more of a court process, so I don't recall the details of that off the top of my head, so those are basically the two models.

Senate Health and Welfare looked at the price gauging, but decided not to do it, I think in part because it's so broad that it would -- it could bring the Bill to many other committees like

Commerce, since really, it's their -- it's really a commerce kind of issue, that type of law or Judiciary area potentially, so they decided not to kind of go that route, and also because they really wanted to keep the focus I think more on prescription drugs specifically.

ATTENDEE: That's sort of how I would be inclined to -- based on reasons (inaudible) because it's so late in the game and for all those reasons, not go in that direction.

Let me ask whether the Committee members have an appetite to move toward what health (inaudible) did do, which was to keep the structure of the way that it's written in the Bill, but narrow the focus of the -- of the serious health threats, so the Commissioner could -- could do and narrow that to a much more emergency-type situation.

Discussion first?

ATTENDEE: Yeah. I want to see some checks and balances in this kind of thing.

Before us, the Commissioner seems to have sole authority, but her testimony was is she has an advisory committee.

I'd like to know what authority the Governor has in that respect, and also, if the

Commissioner's going to have this ultimate authority, what advisors does he or she have in making this judgment? And I think that's important that we have some balance here with respect to what is and what is not.

I know sometimes, it's not black and white. Sometimes, it's gray, and we need a little bit more input for that and more checks and balances than just the Commissioner of Health.

ATTENDEE: I'm with Bill.

ATTENDEE: I think there's -- there's fairly, you know, and I don't know what -- I want to do some research, but there's fairly reasonable precedent for a Commissioner of Health declaring a public health emergency, I mean, so that could be-- and it's not something that happens in exercising power. That might be something to look at.

ATTENDEE: Is there an existing statute on that, do you know?

FEMALE ATTENDEE: I don't know. I haven't noticed it but --

ATTENDEE: Title 18?

FEMALE ATTENDEE: Is should be in Title 18.

ATTENDEE: Actually, I think I have it.

ATTENDEE: Were you done? Did you want to say something else?

ATTENDEE: No. No. Just a couple of things. In the case of emergencies like that --

FEMALE ATTENDEE: So you don't think there's a statute?

ATTENDEE: -- usually, the Governor declares the state -- it's an emergency in the state if you're having an epidemic. Pardon me?

ATTENDEE: I don't know. I mean, I'm thinking of the bird flu as an example.

The Commissioner of Health wouldn't be the one that does that. The Governor would declare that, wouldn't he?

ATTENDEE: No, I think it's --

FEMALE ATTENDEE: No, I think it would be the Department of Health.

ATTENDEE: Right.

ATTENDEE: I don't know. I have no idea.

ATTENDEE: That's what -- see, now there's, "I don't know, I don't know."

You know, and you know, right?

FEMALE ATTENDEE: No, I don't know.

ATTENDEE: Oh, I thought you said it would be the Commissioner of Health.

FEMALE ATTENDEE: I'm pretty sure it would be. I mean...

ATTENDEE: But my point is unless we do it right, I don't want to see stuck in there that we can't back up is what I'm saying.

FEMALE ATTENDEE: I just don't know that there is a right or a wrong.

I mean, he could do -- we could go in our direction. We could do it any way we want, you know, whatever way we wanted.

I mean, there could be a structure there where the Commissioner of the Department of Health goes to the Governor and says, "Hey, by the way, Governor, we have a public health emergency going on."

And the Governor says, "Oh, oh. Well, maybe, I'll declare an emergency. Maybe I won't."

I don't know but, you know, the expertise clearly lies with the Department of Health, right?

ATTENDEE: Don't you think that the law that we have now on price gauging would take effect then?

FEMALE ATTENDEE: What law that we have?

FEMALE ATTENDEE: Well, the only one I'm familiar with is the one for petroleum products.

FEMALE ATTENDEE: And that's all we have.

ATTENDEE: That's all we have.

FEMALE ATTENDEE: I double checked that.

ATTENDEE: Is it limited just to petroleum?

FEMALE ATTENDEE: Yes.

FEMALE ATTENDEE: Yep. That's the --

FEMALE ATTENDEE: There's another one.

ATTENDEE: Maybe we ought to expand that law.

FEMALE ATTENDEE: There is another one for home improvement products, but that is a very different statute, but they are very product-specific.

ATTENDEE: Well, that may be the law that we want to expand.

FEMALE ATTENDEE: It wouldn't be that easy to expand because the pricing comparison is very specific to petroleum products in that statute.

I can get you a copy if you want, but I looked at that for Senate Health and Welfare to see if there's an easy way to expand it, but you'd have to basically rewrite the entire statute because it's so specific to petroleum.

The pricing comparison doesn't really work to neatly transfer it to prescription drugs because the pricing is so different, so -- not that you

Page 30

uldn't do it, but it doesn't -- you wouldn't
eally have much left of the petroleum products,
it would, you know, in there to...
FEMALE ATTENDEE: Steve, can I ask, our deadline for having this out of this Committee, is it really Tuesday?
No, if it's Tuesday, and we always make jokes about oh, the Senate doesn't take testimony, but we wouldn't have -- there's no way we could take testimony on this. So we don't want to do that, do we?
FEMALE ATTENDEE: Well, I feel like we've already heard a lot of testimony on this.
ATTENDEE: We're going to keep pushing to try to get the Bill out on Tuesday.
FEMALE ATTENDEE: Right.
ATTENDEE: You know, whether or not it's a hard and fast deadline depends on whether or not we believe we're going to adjourn on May 4th or 5th and so...
ATTENDEE: Well, you were just asking about this one section though.
FEMALE ATTENDEE: Yeah.
ATTENDEE: And to your question, no. I mean, my preference is not to -- is to have the

Page 31

Committee process, so if we're not --
FEMALE ATTENDEE: Well, because I thought if we're going to change it and try to, you know, get the wording and somehow get testimony in one day, I just didn't know how that was -- what we're seeing is what was going to happen.
ATTENDEE: Yeah, I agree.
Julie?
FEMALE ATTENDEE: I thought what had been envisioned for this provision was a process that would be basically an administrative hearing in front of the Commissioner, which I think would have the checks and balances, for instance, Bill, that you and (inaudible) were talking about that would be -- you know, parties could come in and present evidence, and there would be a discussion, and there would be a finding, which in theory could be appealed.
I mean, there are administrative rules. There is a whole Administrative Procedures Act that we have. It's within Title --
FEMALE ATTENDEE: 3.
FEMALE ATTENDEE: 3. I was going to say 1, but it's within Title 3, and I thought that was the process that was envisioned here.

Page 32

If that's what you're looking for, I suppose you could be very specific and refer to Title 3, the Administrative Procedures Act itself, and I could pull out -- it will take me a second. I would just -- I don't have anything online with me, but I could get you the right reference if you want.
ATTENDEE: Well, I'll take your word for it.
FEMALE ATTENDEE: No, but I mean if you want to actually insert it now, if that's what you're interested in, but there is a -- we do have an Administrative Procedures Act in Vermont which applies to all administrative agencies, and I think the Department of Health and the Commissioner of Health would -- could come within that for this process.
ATTENDEE: Well, I think that's what we need here.
FEMALE ATTENDEE: So I would look -- I would look at Title 3, rather than Title 18 or Title 20.
I think Title 3 may be more (inaudible) for you, if that's where you want to go.
FEMALE ATTENDEE: We were looking specifically for like public health emergency declaration stuff. There is stuff in Title 20.

Page 33

FEMALE ATTENDEE: Uh-huh.
FEMALE ATTENDEE: "The Governor has emergency powers under Section 9 of Title 20, which includes employing such measures and gives such directions to the state or local Boards of Health as may be reasonably necessary."
So there might be something in Title 18 under the state or local Boards of Health, which I can look for.
ATTENDEE: And there are health orders and emergency health orders in Title 18, Section 126 and '7, and these can both be local health orders, which are issued by select boards and a statewide health order, which is issued by the Commissioner, and it lists a whole variety of authority to prevent, remove or destroy any public health hazard, and then a variety of things that the order can -- can do; prohibition and transportation, sale, distribution or supplying of water, food or any other materials or services that might be contaminated, for example, or -- but anyway, those...
ATTENDEE: What's it say about pricing? Anything?
ATTENDEE: About what?

ATTENDEE: Anything about -- how does somebody control the price of something?
ATTENDEE: I'm sure it doesn't say anything about that.
FEMALE ATTENDEE: I think the way -- if you're using sort of existing structure, the only way I really know of that you would control the price of something would be through a condemnation type thing, so I suppose you could try and assert that under our current authority or the state general emergency or police power that we could seize a patent and then -- I mean, you'd have to take -- doing it as a property taking kind of thing.
ATTENDEE: You know, I mean just think of what you just said.
FEMALE ATTENDEE: What I just said?
ATTENDEE: We're talking about getting this thing out of here in the next week? That would take five years.
ATTENDEE: Or two weeks.
ATTENDEE: Other comments?
FEMALE ATTENDEE: Can I ask Harry?
ATTENDEE: Where does the Committee want to go with this?

FEMALE ATTENDEE: I wanted to ask Harry, one of the advantages you thought in this -- in this section is that it would help flush out, give really good information about understanding pricing.
Would this even get at it?
ATTENDEE: Probably not.
FEMALE ATTENDEE: No?
ATTENDEE: This would, you know, establish something that in an emergency that -- and only in that unusual case would it apply, and then you could flush it out, but it would be very rare (inaudible).
ATTENDEE: So what actually happened? I mean, I can remember the news. You know, you hear about the hurricanes or whatever, and then you hear about people trying to sell water for ten dollars a gallon and that.
FEMALE ATTENDEE: Right.
FEMALE ATTENDEE: Doesn't the Governor -- I mean, doesn't something usually happen that (inaudible) that an order comes down from the Governor or something that you can't do that, or does it actually -- does anybody -- do you know how that actually happens?

FEMALE ATTENDEE: Well, what will happen in many circumstances, and even under our price gauging laws, the Governor needs to declare an emergency, and then --
ATTENDEE: Yeah.
FEMALE ATTENDEE: And then once the emergency is declared, then if prices go up a certain percent or a certain amount, a price gauging case can be brought.
The reason you don't hear about it right away is those often take time to work their way through the courts, and there are right now price gauging cases working their way through the courts in other states involving Hurricane Katrina. They're still going on so...
But yes, typically speaking, not in all states, but in many states, a gubernatorial declaration needs to first be made before the statutes kick in.
ATTENDEE: And in our case, would that price gauging only be -- what did Steve say before about -- about petroleum?
FEMALE ATTENDEE: That's what I was referring to just a moment ago.
We -- this body enacted a petroleum price

gauging statute last year, and what it requires before the provisions dealing with how much prices can go up or not go up before you become a gauger, it requires the Governor to declare an emergency.
It's called a market emergency. It doesn't have to be a weather emergency, but a market emergency needs to be declared first.
ATTENDEE: And if we did get a bird flu epidemic --
FEMALE ATTENDEE: Right.
ATTENDEE: -- and it's as bad as some people fear and the market for the drug Tamiflu, or whatever it's called, goes up by a hundred percent, can the Governor issue an emergency order and control that situation in any way?
FEMALE ATTENDEE: I'm not aware of a statute that would allow the Governor to currently do that. I'm not saying there isn't one. I'm not saying there isn't one, but I'm just not aware right now of one.
I know there are some in the petroleum area, and there were even before the statute that was enacted last year, there was an executive authority that the Governor had, but it was, as I recall, in the petroleum area only.

These tend to be -- not always, but they tend to be product-specific.
So you could, you know, if that's what your information was, you could alter this to refer to that kind of a situation, if that's what your inclination was because I don't think that's now on the books.
ATTENDEE: Anybody else?
ATTENDEE: Yeah, I just wanted to ask a question.
How would the consumer fraud action, how would that -- how could that be -- can that be interpreted to take care of this, if there's a --
FEMALE ATTENDEE: That's a really good question.
I'm a pretty creative user of the consumer product, probably one of the more creative ones in this state, and I think it would require -- so you're talking about, for instance, in the flu situation, and suddenly prices started going way up we'd have to -- our office would have to allege that that practice was probably unfair, and the problem we would face is -- I think we'd face some problems in even making the allegation in the absence of a statute.

So the short answer is I'm not sure that it could be currently alleged under the current consumer fraud action. I mean, it would depend.
There might be factors that would allow us to allege it, like they're not being truthful about prices or they're hoarding or they're -- the supplier of the product is engaged in other antitrust activities, such that they're manipulating the market to keep the prices even higher.
Then we could make an allegation, yes, but if it was truly an issue of supply and demand, I'm not sure we could. In other words, demand just shot up. That's why the prices shut up. That's what they would argue.
ATTENDEE: Yeah. Susan?
SUSAN: Maine actually has a general price gauging law. There was a little bit of testimony on that in Senate Health and Welfare, and I actually -- I'm giving Robin a copy, and it's broad. It applies across the board basically in terms of a market disruption.
It would be petroleum, it would be building products. It does specifically mention pharmaceuticals, so if you really look at a

natural disaster type situation, market disruption, and the way it would work is the Governor would declare a state of emergency, and then for 60 days -- I think the way Maine works is for 60 days, prices would be frozen so that they could not go up, and so that's how that one works.
So, you know, that may be something if you do want to go down this road to look at the Maine model.
ATTENDEE: Well, I'm going to make a suggestion.
FEMALE ATTENDEE: Good.
ATTENDEE: I wouldn't mind taking a look at the Maine language, but I'm guess I'm going to suggest that we ask Robin to take out the unconscionable pricing language that's in the Bill so that the next formal version of the Bill would not have anything in it on unconscionable pricing, but that maybe she -- as a separate handout could hand out around this other language so that we could at least take a look at it.
I suspect that you may think that it's -- as someone suggested, that it's too big and perhaps beyond the purview of just this Committee to do that, but I'm intrigued at least to look at it.

(Inaudible) does that seem about right?
FEMALE ATTENDEE: Sure.
ATTENDEE: Well, so why don't we talk about-- why don't we talk a little bit about fiduciary duties and that PBM section.
FEMALE ATTENDEE: Okay. So the PBM section in the amendment that's on page 13, at the bottom, Section 8, and as I mentioned before, this version that I handed out is the same version that you got before because I didn't do anything to it yet.
ATTENDEE: And, Robin, could you start with what if we did nothing?
FEMALE ATTENDEE: If you --
ATTENDEE: How would that relationship be compared to what -- you know, so I wanted to get a sense of what these different levels are.
MS. LUNGE: Well, if you did nothing --
ATTENDEE: You mean, nothing, nothing at all?
ATTENDEE: Yeah.
ATTENDEE: You mean this section wasn't in here at all?
ATTENDEE: Right.
MS. LUNGE: Then it would be what is in existence now, which is there is -- there isn't currently a regulation of the transparency of the

notice provisions or anything like that in contracts, and I haven't, at least not yet, in my research been able to find a specific Vermont case which states the duties between a PBM and their client in their negotiations, so to some extent, that's an open question because we don't know. The court hasn't said that it's any different.

ATTENDEE: (Inaudible.)

MS. LUNGE: Right. There hasn't -- as far as I know, there hasn't been a case that I've seen that has established that, so it could be if someone brought a case where they were unhappy with their interaction with the PBM, I would think that the PBM would argue that it was the regular contract duty which is arms-length negotiation and willing seller, willing buyer.

People -- the PBM would have no special kind of duty to treat the person as anyone greater than anyone else or, you know, someone could make the analogy to the case that I found where it was an insurance agent to their client, which is a little bit -- which is a little higher duty.

And basically, the way the duty comes into play is whether or not when you're sitting down with your insurance agent, let's say, and they're

saying here's your insurance policy, this duty that's established in Vermont law means that they have to treat you a certain way, so they have to make sure you understand certain things and point certain things out to you and just take a little bit of extra time to make sure you know what you're getting into, because the assumption is that they know more about insurance than you do.

So the fiduciary duty is like bumping that up another step, so it means that when you have a fiduciary relationship that several people have mentioned, a common one is with a bank, so the bank is holding your money. They have to treat that carefully. They can't do things which would hurt your financial interest, so their financial interest can't hurt your financial interest, if that makes any sense.

FEMALE ATTENDEE: It's almost like a stewardship-type relationship.

MS. LUNGE: Exactly, yeah. So that's a heightened duty because at some point, someone decided well, if you're entrusting your money to the bank, they should be really careful with it. So does that help at all?

ATTENDEE: And those that had --

MS. LUNGE: Those are sort of the three options. There may be more options than that because I didn't -- I didn't do an exhaustive search on every single duty between different parties in Vermont.

I just -- I was looking for one that looked close to or analogous to the PBM client situation, and the closest thing I could find was an insurance agent so...

FEMALE ATTENDEE: So I just want to make sure, so the highest level if you lived in the state would be the fiduciary.

MS. LUNGE: Yeah.

FEMALE ATTENDEE: Then due diligence or -- no. What do you call it?

ATTENDEE: Insurance agent, whatever this is.

MS. LUNGE: Or -- yeah, whatever.

FEMALE ATTENDEE: How would you --

MS. LUNGE: Reasonable care and diligence and be fair and truthful was the language used in the court case.

FEMALE ATTENDEE: Reasonable care.

MS. LUNGE: It's in 1. It's in the Bill.

FEMALE ATTENDEE: Okay, and then was there a third level, which some (inaudible) or something

like that? No, I'm just kidding.

(Laughter).

MS. LUNGE: The contract, which I didn't look up the contract, but usually, that's like a negligence-type standard.

ATTENDEE: Harry's looking at you.

FEMALE ATTENDEE: Okay.

MS. LUNGE: Okay, if that helped.

So that's kind of the options now, and what the Bill does is sort of set up a preferred option, which is to say if you don't -- if you don't specify that you're okay -- if you basically don't waive this contract, this higher duty, then we're going to assume that the PBM is going to act with reasonable care and diligence and be fair and truthful under the circumstances in their dealings with their clients.

So a court would take that and apply it to a particular factual situation that was in front of it.

ATTENDEE: So when I go buy insurance, when I go to an insurance agent, I don't waive -- I can't waive that, that relationship?

MS. LUNGE: I don't believe that you can waive that in the insurance context. There may be

other contexts that you can, and I'm not entirely sure of that. I tried to kind of look that up, but I haven't had a lot of time to research it very thoroughly so...

ATTENDEE: What kind of insurance are you buying?

ATTENDEE: Long-term care.

FEMALE ATTENDEE: And lawyers usually have a fiduciary responsibility, right?

MS. LUNGE: They certainly do when they're taking -- when they are holding money for their clients, like sometimes lawyers...

ATTENDEE: Yes. Chuck?

CHUCK: Chuck Stoll (phonetic) for Express Groups. Usually, a fiduciary duty is applicable in a situation where an entity has discretionary authority over assets or administration or management of a plan, so it's sort of like, you know, they're entrusted to use their discretion to achieve as best an outcome for somebody as possible, whereas we would argue that a PBM, you know, there is a variety of different types of contracts, but they're pretty cut and dried. Either, you know, we'll give you the blue pill at X price, or we will administer the whole system,

pay the pharmacists, and get, you know, the claims reimbursed and all of that, and we will pass through all the rebates and so forth, and then there could be hybrid mixes of the two, but there doesn't seem like there would be really any sort of -- I mean, the rights and obligations are defined such that there isn't discretion on the part of the PBM as to exactly -- you know, they have to deliver per the contract, period.

And so you're taking a set of rules that's applicable to one type of relationship and imposing it on a relationship that isn't of that nature, and it creates, you know, a high degree of legal risk on the part of the -- on the part of PBMs, if that happens, and it will increase the prices because they'll price that into their risk and that risk into their price structure.

And I, you know, want to reiterate again that under, you know, basic contract law, all contracts have an implied covenant of good faith and fair dealing because there are situations in the performance of a contract where an issue could come up that isn't governed strictly by the contract, and you see that sometimes in situations like in real estate transactions where somebody

wants to try and back out of a contract, and they'll cook up a situation that will allow them to on the face of the contract back out.

You can't maneuver like that in contract relationships. You have to proceed in good faith and deal fairly with the other.

ATTENDEE: Can I ask your -- I mean, if that's a case anyway, do you have a position and what it is that Perry is suggesting we consider?

In other words, I mean, the way that it's written now.

ATTENDEE: You can let me live with --

ATTENDEE: You could -- at least according to this, you could waive this first duty. I hear you saying there's a duty anyway.

CHUCK: There is.

ATTENDEE: And I'm wondering, it sounds like it's a similar duty to the way this language is written.

CHUCK: In some respects, yes.

ATTENDEE: I'm wondering -- I'm thinking about pointing that out, so that it wasn't actually waiveable.

CHUCK: I understand. You know, obviously, we prefer the language as it is right now in the

Senate-passed version.

If there is sentiment upon the part of the Committee to not allow the parties to a PBM contract to contract around it, but it's going to be a hard and fast obligation, then obviously, we would prefer the duty that's in the Bill, as opposed to the fiduciary duty.

FEMALE ATTENDEE: Chuck and I have a fundamental disagreement, and I think that you probably heard from David Balto (phonetic) too that there's a great extent to which PBMs are fiduciaries, and the extent is they get this money from pharmaceutical manufacturers, and the PBM has the ability to characterize it.

Is it going to be an administrative fee? Is it going to be a rebate? Is it going to be a manufacturer's rebate or another rebate?

When you start looking at the various terms under these contracts, what it's called is buckets of money. Where do you put the money, in what bucket?

And the bucket that it's put in is incredibly important to determine whether there's the pass-through or not, and it's that ability of a PBM to characterize money and place it in buckets.

That's where the Maine and the District of Columbia's law are intending to go when they say the PBM must act as a fiduciary.

They have to rise above just the actual language of the contract and really be thinking more about the best interests of their clients in characterizing that money.

That's what happens when they become a fiduciary, is they can't just say oh, well, the contract says we've got these five different buckets, let's just put it where we want, and then maybe the client won't know about it.

No. What in Maine and in D.C. they do is they require that there be a higher -- a higher duty there to honestly characterize that money and to be looking out for the interests of the plans when you're characterizing it and, you know, the question really is from your perspective, is that appropriate or isn't it appropriate?

And I think to a certain extent, that question then begs the next one, which is how complicated do you think these transactions are, and can those clients of PBMs, that is, the plans, understand what's going on?

That's really the fundamental question I

think, and do the PBMs need to -- need to be doing this in a way such that the plans', the plans' interests are being looked out for?

ATTENDEE: Do you characterize the (inaudible) that's in here now, in the Senate Bill?

FEMALE ATTENDEE: I can try. I think it is similar to a fiduciary duty. I think it is possibly slightly lower than one. It is clearly higher than an ordinary contracting duty. So if you've got those on the extremes, the question is exactly how close is it to one or another?

I think it's actually somewhat closer to a fiduciary duty than others around the room might feel.

Ultimately, it would be up to a judge to decide that. It is -- it's requiring more than an arms-length transaction or arms -- the duty that people in an arms-length transaction have with each other. And I'm not trying to obfuscate my answer by any means. I'm just saying it's --

ATTENDEE: So you could consider this an improvement?

FEMALE ATTENDEE: Over -- yes. It is an improvement over ordinary contracting duties, yes,

but it is, as Chuck said -- I do agree with him, and I said this to the Senate, in Vermont, contracting parties have a higher standard than they actually have in other states. There is a duty of good faith and fair dealing.

I think this is higher than just a duty of good faith and fair dealing.

ATTENDEE: If I may, Mr. Chairman, just with respect to Ms. Brill's discussion of the buckets of the money, I want to point out to the Committee that on page 21, under Subsection C, there is a right of audit on the part of PBM customers with respect to administrative service only contracts, and that's a situation where all of the rebate activity and so forth that the manufacturer may be giving to the PBM is supposed to be passed on to the customer, and it's certainly appropriate to back that up with an audit right on the part of the customer to make sure they're actually getting it, but in a case where a PBM -- the contract with the customer is that you're going to get -- you're going to pay X for this price, for this drug, then whether or not the PBM is getting a rebate, that really kind of goes to their cost of buying the drugs.

You know, if you buy a drug for ten dollars and sell it for fifteen, then you get a five-dollar spread, but as long as the person contracted to pay only fifteen, then, you know, whether they buy it for ten or eight or seven, I mean, that's the netting effect of the rebates, and so I mean, I guess what I'm trying to say is that --

(Multiple conversations and laughter).

ATTENDEE: You can tell, right, wrong or otherwise, the way that drug manufacturers price their drugs is extremely complicated and Byzantine, and I'm sure there's actually good reason for that because it's probably, as things have developed over time, situations have arisen where the fluidity of the situation is such that they've got all these pricing arrangements. It's extremely complex. I can't for the life of me figure it out, but it is what it is.

So, you know, the PBMs are the ones who absorb and deal with all that and try and like sort of translate all that confusion over to something that the customer can live with, and the customer should have a choice on exactly how much of that confusion on the pricing or the fluidity

that they -- that's out there that they want to [illegible]ear or not.
And so, you know, there's just an infinite variety of ways that these things can be structured, but it should be by choice of the parties, and if in the end, the choice is well, we don't care what you're making as long as you deliver us the blue pill for five bucks, then they should be allowed to make that choice without any second guessing, and there isn't really any obligation on the part of the PBM to say, oh, by the way, we're actually getting away with murder on -- on what we're paying for this, as long as the notice, you know, is there that we can understand or we can do it differently.
So I think it kind of preserves the beauty of the marketplace in the role that PBMs function if people can tailor these transactions to their own needs.
ATTENDEE: I forget whether any of the rest of you are representing other PBMs.
FEMALE ATTENDEE: I do.
ATTENDEE: Do you have any other comments you'd like to make?
FEMALE ATTENDEE: No, not -- I think that

some of the comments made have been about PBMs offering contracts, but typically, nowadays, (inaudible) the client asks when it puts out an RFP of what they want so -- which goes -- whether the -- which comes first, the chicken or the egg, you know, is -- it is a negotiated thing.
It's not the PBM saying -- they might not come back, saying this is what we can give you for what you want, and if the client doesn't want it, they have the opportunity to go to another PBM for terms that they want in their contract.
So there is a lot of negotiation that goes on, and they don't always -- I'm told clients don't typically -- larger ones don't typically negotiate with just one at a time, and they change clients, or they get a better deal on their second contract as the state of Vermont did with their second Express Script (inaudible) contract, and they got a big deal is my understanding when you first went into it, when the state first moved to it, and then on successive contracts, there has been a savings in millions of dollars to the state because of what they wanted and negotiated in the contract. I don't think that there are other PBMs.

ATTENDEE: Let me ask the Committee, where are people at right now?
ATTENDEE: Well, can I ask you (inaudible) so you would -- I'm going to ask you. This is how I read it.
So you would feel that it would be preferable to allow PBMs and their customers to contract out of discharging their duties with reasonable care and diligence and being fair and truthful?
ATTENDEE: Yes, as long as the customer knows that they have the right to have that term in --
ATTENDEE: So you think that's a better thing, to be able to contract out being fair and reasonable and truthful?
ATTENDEE: No. I mean, obviously, you know...
ATTENDEE: You know, this is why I'm having trouble.
ATTENDEE: As a practical matter, it's pretty hard to argue for, you know, we should be allowed to be unfair and unreasonable.
ATTENDEE: Right.
ATTENDEE: But on the other hand, if you specify in statute and take away the choice that a customer might have on that, if it's okay with the

with plan, you know, should -- should somebody else say no?
I mean, can't they make that decision on their own, or shouldn't they be allowed to, again, with the notion of there is a baseline that you have to treat each other fairly in good faith and in a fair manner?
I hear you; I know.
ATTENDEE: I'm having trouble with that.
ATTENDEE: Yeah. Okay.
FEMALE ATTENDEE: Me too.
ATTENDEE: And maybe it's because I'm not a lawyer, so maybe that's why I have trouble with it.
FEMALE ATTENDEE: It starts to feel like you're holding the client hostage. It's like well, we're not going to give you a really good deal if you're going to make us be fair and truthful. I mean...
FEMALE ATTENDEE: It may sound that way. We don't have --
FEMALE ATTENDEE: It sounds that way.
FEMALE ATTENDEE: We don't -- we don't have the ability to hold the client hostage because they have other places to go, but I understand why

you're reading it that way.
FEMALE ATTENDEE: I have -- well, yeah. I have a real big problem with that too.
FEMALE ATTENDEE: Well, you also heard though David Balto that this market is highly concentrated.
You know, 80 percent of the market is held by -- or the contracts are written by three companies, and the argument that employers will have another place to go assumes that there are a lot of players in the market that are bidding.
And I had a conversation this morning where I heard someone say, you know, if you do X -- one of the PBMs -- the guy's not here right now, but if you do XY and Z, you know, we may decide not to write for Vermont plans.
You know, that's going to lead to even further concentration so, you know, when you really think about it, the concentrated market I think argues very strongly in favor of requiring this kind of duty to insure that these few players that are out there won't say well, you don't like my terms? I'm going to get up and go and leave the employers and the insurers with even fewer options, because they already have very few.

ATTENDEE: If I may, Mr. Chairman, I got to speak to that.
I don't know Mr. Balto, and obviously, he worked at the F.D.C., but since he's apparently left the F.D.C., the F.D.C.'s generated letters to four states, legislative, talking about legislation that's not in all respects (inaudible) but involves some of the same considerations, and they've concluded each time that there is a competitive marketplace, that there's somewhere between 40 and 60 entities that perform PBM activities, and that 12 have more than 5 million lives, and in each case they, you know, they were saying that these type of regulations weren't going to help the situation, that there is a sufficiently competitive market, and I've got those letters. They're long, detailed, and I'd be happy to distribute them, but, you know, it's a lot of reading.
ATTENDEE: Well, Patty would take them. She likes to read.
(Multiple conversations and laughter)
FEMALE ATTENDEE: But if you testify to that, then it's in the record, and there we go.
ATTENDEE: So we have a suggestion on the

table from Harry I guess.
ATTENDEE: Keep the same level, but pull it out.
ATTENDEE: Keep the same level, but what?
ATTENDEE: Pull it out.
ATTENDEE: People don't understand when you say it that way, so let's be more specific.
ATTENDEE: Yeah.
ATTENDEE: Basically, what I would want to do is take number 1 on 15 and make it -- which basically says discharge duties with reasonable care and diligence and be fair, so all of that, and pull it before the B.
FEMALE ATTENDEE: Make it B.
ATTENDEE: Make it B.
ATTENDEE: Make it B.
ATTENDEE: But make everything else below it, you know, the disclosure and all those, make it subject to contract.
ATTENDEE: But the way B is written now, Bill, you see this in B.
ATTENDEE: Yeah.
ATTENDEE: It says, "Unless the contract provided otherwise." It essentially lets the parties in the contract waive anything that

follows.
So what Harry's suggesting is that number 1 would no longer be waiveable. It would come before that "unless the contract provides otherwise" phrase.
ATTENDEE: Gotcha.
ATTENDEE: So that that one would remain in B, but there are all these other ones about how the contract is structured and that there would still be a notice about all that stuff, but -- but that those things could be waived by the -- by the client in the course of the contract negotiation.
Is that -- is that clear now what's on the table?
ATTENDEE: Yeah.
ATTENDEE: Okay.
ATTENDEE: So what happens to the old B?
FEMALE ATTENDEE: Do you want me to --
FEMALE ATTENDEE: It becomes C.
ATTENDEE: It just becomes --
ATTENDEE: You move down. It becomes C.
ATTENDEE: It becomes C.
ATTENDEE: Okay.
ATTENDEE: C, colon, and then --
ATTENDEE: I'm wondering whether 1 becomes --

would it make more sense that 1 becomes A?
FEMALE ATTENDEE: I think -- I think as I was reading it, and I think that would make more sense to me, and then everything under --
ATTENDEE: I don't know. I mean, because the notice --
FEMALE ATTENDEE: Yes.
FEMALE ATTENDEE: Because B is referring to everything that follows.
FEMALE ATTENDEE: Yep.
FEMALE ATTENDEE: And 1 really stands alone.
ATTENDEE: Right.
FEMALE ATTENDEE: So I think it should be A.
FEMALE ATTENDEE: 1 moves up to the top.
ATTENDEE: And then B would be A.
FEMALE ATTENDEE: And B would be A, right, and then everything else would just be renumbered or relettered after that.
ATTENDEE: (Inaudible).
FEMALE ATTENDEE: That's great. We got through that one, right?
ATTENDEE: Well, where are we? I mean, we're clear about what we're doing. I'm not sure that I've let everyone weigh in on where they're at with it.

ATTENDEE: What does that do to the rest of the Section B as we looked at it, before we changed it? What does it do to (inaudible)?
FEMALE ATTENDEE: 2 becomes 1. 3 becomes 2.
ATTENDEE: Now, there are only five of them in that section, rather than the six of them.
The first one, we moved ahead, and then so number 2 becomes 1. Number 3 becomes 2, and they're all still there. There's just only five of them there.
FEMALE ATTENDEE: Yeah.
FEMALE ATTENDEE: But no substance is affected, only numbers?
ATTENDEE: Right.
FEMALE ATTENDEE: No other substance is affected?
ATTENDEE: All the substance is the same.
FEMALE ATTENDEE: Except that --
ATTENDEE: Except that --
FEMALE ATTENDEE: It makes it clear that you can't contract out of --
ATTENDEE: The duties.
FEMALE ATTENDEE: The duties.
FEMALE ATTENDEE: Reasonable care.
ATTENDEE: Right.

FEMALE ATTENDEE: Reasonable care.
FEMALE ATTENDEE: Fair practices and all that.
ATTENDEE: And obviously, there's always a chance to see it written that way so we can see how it all looks.
Do you understand the basic idea?
ATTENDEE: Yes.
ATTENDEE: Do you want to offer a comment? Are you okay with us writing it that way for the next version and then seeing what it looks like, or do you have a different idea?
ATTENDEE: I don't have a different idea.
ATTENDEE: Okay.
ATTENDEE: My concern is that section is so large, I just -- I think the things that are following, when you get into court filings and everything else, and I'm just wondering could you do that or change them by making number 1 the lead paragraph? I just don't know.
FEMALE ATTENDEE: The court filings and all that are specific to particular duties. That's why they're like big As, big Bs, big Cs, big Ds, so you see that repeated twice with duty 2, which will become 1 and with duty 6, which will become

5, if that's helps.
ATTENDEE: It has to be there because they refer to only that one duty.
FEMALE ATTENDEE: Right, so they -- it doesn't apply to all the duties, just to those two.
If it would help, I have it done. I have to get it printed up and copied if you want, just that section to see what it looks like.
ATTENDEE: Sure. (Inaudible).
FEMALE ATTENDEE: If I can get to the beginning of it. Whoops.
FEMALE ATTENDEE: If we have a lull in the action, can I ask you a question about the public hearing, or is that not -- we'll wait to the end?
ATTENDEE: I mean, I just wanted to ask, do people want to wait and look at it and then comment? Are you okay with that?
ATTENDEE: I'm okay with it.
ATTENDEE: Okay.
ATTENDEE: Okay. Well, then yes.
FEMALE ATTENDEE: Okay, so the public hearing on Tuesday night, everyone signed -- you signed -- because I'm not sure of the procedure.
When I'm talking to people back home about

coming, I'm just trying to think. We have the questions.

One of the things that I thought about the questions is unless the person has a real good understanding of where we are right now, some of the questions would be real, you know, tough for them to respond to those, so I kind of tell people those are the questions that you can -- you can bring up anything you want. I mean, I didn't think it was going to be that structure to it. You're giving me this look like oh, (inaudible.)

ATTENDEE: People can say more or less what they want to say.

FEMALE ATTENDEE: And they have three minutes, and everyone has just three minutes.

(Multiple conversations.)

FEMALE ATTENDEE: Just, you know, I just want to -- I don't want them to get surprised, you know, when they come in and find out, and it's first come, first served, so sometimes, there's so many people that come to the public hearings that-- okay.

(Multiple conversations.)

FEMALE ATTENDEE: Steve, one of the PBM representatives pointed out to me a potential

anomaly in the (inaudible) section that I just wanted to bring to your attention. I'm trying to work it through with BISHCA, but do you want to talk about that now while other -- or at some point since you're talking about PBM issues?

ATTENDEE: Sure.

FEMALE ATTENDEE: Okay. I actually didn't notice this, and it actually may have been brought up by Chuck's client, to tell you the truth. I think he was the one who first raised it or someone who works with Chuck. I guess I should put it that way.

The way that this was written -- and I'm now looking at Section 9473.

ATTENDEE: On page 19 in our new version?

FEMALE ATTENDEE: Right, on page 19 in the version you have in front of you, and also page 20, subsection A of 9473 on page 19 says, "Except as provided in subsection D -- " I'm looking at the last sentence of subsection A, "All rights, authority and remedies available to the Attorney General and private parties to enforce the Vermont Consumer Fraud Act shall be available to enforce the provisions of this subchapter."

So that means our office has the right to

enforce it, and private parties also have the right to enforce it, but it's that reference to "except as provided in subsection D."

You then go down to subsection D, and it says, "The Commissioner shall have exclusive authority to investigate, examine and enforce relating to a PBM in connection with -- " and the rest of that really means an insurer, a traditional insurer, and I think what BISHCA, was intending was as between government enforcers they have the right, not our office, and we're fine with that.

But I don't think they were intending to remove the private right of action.

FEMALE ATTENDEE: Right.

FEMALE ATTENDEE: For insurers, and I think by -- it's an anomaly. I've e-mailed to them, to BISHCA and to Robin some language that I think fixes it, and I just -- which would mean that the insurers would have the same private right of action that a plan would have, an employer plan or a governmental plan that's not through an insurer, and I think that's what everybody intends here, but I think the language may need --

(CD 07-150 ended there mid-sentence)

CERTIFICATE

STATE OF FLORIDA
COUNTY OF BROWARD

I, Katherine Milam, Notary Public, Registered Professional Reporter do hereby certify that I was authorized to and did listen to CD 07-150, Track 1, the House Committee on Ways and Means, Friday, April 20, 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.

_____

Katherine Milam, RPR
Esquire Job #887980

STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: April 20, 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 - 151/Track

Esquire Job No. 887980

PROCEEDINGS

Transcribed from: CD 07-151/Track 1

(First audible transmission:)

ATTENDEE: About 15 minutes, I think.

ATTENDEE: Do you have it already?

MS. LUNGE: Lauren's going to go check. I put it in the copy machine.

FEMALE ATTENDEE: Just to remind you that I have to split at 3:00 as well, but I'm very happy to have you --

ATTENDEE: We're going to try to end as well.

FEMALE ATTENDEE: Okay.

ATTENDEE: It sounds like.

FEMALE ATTENDEE: We'll keep working, especially considering it's a nice Friday afternoon.

FEMALE ATTENDEE: Yeah.

FEMALE ATTENDEE: And we're not all screaming to get out of here.

ATTENDEE: Says who?

(Multiple voices conversing inaudibly.)

ATTENDEE: Let me out.

FEMALE ATTENDEE: Can we meet outside?

ATTENDEE: Yeah, right.

FEMALE ATTENDEE: We're meeting on the lawn. Part of the health care assessment that we discussed on the steps of the State House. Remember? We had a meeting with Tom Douse (phonetic) out there.

ATTENDEE: Oh, yeah.

ATTENDEE: And it was some beautiful day like today.

ATTENDEE: Squinting.

ATTENDEE: Squinting.

FEMALE ATTENDEE: Oh, with sunscreen on, I'm sure.

ATTENDEE: I'm not sure we ended up with the best --

FEMALE ATTENDEE: Hindsight is 20/20. I don't think it was April.

ATTENDEE: Sorry?

FEMALE ATTENDEE: I don't think it was April either.

ATTENDEE: No, I'm sure that was May.

(Multiple voices conversing inaudibly).

ATTENDEE: All right. Robin, you can actually walk us through the Bill.

MS. LUNGE: I sure will, but I need a copy myself.

ATTENDEE: Thank you.

FEMALE ATTENDEE: I'd love to have a copy. Thank you. I'm sorry we have to steal yours, so Lauren can make more copies. Lauren?

ATTENDEE: The Chair excuses the fact that it's not double-sided.

MS. LUNGE: See, you shouldn't have me make copies because this is what happens. I'm not paying enough attention.

FEMALE ATTENDEE: I've got more room for notes.

MS. LUNGE: So the new -- the changes to the language are bold and shaded. The shading is just because I wanted in the next version to be able to distinguish between stuff that you did today versus stuff that you've got in version 1 today.

So "A" is the language from -- that used to be in that B-1, except that I made it a complete sentence, so it says "A Pharmacy Benefit Manager that provides Pharmacy Benefit Management for a health plan shall discharge its duties with reasonable care and diligence and be fair and truthful," et cetera, et cetera.

There's no other changes in that paragraph.

"B" used to be "A," and there's no changes in the text, so that's the part that says, "The PBM shall provide notice to the health insurer."

C --

ATTENDEE: Wait. Does B apply to A?

ATTENDEE: It may. Maybe that should say subsection C.

MS. LUNGE: Subsection C.

ATTENDEE: Yeah.

MS. LUNGE: Yeah. Okay. We can change that to subsection C, and then C is the language from before except relettered and numbered, so 1, 2-- what used to be 2 is now 1, and then I renumbered it through the rest of the paragraph, and then I renumbered the last paragraph as D. It used to be C.

I can go through it in more detail if you want, but that's highlighting the changes.

ATTENDEE: How are you doing?

ATTENDEE: Oh, I'm just trying to understand.

ATTENDEE: Well, it is late on a Friday afternoon.

MS. LUNGE: So basically, A -- now, A and B, so the duty of care in A and the notice in B are mandatory, and then C, anything under C can be

contracted around, so those are optional provisions that should be included in the contracted, unless there's waiver of those terms.
And I can go through those details again if you'd like.
ATTENDEE: Would you like her to walk through those items?
ATTENDEE: No, I'm set.
ATTENDEE: 1 through 5? Okay. Anybody else that would like Robin to walk us -- okay?
FEMALE ATTENDEE: I'm good.
ATTENDEE: All right. So let me summarize where I think we are, and then if you like, I'll call it a day.
MS. LUNGE: There's some incentive. Hey.
ATTENDEE: So if we could try to have a new draft on Tuesday, and Lauren, could you maybe print me out something or be ready to tell us what our schedule is on Tuesday when I'm done, so we can --
FEMALE ATTENDEE: Yes.
ATTENDEE: -- make sure that we all know what we're doing then on Tuesday?
ATTENDEE: I would ask people, there are some things in here in bold that you could go through

over the weekend to see what little things we could do.
ATTENDEE: Right.
ATTENDEE: I don't believe they would substantially change it.
ATTENDEE: Yeah, we could walk through those more carefully while everybody's here on Tuesday, but if we can incorporate then a new draft, taking out the section on unconscionable pricing as a separate document to look at, the --
FEMALE ATTENDEE: The main?
ATTENDEE: The main --
FEMALE ATTENDEE: Yep.
ATTENDEE: -- gauging law, this section that we just did on PBMs, and for the time being, we didn't talk much at all this afternoon in any additional way about the data mining section, so I guess for the time being, keep that in as it is in this draft, so it's the same as in the Senate version. Is that right?
FEMALE ATTENDEE: Yes.
ATTENDEE: That's what we're looking at still?
ATTENDEE: Okay.
ATTENDEE: Okay?

FEMALE ATTENDEE: Yeah, progress.
ATTENDEE: Great. Well, thank you for a good-- good week. Thank you, everybody in the room for helping us. Thank you. Have a great spring weekend.
Robin, hold on, before you leave, I wanted to hear about the scheduling.
ATTENDEE: I don't know off the top of my head, but it's in bold.
MS. LUNGE: Next Tuesday, I have House Floor 10 S-115 the rest of the morning, and I'm not sure (inaudible.)
FEMALE ATTENDEE: Maria.
FEMALE ATTENDEE: Caucuses and then S-115 in the afternoon. Good luck.
MS. LUNGE: Thank you.
FEMALE ATTENDEE: Thank you.
MS. LUNGE: Tuesday, I've got starting -- we're lining up witnesses for H-304, Vermont Hospital Security Plan.
ATTENDEE: Wednesday.
MS. LUNGE: Sorry.
ATTENDEE: No, she said Tuesday.
MS. LUNGE: I meant -- I meant Wednesday, and Wednesday afternoon is a joint hearing with the

Senate Health and Welfare with Dr. Mark Novotny who's been carrying out different pilots in Bennington, and then Thursday, most of the day, probably H-304. I'm still lining up witnesses for that.
ATTENDEE: (Inaudible.)
MS. LUNGE: Dr. Debdin, (phonetic.)
ATTENDEE: That's the only one.
MS. LUNGE: Yeah, (inaudible.)
ATTENDEE: And I mean someone asked me in the hallway today, Does that mean you're going to try to pass the 304 this year?
ATTENDEE: What?
ATTENDEE: Someone asked me in the hall today, "Does that mean -- I hear you're scheduling testimony on H-304. Does that mean you're going to pass that and put it on your Bill this year?"
And I said, "No, I don't -- that's not what that means."
Is that consistent with what you think?
ATTENDEE: At this point in time, that's consistent with -- at this point in time, at this point in time, that's what (multiple speakers, inaudible) if you're talking to the speaker.
ATTENDEE: No, it was somebody who heard the

notice.
ATTENDEE: Oh.
ATTENDEE: And was curious to know what it meant.
FEMALE ATTENDEE: So I will just run this off in the copier down the hall.
ATTENDEE: It's in the same spirit as the public hearing on Tuesday night. We're starting to bring in, Are we moving forward? And -- all right. Thank you.
(3 minutes and 15 seconds of multiple people conversing on different topics.)
ATTENDEE: Read this next one.
FEMALE ATTENDEE: 4?
ATTENDEE: Uh-huh.
FEMALE ATTENDEE: If PBMs (inaudible) for drugs based on sales volume, so another way that the PBMs could benefit --
ATTENDEE: So it's just based on sales volume?
FEMALE ATTENDEE: Yep, yep, for certain drugs or classes or brands of drugs.
FEMALE ATTENDEE: Have a good weekend.
FEMALE ATTENDEE: And they will give sales volume discounts to the health insurers.

FEMALE ATTENDEE: Have a good weekend.
ATTENDEE: Okay, so then --
FEMALE ATTENDEE: So that's not just --
ATTENDEE: All right. What I was trying to -- in my mind, I was saying (inaudible) drugs within the state, regardless of the volume. If I just do it, I make money.
FEMALE ATTENDEE: Right.
ATTENDEE: But I don't pass that on to the system. You know what I mean?
FEMALE ATTENDEE: Yeah.
ATTENDEE: To reduce the price.
FEMALE ATTENDEE: Yeah.
ATTENDEE: That's why I thought that was quite a bit of (inaudible.)
FEMALE ATTENDEE: Yeah, but it's two different situations. With this one, when you're substituting, you need to give the person information.
ATTENDEE: All right. Now, let's go back to this (inaudible.)
FEMALE ATTENDEE: Yeah.
ATTENDEE: Okay?
FEMALE ATTENDEE: And we'll change this to (inaudible) so the PBM has to provide notice to

the insured that the terms contained in "C" may be included in the contract so...
ATTENDEE: Okay, that's all this stuff.
FEMALE ATTENDEE: Yeah.
ATTENDEE: All right. Now I'm cool on that one, okay, because that was another problem.
FEMALE ATTENDEE: Yep, yep.
ATTENDEE: All right. Now, this first part.
FEMALE ATTENDEE: Yeah.
ATTENDEE: Is there anything that we can see in there --
FEMALE ATTENDEE: Yeah.
ATTENDEE: -- that would affect 3 or 4 in terms of money that they're getting?
FEMALE ATTENDEE: No. No, because this is a duty of care, so this is how when I send out an RFP (inaudible.)
ATTENDEE: I know that, but I thought -- what about this being a fair payout?
FEMALE ATTENDEE: In the contract, being relationships?
ATTENDEE: Yeah.
(various conversations occurring simultaneously regarding personal issues.)
FEMALE ATTENDEE: So they have to be -- so

when this usually comes up is I might say (inaudible) you told me X, but then you did Y.
ATTENDEE: Yeah.
FEMALE ATTENDEE: So you -- you basically lied to me, or you didn't lie to me directly, but you didn't give me quite enough information so that I really understood the situation.
ATTENDEE: Okay.
FEMALE ATTENDEE: So it's meant to -- it's really applied in situations where the dispute is about what I thought was in the contract when I signed it, versus what you thought was in the contract when you signed it.
ATTENDEE: Okay. Now, I'm going to give you one sentence to look at.
FEMALE ATTENDEE: Okay.
ATTENDEE: On the -- on the PBM.
FEMALE ATTENDEE: Okay.
ATTENDEE: I'm selling a drug.
FEMALE ATTENDEE: Yep.
ATTENDEE: Over the cost. I'm making money.
FEMALE ATTENDEE: Yep.
ATTENDEE: And then I go back to "A" and I say -- I ask myself the question. I make the money off of myself.

FEMALE ATTENDEE: Yep.
ATTENDEE: I don't pass it through to anybody.
FEMALE ATTENDEE: Yep.
ATTENDEE: Am I being fair?
FEMALE ATTENDEE: You are being --
ATTENDEE: That's my dilemma.
FEMALE ATTENDEE: You are being fair. You're not violating this unless you say in your contract I'm going to pass through every cent that I make except for a thousand bucks, and obviously, it would be more than that, but that's my simple-minded little thing that I -- the best I can get my head around this thing.
ATTENDEE: Uh-huh.
FEMALE ATTENDEE: If my contract says, if you're telling me you're going to pass through all the money to me --
ATTENDEE: Yeah.
FEMALE ATTENDEE: -- but then you don't, then you'd be violating it.
ATTENDEE: I understand that.
FEMALE ATTENDEE: But if you say to me, I'm not passing everything through, I'm giving you "X" price for "X" pill, then you're being fair,

because you haven't said to me that you're not making a profit.
ATTENDEE: Yes, I gotcha. I haven't said it -- though I haven't said it, but then the situation I was setting up was --
FEMALE ATTENDEE: Yeah.
ATTENDEE: -- all of a sudden -- I haven't told you about this.
FEMALE ATTENDEE: Yep.
ATTENDEE: But all of a sudden, I see a chance to make a bundle, so I sell a whole bunch of these pills that are over cost. That's what I'm worried about when we move that up to there is being fair. I don't think it's fair, personally, for them to do that.
FEMALE ATTENDEE: Then what you would want is to make these mandatory.
ATTENDEE: Yeah.
FEMALE ATTENDEE: Because this I think has to do with your general interaction. It really depends on what the contract says in terms of whether or not it's fair, so you really -- you know, it's kind of together, so by making these ones optional, you're letting them potentially do that.

ATTENDEE: I made it optional whether they can be fair or not. That's what I'm worried about.
FEMALE ATTENDEE: Fair in your definition of fair.
ATTENDEE: Yeah, I'm a fair guy.
FEMALE ATTENDEE: You are a fair guy.
ATTENDEE: So that's -- okay, I'll think about that one over the weekend.
FEMALE ATTENDEE: Okay. Well, then --
ATTENDEE: While I get myself prepared for this thing here.
FEMALE ATTENDEE: Do you want me to do this?
FEMALE ATTENDEE: Yes, please. They want that for Tuesday, so if you could make copies for Tuesday, then Maria won't have to worry about that, and then I'll let her know that you have it.
ATTENDEE: Hey, Robin, you sent me some --
MS. LUNGE: I sent you the pilot language.
ATTENDEE: Oh.
MS. LUNGE: I was writing it as I was sitting here.
ATTENDEE: Oh.
MS. LUNGE: So...
ATTENDEE: I don't want to deal with it right

now.
MS. LUNGE: Okay.
ATTENDEE: And do you check your e-mail on the weekend?
MS. LUNGE: I do. I'm going to be flying Sunday, and I don't know if I'm going to have e-mail access in D.C., although I hope so.
ATTENDEE: Okay, because I'm going to e-mail Ann's cousin who lives --
MS. LUNGE: Cool.
ATTENDEE: Well, she lives in Falls Church, but she has apartments in D.C. but...
MS. LUNGE: Great.
ATTENDEE: But I think it would be too big for you so -- but I'll see if maybe she knows where -- some suggestions.
MS. LUNGE: Okay. Cool, thank you. I'm going to get down there and have an apartment and have everybody helping me out.
ATTENDEE: Who else is helping?
MS. LUNGE: John Kennedy.
ATTENDEE: Get Hanz (phonetic) to help you.
MS. LUNGE: I should get Hanz. Hanz, however, would be like, Oh, don't you want to live in this gated community that costs 5,000 gazillion

Page 18

dollars a month?
ATTENDEE: But he might tape-record you.
MS. LUNGE: In that case, I'm cool with it.
ATTENDEE: And you wouldn't notice it.
Can you answer one more question?
MS. LUNGE: Of course.
ATTENDEE: We're out of this Bill now.
MS. LUNGE: Okay.
ATTENDEE: "Vermont residents accessing health care services at a hospital shall be considered Medicare beneficiaries for the purposes of --"
MS. LUNGE: Balanced billing.
ATTENDEE: Chapter 65, yeah, of this type of a Medicare balanced billing.
Just tell me --
MS. LUNGE: What that means?
ATTENDEE: So I can get that back in my head.
MS. LUNGE: That is when I go to the doctor --
ATTENDEE: Yeah.
MS. LUNGE: -- the doctor can't charge me the difference between what --
ATTENDEE: Medicare pays?
MS. LUNGE: Medicare pays, and what they --

Page 19

they're --
ATTENDEE: What they've agreed to?
MS. LUNGE: What -- what their charge is, so they have to bill me at Medicare rate, and they can't take the difference and make the --
ATTENDEE: Send you a separate bill?
MS. LUNGE: The person, right, exactly.
ATTENDEE: That's what I thought. Okay. Okay.
MS. LUNGE: Who else am I e-mailing this to? What's Maria's address? Not Maria Royale, Maria from --
ATTENDEE: Mitiguy.
MS. LUNGE: Mitiguy.
FEMALE ATTENDEE: Maria@bddow.com.
MS. LUNGE: Bddow.com.
FEMALE ATTENDEE: B, as in boy, d, as in dog, d as in dog, ow.com. Thanks, and could you copy me on it?
MS. LUNGE: Yes. I'm sending her the Bill, but not that main thing, so if you could send her the main thing, that would be helpful.
Ooh, I'm going to be here late on Tantiff (phonetic), aren't I? They're still on the floor.
ATTENDEE: Looks like they scheduled the

Page 20

legislative -- the legislative gun shoot for the same night as the public hearing next week.
FEMALE ATTENDEE: Skeet shoot. Trap shoot.
ATTENDEE: Trap shoot.
MS. LUNGE: What is a trap shoot? I think I have a vague idea about a skeet.
ATTENDEE: Isn't that the things that fly up in the air?
MS. LUNGE: It's the same deal as skeet?
ATTENDEE: Yeah.
MS. LUNGE: Oh.
So Lauren, the 1.2 that I just sent to you, can you make copies of that for Tuesday, too?
FEMALE ATTENDEE: All right.
MS. LUNGE: That will be great.
ATTENDEE: Hey, Lucy?
REPRESENTATIVE LERICHE: Yeah?
ATTENDEE: Are you getting a lot of questions about that now?
FEMALE ATTENDEE: Yes.
ATTENDEE: The rebate stuff?
REPRESENTATIVE LERICHE: Well, my newspaper asked me to do -- call them on it this week because a couple -- somebody had talked to him about it and --

Page 21

ATTENDEE: Yeah.
REPRESENTATIVE LERICHE: So I am -- I have gotten about four people contacting me about it.
ATTENDEE: I have too. I got more than that. I got people calling me up and saying, How is my bank going to deal with this, you know, in the escrow account?
REPRESENTATIVE LERICHE: What the banks will do until an adjusted bill comes out --
MS. LUNGE: And Lauren --
REPRESENTATIVE LERICHE: So they have to escrow based on a full tax bill.
ATTENDEE: That's right.
REPRESENTATIVE LERICHE: So they're going to have more than escrow taken out. They just are. They're going to have more actually taken out than they really need to.
ATTENDEE: Talk to your town treasurer.
ATTENDEE: I did. I talked to the town treasurer, and she told -- as a matter of fact, the select board just passed a policy that we would do it in four equal installments. We're not going to do it up front.
ATTENDEE: Right, but you're -- what my town treasurer has said, and I don't know -- is that

[redacted]he -- they and like 90 percent, some huge
[redacted]ercentage of all the escrow calculations are done
by -- this is months ago, so I'm not sure I have
it all clear in my head, but there's a single
company that does most of this stuff for the banks
and for everybody else, and most of -- she
suggested that most of the town, but maybe it's
just some of the towns' treasurers, town
treasurers work with this same company, so what
she said basically is that they will be able to
send this -- they send the information to this
company in early July. Once our tax rate is set,
they will send the information electronically to
the same company, and that should get turned
around.
ATTENDEE: To the banks?
ATTENDEE: Through the banks to the people
and -- you know, is it going to happen in time for
July? Probably not, but certainly, you would
think by August or September that those changes
ought to be made, and then your -- there's going
to be -- so in my sense, there may be one or two
higher payments than there should be that need to
get -- I forget whether it's the town. I forget
whose sort of obligation it is, who's sort of

holding the money and the authority of money, but
I think it's going to be -- the town has some role
in that, so will that -- will your taxpayer get
reimbursed that little extra like in September, or
will they -- my guess is they probably won't get
reimbursed till the end of the year.
FEMALE ATTENDEE: Till the end of the year.
ATTENDEE: The only time they could get
reimbursed is at the end because there's no money,
no money. It passes to the town.
ATTENDEE: From the escrow agent?
ATTENDEE: It passes from the escrow, which
is the banks, but no money from the state goes to
the town. It's deducted from your -- (inaudible)
it's deducted.
ATTENDEE: Oh, I see.
ATTENDEE: No money passes between the state
and the town.
ATTENDEE: You don't actually get a check?
ATTENDEE: No. It just reduces what you --
you have this formula.
ATTENDEE: For July and August, you're going
to get extra money on my behalf from the escrow.
ATTENDEE: Yes.
ATTENDEE: And at some point, you're going to

have to give it back to me.
ATTENDEE: If you own the house as of
whatever date, April 15th.
ATTENDEE: Yeah.
ATTENDEE: The prebate is based on when you
own a house.
FEMALE ATTENDEE: One of my constituents just
went through this, and they didn't get it back
until -- they're going to get it back -- the
escrow agent --
ATTENDEE: At the end?
FEMALE ATTENDEE: The bank told them that
they would get it back at the end of the year.
ATTENDEE: But it shouldn't have to do with
the bank, the way I worked it out. I think it's
the town. The escrow agent sends the money to the
town.
ATTENDEE: The only --
ATTENDEE: Right?
ATTENDEE: That should -- if, if the escrow
agent sends (inaudible.)
ATTENDEE: Under my current agreement, I'm
supposed to send you $1,000 a month.
ATTENDEE: Yeah.
ATTENDEE: Well, it wouldn't be $1,000.

ATTENDEE: Whatever it is.
MS. LUNGE: Whatever it is.
ATTENDEE: $500 a month for property taxes.
ATTENDEE: Right.
ATTENDEE: Under the new arrangement, if I'm
only supposed to send you 350, then you're going
to end up having -- and if it goes on for two
months, you're going to have 300 of my dollars --
ATTENDEE: Correct.
ATTENDEE: -- that you shouldn't really have.
At some point, you're going to have to either
credit me or give it back to me.
ATTENDEE: That's right, and since -- and the
interesting thing is if you say to me, I want the
money --
ATTENDEE: You're going to say --
ATTENDEE: The question is (inaudible) going
to say? Okay, we'll give you the money. Now,
what's that -- the relationship between the --
ATTENDEE: The town and the state?
ATTENDEE: Yeah. The town has already told
the state how much they're going to give them, you
know, based on the rebate, so the town may end up
shot on this thing if a person says I want the
money, but the more complicated piece is if they

sell that property, who is -- who's eligible to get that money?
ATTENDEE: Well, now I can remember. I can remember Mary Peterson talked -- answered all those questions on this floor.
MS. LUNGE: Yeah, that's something that the seller needs to negotiate.
ATTENDEE: Remember Bud Otterman and all the lawyers were going -- all the property lawyers on the floor were talking about that, and actually, I think Doug was supporting it because he was saying, you know, you got to work -- you got all these things you got to work out at closing anyway, so this will just be one more thing you work out at closing. You'll do that calculation based on (inaudible), whether it's prorated or -- you agree to do it or you don't in the context of the closing, you know.
FEMALE ATTENDEE: And I think, I think it would be wise for the seller to be negotiating that up front with the potential buyer before -- as part of their contract, rather than waiting for the closing because I just had a situation where I was contacted by a realtor who said that the seller -- no, the buyer -- no, the seller had to

disclose their income at the closing to prove how much, you know -- yeah.
ATTENDEE: It's pretty complicated now.
FEMALE ATTENDEE: Yeah.
ATTENDEE: What we did -- we thought was an easy thing.
FEMALE ATTENDEE: I think what's complicated is this transition here. I think once everybody gets in the groove, it's going to be a lot better, but -- but it's just a really rough transition.
I mean, well, it remains to be seen, but I think a netted Bill makes sense, so just get a Bill and say all right, instead of rebates, prebates. That's confusing.
(Telephone call placed by. Representative Lucy Leriche.)
REPRESENTATIVE LERICHE: Yes, hi. This is representative Lucy Leriche from Hardwick. I was even hoping to talk with somebody about the Act 68 Simplication. I just -- I have a constituent question about some of the timing of all of that, and I was hoping you might have somebody there on staff who could help me with that.
Well, it's actually for an individual who believes that the state is skipping a year,

skipping their prebate or rebate or -- I don't -- I don't know which, and so they won't be getting the rebate this spring? It will be on their tax bill when they get it?
(Multiple conversations occurring simultaneously).
REPRESENTATIVE LERICHE: (Continued telephone conversation) I mean, it will be applied to their netted tax bill and like -- I guess I just need to understand the timing, yeah, the timing of it especially.
FEMALE ATTENDEE: Uh-huh, yeah.
ATTENDEE: It's written, the fee thing is written in as the OVHA 1?
FEMALE ATTENDEE: I have two options because I wasn't sure which way, so I have the original, and then I have the OVHA in there.
ATTENDEE: Is the OVHA option in the --
FEMALE ATTENDEE: .5 percent on the codes.
ATTENDEE: And -- and does that by definition mean that it's more of that prorata based on their (inaudible)?
FEMALE ATTENDEE: Yeah. Yep.
ATTENDEE: Have a good weekend.
ATTENDEE: Is it possible to do the --
REPRESENTATIVE LERICHE: Uh-huh.

ATTENDEE: Do it on the -- on the code, but do it on a flat fee basis?
FEMALE ATTENDEE: Yes.
ATTENDEE: That is, technically? I don't -- I don't personally want to do that, but it's technically possible to do it that way?
FEMALE ATTENDEE: Uh-huh.
REPRESENTATIVE LERICHE: Okay, so --
FEMALE ATTENDEE: It is, and I think that's where it's --
ATTENDEE: Susan Gretkowsky wants (inaudible).
REPRESENTATIVE LERICHE: (Continued telephone conversation) Before, the state -- does the state send out two checks, a rebate check and a prebate check?
FEMALE ATTENDEE: Well, that's good for bigger manufacturers.
ATTENDEE: She just happens to represent number 1 on the list.
FEMALE ATTENDEE: Right. Oh, does she do --
ATTENDEE: Glaxo.
FEMALE ATTENDEE: Oh. All right then. I'm sure they were assuming they were only paying $1,000, and that's why they didn't (inaudible) the

Senate.
REPRESENTATIVE LERICHE: (Continued telephone conversation) So there are instances where somebody might have gotten two checks within the calendar year?
ATTENDEE: Did they actually say in the Senate -- where did the 70,000 come from?
FEMALE ATTENDEE: That came out of discussion here. There was no testimony at all on the fee in the Senate. It was crazy. Steve didn't go over numbers. Nobody asked for a fiscal note or an estimate, and so there wasn't any.
The 70,000 just came I think because Julie had handed out a one-pager about the marketing disclosures, and I think in that, it said there were 71 manufacturers who reported marketing in the state.
ATTENDEE: So I just -- I just multiplied, and somebody just said 71 times a thousand.
FEMALE ATTENDEE: Exactly, yeah. I don't think it was you, but I can't remember exactly who it was.
ATTENDEE: Okay.
REPRESENTATIVE LERICHE: (Continued telephone conversation) I didn't get them to her before she

flew out of here in a hurry this afternoon. I'd be glad to drop them off at your guy's office. I'm right next door, if there's going to be someone there. Sorry.
ATTENDEE: And so did Perry give -- are you working on language about that pilot project?
FEMALE ATTENDEE: Pilot?
ATTENDEE: Pilot project.
FEMALE ATTENDEE: Yep. Yeah, he has it.
ATTENDEE: So -- but it's not in the draft that you're --
FEMALE ATTENDEE: No. He's asked for a few different things, and I've just been giving them to him because I didn't know -- I figured he would offer them separately if he decided to, kind of thing, so that was one that I just e-mailed him.
Also, he had asked about clinical trials, so he has a couple different versions of that. I think that's it.
REPRESENTATIVE LERICHE: (Continued telephone conversation) I guess I'm wondering if this -- when we get -- (inaudible) for a person's rebate, prebate, say this rebate they were expecting, okay, and that they were expecting in the spring, and that's applied -- and the town clerk nets --

deducts that from their property tax bill and nets out their bill and sends it to them, does mean that mean that they'll have one year where their property tax will include two rebates and a prebate?
Okay, no. So there isn't any kind of timing weird thing with -- with this year, except that they won't be getting rebate checks. They have to wait until July to see the benefit of that until they actually get their tax bill. Right?
FEMALE ATTENDEE: Oh, come on.
ATTENDEE: Oh, that's what I wanted to do. I had something I printed out.
FEMALE ATTENDEE: Oh, I hate that.
REPRESENTATIVE LERICHE: (Continued telephone conversation) Right so you -- yeah, all right.
All right. Well, I think you've actually answered my question.
No. Yeah, that's -- that's -- that's the perception, yeah, because they're going to be getting it. They won't be seeing the benefit of it for this year's tax bill.
Yeah, it's going to be next year's tax bill, yeah.
So prebates, prebate checks, you mailed --

before Act 68, you used to mail the prebate checks out and -- okay. Yeah, right, and that's -- that's the issue is that, you know, we're disrupting people's routine with their money. Yeah. Yeah. Yeah. That's true. Okay.
Well, I really appreciate your help. Thank you very much. Thanks, you too.
Bye-bye.

CERTIFICATE

STATE OF FLORIDA
COUNTY OF BROWARD

I, Katherine Milam, Notary Public, Registered Professional Reporter do hereby certify that I was authorized to and did listen to CD 07-151, Track 1, the House Committee on Health Care, Friday, April 20, 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.

_____
Katherine Milam, RPR
Esquire Job #887980

HOUSE COMMITTEE ON HEALTH CARE

STATE OF VERMONT

STANDARD MEETING

CD 07-152 DISC 1

April 24, 2007

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

- - -

SENATE BILL 115
CD 07-152 DISC 1

SPEAKER 1: What we'd like to do is have you walk us through what the changes are and we can all get our minds back around it and see where we are.

MS. ROYAL: All right. I'm Maria Royal with legislative counsel. I'm going to be handing out a new amendment. This is an amendment to Bill S115 draft 1.2, that robin prepared at the end of last week based on what she heard in this committee. The substantive changes, I believe, she has bolded throughout, to highlight where those changes have been made.

SPEAKER 3: Is 1.2 showing the differences from 1.1?

MS. ROYAL: That's my understanding, yes. I think Robin put the new changes in bold and highlighted some other provisions.

SPEAKER 1: I think what she has done is the bold is still --

MS. ROYAL: Those are outstanding issues.

SPEAKER 1: There is bold and shaded which are a few things that happened on Friday.

MS. ROYAL: Okay. I think you're pretty familiar, generally, with section 1. This is the pharmacy best practices and cost control program that is already operating through OVA and there are some changes made here, some amendments to that program.

Let me know how much detail you want here, not that I'll be able to provide all of it. You can stop me, as well, or hurry me along.

You'll see on the first page in subdivision A1, that the PDL, the preferred drug list, is evidence-based. I don't think that's particularly controversial. The next subdivision, A1A, you'll see that language is the language that eliminates the requirement of a statewide PDL, and the new language is around the joint pharmaceutical purchasing consortium, which we'll get to eventually. That is essentially the change there. That is why those provisions are stricken.

On page 3, you'll see subdivision 4 is also stricken. This is the counter-detailing program that OVA was supposed to implement.

That has been moved to the Department of Health and we will get to. That's in a separate section of the bill that we'll also get to.

On page 4, the bold language there, in what was subdivision 7, this is the provision that's asks OVA to inform Vermonters about the availability of 340B that's the discontinued drug pricing for patients of FQHCs. I have a note here that I believe it was OVA that suggested that Medicaid -- well, two things. One, this whole substantiative section has been moved to the Department of Health, so we can maybe talk about it when we get there.

SPEAKER 1: You mean the part that's missing is somewhere else then?

MS. ROYAL: On page 4, subdivision 7, that the language is stricken here.

SPEAKER 1: I know, but in the version passed by the Senate, there was a new 7. I know you might not have this in front of you.

MS. ROYAL: There was a new 7 and what you see written down is the new 7 but it's stricken and moved to another section of this

bill, to section 14, on page 25. If you want, we can look at that now. Whatever is easier for you in that regard. Would you like to turn to page 25 and look at it now?

SPEAKER 1: That's okay. We'll get there.

MS. ROYAL: I believe that's modeled after the language passed in the Senate with one change that OVA suggested concerning Medicaid patients.

SPEAKER 1: Okay.

MS. ROYAL: Then the next provisions of the bill that you'll see here, not too many changes made from the Senate version, concerns the joint pharmaceutical purchasing consortium. On page 5 healthy Vermonter Plus has been deleted, and that is because that program, itself, has been deleted from the healthy Vermonter Program which again we'll get to that in a subsequent section.

But, otherwise, I don't think this committee made other changes to that provision. Again, this is to have various state actors negotiate collectively for drugs that they have in common on preferred

drug lists to negotiate better prices.

On page 6, this is just a few minor changes to the drug utilization review board recommendation made to OVA regarding preferred drug list insuring that those recommendations are based upon evidence-based considerations that they note adverse side effects, appropriate clinical trials, and there's also for purposes of uniformity, a cross reference to the new counter-detailing program, which starts on page 24, but that's the definition of what evidence-based means.

So that's just an attempt to make things uniform, as well as clarifying what the DUR's responsibilities are.

Also on page 6 in bold, I believe that's just a technical change. I think it said section C1, and technically is should be subdivision C1. This is the provision that encourages voluntary participation in the joint purchasing consortium. It's similar to language that was in the requirement under the old statewide PDL, that has been deleted, inviting representatives to use the

preferred drug list, so that all parties or participants can achieve lower prices through increased volume.

On page 6, section 2, this is the cost containment provision that permits or asks OVA to seek assistance from entities that have done independent research on prescription drugs. This was the reference to the Oregon research that had been done under the FDA.

Most drugs are compared to a placebo. There have been some programs in various states like Oregon where drugs were compared against other drugs for their clinical effectiveness. So this is just a provision for OVA to work with some of those other research entities and use that information, and use that information in administering the PDL.

On page 7, these are amendments to the existing pharmaceutical marketing disclosure law. These are required reporting that drug companies need to do currently. Gift disclosers, and that kind of thing. There is an exception here that allows the

attorney general to share the information that it receives under this section with both the Department of Health and OVA, and the purpose is basically to allow OVA and the Department of Health to do more targeted counter-detailing efforts on their own by understanding some of the marketing practices of drug companies that that might help them as to where they should focus some of their counter-detailing efforts, and I think what Robin --

SPEAKER 4: Can I ask a question?

MS. ROYAL: Just out of curiosity, think about the naturalpath bill we just worked on. How does this affect what they would do?

MS. ROYAL: In what sense?

SPEAKER 4: You talked about the preferred drug list. What about a preferred herb list, or any of that? How does this affect that when we are talking about evidence based medicine here?

MS. ROYAL: I'm not sure -- I don't have any clinical expertise. I'm not sure what the naturalpath or maybe the herbs would fall under on the PDL. I'm not sure that is part

of your preferred drug list, because that is not something --

SPEAKER 4: I don't know. This seems pretty restrictive and I thought we kind of opened this thing up.

MS. ROYAL: The other thing is the PDL applies to OVA, the medicaid programs. So you're now also talking about private providers. There is an issue of whether they're prescribing herbs or other medication for medicaid patients, and then also to other private individuals, but I don't know how they're prescriptions are regulated under this.

SPEAKER 4: Okay.

SPEAKER 5: The naturalpathic supplements, nobody pays for them. So there would be no remuneration under the PDL, because they're not involved in paying for them, but the ones they use come out of the naturalpathic fields of research.

SPEAKER 1: I'm not sure where we are headed with this.

SPEAKER 5: There is no cost involved other than to the individual that purchases them.

SPEAKER 1: But I think Ed is interested on the evidence-based part as well as the cost side.
SPEAKER 4: Both.
SPEAKER 1: We did one thing here, and I'm not sure this is where that conversation should be taking place.
MS. ROYAL: I can do some asking around over lunch maybe.
SPEAKER 1: Let me ask the committee how you're doing with this walkthrough in terms your focus. She is focusing on more of everything. Would we like her to focus on the bolded and shaded parts, the things that would be new recently, or do you feel it helpful to have a slower walkthrough.
SPEAKER 6: I think it would be helpful to have a slower walkthrough. Things have been put to different areas and switched and stuff.
SPEAKER 1: Okay.
SPEAKER 6: I would just like to know where something has been switched to.
MS. ROYAL: So you see under the section Robin bolded, "OVA," just a technical change specifying that the Department of Health and

OVA shall keep the information confidential.
On page 8, the change here again in the Senate version of the bill which was not changed, you'll see the unrestricted grants for continuing medical education programs are now required to be disclosed under this reporting statute, but at the very bottom of page 8, subsection D, there are some limits on those disclosures, and this was some issues about UVMs sponsoring programs but not having to convey who the actual participants of the programs were, and that kind of thing.
On page 9, this is section 6, the "Price disclosure and certification." This is the information on prescription drug prices that's currently provided to the federal government to CMS. Now, that same information here is to be provided to OVA and the purpose is to allow OVA to compare prices and to ensure OVA is, in fact, getting the best prices it's entitled to under the Medicaid program.
There were some changes made. Here you'll see bolded language. I believe

the intent is the way the previous version had required the information to be disclosed, the manufacture price as well as the best price, that was re-worded to just cross-reference the prices that are already required under the federal Medicaid program to be disclosed to CMS, and the purpose there is to just keep track of changes made under the federal law.
I guess there have been some current initiatives that are going to amend how the prices are reported, exactly what's reported to the federal government, and this would just track those federal requirements. That, I believe, was the primary change, there in bold. Then, otherwise, the methods for reporting track federal standards.
On page 10, subsection D, this is the provision that specifies who actually reports the information to OVA, the president, CEO, or designated employee, of a drug company. I think a question had come up about whether or not there are criminal penalties, and the quick answer to that is, no. There are no criminal penalties for

violations of this section unless they were actually submitted under oath, which they are not for this particular section.
SPEAKER 4: But there are civil penalties.
MS. ROYAL: Yes. I believe this section actually has --
SPEAKER 5: It notes, "Consumer fraud $5,000."
SPEAKER 4: Okay.
MS. ROYAL: The Healthy Vermonters Plus section on page 11, is now the Healthy Vermonters Program, the plus portion was eliminated to an extent, although substantively part of what was Healthy Vermonter Plus, is now just an expansion to the Healthy Vermonter Program. This is the discount card program for uninsured or underinsured Vermonters.
It allows them to receive the Medicaid price for prescription drugs. It also allows for a secondary rebated price. Apparently OVA has not implemented that as of yet. It would require a waiver from CMS. It would also require that the state contribute towards the cost of drugs. I think there is a waiver

impediment, and I think there might be a money impediment, too, to seeking those supplemental rebates.

However, you see on page 12 that provision is still in the law. That is just to notify you that that has not been implemented to date.

The substantive change to the program you can see primarily on page 13, the Healthy Vermonters Plus program as it was enacted a few years ago raised the income level of persons eligible to 350 percent of poverty. It also allowed for individuals whose expense for drugs exceeded a certain amount of household income.

Two things. One, the Healthy Vermonters program, itself, raises the income level to 350, so there is not a separate Healthy Vermonters Plus program for those between 300 and 350. So that is just a simplification, not a substantive change. But there is a proposed removal of coverage for unreimbursed expenses for those people that had drugs that were five percent or more of their household income.

I believe the testimony you heard was that is extremely difficult administratively to calculate, and it also would only benefit a small number of people. So there was a proposal to strike that portion of the provision. So those changes are primarily substantive changes.

SPEAKER 1: Can you focus back on page 12?

MS. ROYAL: Yes.

SPEAKER 1: The bold line that the senate cut out, why are we putting it back in?

MS. ROYAL: I'm not sure the senate did that. I have to look. That's actually existing law.

SPEAKER 1: The senate took it out. If you go to page 13, did OVA recommend putting it back in or something?

MS. ROYAL: I don't know.

SPEAKER 1: I remember talking -- the testimony from Robin was that the Senate felt it was not needed, that CMS's approval wasn't needed.

MS. ROYAL: I have a note from when Robin went through it that the testimony was that they didn't need the waiver because that

weren't using Medicaid funds. However, I'm not sure that that was accurate, because in order to get the supplemental rebates, they do need to make a state contribution, which would require waivers. I want to clarify that further. It wasn't part of any of the Senate testimony. That may be something -- I may be able to get hold of Robin over the lunch hour to see if she knows more of what happened there, the history.

SPEAKER 1: I think maybe you should, because I'm looking at OVA's submission and they still had it out. I wonder if it's a typo, or if it should be crossed out, as well.

MS. ROYAL: I will ask her. According to her note here she specifically kept it in. I don't know exactly what the change was. I'll see if I can find out.

SPEAKER 1: Thanks.

MS. ROYAL: That brings us to the bottom of page 13, to the PBM regulation. I think you're pretty familiar with this section. The first section of this section 8 is the definition section. The real substance of it begins on page 15, section 9472, and I think a

significant substantive change proposed in this committee is that the duty of care in subsection A is mandatory. "All PBMs that provide pharmacy benefit management for health plans shall discharge their duties," and so on and so forth.

If the duty itself has stayed the same it's no longer optional, it's a statutory requirement, and a provision on page 16 -- let me step back for a minute. That's now a mandatory duty of care applicable to all contracts between PBMs and health insurers.

SPEAKER 1: Why don't we take a short stop here, before I take your questions. Why don't we ask Harry to remind us of his thoughts. He can articulate it the best.

SPEAKER 7: In the previous version we had that phrase, "unless the contract provides otherwise," at the very front, and before the duty of care. In my mind, it didn't make sense that if we felt there was a certain standard of a relationship between two parties we felt that shouldn't be something you could contract out of. My example was, were I going to be honest and be a good guy, if

that's the standard we wanted to put in, it doesn't make sense to say that is the way we wanted to think people should behave, but they could contract out of that.

That's why I moved this out to the point where the standard would apply, period, but they could contract out of the other things.

SPEAKER 1: So that phrase, "unless the contract provides otherwise," is still in.

SPEAKER 7: It's still in there. It's just moved down and shows up in C.

SPEAKER 5: It applies to everything that it applied to before, except it no longer applies to this "good guy" clause.

SPEAKER 7: Yes. The duty of care. We left the duty the same, short of the fiduciary duty.

SPEAKER 1: Are there any questions?

MS. ROYAL: In terms of the optional duties they are, as just mentioned, listed in subsection C on page 16. Before that, in subsection B, there is a requirement that the PBMs provide notice to insurers that those terms in subsection C, which we'll get to, may be included in the contract. So just note

those optional provisions.

I think you're familiar with those requirements. I will go through them quickly. There are five, I believe. The requirement of disclosing financial unutiliztion information requested by a health insurer.

There's the confidentiality provisions specific to this requirement, and then you'll see also exceptions to confidentiality provisions for information required to be disclosed under court filing, et cetera. It's just some standard language. That is what you'll see in subdivision C1, A through D.

The next one, on page 17, subdivision 2, "shall notify insurers of any conflict of interest with respect to the requirements of this section." Subdivision 3, this is the section that pertains to a PBM dispensing drugs, substituting prescription drugs that actually might cost more than the prescribed drug. The PBM needs to disclose any benefit or payment that it receives from making the substitution, as well as the cost for both

the drugs, the prescribed drug and more expensive drug, and any benefit or payment it receives by making the substitution.

Subdivision 4 is a requirement that the PBM pass through any savings it is able to garner as a result of the volume of sales and drug purchases, and finally, subdivision 5. This is the so-called "kick-back" section.

Notice of any financial terms or arrangements for remuneration the PBM has received from a drug company, and again there are confidentiality provisions related to this section, as well, with exceptions as required by law.

D is just the compliance section that applies to all PBMs entering into contracts with all health insurers in Vermont for PBM services.

The enforcement provision, I understand maybe there's some questions about that. You heard some different proposals, I think, from Chuck Starro from Express Scripts. I don't know exactly where you are in that regard or if you've seen his language.

SPEAKER 1: We did see his language, and we are okay where this is at right now.

MS. ROYAL: I think Julie Brill also had a proposal.

SPEAKER 1: I think she is okay with this.

SPEAKER 5: That was something that we all sort of thought was a good catch.

SPEAKER 6: You don't want to remove private right of action.

SPEAKER 1: Where is that?

SPEAKER 6: That is in subsection A.

MS. ROYAL: I think subsection D might have been her concern. I think what you heard may be from Chuck Starro, who maybe wanted to eliminate the consumer fraud provisions. I think the condition under subsection D that Julie was raising is the way it's worded now. "The commissioner shall have the exclusive authority to investigate," might be read to prohibit the private health insurer from bringing -- she does have some proposed language. I wasn't sure if she would be here today. I don't know if she's coming in this afternoon, or if you want -- I'm not sure how you want to proceed. I just have an e-mail

from her.
SPEAKER 1: Why don't you just mark it and come back to that.
MS. ROYAL: Okay.
SPEAKER 1: Not surprisingly, I haven't seen the language, but I hear from BSHCA, they don't agree with the language. That's why I want to come back to it. Neither of them are here right now.
MS. ROYAL: Okay. The PBM the audit section requires PBMs to register with BSHCA to provide health insurers the options of administrative services only contracts, and allows the health insurers to conduct audits and BSHCA does the rule making to set up how the process works. You're pretty familiar with that and maybe don't require --
SPEAKER 1: And the bold here --
MS. ROYAL: The bold, I believe this was a proposal that came from OVA. It eliminated the bill-back to Medicaid. That was the only substantive change there.
Section 10, I think there is a typo there. This is the application of the two PBM sections. I think they're now 8 and 9,

and not 7 and 8. I think that's a technical change.
Section 11, 12, and 13, this is the counter-detailing program. Some technical statutory changes. The bulk of the counter-detailing evidence-based educational program begins on the bottom of page 23. This was the section, or the program, that was initially with OVA and was moved to the Department of Health, and requires it to work with the attorney general, as well as AHEC. I think on page 24, subsection A, the second line, I think that's UVMs Area Health Education Centers Program. I believe that is the reference there. That might be a typo.
SPEAKER 5: I'm sorry, where?
MS. ROYAL: On page 24 under section 4622 subsection A. That's just a typo on line two, the second line there there's reference to the UVM Area Health Center Program. I think it should be UVM Area Health Educational Centers Program, AHEC. It says "The department shall establish the evidence-based prescription drug program."

There's a provision in bold here, I think, maybe, representative ten had suggested this, "The program shall also notify prescribers about brand name drugs for which the patent has expired in the last 12 months, or will expire within the next 12 months. The Department of Health and OVA shall collaborate in issuing those notices. That is a new proposed substantive change."
SPEAKER 8: How much drugs -- how much work is in that department -- like six, or seven, or 20, or 100?
SPEAKER 1: There are a fair number, but most of them are neither significant or applicable. There are probably 10 that are important people. 10 to 20 each year, so not many.
MS. ROYAL: You'll see on page 25 this is the 340B pricing.
SPEAKER 1: That's just the same thing but moved to a different place.
MS. ROYAL: Same thing, with the one change that I mentioned, that it does not include Medicaid.
SPEAKER 1: Right.

MS. ROYAL: I'm not entirely sure what the reasoning was there. I wasn't here for that. I don't know if there was some concern specific to Medicaid patients that they may might want to switch providers.
SPEAKER 9: It's because Medicaid gets a lower price than the 340B. There are supplemental rebates.
MS. ROYAL: On page 27, this is the data mining section, and I believe it is the version that passed the Senate. Again, I think you're familiar with the information, the prescription drug information, the prescriber information, and the prohibited use of that information for commercial purposes.
On page 30, section 16, this is an amendment to the public records act. It exempts from public disclosure a number of things. You'll see it on page 31, but in particular from what we just read, the information we just went over, that would be collected, that's prohibited from disclosure under the data mining section, but does allow that information to be used for research purposes, and does allow disclosure

for the counter-detailing program.
The citations on page 31 at the very top of that page, you'll see just the cross-references to the other sections of the bill, disclosures from the counter-detailing program, prescription data -- I don't know if you want to go through each of these, but, I think it lists exactly what those provisions apply to. Maybe if you have questions we can come back and address those.
SPEAKER 1: Where are you again?
MS. ROYAL: I'm on page 31.
SPEAKER 1: I think you have a different version. You're in section 16?
MS. ROYAL: The section 16 which I have begins on top of page 30.
SPEAKER 1: On top of 30; correct.
SPEAKER 10: And section 17 starts in the middle.
MS. ROYAL: I don't know why I have a different one. Thank you.
SPEAKER 1: So what you're taking about is section 16.
MS. ROYAL: I am talking about section 16,

yes. The exception to the public records.
Let me get to where you are.
Section 16, you follow substantively what the purpose of this section was.
SPEAKER 1: Yes.
MS. ROYAL: To prohibit public access to confidential information.
Section 17, I believe you have a choice to make here. This is the fee on pharmaceutical manufacturers. There are two options presented here. One is a flat fee of $1,000 per year on each drug company doing business in Vermont. The other option, and I think Steve Koppel went over this, is to use a percentage that is specified on page 31, point five percent of the company's drug spending in the previous calendar year.
These fees are used both for the evidence-based education program, as well as under title nine. I think that's a cross-reference to the proposed provisions on false advertising on consumer fraud. I guess we'll get back to that in terms of which option is the preferred option.

Then speaking of the false advertising, on page 31, this amends the consumer fraud act and specifies, first in subsection A, that violations of the data mining section are considered violations of consumer fraud act. Subsection B pertains to the PBM section, and then subsection C is the advertising provision, which I believe should allow for state enforcement of federal law under the consumer fraud act.
I think you'll see bolded and stricken, the language misbranded, based on Robin's note here that was maybe confusing language, and Sharon Treat re-worded that to be a little less confusing. Also, on the subsequent page, added some new language under regulated advertisement sections, which is on page 32 about halfway down.
If I understand this correctly, under that section B, Roman numeral I, pertains to direct consumer advertising. The proposed Roman numeral II pertains to advertising in a doctor's or prescribers office.
On page 33 you'll see Roman numeral I is

in the office of a prescriber and Roman numeral II is advertising at a conference or other professional meeting. Again, I think that the change --
SPEAKER 1: We go from little Roman numerals to big Roman numerals and not back to some letter.
MS. ROYAL: That's unusual. Usually it doesn't work that way.
SPEAKER 1: That doesn't look right.
MS. ROYAL: I can check on that, too.
SPEAKER 1: It should go to a number or letter.
MS. ROYAL: I think I would go to double A and double B, or something like that. I can get the answer to that by this afternoon.
The next section concerns insurance marketing, and this is based on the proposed changes you see in bold. Again, I can't say I'm very familiar with this section. I'm reading from Robin's notes that Sharon Treat had some suggestions based upon a bill proposed in Maine. So there is some restructuring, some moving things around, and like I said, you actually are probably

more familiar.
Page 35 is just some technical changes moving things in statutes.
SPEAKER 1: I think we'll break here for lunch and caucus.
MS. ROYAL: I'll look at the Healthy Vermonters, the waiver issue, and talk to Robin and find out the information about that.
SPEAKER 1: There's one other thing in play that did not come up last week, but early on when we went through this, maybe when DeAnn Khan was here, explaining the multi payor database, the question was raised as to whether we needed to be more explicit in our statute about any penalties for if someone signed a confidentiality agreement, say a researcher, using a multi payor database or something, and we heard that Maine is several years down the road with this, and they and a few other states that are doing this, believe that it's very important to have explicit penalties if you disclose the information legally, if you sign an agreement and then you don't disclose it.
Robin e-mailed me on Friday because she was

going through her notes and said this is one of those pieces that's hanging out there that we haven't heard back about. I e-mailed BSHCA and they might have some language for us on that this afternoon. The language, itself, is just is technical. The idea we can talk about after we see it, as to whether we want to do it or not. I didn't care how they wrote the language. It was just the idea of now versus later.
SPEAKER 10: I still would like to find out if we can put language around PBMs changing in January. We got this letter from our insurance company notifying us to tell us about the recent changes to our formulary and pharmacy benefits that changed in January. I really think that --
SPEAKER 11: We talked about a kind of grace period or something.
SPEAKER 10: Yes. I'd like to see if we could somehow address that. I think that is one of the biggest issues our constituents are dealing with, and how do they get the medication. I think that does more to help people back home.

SPEAKER 1: Just so we can move this along, do you want to sit down with Maria just so she could at least bring a draft to us?
SPEAKER 10: Okay.
SPEAKER 1: Let's break for lunch.

END OF CD 07-152 DISK 1.

CERTIFICATE OF OATH

STATE OF FLORIDA)

COUNTY OF MIAMI DADE)

I, the undersigned authority, certify that I was authorized to and did listen to CD 07-152 Disk 1, the House Committee on Health Care, April 24, 2007 proceedings, and transcribed the foregoing proceedings, and that the transcript is a true and accurate record to the best of my ability. Witness my hand and official seal this 7th day of April, 2008.

Michael Todd Berkowitz
Notary Public - State of Florida

HOUSE COMMITTEE ON HEALTH CARE
STATE OF VERMONT

CD 07-152 DISK

STANDARD MEETING

APRIL 24, 2007

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

- - -

SENATE BILL 115
CD 07-152 DISC 2

MS. ROYAL: There was one issue in particular that I was able to talk to Robin about and that's under the Healthy Vermonters Program, the waiver issue.

SPEAKER 1: Do you want to give us a page or section?

MS. ROYAL: Page 12. The Senate had stricken the existing statutory language about getting the waiver to provide the secondary discounted cost to beneficiaries, and Robin said that was really inadvertent. There was some discussion they thought the waiver was needed for raising the income level to 350 percent of poverty. Initially, there was some discussion about that, and OVA said we don't need a waiver to do that.

That language was then stricken, but that's where the problem was, because they do need a waiver to get the secondary discounted cost. So the way you see it on page 12 is actually the way it should be. This allows them to get the waiver if they seek the secondary discounted cost for beneficiaries.

Right now, they aren't doing that. They don't have money to do that. It's on the

books subject to an appropriation. That'S one thing I was able to clarify.

Then there were some options in the bill that you were going to get back to. The manufacturer fee on page 30. You heard Steve Koppel provide some information on this. This is the fee for drug companies, and whether you wanted to go with option one, the $1,000 per year fee, or option two, which is a percentage of the previous calendar years' drug spending.

SPEAKER 1: Harry needs to be here for this conversation. Why don't we move instead to -- was there another one that you have Maria?

MS. ROYAL: Let's see.

SPEAKER 1: Do you want to talk about yours Patty?

MS. ROYAL: There are the enforcement issues from BSHCA and Julie. I believe BSHCA and Julie are coming in at 3:30.

SPEAKER 1: Why don't we hold off on that.

MS. ROYAL: This is a huge issue, the numbering on page 32. Actually, it's on 33. It actually is correct the way you see

it according to the proofers.

SPEAKER 1: Why don't you explain what it is we'd like to see again.

SPEAKER 2: We've discussed the PDLs changing in January, and patients not being able to get their prescriptions, and all this does is say that the insurance companies have to notify patients ahead of time, so that they're not getting letters like the one I got in April of the PDL changes, and if they haven't been notified, then a 30-day supply has to be given to the patient. That's basically what it says.

SPEAKER 3: This was a current practice. If you get the notice in April, and you've been getting the medications since January --

SPEAKER 2: You don't. When the PDL changes in January, and you go to the drugstore January 2nd, you don't get your medication. So then the pharmacy notifies your doctor, and your doctor has to notify the insurance company, and then they play back and forth, and have you try this and you have to try that, and this process goes on, which sometimes can take weeks.

SPEAKER 3: And in the meantime they're out of medication.

SPEAKER 2: The patient is out of medication. They can buy it by the week if it's very expensive, but sometimes to buy it by the week is $40 or $50, and Medicaid also is a problem.

So patients really need to be notified ahead of time. If you notify them by April, you can notify them by January. They've got to know by December what they're new formularies are going to be. Send a notification out to your clients, or to your patients be it medicaid.

SPEAKER 3: So this would be either notification, or a 30-day --

SPEAKER 2: Well, here's the thing that passed. A one prescription grace period it would be.

SPEAKER 4: Is this when it totally drops off the list or changes as to where it is on the list?

SPEAKER 2: It could be either or. It could be dropped off the list, but it says written notice specifying the drugs that have

been added or removed from the drug list, which shall be provided to beneficiaries at least 30 days prior to the effective date of such change.

So, it's saying they have to notify them 30 days ahead of time of changes in the PDL. It says, "Written notice to a beneficiary that a specific drug is no longer covered on a preferred drug list at the time the beneficiary seeks a refill of that drug. In such circumstances the beneficiary shall not be denied coverage for the first requested refill after the change to the preferred drug list has taken place. Subsequent refills, however, shall be subject to requirements of the preferred drug list."

So this just kind of gives a safety net to patients.

SPEAKER 1: You need to get it in writing 30 days ahead of time, or if you show up at the pharmacy at that point they give you something in writing, and they have to give you the --

SPEAKER 3: What happens if they claim, "Well, you got a notice. The company said

you got a notice. We posted it on our website"?

SPEAKER 2: We'll never be able to cover everything.

SPEAKER 1: Right.

SPEAKER 3: I'm just throwing it out there.

SPEAKER 2: This is more than anything to make sure that some effort is made in letting people know about the preferred drug lists.

We can try this with a hammer and if it doesn't work, I guess we try a mallet next time.

SPEAKER 4: Make it registered mail or something.

SPEAKER 2: That would be a little expensive. This is a start.

SPEAKER 4: It's a good idea. I like that.

SPEAKER 3: Can you tell me a pharmacy benefit manager as defined in subsection 94715, what is that? Who's not going to be covered by this?

MS. ROYAL: That is taken from your proposed PBM section. That would be on page 15. "Pharmacy benefit manager includes any

entity that performs any pharmacy benefit management," and pharmacy benefit management is defined, and that includes mail-order pharmacy development of formulary.

SPEAKER 3: Wouldn't it not be the PBMs that notify the patients, the insurance companies would. PBMs don't know who I have for an insurance company. My insurance company would have to notify me.

MS. ROYAL: Well, that's a good question, and actually Steve is in the room, even though he is looking the other way. I discussed this with Steve earlier today and, actually, he came up with a basic concept of having an option here, written notice, generally, or upon an attempt to refill a drug.

But I think Steve might have a better sense of whether the health insurer or the PBM would be in a better position to notify the beneficiary of changes to the formulary.

SPEAKER 3: I don't know see how the PBM would know who I have for an insurance company.

SPEAKER 5: The PBM would have to know who whose contract you're under because they

probably will have different deals with different companies with different benefit sets.

They would have to know a lot of details about, specifically, what coverage you have got and from whom. I'm not sure who would be better to do that notifying.

SPEAKER 2: I think we would put it to the insurance company, because if the insurance company wants to delegate it to the PBM according to the contract, then they can do that. It's really their jurisdiction.

SPEAKER 3: The thing about doing it with the insurance company is we get -- I don't know if it's quarterly -- we get a newsletter from our insurance company telling us about different screenings and stuff that's going on. A new formulary could just be put in that newsletter.

SPEAKER 1: The only reason to do a PBM would be that they need -- a PBM would cover a lot more people. You have got more people in the self-insured plans that do almost all have PBMs, but don't all have --

SPEAKER 6: But they have TPAs; don't they?

SPEAKER 1: We're not necessarily regulating TPAs.
SPEAKER 4: Wouldn't it be to anybody that's producing a PBL, whether it be Medicaid or -- that is the crux. That is the place where it begins, or where it changes.
SPEAKER 3: But we can't regulate self-insured plans.
SPEAKER 1: This as written would not apply to Medicaid?
MS. ROYAL: I intended that it would, because they do formulary development. They provide pharmacy benefit management services.
SPEAKER 2: Then they should let people know, too.
SPEAKER 4: Right.
SPEAKER 3: Of all of the insurers in the State of Vermont, Medicaid purchasers are the ones that will have the biggest problem if they go into the drugstore and they're drug isn't on a PDL, because they're not going to be able to pay out of pocket.
SPEAKER 2: Right.
SPEAKER 3: I mean Medicaid was the first

one I wanted to hit.
SPEAKER 6: So you think the pharmacy benefit manager would hit all Medicaid folks?
SPEAKER 2: They have their own PBM.
SPEAKER 6: Would Medicaid hit that, Steve?
SPEAKER 7: I'm not sure if we will.
MS. ROYAL: Yes. Because they provide pharmacy benefit management as defined under the PBM section, page 14.
SPEAKER 3: Then all of our private insurance carriers in Vermont all have PBMs?
SPEAKER 2: Yes.
SPEAKER 3: Then the self-insured, we don't know about.
SPEAKER 2: They probably do.
SPEAKER 8: They probably have their TPA.
SPEAKER 3: Because they all have third-party administrators.
SPEAKER 2: So, it's a yes, yes, and a maybe.
SPEAKER 1 : I think the best way the get to the most people is through PBMs.
MS. ROYAL: That was part of the thinking, because you can't directly regulate the self-insured patients, but if they contract

with PBMs --
SPEAKER 3: You can regulate.
MS. ROYAL: You can regulate the PBMs.
In terms of the logistics, and information, and data, that they have, I don't know off the top of my head.
SPEAKER 3: This is -- I don't what a pharmacy benefit management company would say about this. "There's no way. We can't be liable for this." I don't know.
Do you have any idea?
SPEAKER 2: I don't, and I wasn't even thinking of doing it through the PBMs anyway. I was thinking of doing it through the insurance companies, and specifying Medicaid, also. I was thinking that they already have a newsletter, and it wasn't that difficult, but I understand what you're saying, too, with the self-insured.
SPEAKER 3: You can go either way.
SPEAKER 2: Now this simple little thing has turned out to be very very complicated.
SPEAKER 4: Well, it's a good idea though. I like what you're trying do there. I don't know how we word it right.

SPEAKER 2: I'm just trying to protect, you know, especially Medicare Part D -- elderly people, they show up at the drugstore, Medicaid people they show up, and those people are very sick.
SPEAKER 3: I couldn't agree more. I just don't know how we can do this without hearing from PBMs.
SPEAKER 1: Can I ask any of the folks in the room that represent PBMs if they have a quick thought on this?
MR. SMITH: A quick thought. Bill Smith CVS/CAREMARK.
I have to run this by my boss, I guess, but the question that came to my mind is who controls the change to the preferred drug list, and then you want the find out who knows who is taking that medication when that was changed.
I can see how the PBM might be the entity that tells the pharmacist who's filling it that it's not on the PDL anymore, but do they know -- who controls the PDL change? If it's the PBM, then maybe that is who ought to be doing this.

SPEAKER 2: I think that's what we've been told in the testimony, that is what they do. They pay the bills.

MR. SMITH: They help develop the PDL.

SPEAKER 3: I think it's collaborative between the insurance companies and the PBMs.

MR. SMITH: So I hear both sides, that maybe it should be the PBM because they're the ones with the technology, and might be the company that can link it.

SPEAKER 1: Even if you don't know exactly who it is, or you aren't able to make that link for some reason, then you fall under number two. If somebody shows up and you don't know who they are ahead of time, and they present a prescription for the now newly unPDL'd drug, at that point they're given a notice. They're given one more prescription, then given a notice.

MR. SMITH: Right. It's a more confused issue than I thought when I was first handed this. I guess I'd like to defer it a little bit and get you an answer, but I don't want to hold you up today. I will go make a phone call.

SPEAKER 1: Go make a phone call, I guess.

MS. KENNEDY: Shannon Kennedy, Medco. I've already been trying to make phone calls today on another issue, and my people are in other statehouses, but conceptually, I understand what representative O'Donnell is trying to do, and I support the thought of it.

I'm not sure how this works, but my understanding of the PDL is in the whole contract situation was that it's contracted and negotiated between the buyer and the PBM. I would think that both sides would know if there's a change in it.

So, I don't know who the best one is to notify of the changes, because I haven't asked. I had heard of this, but it never occurred to me that it would come in the PBM section of the bill. It's just my miscalculation.

I can't tell you for sure. I can continue to try the get someone on the phone. I also think that self-insured plans probably wouldn't come into play or wouldn't work.

SPEAKER 2: Let's just go back to the insurance companies and Medicaid.

SPEAKER 3: Who cuts the check to the drugstore?

MS. KENNEDY: I don't know exactly how that goes.

SPEAKER 3: The only experience I had where I pursued anything along this line, it was not my TPA.

MS. KENNEDY: I've never seen a check so I --

SPEAKER 1: I would say if you can get your phone calls --

MS. KENNEDY: I could try.

SPEAKER 1: And I would say we support the concept. This is not -- I don't like to do this, but it's not the last step for this bill. In order for it to be discussed later on, we need to have something in the bill to reflect the concept, whether it's this version or another version, and we can hear it and tweak it a little later on if it seems appropriate.

SPEAKER 3: Was this modeled after any place, or is this brand new stuff.

SPEAKER 2: Brand new stuff. I think we came up with it ourselves.

SPEAKER 1: Does anybody want to raise a concern with the concept?

SPEAKER 4: No.

SPEAKER 5: No.

SPEAKER 1: So let's put it aside for the moment, and let's see where we are in an hour, and whether anybody had reactions from any other places.

SPEAKER 9: Let me ask a question. You say the preferred drug list may mean different things, like where the co-pay went. If it went from a tier one to a tier two, that kind of stuff.

SPEAKER 2: I think under rule 10, none of this can happen without notifying the patient. If your co-pays change, you have to notify the insured, but you don't have to notify them on the change of a PDL.

Maybe we're looking to deep on this. Maybe we have to attach onto language and say any PDL --

SPEAKER 1: Because it potentially a change in benefits.

SPEAKER 2: Right. In that case it's the insurance company that has to notify the insured that there is a change in the co-pay. That's why I always thought it was the insurance companies -- my notification here came from my insurance company, not from my PBM. I don't know who my PBM is.

SPEAKER 1: Where is the statute that directs rule 10? Susan Brancowski probably knows.

MS. ROYAL: I don't know. I can look.

MS. BRANCOWSKI: It's in title 18. I don't have the exact section. It's 94-something.

SPEAKER 1: What I'd like to do now is talk to Harry who is going to talk about the fee thing. We need to decide which option to go with.

We need to decide how we're going to go with the fee. I guess we'll do that second. In either case, we generate somewhere between $450,000 and $550,000 in one of the two ways we'll decide on. We raise about a half million dollars either way. Now I'll hand it off to Harry.

MR. CHEN: I looked some of this stuff up

over the weekend. Generics cost anywhere from 35 to 70 percent less than brand names. Although I actually think it's more in some classes. In 2004, the average generic cost $28.74, and the average branded prescription cost $96.

So there is a large difference. It was estimated in this one report, I think in 2004, that we saved eight to $10 billion across the country a year using generic drugs. We had an opportunity to save another eight billion dollars by moving the market towards generics.

Throughout our testimony, we heard about generics. We heard about marketing and what the drug companies do with it. We heard that samples are a powerful way to market to doctors and patients, and that generics don't have detailers, and generics don't have samples.

So what I tried to do is attach it to our evidence-based education program. Basically, attach a program that would provide for generic "detailing and marketing" that would be under an

evidence-based -- for instance, here are drugs you can use to treat high cholesterol. Here's Lipitor. Here's Crestor. But here are two generic drugs that you could also use, and in certain instances they would be appropriate to use as a starting drug.

Then with that, educational materials would be distributed to a doctor's office about the drugs, and this voucher would be good for a starter dose of the generic prescription.

I hadn't come up with a week or two weeks. I don't know what the average cost is, but it really, since it's so cheap, may be one or two weeks or something that you will get from your doctor, and you would go to a pharmacy and turn this voucher in and get your samples.

Many drug companies now are giving vouchers instead of giving actual drugs for the obvious reason, in terms of a sample prescription.

So, you go to the drug store, and then OVA would pay the drugstore for the prescription.

I did talk to Josh, and he understands exactly why we are doing it. There are some details to work out and things he will do.

SPEAKER 3: Is this just for Medicaid?

MR. CHEN: No. It's for everyone.

SPEAKER 1: But the money goes to OVA.

SPEAKER 3: So what would happen if it's more than $400,000?

MR. CHEN: Well, there is something in here that says, "if permitted by funding." So the funding would stop if --

SPEAKER 1: Or they would reorganize. He has written it to start with one drug.

MR. CHEN: We might start with the statins. You can't do them all. You pick one drug like the statins, and then you might, if you had more money or availability, you might pick a drug like the hypertensives.

So again, product, prescriptions, maintenance, and medicines.

SPEAKER 3: With that money -- I have no idea. What will that buy you, $400,000? Assuming you have this new source of funds, you have people going out and educating. Then the samples. How much of a dent will it make?

MR. CHEN: I don't know. I'll try to come up with some numbers. If you take the average generic cost $28.74 a month. $7 a prescription for a week; right?
SPEAKER 3: Per week?
MR. CHEN: You do a week as a starter. You don't really give a month. You give a couple of weeks.
What's seven into 400,000?
SPEAKER 2: Some of the money will be for the education expenses.
MR. CHEN: Okay. Just seven into 200,000.
SPEAKER 3: Why don't you say seven into 140,000? That makes it easier.
MR. CHEN: Remember that these are cheap drugs that don't cost much for a prescription. We already have this education program going.
SPEAKER 2: So it's just adding one little thing. So finally the counter-details can give a free sample.
MR. CHEN: And it's something you do for everybody. There is advantage for Blue cross. There is an advantage for state health employees, for Cigna, and people using

generics.
SPEAKER 2: And it would be nice if some research was done to show what are the most over-prescribed, or over-used, name brand drugs that we could maybe start with to make a bigger dent in the whole process, and start with a drug that's over-prescribed, or not over-prescribed, but that's used a lot, where there are generics that aren't used a lot.
SPEAKER 1: Comments?
SPEAKER 3: A little thing on the second page, the B, at the bottom. "And shall provide payment to the pharmacy dispensing the prescription drugs."
Anyway, it says all this stuff and I just wonder is the administration of that going to suck up the $7, so it's going to be a wash?
MR. CHEN: Again, I think, administratively Medicaid tends to have a relatively low administrative cost, and they already have a mechanism in place. We're not going to have to reinvent the wheel. That's why I picked OVA. They're the people that pay the prescriptions.

SPEAKER 3: Okay. Just start with that one illness, and start with OVA.
MR. CHEN: And I think that you have to look beyond the $7 cost. Because that $7 cost becomes a $60 a month cost savings down the line, and that is a savings to the system. Again, something we are trying to do here in this committee to do something for whole system.
SPEAKER 1: Do we like the idea?
SPEAKER 4: Yes. A very good idea.
SPEAKER 1: Do you know where it's going to go already?
MS. ROYAL: I think it will be 13A following right after section 13.
SPEAKER 1: When we're done with the bill do you need to end up with these little A's? Can we just renumber all the sections?
MS. ROYAL: We can.
MR. CHEN: Would you like to make a change up on the 2462 2A2, just about the notification of generic drugs.
SPEAKER 3: What page are you on?
MR. CHEN: It's page 1 of this. Just to add commonly used brand name drugs. It

doesn't have to be all of them. Sometimes there are a hundred of them that no one is going to see. But if there is 20 of them, let them use their judgment as to what is commonly used.
SPEAKER 1: Okay. Let's figure out what we are going to do with this "B."
SPEAKER 2: I think we should go with OVAs recommendation.
SPEAKER 1: Do you want to summarize that, or do you want me to do that?

END OF CD 07-152 DISC 2.

CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF MIAMI DADE)

I, the undersigned authority, certify that I was authorized to and did listen to CD 07-152 Disc 2, the House Committee On Health Care, April 24, 2007 proceedings, and transcribed the foregoing proceedings, and that the transcript is a true and accurate record to the best of my ability. Witness my hand and official seal this 8th day of April, 2008.

_____
Michael Todd Berkowitz
Notary Public - State of Florida

STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: April 24, 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: 07 - 153/Tracks 1, 2, 3, 4

Esquire Job No. 928018

PROCEEDINGS

- - -

07-153/Track 1

FEMALE ATTENDEE 1: And then if that happens, what's happening is it's a back door raid on the Medicaid budget.

CHAIRMAN MAIER: I'm not sure how it would offset but it would be dollar for dollar.

FEMALE ATTENDEE 2: And -- and how would you measure that? Let's say we pass this and it's -- how would you measure that between now and 2010?

CHAIRMAN MAIER: Well, I think the one thing you can do is look at what supplemental rebates you're able to negotiate before this passed as a percent of sales and then whether -- after there -- it passed those rebates percentages went down or up first, do the same.

ATTENDEE 1: And at the same time we'd have to calculate what the savings --

CHAIRMAN MAIER: Yeah. You want to really offset all -- (inaudible.) The bottom line is you just look at your total pharmacy spent per person and see how that's it's moving.

FEMALE ATTENDEE 2: And if -- if we were to find that was a reality, could we crack down on the use of generics, like you said tighten it up?

FEMALE ATTENDEE 1: Offer no pill. Okay. I mean, we go after the people who are using the drugs, you know, the people that are watching TV and saying, Oh, I want --

FEMALE ATTENDEE 2: Where's my Lunesta?

FEMALE ATTENDEE 1: You know, make them go to the pharmacy and make it a financial incentive for them to do the -- the generic drug.

FEMALE ATTENDEE 3: Except we've heard so much testimony that it's putting it way down -- we've heard so much testimony that detailing is very effective and so it's the doctors who are writing the brand name. It's the doctors not --

FEMALE ATTENDEE 2: Yeah.

FEMALE ATTENDEE 3: So then that puts -- because that makes the patient have to fight their doctor and you don't want to fight your doctor. You want them to work for you, but they're not because they're being influenced --

FEMALE ATTENDEE 1: The doctor gives you a prescription. You go to the pharmacy and you say, Is there a generic drug for this, and the -- the pharmacy calls the doctor and says is it okay if he takes the generic and the doctor says yes.

FEMALE ATTENDEE 2: What is the doctor is on the --

FEMALE ATTENDEE 1: I don't think that there are many doctors that are in the pockets of -- of prescription drug companies in the State of Vermont.

FEMALE ATTENDEE 2: I interviewed one over the weekend.

FEMALE ATTENDEE 1: I think there's a lot of doctors that give out the -- the samples to -- to make it better for their patients but certainly my doctor always writes generic if it's available and I think (inaudible).

CHAIRMAN MAIER: But that's not the question we have in front of us.

FEMALE ATTENDEE 2: No.

CHAIRMAN MAIER: I know we -- I'd rather talk about writing other things we might -- but the question is about which way we want to go

with this D.

FEMALE ATTENDEE 3: I like option two and I think also just -- I hear your concerns and the truth is we'll never know but I think what option two does is it provides for a greater good, a statewide good that is -- that goes beyond the Medicaid program, and that's part of what really appeals to me about it.

FEMALE ATTENDEE 2: The cost is far in excess of .1 percent so that -- they're going to be increasing their costs anyway. I mean, to try to think that the pharm -- that they're not going to continue when you can make the money, who say's they're not reining themselves in? Nobody is reining them in. The only people that's going to rein themselves -- rein in at all apparently is us. I mean, if they're making a profit margin, why would they ever -- you know, why not?

FEMALE ATTENDEE 1: They'll just get it on the other side. It just costs Medicaid more money.

FEMALE ATTENDEE 3: You don't know that. I guess that's the other --

ATTENDEE 1: Well, there is a fundamental

rule in business. You go after a certain profit margin and you're going to obtain that profit margin by whatever means it takes.

So if the government takes money from you, that's going to impact your profit margin, you're going to find some way to make it up then. And you can argue about whether or not -- you can argue whether that profit margin is a fair one, that's a different topic, but they're looking to get a -- I'm going to throw a number out -- 10 percent profit margin, they're going to make sure they're going to get 10 percent. So if you take it from here, they're going to grab it from someplace else. That's why I think our -- I think it's there. I'm still in favor of option two, by the way, and I am willing to risk it but let's not be naive enough to say, Well, they're rich enough, they can afford it.

CHAIRMAN MAIER: Well, the argument is in favor.

Following your argument, it seems to me that everyone is in favor of option two as opposed to option one, is that finding a way to recapture .5 percent in your profit margin is a

whole lot easier than finding a way to recapture 50 percent in your profit margin which is what the impact would be on these lower volume samples. You know, obviously that's not something you're going to be able to do. It -- it actually unlevels the playing field as far as the competition between these different companies.

Do you want to add something?

ATTENDEE 1: I was just going to say, just to remind everybody, these assessments are all calculated on gross reimbursement that Medicaid pays. If you want to consider the option, you can calculate them after you've factored out the supplemental rebates which in effect --

CHAIRMAN MAIER: What would that be?

ATTENDEE 1: I'm not even sure dollar for dollar but it would reduce the concern about folks who are giving us the supplemental rebates because that would come right out of their pockets.

ATTENDEE 3: And we do know how much this would reduce it?

ATTENDEE 1: That's what I have to go back to OVHA and ask.

CHAIRMAN MAIER: I'm not sure all those rebates are meant to be.

FEMALE ATTENDEE 3: Do we have transparency in all those rebates? Can we talk about that (inaudible).

ATTENDEE 1: On individual drugs --

FEMALE ATTENDEE 3: Aggregate.

ATTENDEE 1: -- but they are aggregate on one of the NBC codes I think. So I just wanted to give you that option if you wanted to think about it.

CHAIRMAN MAIER: I guess I'd ask where we are at at this point?

ATTENDEE 2: (inaudible) May 4 we're spending a lot of time.

FEMALE ATTENDEE 2: I'd like to -- to leave it in the Bill, option two or put option two in the Bill and move -- you know, it certainly would be worth getting an aggregate rebate amount -- (inaudible) that could be done in the Ways and Means. We don't have to do that here. It's their job to figure it out.

FEMALE ATTENDEE 3: You know, we still have to ask OVHA what they think of trying to use the rebates amounts.

FEMALE ATTENDEE 2: Right, but that's -- I mean, that can be done downstairs.

FEMALE ATTENDEE 3: Yeah.

FEMALE ATTENDEE 1: Well, Patty's question as well is checking in with Josh and see is this the option you gave of the lesser of two evils and you'd rather not see us there at all. At least, have him weigh in on that.

CHAIRMAN MAIER: Well, this has been --

FEMALE ATTENDEE 3: What's your question?

CHAIRMAN MAIER: This particular recommendation from OVHA has been --

FEMALE ATTENDEE 3: It's been a while.

CHAIRMAN MAIER: You know, April 11th is the date of the memo that they gave us so as far as having it in front of us and everybody else in the room, that's -- it's been out there a couple weeks.

FEMALE ATTENDEE 3: I have a feeling we're --

FEMALE ATTENDEE 1: -- that close to the end of this either. I mean, it has to stop at Ways and Mean. It has to come to the floor and then presumably it will go to conference. So it's not like this is going to be a done deal

tomorrow.
CHAIRMAN MAIER: Did you want to say something?
ATTENDEE 3: I think we should put in option two then spend a lot of time talking about this. (Inaudible.)
FEMALE ATTENDEE 4: And have it all be changed by somebody else anyway.
CHAIRMAN MAIER: Are people okay with the idea of taking a straw vote at this point in terms of which one to put in the Bill?
FEMALE ATTENDEE 1: Uh-huh.
ATTENDEE 3: Are we going to take subsequent testimony on that or -- on that, on option two -- if option two prevails, are we going to take additional testimony?
CHAIRMAN MAIER: In this Committee, you mean after we pass the Bill out? Well, before we pass the Bill out.
ATTENDEE 3: Okay. So we'll try the question.
CHAIRMAN MAIER: I mean, we can still take -- I'm not sure when because we've got the schedule, but we can be asking the questions --
ATTENDEE 3: Okay, okay.

CHAIRMAN MAIER: -- and seeking answers here but I mean I think the venue will then move to downstairs after that discussion and --
ATTENDEE 3: I just -- (inaudible) testimony on this issue but (inaudible).
FEMALE ATTENDEE 1: It's been around since April 11.
ATTENDEE 3: I know.
FEMALE ATTENDEE 1: Nobody's beaten down the doors.
ATTENDEE 3: Well, we haven't either.
FEMALE ATTENDEE 1: (Inaudible).
CHAIRMAN MAIER: Okay. The only thing that's new today is the idea about using the -- using some of the money being allowed for the counter-detailing samples.
ATTENDEE 4: The other thing is talking about having force.
CHAIRMAN MAIER: Yes.
FEMALE ATTENDEE 3: Actually, Steve brought that up when he gave us those numbers (inaudible.)
ATTENDEE 4: Right. I understand force is not in the words.
FEMALE ATTENDEE 2: First if we -- which

one we support going in and then we can give the details.
FEMALE ATTENDEE 1: If we're trying to get this out of here by today (inaudible).
FEMALE ATTENDEE 2: (Inaudible) Just at the very bottom, that's all.
FEMALE ATTENDEE 3: So you want straw?
CHAIRMAN MAIER: So I guess raise your hand if --
ATTENDEE 3: Before you do that, though, are we going to take straw votes on all these sections? Is that what you're saying?
FEMALE ATTENDEE 2: Not necessarily, no.
ATTENDEE 3: Because we're going to get to another one, I mean, when we get to that data mining thing and we're going to have some controversy on the other -- the pricing.
FEMALE ATTENDEE 1: What pricing?
FEMALE ATTENDEE 2: What pricing?
CHAIRMAN MAIER: We can do straw votes on any section you would -- you're feeling uncomfortable about at this point.
ATTENDEE 3: It's not me. I'm just wondering what their plan is today so --
CHAIRMAN MAIER: We're not going to take a

straw vote on every section but I'd be happy to take one on several sections that we know are more controversial. Does that seem fair?
ATTENDEE 3: Well, that's fine with me. I was just wondering if you had already made a decision.
FEMALE ATTENDEE 2: I think (inaudible). We can track down Joshua's cell phone (inaudible).
FEMALE ATTENDEE 1: Okay (inaudible).
FEMALE ATTENDEE 2: I put him on speaker phone.
ATTENDEE 1: Okay, thanks.
CHAIRMAN MAIER: Joshua, are you there?
JOSHUA: I am here.
CHAIRMAN MAIER: This is Steve Maier. Thank you. We're in the middle of S 115 of the pharmaceutical drug Bill.
JOSHUA: Okay.
CHAIRMAN MAIER: And we're considering the section that would establish a -- a pharmaceutical manufacturer fee, and you had proposed to us a different way of doing that fee. You recalling that?
JOSHUA: Yes, I am.

CHAIRMAN MAIER: Okay. And you had suggested two things I think in that -- in that way. One was to use labeling code, if I'm using the right words, and then -- and then secondly to charge the fee based on a percentage, a point -- 0.5 percent of their previous year's drug spending.

And the question has come up which, I guess, would be relevant for -- regardless of how the money was assessed, how the fee was assessed, but the question has come up as to whether the -- these fees would have a negative impact on the Medicaid program in some other ways and in particular as it might relate to supplemental rebates or other things. And so we were wondering if you had an opinion about that.

JOSHUA: Well, I can try and assert an opinion but, first of all, I just want to make sure I understand. I recall correctly if I'm speaking to the right section, I believe it's Section 16 --

FEMALE ATTENDEE 2: Yes.

JOSHUA: -- of the -- 18 of the legislation--

FEMALE ATTENDEE 1: Yes, 16.

CHAIRMAN MAIER: Well, the section numbers have changed so --

JOSHUA: It starts from 1998 A, the manufacturer, B.

ATTENDEE 1: B.

JOSHUA: (inaudible) a thousand dollars per --

FEMALE ATTENDEE 2: Right.

JOSHUA: -- manufacturer prescription drugs that are paid by Medicaid.

CHAIRMAN MAIER: Yes, right.

JOSHUA: And our assessment is that by drug manufacturer code or labeler code as a policy for manufacturer, there's about 429 labelers in the most recent quarter from which Medicaid paid.

Again, at a thousand dollars each, that would raise 429,000 or about, you know, somewhere around 500,000 depending on which quarter it was that we utilized the data.

Then we did a run in order to approximate something around that level of revenue.

I want to be clear that OVHA is not advocating for a specific level of -- of

revenue production and that the percentage base looks -- concept was based on the fact that there's lots of manufacturers that -- pages of these 400 and some odd that are less than a thousand dollars and more -- and many, many more pages that are less than, say, $5,000 in total -- in total to -- in total payments.

So I just want to be clear that the -- the spreadsheet that we produced for state (inaudible) is not a recommendation that we -- that we apply a fee at any level but that simply if the legislature is going to apply a fee, that it's more equitable to apply it on a pro rata basis instead of on a flat -- instead of a flat thousand dollars per manufacturer basis because the flat fee does charge a number of manufacturers far in excess of what they've -- of what they're actually paid and -- and that may have -- that could have a -- a negative effect on participation among very small -- among manufacturers that have very small levels of -- of reimbursement from the State. So --

CHAIRMAN MAIER: Yeah, I -- I -- I think that's -- that's clear.

Does anybody have a question for Josh at this point?

FEMALE ATTENDEE 1: Josh, my concern is --

CHAIRMAN MAIER: Patty, in case you can't tell.

FEMALE ATTENDEE 1: One, we get the reimbursement from the drug companies now, okay. If we start charging them a fee, my concern is they're going to deduct that fee out of the reimbursement we're already getting which will have a negative impact on the Medicaid budget.

JOSHUA: Well, if I understood correctly your concern is that there will be a direct relationship or some sort between rebates paid to the Medicaid program and the fee paid to the State. It's certainly reasonable to have a concern in that area.

I don't believe that we can draw a direct line between the two -- the two pieces because there's a -- there's a -- a -- there's a whole separate process for negotiating supplemental rebates and for the over 90 rebates obviously. And so it could have an impact. I don't want to say it couldn't especially if there was a --

a large flat fee and the number of the smaller -- a number of the folks that are paid at -- at lower levels in total payments there may be, you know, a -- there may be some incentive to -- to not purchase and be paid at all but that's one of the reasons that we suggested a different methodology beyond the flat fee.

I think on the -- using a percentage basis, a concern, that is how big is the fee, so if the fee is small enough on a pro rata basis, it seems the most equitable way to go about it. From my perspective, if it -- if it's a large enough fee, then of course it could have impact on, you know, lot of things.

So -- so there I would say the -- the total amount of the fees as opposed to the -- as opposed to the fact that there is a fee.

CHAIRMAN MAIER: Anybody else? Thank you for indulging us in the moment here.

JOSHUA: No problem. Anytime.

CHAIRMAN MAIER: Okay. Bye-bye.

Are people ready to do a straw vote? Any other questions or comments? Okay.

People that would prefer option one which

is the flat fee?

People that would prefer option two which is the pro rata fee?

People that would prefer no option at all? Okay.

So I will go with option two. Any other comments on that? Okay. What's next?

FEMALE ATTENDEE 1: What's next?

CHAIRMAN MAIER: Julie is here. Is someone from BISHCA out here in --

JULIE: I've spoken with them but --

CHAIRMAN MAIER: Today?

JULIE: Oh, yes, since I sent my e-mail to you.

CHAIRMAN MAIER: Okay. Okay. So let's move to the enforcement section which is on page 19 of our current draft -- 19 and 20.

And, Julie, do you want to -- do you want to lead us to the right spot here.

JULIE: Sure.

FEMALE ATTENDEE 2: I'm sorry. Just for sure clarity, did we just also make a decision about Harry's proposal? Are we --

CHAIRMAN MAIER: Good question. Are we okay with Harry's?

FEMALE ATTENDEE 2: Before we leave that part?

CHAIRMAN MAIER: Yeah, I think so.

FEMALE ATTENDEE 2: All good.

JULIE: All right.

CHAIRMAN MAIER: Yeah.

JULIE: Would you -- would you like me to --

CHAIRMAN MAIER: Yeah.

JULIE: Okay. Great. I think the --

(Whereupon, CD 153/Track 1 ends.)

07-153/Track 2

JULIE: Under Discussion, it's on page 19 of the April 19 draft. It's Section 2473 Enforcement.

Before we go there, I have not seen Patty's proposal, Section 8A. I think that's a great addition. I think we did something similar to that in the Medco settlement regarding notice of changes in PBLs. So I don't know if you took comment or testimony on this but that's a different issue.

CHAIRMAN MAIER: Well, we had -- we all liked the idea.

JULIE: Yes.

CHAIRMAN MAIER: We're a little confused about whether this is the -- the PBMs are the right way to do it and we're waiting -- some of the PBM reps are waiting to hear back and at some point in the next half an hour we'll make a decision.

JULIE: Whether it will be the PBMs or the plans is the question?

CHAIRMAN MAIER: Yeah.

JULIE: I understand but I -- that's a good question but I think the concept is (inaudible).

CHAIRMAN MAIER: If you have a comment about that --

JULIE: I think legislatively obviously you could decide that it -- that the PBM is the appropriate entity. I can see the argument that the plan is closer to the beneficiary, and that's really the entity that is communicating with the consumer or in this case the beneficiary.

Oftentimes a consumer will not even know what -- what the PBM is.

In the State of Vermont, for instance, most people are familiar with Cigna, not -- I

mean, we all have Express Script cards, which is a PBM, but I don't think people are as familiar with (inaudible) communications with the PBM. But I -- I actually don't think that it's that big of a difference and I think it could be the PBM and that would be all right.

CHAIRMAN MAIER: Well, the PBM -- the upside of doing PBM is that you also get all the self-insured plans --

JULIE: Exactly, absolutely.

CHAIRMAN MAIER: -- that you wouldn't necessarily get -- if the obligation were put only on an insured.

JULIE: That's absolutely true. I think that that's true.

You would have -- you would have to -- if it were on the plan, it would either have to be the insured, the employer or the governmental entity. You'd have to make sure you're covering all the plans that are out there but yes, the PBM --

CHAIRMAN MAIER: But then wouldn't we run into -- if we try to regulate the employer, wouldn't we run into an ERISA issue? I mean, you couldn't -- that's --

JULIE: Possibly, yes, yes. So maybe --

CHAIRMAN MAIER: Arguably you get -- you might get to them anyway but --

JULIE: Yes, the PBM might be simpler legally.

CHAIRMAN MAIER: Okay.

JULIE: Okay. I just wanted to kind of (inaudible) so I apologize for the digression.

The issue with respect to Section 9473 on page 19 -- it was raised by some of the PBMs, not by me and not by BISHCA -- some of the -- some of them came up to me and said, Gee, it seems as if you're giving a private right of action because if you look at Subsection A, the second sentence says, "as except with respect to Subsection D, all rights, authorities, remedies available to the Attorney General and private parties to enforce the (inaudible) shall be available to the first conditions of the subchapter." So that means anyone that comes within Subsection A would have a private right of action. And that is correct and that's what we want.

You move to Subsection D, Subsection D is the provision that says the commissioner shall

have exclusive authority to regulate PBMs with respect to their relationship with a health insurer, and then it has a statutory cite. And that is the traditional health insurer. That is like a Cigna or MBP or BlueCross BlueShield. So to the extent that it is insurer that is contracting with the PBM, there would be -- if you read A and D together, there would be no private right of action with respect to the insurers per contracting with the PBMs but there would be a private right of action for employers or governmental entities.

I -- I actually thought this was a -- a mistake. I thought that BISHCA wasn't intending this, didn't really think much about the private right of action so I e-mailed them. And I think I copied a few -- I mean, I copied Steve and Harry on the e-mail and I think Maria saying -- I said to BISHCA, You know, gee, I think this was a mistake, here's a way to fix it.

They e-mailed me back this afternoon and said no, they don't want to offer the private right of action to the insurers. They think the insurers should be able to vindicate

whatever rights they have under the contract.

I personally disagree with that. I think that -- because what we're doing is we're creating rights under this section. These are not contractual rights. These are rights to get notice and rights with respect to how the PBM is supposed to be treating the plan or the insured, whoever their client is. And the failure to live up to those rights is not a contractual issue, it's a statutory issue. But BISHCA does have primary control over insurers and if they feel that insurers don't need a private right of action, no one here is screaming for a private right of action on the insurance side. That's fine. You know, we're -- you know, I think -- so I think the bottom line is we just -- we should just leave it as it is, just to recognize that some of these entities will be getting a private right of action and others won't.

I think that a private right of action is beneficial and that's why I don't think it should be eliminated but just -- I just want you to understand that because of the way A and D are interacting with each other some entities

will have it and other entities will not.
So is that -- that's presenting you the issue and I think the best solution that we can accomplish today.
CHAIRMAN MAIER: You think the best solution is what?
JULIE: That is the best solution we can come up with today. Ultimately, I --
CHAIRMAN MAIER: With which, to leave it the way it is?
JULIE: Correct.
CHAIRMAN MAIER: Has any -- I mean, I'm sort of inclined to agree with that at this point in the process.
Does anybody want to argue strongly in the other direction?
ATTENDEE 1: I just want to ask a question.
FEMALE ATTENDEE 1: Sure.
ATTENDEE 1: When you say some will and some won't have --
JULIE: Correct.
ATTENDEE 1: Who won't have?
JULIE: The Cignas, MBP, BlueCross BlueShield will not have a private right of

action.
The private right of action will be lodged instead with IBM, the State of Vermont, towns, anyone who has a self-insured pharmacy benefit. There -- and there are lots of them in the state. I don't -- by just listing IBM, I don't want you to think that that's the only one out there. There are many, many in the State of Vermont.
CHAIRMAN MAIER: Okay. Maria, help me out here. We have -- has anybody gotten penalty language from Herb today regarding --
MARIA: I have.
CHAIRMAN MAIER: Okay.
MARIA: From Peter Young.
CHAIRMAN MAIER: -- regarding the breach of confidentiality -- the privates -- what am I talking about?
MARIA: Well, this is the penalty provision --
FEMALE ATTENDEE 2: Database.
MARIA: Well, no. This is for 9410 which is the multipayer --
CHAIRMAN MAIER: Multipayer database, if you -- presumably if you do something like sign

a confidentiality agreement and then you let out the data, this would be a penalty. Otherwise, it's unclear if there are actually penalty provisions. It's clearly against the law from what we've written but it's not clear that there's actually a penalty for failure to live up to your obligation.
MARIA: And I can review it. I thought BISHCA was going to be here but I can make copies of this and also read you the purpose of this. It does provide an entry of penalty for that section which is -- I mean, you want me to make copies or --
CHAIRMAN MAIER: Copies would be good. You want to explain -- can you just give the rest of the Committee members the --
MARIA: My understanding is it does create administrative penalties under the multipayer claims database section for breaches of confidentiality, and I believe we based it on the Insurance Trade Practices Act, modeled it over those civil penalties so it's actually pretty straightforward. It just sets the amounts, what those penalties are. It specifies that violations are subject to those

penalties. I have another copy.
CHAIRMAN MAIER: Does anybody have -- do people think this is -- people remember the issue. Do you think this a good idea?
FEMALE ATTENDEE 2: Good idea, I remember.
FEMALE ATTENDEE 3: What section is this connected with so I can just be there?
MARIA: It's actually not in the Bill, the Amendment, because I don't think you've amended that section in this Amendment.
FEMALE ATTENDEE 3: Like I said, there's no section in the Bill that pertains to this?
MARIA: Correct.
FEMALE ATTENDEE 3: Okay.
MARIA: Other than indirectly.
FEMALE ATTENDEE 3: Well, I just didn't know if there was other stuff in here about the topic.
MARIA: Yeah. I think it came up generally with relation to the data mining section because there's an exemption --
FEMALE ATTENDEE 3: Okay.
MARIA: -- for the information that's collected by BISHCA under the multipayer claims database and then there's a question about,

well, are there penalties for that as there are under the data mining section. So this is an attempt to address the penalties issue.

Thank you, Lauren.

So while that's going around, I'm just going to read you the notes that BISHCA provided to this proposal which states that "This Amendment creates enforcement remedies for a violation of the multipayer data collection project laws and regulations that are consistent with BISHCA's remedies under the Insurance Trade Practices Act. This Amendment also has a provision similar to one existing in Maine, while that provides a significantly greater penalty for violations relating to the improper disclosure of confidential information." So it's a -- a general penalty with respect to the filing requirements, I believe, of this section and then an enhanced penalty related to improper disclosures of confidentiality -- of confidential information.

CHAIRMAN MAIER: Any comments, questions? In or out?

FEMALE ATTENDEE 4: In.

CHAIRMAN MAIER: In? Raise your hand if

you want it in.

FEMALE ATTENDEE 1: I have a question about this $1,000 violation. I just wonder if that's high enough to really -- I don't know.

MARIA: The 1,000 penalty is for -- is in the existing law even though that's not underlined. The higher penalties, the commissioner may impose an administrative penalty of not more than $10,000 for those violations the commissioner finds were willful and in addition any person who knowingly fails to comply with the confidentiality requirements of the section and rules and sells, uses, transfers the data for political advantage, pecuniary gain, et cetera, shall be subject to an administrative penalty of not more than 50,000 per violation.

FEMALE ATTENDEE 1: So does this (inaudible) Do you know what the main numbers are? Did she give you that, Maria?

MARIA: I don't, unfortunately. I have the citations that I can --

FEMALE ATTENDEE 1: This is fine. I don't want to hold things up.

MARIA: Okay.

FEMALE ATTENDEE 2: This is the cost of doing business.

FEMALE ATTENDEE 1: So the thousand dollars per violation for not -- for failing to comply with the requirements of this section, so that's an existing --

CHAIRMAN MAIER: Participating (inaudible)

FEMALE ATTENDEE 1: And so that's something we put in.

MARIA: No, that's existing.

FEMALE ATTENDEE 1: So that applies not just for the multipayer database submissions but for other submissions?

MARIA: No, that's specific for the multipayer claims database for violations of -- by not complying with the existing program. So that's an existing penalty. These are enhanced penalties --

FEMALE ATTENDEE 1: Yeah.

MARIA: -- for specific circumstances, for willful violations or for breaches of confidentiality or using the data for commercial advantage.

FEMALE ATTENDEE 1: Yeah, yeah, I got it. I just thought that thousand -- that a thousand

dollars seemed low.

CHAIRMAN MAIER: A thousand dollars isn't related to --

FEMALE ATTENDEE 1: But it's not -- I know --

CHAIRMAN MAIER: It's related to participation in the program, not to confidentiality issue.

FEMALE ATTENDEE 1: Right. But if I were -- if I'm supposed to be submitting data and I say, Oh, that's a pain in the butt, I don't want to submit that data, all I have to do is pay the thousand dollars. It just doesn't seem -- that was my concern.

MARIA: (Inaudible.) I don't know the answer. BISHCA would know but it might depend on how they calculate the violation.

FEMALE ATTENDEE 1: Well, if it becomes a problem, we can (inaudible).

MARIA: It could be a very small or huge number based on how that's --

FEMALE ATTENDEE 1: That's true.

MARIA: Or every day that it's not submitted, and I don't know the answer to that but it -- it -- it might not be as small as it

appears.
FEMALE ATTENDEE 1: Okay. All right.
CHAIRMAN MAIER: Are there questions or comments?
ATTENDEE 1: Could I just make a comment? I think it should be mandatory (inaudible).
MARIA: It is, it is mandated.
ATTENDEE 1: We're not mandating (inaudible) submit the information. This is not -- this is not --
CHAIRMAN MAIER: These are the claims. So it's not the doctor we're talking about here. This is -- these are insurance companies.
ATTENDEE 1: But in the final analysis all of this comes together. What I'm saying is it has nothing to do with this, but I think the submission of the information should be mandatory.
CHAIRMAN MAIER: Right. That's a separate question but not typically (inaudible).
Okay. Are there other questions or issues that anyone on the Committee would like to raise at this point in time before we order a clean draft? Hold on, just a second, John. Let me -- we're on the Committee first. Sorry.

Okay.
John?
JOHN: Sorry (Inaudible). Relating to the notices per drug list Representative O'Donnell --
CHAIRMAN MAIER: Oh, yeah. We still have that --
JOHN: I just wanted to comment because -- on behalf of the (inaudible) health plan, our view is that -- that this is probably doable. I do think that there are adequate remedies that are available now but this is not a terrible burden. You would think it's more appropriate to -- this is going to be unusual. I'm asking to actually specify health insurers as opposed to PBMs that would be required to do this.
And our view is that PBMs, it's ultimately -- ultimately the responsibility is going to flow to the health insurer. It's going to be fairly complicated if the mandate goes to the PBM and then they have to delegate that to us or we have to fulfill it. There's going to have to be some indemnification and it just becomes more complicated. So the

requirement is going to be on health insurers. Ultimately we think it's --
CHAIRMAN MAIER: Be cleaner.
JOHN: -- more cleaner to simply say that, so. . . .
JULIE: And what you could do to follow up on that, if that's what you decide to do, is you could say that with respect to a plan where there is a health insurer it shall be the health insurer's obligation but with respect to a plan where it is a self-funded plan, it could be the PBM. So you could split it up. Because again, many, many benefits are provided through employers, not through the type of entity that John is speaking of.
CHAIRMAN MAIER: Bill.
MR. SMITH: Bill Smith for CVS Care Mark. Yes, I did receive a response back from CVS Care Mark on this and in a sense I guess I would kind of echo surprisingly both what (inaudible) and Julie just said and that is that the plan controls the formulary and has the primary duty to the beneficiary of the plan. And the PBM might well contract to do that for them and, in fact, they do have

contracts right now where they provide all notices to affected beneficiaries of negative changes to their -- to the formulary that would affect them specifically. So they do -- both the traditional health insurers and the plans that have the PBM as the administrator of the pharmacy benefit have the capability to -- to target specific beneficiaries and the only -- and only do it when your -- your drug is affected. And -- and -- and so there are some changes to this I think might -- instead of having everybody as a beneficiary of, you know, BlueCrosses for them to get every notice that goes out, which is how this would play out now, you might want to make a few changes to this and -- and to the issue of whether or not a health plan or an employer or -- employer versus a traditional health insurer or a PBM, who should be the entity that has the duty. We feel it should be whoever is telling us what to do because they have the relationship with the beneficiary and -- but you can bring all that in I think if you link it back to your (inaudible) on the PBM section. (Inaudible.) 9471, two, you define health insurer to include

health insurance companies, HMOs, employer, (inaudible) union, and other groups organized in Vermont to provide a health plan, State of Vermont, agencies -- (inaudible) sorry, I talk too loud, talk too fast -- the State of Vermont or any agent instrumentality state that offers a plan, Medicaid contract (inaudible) RX.

So if they're defined -- they're defined already in this section of the Bill and so if you say -- if you say to the health insurer who creates a plan -- and that's defined very broadly, health insurer for the purpose of this Subsection -- (inaudible) then they can contract with our folks to do it or do it themselves if they as John said they're more traditional (inaudible) is who has the link, you know, to the insured.

And I tried to follow-up with my pharmacy benefit card and I don't even know who does my pharmacy benefit but I know I've got a BlueCross card, you know. So what I'm looking for, an issue or I got a problem, if I go to my pharmacist and say, Oh, my wife has a condition and she goes in and they say, Oh, you can't get that anymore, we don't even know who our PBM

is -- and I work for one so I know it's not CVS Care Mark because I would have asked, curious to find out. But anyway so who does that beneficiary go to if there is a problem, where's -- if there's an issue of whether he's truly covered or not, where is the grievance procedure in place already and, ultimately, who do you want to hold accountable for whether or not that notice is out there.

I think everyone agrees, the PBMs agrees, that notice needs to go out as soon as possible so that people don't have the situations like Patty described earlier today where you walk in to the pharmacist and don't get what you need right now and create some dirt bag problem. You want to avoid that. But to -- and to the extent that my client is able to provide that and contract to provide that service, they're happy to do it. So -- I'm sorry.

CHAIRMAN MAIER: So our health insurer then as so defined?

MARIA: Yeah, I like that.

JOHN: Because you can say health insurer or their designee and then if we're the designee, that's our job. If we don't do our

job, the health insurer or the health plan has a very clear remedy on -- on what to do with it because it would be spelled out in the contract what happens if PBM XYZ doesn't provide notice properly.

CHAIRMAN MAIER: Okay.

FEMALE ATTENDEE 1: I guess I'm still not sure since health plan -- since -- what are we going with, health insurer?

CHAIRMAN MAIER: Health insurer.

FEMALE ATTENDEE 1: Health insurer. Okay. So that includes employer who we can't regulate. So if we say the health insurer or their designee, we have no right to even tell them they have to have a designee. We can regulate their -- their PBM but we can't tell -- am I correct?

JULIE: I think -- can you say it again? I missed the beginning.

FEMALE ATTENDEE 1: And the definition of the health insurer is an employer.

JULIE: Right. That's my concern.

FEMALE ATTENDEE 1: We can't regulate employers. Can we -- and my guess is we can't even tell them they have to designate this

because we're regulating them by doing that whereas we can regulate their PBM.

JULIE: That is -- that is -- yes. I -- my concern is the extent to which Bill's suggestion, while from a policy perspective makes a lot of sense, I understand what he's saying, my only concern is the ERISA issue. And to the extent that we are directing a self-insured plan to do something, under ERISA we may have a problem whereas if we say either an insured using -- going to that language that you just had in front of you, just using 2A, that's a traditional insurer. B is the one where ERISA comes in. I'm on page 14; capital B is the one where ERISA gets triggered. C is the State Vermont instrumentalities, you can do whatever you want, you guys control them entirely. Same with D. So (inaudible).

CHAIRMAN MAIER: It's a matter of (inaudible).

JULIE: Legally -- I'm speaking purely legally here. So while from a positive perspective I may or may not -- I actually think what Bill said made a lot of sense.

FEMALE ATTENDEE 1: Oh, it makes very good

sense.
JULIE: I think the real issue is are we going to run into trouble under ERISA and so I would suggest carving B out with respect to the self-insured plans or the -- the employer plans, if you will, and placing the duty with respect to those on the PBM rather than the insurer.
FEMALE ATTENDEE 2: Can we review TPAs? (inaudible).
CHAIRMAN MAIER: Let me -- let me phrase the question so we can -- I think the option in front of us at this point is to do what Julie is suggesting, which is make it health insurer except for those self-insured plans in which case it would be the PBM or I guess another option is at this point just do the more traditional insurers and realizing that they'll be -- the self-insured plans we won't be getting to. It would be at least a step in the right direction.
JULIE: Well, my concern is not so much you won't be getting to them but they'll actually facially attack the legislation and this -- and this provision and which I as I

said -- well, Patty, you were out of the room -- I said I like the idea but I don't to want see a facial attack in litigation before we ever get out --
CHAIRMAN MAIER: No, no, I'm not suggesting that.
JULIE: No. I'm just concerned that that may happen. I'm sorry, I made a mistake.
CHAIRMAN MAIER: No, no. I meant to carve them out completely and not address them at all.
JULIE: Oh, I --
CHAIRMAN MAIER: So --
JULIE: Now I understand. Sorry.
JOHN: I'm sorry. Again, so is the concept of the Committee to define it as it is defined in 9471 2A, C and D, shall have this duty and then if you're a B, PBM does it?
FEMALE ATTENDEE 1: That's one option.
JULIE: Yes.
CHAIRMAN MAIER: That's what she's suggesting.
JULIE: And as Steve is suggesting.
JOHN: I'm just trying to think about the situation where the PBM tries to enter into

contract negotiations with B and says to them, Okay, you know, we can do this notice thing if you want us to and, you know, the cost will be 25 cent per notice. No go, we're not paying you a nickel, you already have a statutory duty to do it. So you could have a situation where we'll provide it, we'll sort of have an unfunded mandate on the future hypothetical PBM.
FEMALE ATTENDEE 1: You said some already do this.
JOHN: Some do it when it's in their contract, and then they can negotiate for it and it's one of the services that they might provide if -- if it's in the RFP.
JULIE: So let's just carve B out.
FEMALE ATTENDEE 2: We could carve B out and put in -- I mean, I don't see TPAs.
CHAIRMAN MAIER: They're in there.
FEMALE ATTENDEE 2: They are?
JULIE: TPAs are --
FEMALE ATTENDEE 2: Oh, just as an insurer?
CHAIRMAN MAIER: Yeah.
FEMALE ATTENDEE 2: Okay. All right.

FEMALE ATTENDEE 1: Are they in A? Where are they?
FEMALE ATTENDEE 2: They're health insurance company.
FEMALE ATTENDEE 1: They're counted as a health insurance company?
FEMALE ATTENDEE 2: A.
FEMALE ATTENDEE 1: Okay. All right. So that covers almost everybody.
FEMALE ATTENDEE 2: Yeah.
ATTENDEE 2: I mean, there's a piece of me that says if we mandate it, I mean, then they have to do it and that's a good thing. I mean, if we mandate it and --
FEMALE ATTENDEE 2: The PBMs?
ATTENDEE 2: Yeah.
FEMALE ATTENDEE 1: Do we know how many employees have their own health contract with either a TPA or --
JULIE: Don't have a TPA.
CHAIRMAN MAIER: That's fine. Where are we?
ATTENDEE 1: Covered amount.
FEMALE ATTENDEE 1: Let's put it in next year.

FEMALE ATTENDEE 2: We're talking about carving out B.
CHAIRMAN MAIER: Okay. Maria, are you -- do you know how you would do that? For the section you'd have to redefine -- undefine it or redefine it in the --
MARIA: (Inaudible) redefine it (Inaudible.) defined under Subdivisions A, C and D. I would also probably put it in -- in the other section or maybe another title, maybe title eight, but I'll figure that out. That's a second issue but I think I understand that.
JULIE: We've actually heard consumer complaints on this issue, which is why I'm so pleased that somebody brought it up. But I just want you to know that the consumer complaints have been with respect to Part D claims and there's nothing that we'd be able to do with respect to Part D because we are clearly preempted there, but I still think this is a great thing to do.
I don't know if you heard actual testimony on this or anyone talked about Part D.
ATTENDEE 1: No.
CHAIRMAN MAIER: No.

FEMALE ATTENDEE 1: No.
MARIA: We did hear testimony.
CHAIRMAN MAIER: We heard Patty.
JULIE: Oh, okay.
ATTENDEE 2: Sorry, I have a hard time hearing.
CHAIRMAN MAIER: Okay. I think -- I think that covers all of the sections that I have in my file here and the question to -- the first then for Maria is how quickly can we get a clean draft?
MARIA: As quick as I can get it. I'll try to be back here by 5:00. By the time we copy it --
FEMALE ATTENDEE 1: We need to copy (Inaudible.)
MARIA: Okay. I think then -- I think we can use the printers downstairs, the copier.
CHAIRMAN MAIER: That would be my first choice of the Committee meeting. The other option would be to come in early tomorrow but like we're all here and we're all staying here so people okay for this?
(Whereupon, CD 153/Track 2 ends.)
07-153/Track 3

JULIE: This is draft 123 dated today. It doesn't show any highlighting, simply recommended or bolded (inaudible). It would take too long but I'll tell you --
COMMISSIONER MAIER: Is that 30 seconds?
JULIE: Yeah.
ATTENDEE 1: What did you do, run a 10K?
JULIE: No.
COMMISSIONER MAIER: You can run twice as far, twice as fast.
FEMALE ATTENDEE 2: But she won't be pregnant for her whole life.
JULIE: So let me just tell you the new sections that were added. The first one is on page 23. There's a new Section 11. And this is Representative O'Donnell's proposed Amendment, only it no longer refers to PBMs, it refers to health insurers as defined in the applicable Subdivisions A, C and D. Right? You all recall that it occurred in the self-insured plans.
And also in Subdivision 1, Representative Chen suggested that the written notice be sent only to affected beneficiaries or Subdivision 2 depending on -- that's left up to the insurers

to which approach.
And then you'll see on the next page, the bottom of page 24 that reflects Representative Chen's amendment to the counter-detailing program so that's his Subsection A. You will see the changes there on page 25, his proposals in Subdivisions 2 and 3, funding for the pilot program which appears in Section 15 on the next page. And I think there's a couple of other technical changes there in reference to APAC (phonetic) and then Subsection B, specifying that's payments to pharmacy dispensing to the -- okay. So just -- so you're familiar with that. Right?
And then we have the BISHCA penalty section and that appears on page 31, Section 19 and that is as it was provided by BISHCA for the multipayer claims database, and so I'm going over that.
On the very bottom of that page, Section 20, is the manufacturer's fee and that should be option two. Did I get that right? Yep, the five percent based on standing. And so I think those are the new sections. Of course, they've all been renumbered and it hasn't been -- and

there were some minor technical changes that I also made and a couple of others that I did catch while this was printing but nothing substantive, so --

COMMISSIONER MAIER: We do have the -- a little bit of shading on pages 16 and 17.

JULIE: Right. That's inadvertent. That should come out.

And there was also on page nine, Section 6, that's stricken language there, Subdivision A1 and 2 needs to come out. That was just an oversight on my part.

I believe there might have been a citation correction. There was the application section of PBMs that needed a correction. I think that was Section 10. That had said Section 7 and 8 so now it's in Section 8 and 9 to reflect the renumbering.

I think that -- on page five, the very last line, Section 4621, I think that's a reference to the counter-detailing program and it was 4261, I think. Let me make sure that's the right citation.

COMMISSIONER MAIER: 4622.

JULIE: Yeah. That's right.

ATTENDEE 2: What page are you on?

JULIE: Okay. On page five, the very last one.

FEMALE ATTENDEE 2: Page five, the very last one.

JULIE: There's a cross reference to 4621 and that should be 4622.

And I will say -- I just forgot to mention -- I didn't have time to actually do this. On page 31 regarding the BISHCA penalties for multipayer claims database, we changed it to -- sorry. That's not what I'm -- the -- the notice provision by Representative O'Donnell, on page 23 originally it was for PBMs. I put it in title 18. Because it's health insurers now, it should be in title eight and I just didn't have time to find the specific statutory section. It will only take me a minute or two but --

ATTENDEE 2: Where are you?

JULIE: On page 23, Section 11. It should be just in a different title and so it will be a different title and different section number as soon as I get a chance to look in there and see if that's the place for it.

COMMISSIONER MAIER: So you'll have to then clarify that cross reference in the first line?

JULIE: Well, no -- yes, yes, because I will have to specify title 18 and not this title.

COMMISSIONER MAIER: Right. Take out the word plan.

So how do we do that procedurally then? Do we vote and get to the clerk's office? How do we --

JULIE: That's entirely -- let's see. Is it going to the clerk's now? Are they open now? They're waiting. Okay. Well, why don't I just look in title eight right now and see if I can put a section down, realizing that there will be changes. Okay. Yeah, I'm not familiar.

COMMISSIONER MAIER: Susan, do you know where to direct her in title eight?

FEMALE ATENDEE 4: (Inaudible).

COMMISSIONER MAIER: You are good. (inaudible).

JULIE: So how about -- (inaudible) so we have a new citation.

FEMALE ATTENDEE 2: Okay, great. What is it?

JULIE: It's title eight, Section 4088d.

FEMALE ATTENDEE 2: 40 --

JULIE: 88d and it's not a Subdivision. It's just 4088d.

FEMALE ATTENDEE 3: Small d?

JULIE: Small d as in David.

FEMALE ATTENDEE 2: Okay.

FEMALE ATTENDEE 3: You're saying that's (inaudible) of title --

JULIE: Of title 18. The health insurer as defined in Subdivisions A, C and D of title 18.

FEMALE ATTENDEE 2: So that's the only --

JULIE: And then some cleanup, getting rid of the highlighting is that one in a couple of places, so. . . . and I can do that right now so that the clerk has a clean copy. (inaudible).

COMMISSIONER MAIER: Okay. Did we get that -- I'm sorry. We got that resolved?

FEMALE ATTENDEE 2: I believe so.

COMMISSIONER MAIER: Okay. And we got the correct reference and the copy.

FEMALE ATTENDEE 2: Yes, we did.
COMMISSIONER MAIER: So you're going to have to sign a copy and then down -- give that copy then.
FEMALE ATTENDEE 2: No, she's going -- Maria is going to clean it up (inaudible).
COMMISSIONER MAIER: You're going to call it 1.4?
JULIE: I'll call it 1.4.
COMMISSIONER MAIER: Okay. Is the Committee ready to vote?
FEMALE ATTENDEE 2: Yes.
FEMALE ATTENDEE 3: Yes.
(Whereupon, CD 153/Track 3 ends.)
07-153/Track 4
CHAIRMAN MAIER: Okay. The motion. She has to pull that out.
FEMALE ATTENDEE 1: I will note that we passed the House Health Care Amendment to 115 with version 1.4 with the changes Maria Royle has just made with us in Committee here.
CHAIRMAN MAIER: Okay.
FEMALE ATTENDEE 1: Okay.
CHAIRMAN MAIER: Ready to vote.
FEMALE ATTENDEE 1: Start calling the

roll.
FEMALE ATTENDEE 2: Do we have to have a second?
FEMALE ATTENDEE 1: We don't have to have a second.
Representative Maier.
CHAIRMAN MAIER: Yes.
FEMALE ATTENDEE 1: Chen.
REPRESENTATIVE CHEN: Yes.
FEMALE ATTENDEE 1: McFaun.
REPRESENTATIVE McFAUN: Yes.
FEMALE ATTENDEE 1: Copeland-Hanzas.
REPRESENTATIVE HANZAS: Yes.
FEMALE ATTENDEE 1: Keogh.
REPRESENTATIVE KEOGH: Yes.
FEMALE ATTENDEE 1: Leriche.
REPRESENTATIVE LERICHE: Yes.
FEMALE ATTENDEE 1: Milkey.
REPRESENTATIVE MILKEY: Yes.
FEMALE ATTENDEE 1: O'Donnell.
REPRESENTATIVE O'DONNELL: No.
FEMALE ATTENDEE 1: Ojibway.
REPRESENTATIVE OJIBWAY: Yes.
FEMALE ATTENDEE 1: Wheeler?
Zenie.

REPRESENTATIVE ZENIE: Yes.
CHAIRMAN MAIER: Under our policy recently established, we'll count that as absent.
FEMALE ATTENDEE 1: Okay. So the vote is nine/one -- nine for, one opposed, one absent.
CHAIRMAN MAIER: Sarah is going to be the -- I guess both Sarah and Harry took reports. Sarah will be the main reporter.
Thank you. Thank you all for your hard work on this issue and --
FEMALE ATTENDEE 1: Yahoo.
CHAIRMAN MAIER: -- I appreciate where we came from, where we go to.
REPRESENTATIVE O'DONNELL: And I do too. You know, I think everybody in this building knows that I ate, drank and slept medication for a lot of years and that was really the reason I voted no.
CHAIRMAN MAIER: Maybe we'll be able to -- next time we got to the forum, maybe we'll be able to (inaudible).
Thank you. Great. So please be back downstairs promptly by 6:30. (Inaudible)
(Whereupon, CD 153/Track 4 ends.)

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 listen to CD 07 - 153/Tracks1, 2, 3 and 4 of the House Committee on Health Care, April 24, 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 4th day of April 2008.

Dona J. Wong, RPR, CSR

Esquire Job #928018

TAB P

STATE OF VERMONT

PUBLIC HEARING

Held on April 24, 2007

Before Senate Health and Welfare Committee

and

House Health Committee

TRANSCRIBED BY: Sherri L. Bessery, RMR, CRR

DEPOS UNLIMITED, INC.

P.O. Box 4595

Burlington, Vermont 05406-4595

(802) 658-1188

depos@together.net

VOICE: This is a public hearing of the Senate Health and Welfare Committee, and the House Health Committee. It's being held in Room 11 of the Statehouse. Today is Tuesday, April 24, 2007.

MR. MAIER: If you're here to talk about health care, you're in the right place. My name's Steve Maier; I'm the Chair of the House Health Care Committee. I'm joined here tonight by my colleagues on the House Committee and by our other colleagues on the Senate Health and Welfare Committee. Perhaps we should just all introduce ourselves. Start down with Kevin.

MR. MULLIN: Senator Kevin Mullin, Rutland County.

MS. LYONS: Janie Lyons, Senator from Chittenden County.

MS. KITTELL: Sarah Kittell, Senator from Franklin County.

MS. OJIBWAY: Hilda Ojibway; I'm a Representative from Hartford.

MR. RACINE: Doug Racine, Senator from Chittenden County and Chair of the Senate Health and Welfare Committee.

DR. CHEN: Harry Chen, from Fletcher, Representative.

MR. WHEELER: Scott Wheeler, Representative from Derby.

MR. MILKEY: Ginnie Milkey, Representative from Brattleboro.

MS. COPELAND-HANZAS: Sarah Copeland-Hanzas; I represent Bradford, Fairlee, and West Fairlee.

MR. ZENIE: John Zenie; Representative from Colchester.

MS. WHITE: Janet White, Senator from Windham County.

MS. O'DONNELL: Patty O'Donnell, Repreasentative from Guilford and Vernon.

MR. MAIER: And not quite sure exactly where she went, but Representative Lucy Leriche's, sitting here next to me, is from Hardwick and she'll be back momentarily. And I told Topper I would make sure to explain that he has a Select Board meeting in Barre Town that he could not miss. We legislators have been trying for years, and we're getting pretty close I think, to perfecting the being in two places at one time thing, but haven't quite gotten there yet. So he's here in spirit, his name's right here, we'll keep him in mind, and I'll, I might channel him once or twice tonight.

Anyway, thank you for coming. Just a few

brief remarks. As you're probably well aware, we've spent a lot of time in the Legislature so far this year working hard to ensure the success of the health care reform measures that we passed last year. We've got a couple of bills, or several bills working their way through the two Houses right now that, that are some technical amendments and other substantive changes to, to do all that we can to ensure the greatest amount of success for those initiatives.

We're also working on an important pharmaceutical bill, we just passed out of my committee about an hour and a half ago, that started in the Senate. So we're doing, we've done some good work here this year relating to this. And but we're now ready to begin to sort of turn our attention forward.

It was our intention when we passed the health care affordability acts of 2006 that they represent a significant but still a set of first steps, and that we made a commitment at that point in time, which we are starting to head down the road tonight on the commitment toward additional steps in health care reform.

And so in that vein we invited folks to come

tonight and give us their ideas on where we should go from here with Catamount Health and with our other health care reform initiatives.

We created some questions to help focus our conversation tonight. We will not rule you out of order if you go away from these questions; but it would be helpful to us if you could address as many of your comments as possible to these, to these questions. We didn't know how many people we would have and how much time we would ask. But since we're not a hundred people tonight, we've got about 20 people signed up to testify, if you would like to testify and you haven't signed up yet, see Loring, or Jan is still out in the hallway. Otherwise you're welcome to listen.

But I think at this point we'll, we'll, we've got a timer, and I think because there are 20 and not 50 or more people, I think we'll start with five minutes per person. And Doug has a little board here that we'll -- if we're focusing on the clock, we'll try to give you a 30-second warning. And if we get to the end of that and there are more people that want to testify or people that would like to say more than that, then we can go back at that point. That seems like a fair way to get through at

least the first couple hours of the evening. And if there's more energy left at that point in time, we'll reconsider again.

Did you want to say anything before we get going?

MR. RACINE: No. I just will say thank you to everybody for being here. I wasn't here, one of the only people at the table who wasn't here last year when, when this legislation passed. So it's been a learning experience for me. But I, too, see it as what we have in place now as a foundation, that's the way I've described it, foundation for a better health care system. And now we want to know how we can build on that foundation, cover more Vermonters, deal with the number of people who are underinsured for various reasons, make sure that we're finding all the uninsured people who qualify for programs and make sure we're getting them signed up, and that's part of the initiative as well.

And something that we've all talked about at this table a little bit and we hope to talk about more at length is how we can control costs of health care. And that's going to be part of the discussion over the summertime as well.

So we're looking for creative ideas, we're

looking for suggestions on how best to proceed with what we have and how we can provide insurance coverage to more Vermonters at more affordable prices. So I thank you for being here and contributing to the discussion.

And first up is Andrea Cohen.

MS. COHEN: Good evening. Thank you for the opportunity. My name is Andrea Cohen, I'm the Public Policy Coordinator with Vermont Businesses For Social Responsibility. VBSR, if you do not know, is a non-profit, statewide business association. We have about 650 members. We employ 10 to 12 percent of the state's population -- business workforce, rather, and we contribute about $4 billion annually to the State's economy. VBSR has been working on health care policy since 1992 and has issued numerous policy positions, arguing that health care and health insurance are economic development issues in this state and that health care insurance systems need reforms so that our employees, meaning our neighbors, our families, can have universal access to health care, to quality health care.

We strongly believe that the policy focus needs to be on separating health insurance from

employment, or for that matter from marital status, veteran status, economic status; that it should be separate from those things. Our members have been forced to cope with increasing insurance premiums over the past few years. And this past January we surveyed our members; we had 130 respondents. 37 percent responded that their insurance premiums have gone up more than 20 percent in the past few years; 75 percent have had their premiums go up at least 11 percent in the past few years.

The rising cost of health insurance premiums is one of the most uncontrollable elements of business overhead and is forcing Vermont companies to make difficult choices, such as dropping or reducing coverage. When this happens, the cost of the health care is either absorbed by the business or shifted to the families or State programs or back on to those who are insured and whose employers are paying for health insurance.

In this survey we found that 67 percent of the businesses said they're absorbing some or all of the rising costs. 41 percent said that they, they ended up choosing a plan with a higher deductible than they otherwise would have. And 52 percent were forced to increase the employers -- employees'

contribution to the plan, passing those costs to the employee. And in that survey they could check more than one so the numbers are more than 100. So a combination of things are happening because the premiums are going up. Increased health insurance premiums mean the businesses are reduced in their ability to invest money back into their businesses or raise employees' salaries or other benefits, like retirement savings and other things; they're forced to make these choices, they're spending more in health insurance rather than many other things.

So we believe economic development of the state is very closely tied to the solution of this worsening problem. I don't know how much time; I've just got a little left. VBSR believes that a health care plan for Vermont should include universal coverage and access, cost management to provide accountability and sustainability, an integrated sytem of care, promotion of healthy behaviors and prevention, and an equitable funding mechanism that takes into account contributions that businesses have already made.

Financing the system is perhaps the most challenging aspect, and we appreciate the steps that have been taken to reduce the cost shift to date.

We think more needs to be done. VBSR believes that a progressive financing mechanism is essential, using public financing if necessary. There should be no financial barriers for patients to obtain care. Ideally decisions about coverage and affordability should not be placed on employment or income status; and as long as we have an employer-based system, the goal is difficult to obtain. If, however, the health care system were independent of employment status it would provide a number of significant advantages, including the freedom of employees to change employment without concerns over losing health coverage and eliminating health coverage as a labor management contract dispute item.

So in sum, the benefits to Vermont of implementing a comprehensive system of universal health care are significant. They include a more stable and productive workforce, improved efficiency and reduced costs throughout the public and private sectors, and a healthier population of Vermonters. We believe the time has come to gather the strengths of our citizens, the dedication of the business community, and the political will of our elected leaders to move this universal health care policy

forward.

Thank you for the opportunity and look forward to working with you on your next steps and hopefully have more creative ideas for you. Thank you.

MR. MAIER: Thank you. Eight seconds to spare; that was very -- I'm impressed that you could do that without looking at the clock. I'll be impressed.

Next up is Veranda Porsch from Guilford.

MS. PORSCH: Hi. Can you hear me everybody? Okay, my name is Viranda Porsch, and I'm a traveling poet from Guilford, Vermont. I'm also a freelance teacher and writing partner.

A great deal of my life I've spent in Vermont listening to the voices of the unheard. Not specifically about health care until recently, but I've worked with elders, with adult literacy students, with patients in hospitals, and listening to people's unique voices and trying to transmit them is a very important part of my work.

Vermont has a wide array of self-employed people, of freelancers, many of them are artists, and all of us have precarious incomes. We have fluctuating incomes. And so in looking at the fee structure for the Catamount Health plan, many of us

would not really know how -- what we were going to be able to afford from one year to the next. As workers in Vermont, we've been invited to participate in the so-called creative economy. But for many of us it feels as if the creative economy is a way of using our nouveau Yankee ingenuity to create the new Vermont brand, which makes our State more attractive to tourists and second home owners. There are so many people out there who are the smart, young, and aging farmers with their niche markets. The artisans who fill the quirky store-fronts when the hardware store goes out of business. All of us don't know from year to year what we're going to be able to afford. And I'm hoping that you'll take that into consideration in looking at the fee structure. Since I am a poet, I'm going to end my presentation with a poem about my situation. It's a self-portrait as an uninsured poet. So here we go; bear with me. I'll read it slowly.

Uninsured. Though able for the moment, my body and I roll into golden age. Its passing strange.
The vehicle and home I shuttle from have coverage.
Whack a fender, trip and fracture on my premises,
adjustors gauge the damage you endure and dole out a sum. Rest assured I pay. I pay the premium.

Calculate the odds I gamble on. My heart, a slot machine, my dice, the density of bone, my fear, it rhymes with answer. The care I may postpone. Risk is the lien on all I own and owe. Luck is my doctor. Touch and go. Listen. My body's coverage is skin, thick or thin. My only coverage is skin.

(Applause.)

MR. MAIER: Thank you very much.

Next up is Duane Young from Brattleboro.

MR. YOUNG: Good evening. It's nice to be here. My name is Duane Young. I'm a logger/musician; I live in Brattleboro. And I think the reason, I don't have a big speech written out, but I think the reason I'm here is to kind of give you a perspective on the working man's point and how you can try to get something going here.

The next steps in health care reform, that's, that's like impossible, but I think a simple, a single-payer program would be the easiest thing to try to tackle. The thing that's critical is what makes health care affordable. What doesn't make it affordable when a guy like me who is just over 30 grand can't afford insurance and the price of life is going up.

I'd love some insurance. I got injuries; I could

have it chopped up, you know, fixed and get a deal, you know, I got doctors that are friends, but I still can't afford it. So, you know, thank God for the walk-in clinic; I'm an old walk-in clinic guy, you know, that's where, that's my best luck, you know, Wednesday night run up I'm there if I'm sick and hope for the best.

But the bottom line is I'm not alone and there's so many people in Vermont that are, that are either working for a small company or they're self-insured, or working for themselves, they're trying to get a business going, they can't even afford the insurance so they're on the non-, the non-(inaudible) stage where they can't, they can't afford it until maybe down the road when my business is doing better I can get some insurance. So those guys are all walking on thin ice like me, you know; they're all on the ice thing. And I think there's a lot of people in Vermont, and it would be astounding if you knew who is walking on ice and who is not and how that's getting harder all the time. My girlfriend said well if you marry me, you'll have -- you can get those teeth fixed, you know, and (laughter.)

Is that what it takes? I'm a logger, so I'd

like, I want to keep logging. But if I'm working, I'm safer at work because I've got comp. When I go home and I go play basketball with my son, I'm, you know, if I pull a knee muscle, then what do I do, you know? Call, you know, be a cheese ball and go up to the comp guy and say gee, I think I hurt it at work, my boss, you know. That's what people are up against. I'm not one of those kind of guys and I don't think most Vermonters are.

But the problem is if you're in an upper lower class middle bracket like I am, you know, the lower 30, you're barely getting by, you've got to have some kind of program that people can afford.

My, I jumped through all the hoops to get Vermont insurance. They gave me a little green card that said I get 10 percent of prescriptions, and it's like that's just like almost like a slap in the face. It's like you got to feel, my theory is you have to come up with something that's affordable, even if it's, you know, even if it only covers the most dire things, because I think you'll find most people are only going to get surgery when they need it. They're not going to go oh, free insurance, oh, here I go man, I'm going to get it fixed. So that's, you know, I would love to see some kind of

policy where people in my bracket could afford it, you know, there be a lot more security for me. And I guess that's number 4, that answers number 4. Thank you.

MR. MAIER: Thank you. Jeannie Keller from Burlington.

MS. KELLER: Good evening. I'm Jean Keller, I'm a resident of Burlington, and I've been working in and around health care for 27 years now in Vermont.

What do you believe the next steps should be in health care reform? My answer is we need to focus on achieving success and results in the key initiatives that are already underway before we take on any new areas of reform. For example, let's actually get Catamount up and running for the uninsured so that decisions can be based on evidence and experience as opposed to computer-generated assumptions. The premiums are already higher than expected, significantly higher than were expected, and enrollment isn't even going to start until October 1st. We're 18 months from the end of year one for Catamount Health. 18 months until the first year is over, where we'd have any data about whether it works, how much it's going to cost, how fast

costs go up, what kind of people are interested in it, whether anybody is interested in it at all. We're 18 months from the end of the first year. Maybe we need to give it a chance to produce some evidence and some data upon which to make significant decisions about what happens next.

Number two; implement the recommendations of the various Act 191 work groups, the task forces that you've already committed to do studies for you. These were designed to reduce the rate of growth in health care costs. Now I go to Susan Basio's web site, hcr.vermont.gov. Every month she posts a spreadsheet of the different activities in health care reform taking place in Vermont right now. 222 different tasks that came out of Act 191.

Now I go to a lot of meetings, and I think it would be wonderful if you folks would start going to these meetings rather than waiting for a task force to come and do a canned report in a little period of time, come and sit down with us who are hammering out these reforms and making them work, trying to make them work in the real world, see how hard it is.

Today, for example, I was at the committee that meets every month to work on the section of the

hospital report cards that will report on infections. Now that was one little tiny piece of 191; we're working every month on that. And what we got today was a report on what the hospitals are doing to stop methacylin resistant infections in hospitals. It's really complicated and it's really tough and these people really have their hands full. And to start saying okay, we're done, let's move on and start a new round of reforms assumes that there are a lot more people available who aren't doing anything right now.

We also have some really significant cost containment legislation that was passed three years ago, Act 53. I think it would be a great thing for you folks to go look at every reform legislation that's been passed since 1996, which is when the big ones really started rolling out, line by line; did this work, why hasn't it been implemented, how could we have improved on this. A really significant cost containment piece that was passed in Act 53 was batching of Certificate Of Need applications so that once a year all hospitals that wanted to do projects would come in and compete and see where the best expenditure of our money was.

BISCHA has not had time to issue any

regulations on this because Act 191 passed. They completely suspended their work on the Certificate of Need program. As a result, last week an ophthalmologist in Burlington got a Certificate Of Need to build a free-standing ambulatory surgery center in Burlington which is going to duplicate what you can get at Fanny Allen or Northwestern or Porter. It is going to cost less on the unit, per unit cost, because they're going to charge Medicaid less -- Medicare less. But it's going to leave capacity, as Dr. Fisher has pointed out, that will just be filled with more surgery that will cost us all more money.

The most important thing you could do to make health insurance more affordable, and your question is health care, but there's health care, cost of insurance, out-of-pocket expenses, three different things with three different causes and three different solutions. Most important thing you can do is cost shift, and I know you don't want to hear that. But to talk about debating whether we should universally cover hospital care for Vermonters when right now more than half of the Medicare hospital benefit is paid for by a tax on private insurance, seems ludicrous to me. If the State cannot pay even

50 percent of the cost of Medicaid hospital benefits, why are we talking about a universal hospital benefit? Why are we talking about adding people to Catamount when we're 18 months from the end of the first year and not one single person has been enrolled yet?

So my longer remarks are in a piece that has been handed out to you and I would really, really like you to start coming to some of the meetings of the people who are trying to implement Act 191 and to think about how to help that all really come to fruition before another layer is added on to for the same people to try to carry out. Thank you.

MR. MAIER: Thank you, Jean. Malcomb Severance.

MR. SEVERANCE: I'm Malcomb Severance from Colchester, and I've come to sit on the other side of the table. I've worked with many of you people here already, I know most of the people around the table, and I spent my last term here as Vice Chair of the Health Care Committee, and I'm sort of saturated with all of it. And it's sometimes helpful to be away from it and think about it, as you -- and I've never got away from it really quite. And that's what brought me tonight. Because I felt

that you raise some interesting questions, but I think you have a different obligation.

I think your obligation is to make certain that Vermonters understand that there is -- what the realistic possibility is for health care in Vermont. And I say that because there are clearly national limitations, which you can't do anything about, and that perhaps is this goal of separating health care from the employment base is classic, part of that problem; there are other parts of it as well.

But setting that aside, I go back to, as many of you heard before, basic economics 101 and what's that all about? Well in the very first lesson you learn that there are unlimited wants and there are scarce resources. And given that, you have to allocate, you have to prioritize, because you can't have it all. You can't have it all as individuals; can't have it all as societies. And that whole concept applies to health care. But that message has been crowded out these last two-plus years by rising expectations created by us.

Those rising expectations are based on a notion that somehow if we change the system, if we tweak it one way or another, somehow we'll be able to have it all. Those rising expectations have come

about because we went around the state and we took testimony, we listened to people. Those rising expectations came about in part because the bill itself speaks to getting everybody insured that's not insured. And in part we defined a pretty generous benefit package for people of Catamount Health leads us people to believe that somehow this is going to solve our problems. Even the title of the act makes certain suggestions; it's the Health Care Affordability Act. Even this hearing, it's interesting, you have, you raised four questions, but none of them is there nary a hint anywhere that there might be some limits on what's possible.

Take number 3, "Catamount Health is the current program for moving toward access to forward affordable quality health care for all Vermonters." It's a great goal and I agree with it. But quality, access, cost; three things. You can get any two; you can't get three. And people need to know that. There's a tradeoff here; this is the classic economic tradeoff. Quality, affordable, access to low cost health; you can't do it all. And I know the bill, and there are some good things in the bill, and they speak to issues which will have implications on costs. If we talk about common

claims forms and information technology and chronic care initiative and transparencies and all the other things, they'll, they'll have an impact, minor as it will be.

Those are not drivers of the cost of care; they are not the things that are pushing the price rate up by 5, 8, 10, 15 percent per year. Those rising costs come about because of the cost of health care services that are rendered. It was fascinating, the other day I went to my bookcase and I'd kind of forgotten, I saw a little paperback, and it was interesting, talking about health care services. And in it was a reference to President Eisenhower's heart attack in 1955. And what happened at the time? Paul Dudley White, the most eminent cardiologist in the country, came and prescribed what was then the most advanced therapy. Listen to what he thought. Bed rest, oxygen, deoxidant to strengthen the cardiac contractions, anticoagulants, and morphine for pain.

Contrast that with two weeks ago on Sunday, front page of the New York Times had a classic example or a classic case of a young man who had a heart attack and what happened to him. He got to the emergency room, and immediately electrocardio-

gram and referred to the cardiac catheterization station, dye cast into his heart, x-rays to start, stent was put in the heart, a second stent was put in the heart, and he was then in the Intensive Care Unit within an hour. Which costs more? Pretty clear; it's the technology, it's new ways of doing things that are driving the costs.

We can't end up having it all, having it affordable, having it available for everybody, and having quality. There are clear tradeoffs. We need to recognize it and you need to make sure that people understand that in the final analysis there are tradeoffs. You can't have it all. Thank you.

MR. MAIER: Thank you. Chuck Fenton from Windsor.

MR. FENTON: Brought some supporting documents for my remarks. No difference between the ivory and the white copies; I just ran out of ivory paper, that's all.

My name is Chuck Fenton; I'm the Executive Director of Reinventing Health, which is based in Windsor, Vermont. And I'm going to address primarily questions 3 and 4.

I'm here to advocate for a prevention strategy that's generally known as Community Health Advisors.

We at Reinventing Health have been working on a model, a program called Wellness Navigators, which is based on the Community Health Advisor model. Although mostly unknown in Vermont, Community Health Advisor programs have a long and notable history across the nation and internationally. As you will see in your packets, the first national Community Health Advisor enabling legislation was introduced in the 103rd Congress in 1993 by our own Bernie Sanders. That came at the same time as the Clinton health initiative and suffered the same fate.

However, over the last two decades over 200 model programs have been carried out nationally, many with dramatic impacts on the population they've served. Community Health Advisors serve a distinct role in the prevention of chronic disease, the improvement of health literacy, and the promotion of healthy choices. Community Health Advisors are basically peer educators and role models working with indigenous population groups to engender healthy behaviors. They are effective because they know the communities they serve, they focus on hard to reach populations that may be resistant to change, and they are indigenous to these populations.

Community Health Advisors are non-professional. They fill an important access gap in the delivery system by demystifying system barriers and by providing motivation. As extensions of primary care teams, they can prevent unnecessary reliance on costly emergency department and specialty services. They are from within the target population; this is a peer-to-peer model. They promote healthy living. For example, preparation of healthy meals rather than foods that are high in fats, added sugars, salt, and caffeine. They offer helping knowledge about injury prevention, about breast feeding, relationships, and access to the formal health and social service systems at an early point in the onset of evolving issues.

CHA programs also offer low skilled, unemployed workers the opportunity to explore new occupational choices. There's abundant evidence of the outcomes and cost effectiveness of this model, some of which you'll see on page 2 of the packets. In one example evaluation at seven sites across the country indicated improved heart healthy behaviors among participating families. The valuation of another group of programs demonstrated marked increases in birth weight, improved prenatal care, and improved

maternal-child interactions, including dietary practices.

Perhaps of most interest to this panel was the outcome of a program in Harlem County, Kentucky, an area that's similar to some parts of Vermont, where that program was shown to reduce hospitalization payments for ambulatory care admissions from over $1,600,000 in the year before the clients were enrolled, to less than $240,000 during the following year after enrollment. That's from one million -- that's from over 1,600,000 to under 240,000.

Likewise, in the same study emergency room costs were reduced from $20,700 before enrollment, to $5,300 after enrollment. The indicators used included stomach ulcers, hypertension, asthma, heart disease and diabetes.

A significant startup barrier for type of program is the development of a training program for participants. However, in Massachusetts there's currently under development a regionally appropriate training curriculum that will be offered through their community college system. I've spoken with them, and they would be open to collaboration on our training needs in Vermont. You'll see details of this program on the third page in your packets.

Based on these and other studies, it's my conclusion that the Wellness Navigator initiative, that's what we call our Community Health Advisor plan, could have significant impact on community wellness in Vermont and the cost of delivering quality health care services. The proposal fits well with the Vermont prevention model, which is on the last page of your packets, supporting the individual relationship and organizational and community levels and is a significant change in policy away from industrialized health care solutions towards a focus on wellness.

Our proposal would be to identify Wellness Navigators in publicly financed housing sites, such as those found in Vermont cities, to help the economic development benefits to rise will be manageable and tangible, and I encourage you to consider inclusion of a Community Health Advisor model in the Catamount Health initiative as a prevention strategy. Thank you.

MR. MAIER: Thank you. Lynnette Courtney from Greensboro Bend.

MS. COURTNEY: I guess I've been doing this since Senator Leddy had his hearings two years ago. And I've tried to come to as many of these sorts of

programs as I can. I was -- I went when the Governor came around to listen to everyone, and I stood eye-to-eye with him and explained what I will explain to you about our situation. And I didn't feel that I was listened to at all; I felt like I was patted on the head and said there, there, that's too bad, and it didn't feel to me like it went anywhere.

As opposed to the gentleman who's the logger and has no insurance, my husband and I are micro business owners who have insurance, and we are paying for it out of our savings. Last year we netted about $11,000. Our medical insurance cost was $9,600. Our total medical expense was $16,000, which was more than what we made. We can't afford our insurance. We -- unfortunately someone in the family died and left us some money, and we've gone through two-thirds of it trying to keep the business moving ahead and paying the insurance.

Okay, my medical expense from last year was $16,000; that was approximately 10,000 for the insurance, 3,500 for meds, and another 3,000 for doctors, doctor visits. Nothing out of the ordinary except that we have some chronic conditions. We can't give up our insurance because the meds would

cost more than our premium. A lot more than our premium; like $1,200 a month if we didn't have the insurance.

So my mortgage and real estate taxes are $6,600 a month. My utilities are about $45,000 -- or excuse me, $4,500, and my groceries are about 4,000. Altogether the things that I need to live in my house outside of the business are $700 less than my medical expenses and you guys are real people, I know that, you know, you come from our communities and you've got other jobs, other backgrounds. You work for the State and you get your insurance paid for. You work hard.

BOARD MEMBERS: No, we don't.

MS. COURTNEY: You don't? Give me a break. You don't? Oh, then all the more you've got to understand. I would hope -- we've been getting some really signs our businesses are going to be better this coming year, and if we ever get a chance to do better, and maybe break even, I still can't see how we're going to be able to afford our medical expenses.

Do we really have a tax on our, on our insurance? Is that, is that a true thing? Are we being taxed on our insurance policies? Someone

mentioned that and I, that just drove my crazy.

And as far as, I mean this year I lowered our coverage; we're paying higher co-pays. I'm saving $30 a month as to what I was paying last year. But as soon as the saving runs out, where are we going to be, you know? I feel like I'm one of the people that doesn't have health insurance, but I have health insurance.

And my answer to question number 1 was let the poor folks buy in to something. I don't want, I don't want anything free; I want to be able to pay what I can afford; I don't want anything handed to me. But we need help. I guess that's all I've got to say.

MR. MAIER: Thank you for coming. Dr. Deb Richter from Montpelier.

DR. RICHTER: Thank you, and I appreciate being given the opportunity and I commend you all for, you must be exhausted, you've been working all day and to be listening to all of us, and I appreciate it.

Let's face it, the big issue here is cost. And I actually ran across, you know, just to know how bad it is, I ran across a BISHCA estimate from the year 2000, it's the only copy could actually find, I save everything, thank God, and found that

they did ten-year expenditure analysis of what we would be spending from the year 1997 to the year 2007. And it turns out they estimated that in 2007 we would be spending $3.5 billion on health care. We reached that two years ago. This year, as you know, we're going to be spending $4 billion. So this is even bigger than the people who -- this is not, you know, these are experts, these are people who are very good at predicting. This is getting bigger than we even thought; $500 million more. So we are in big trouble.

And I would also like to have this report also touted the fact that they had implemented a broad disease management program on Blue Cross Blue Shield, which by the way at this time I believe was 60 percent of the market. Obviously it didn't do anything for costs. This has been going on since the year 2000.

So we have a huge problem. But one of the biggest parts of it is, is hospital costs. That's one-third of the hospital -- of the spending, is in hospital costs. And those are mostly fixed costs in the form of salaries and nurses and doctors and adminitrators and CEOs, etc. And, and I think it's important for us to remember that we're not trying

to raise money; we're already paying that whole bill in the form of the larger premiums that this woman was just talking about. They're those premiums are going up and we're all paying in various ways in the economy. The problem is we're not paying fairly, and we have no effective cost control as we can see if we have this enormous problem.

The other thing is is on the other side there's no guarantee of income for hospitals, so they have to grab at any good payment scheme they can. So it's understandable why they build cardiology units and ophthalmology wings and all this other stuff, because those are good paying from Medicare; they get good reimbursement. So it's understandable why, because they need to guarantee their income to pay those fixed costs.

So we're in this big mess and not even recognizing that our biggest problem is we don't have a health care system, and we didn't implement one last year.

So in terms of your questions, what I would suggest that we try to do is do something for everyone instead of doing some (inaudible). Topper McFond, Republican from Barre Town, introduced a bill, H.304, which provided universal hospital

coverage, so basically everyone in Vermont would have hospital coverage.

What would this do? Well essentially it would decrease premiums at the outset, because that's the biggest share of the risk. So premiums would no longer have to include hospital coverage, so premiums for everybody would go down. Everyone would have the hospital benefit. It would guarantee hospital incomes. And but it, on the flip side it would also make sure that they did so within a budget. It would also decrease administrative costs, which as we know, we talk about not wanting to spend money on things and we can't have it all, that's true, but I, I would dare wage that most Vermonters would trade administrative costs for better coverage; I'm sure of that. I'm sure if we took a poll, most of them would say yes, let's spend less money on paying for billing and administration and guarantee coverage for everybody.

The most important thing is that we give Vermonters peace of mind, because they don't stay up nights worrying about whether to pay their family doctor, they worry about whether they can pay for an appendectomy if their kid needs one, or if they get cancer. And these would be things that we would be

guaranteeing.

The thing that's important is this would have all elements of the health care system, and I'd like to simplify what I mean by that by remembering the acronym BUUDAS. Essentially it has a budget, universality, uniformity, dedicated financing, accountability, and stewardship. It has all the elements of the system and it would guarantee everyone. That would also, most importantly I think, because you did pass legislation, it is compatible with Catamount. It would also take the hospital portion out of the Catamount. So the point is everybody would be covered, so it's completely compatible with that. And I think most Vermonters you could explain it in one sentence. Everyone's going to pay based on their ability to pay and everybody would get coverage. You can say that in one sentence.

I think if we think it can't work, because we doesn't even have to look around the world to see whether it can work or not. Back in the 1980s there was an experiment done, it was the Rochester Community Health Experiment, where they did local budgeting and they had near universal coverage, and they managed to have insurance premiums that were 33

percent below the national average and 45 percent below the state average. It's been done already. When they removed the budget and the caps and all those things and let everything, costs went through the roof in Rochester. So we already know it can be done; it can be done, it's been done in the United States, and we need to do it now. Thank you.

MR. MAIER: Thank you. Hal Walstein from West Berkshire.

MR. WALSTEIN: Yup, West Berkshire. $70 in gas, four hours of drive time, and gas isn't getting any cheaper. But thank you.

So I'm here to share my perspective as a patient. And I stood out here on the steps with Dr. Richter and a few others, and I was very disappointed that folks in this building didn't think enough of us to come out there and talk to us. My main reason for being here is because I'm being denied an opportunity to pay high taxes. Now that isn't as altruistic as it might seem once you know the facts.

I had a job back in 2000 working for a company named Teradyne. I'm an IBM retiree; and because I bailed at ten years, I got very little benefits because of the way they defined their pension plan,

and anybody else who's been working there can tell you that the wonderful health care benefits that they had that were supposed to be golden have rapidly dissipated. Teradyne decided they would rather fire me rather than accommodate me under the Americans With Disabilities Act. So I was forced out on short-term and then long-term disability.

And what I found as far as cost shifting goes is that all cost shifting is going from private sector, the wonderful capitalists that we look up to all the time and tout, to the public sector. And here is how it happens. I lost my job. Instead of them trying to work with me, they started writing me up. And the last time they wrote me up it was with the understanding that they could fire me at any point in time. I didn't have a choice about whether I wanted to remain on the job or not; they didn't give me a choice. They forced me out the door. So I had to go on disability.

I have rheumatoid arthritis, and over the years my eyes aren't as good as they used to be. The rheumatoid arthritis was the thing that sealed my fate. And as far as health care goes, I'm locked into the system. And if you guys can't find a way to make it work for me and other people, I'm very

likely to die.

I see where you have a meeting here about death with dignity. Well I'd like to propose life with dignity. Because if you can't solve this problem, we're not going to have any choice but to deal with death with dignity, because that's all that's going to be left. And if you don't think that I'm speaking the truth, just keep in mind the baby boomers are coming. I'm one year too old to be a baby boomer; they're right behind me. And the irony is is that we paid tons of money into this system and they raised Social Security multiple times, and I keep getting told this is a pay as you go plan. Well under the pay as you go plan, we should have been seeing reductions. We never did. Now that I'm here and I'm in need, I'm finding that a lot of the promises that were made aren't being kept. Teradyne forced me on to SSDI; Social Security Disability Insurance. Ronald Reagan under his term when he took over from Jimmy Carter, they did some readjustment with Arnold Greenspan to the cost of living increase, and from what I understand I would be getting 70 percent more if they had kept the old formula which was deemed to be more favorable.

Teradyne had an insurance plan that really sounded good to me; they said if you want to go -- if you end up becoming disabled, we got an insurance policy on you for $2,000. And I'm finding that with almost all of these programs all the way up and down the line, government or private, there's always a thumb in the eye. This thumb in the eye was that they had a $2,000 and they would subtract off any other payment I got from any other source for disability. So Social Security was paying me around, at that time around $1,500, $1,600, so they opted out. I was led to believe I got the $2,000 over here, and I got what SSDI has, and I had that wonderful IBM plan that I worked ten years to get. And now I find myself out there with little or nothing, and this past year I ended up having to spend all of my money and turn in a 401K plan. I cashed it in for $3,000 and the State and federal government is going to take 800 of that in additional taxes.

I'll be eligible for my heat because you guys got a program here that takes everybody who has some issues and moves them into poverty because they can't get any of the benefits until they meet certain criteria and that usually means becoming

very, very poor. When you hit the bottom, you'll be able to get help, not until.

I would like to point out that everybody talks about we don't have the money. Well we seem to have an inexhaustible source of money. I understand that they spent like $4 trillion in this war that we're in right now, and that seems to be an inexhaustible supply. When I was in the military service in Vietnam we had an inexhaustible supply. So I think it's a matter of will. And I'm reminded of that saying whether you can or not, you're right. And I'm asking what do you think? Thank you.

MR. MAIER: Thank you. Shawn Cerra.

MR. SARA: Good evening. My name is Shawn Cerra; I'm the Field Associate at VPIRG, and I'd like to begin by thanking you all for this opportunity to testify. I also think it's really great that we live in a state that holds hearings like this where people from anywhere around the state can come in and testify.

Vermonters are facing a health care crisis. Health care costs are up nine percent in the last decade, outstripping real earnings growth in Vermont by nearly four percent. This means an increased burden on everyday citizens and the companies

struggling to afford health care for their workers. Simply put, it is unfair to ask Vermonters to make the choice between health care for them- selves and their families and buying groceries. Thus, it is imperative that we seek out a new way, a cost effective way for both the citizen and for the State. The most recent estimates of the per member per month cost of Catamount range around $380 per month; far less than the industry standard, and far less than what most Vermonters pay right now.

I've handed each of you two sheets that explain how Catamount can best be expanded to other risk pools and the possible economic benefits of such an expansion. These numbers you should note are strikingly similar to Ken Thorpe's testimony from last week, which I believe only underlies our need to take action in the next legislative session.

Looking forward, small businesses are the best target for Catamount expansion. They are stable and moderately sized risk pool, right around 17,000 businesses, and employing near 60,000 Vermonters. The Catamount benefits menu of benefits is far stronger than what most of these companies are able to afford and at a much cheaper cost.

In the final analysis, expanding Catamount to

businesses that employ ten or fewer people would save small businesses and their employees more than $2.8 billion over the next decade. Expansion of Catamount just makes economic sense. I was going to go and talk about Topper McFond's H.304 as well, the hospitalization bill. But Dr. Richter did such an excellent job that allows me to just nod in her direction and just say that it's an excellent bill and should continue to be under consideration.

Thank you. I've been brief and thank you for your time.

MR. MAIER: Peter Sterling from Worcester.

MR. STERLING: My name's Peter Sterling, I'm the Coordinator of the Vermont Campaign For Health Care Securities, a coalition of groups which includes VPIRG, AARP, NEA, AFL-CIO, that worked in supporting Catamount last session.

In my role as the Coordinator I often go out and talk with the public about health care reform; and it's not really the kind of job you leave at home -- at work. So when I go out and I'm talking to people about health care, their eyes light up and they say what can you do for me. And one thing that strikes me when I go out and I talk to people about health care, the people who have it, when you tell

them about Catamount Health, they get very excited until they understand that they're not going to get it; they can't enroll because they're in health insurance.

So I mean, I agree with Shawn that expanding Catamount Health seems to be a great step. I also believe getting rid of the one-year waiting period for people with insurance will help a lot of working people who are currently paying a lot of money and really struggling to stay afloat would really, would really be a benefit. Thank you.

MR. MAIER: Thank you. Andrea Standard, from Montpelier.

MS. STANDARD: Members of the committee, thank you very much for this opportunity to speak in favor of expanding eligibility for the Catamount Health plan to more Vermonters. For the moment I'm one of the lucky ones; I have health insurance supplied by my employer.

But I'd like to testify today based on my experience working with a very important segment of Vermont's economy; its professional artists and craftspeople. For six years I served as the Communications Director for the Vermont Arts Council, and in that role I had almost daily contact

with both established and emerging artists and craftspeople from throughout the state. Based on my conversations with scores of these creative individuals, I learned that gaining access to and more importantly being able to afford health care coverage for themselves and their families was a constant struggle, a nagging worry, and in some cases a critical determining factor in whether they were able to expand or even continue to pursue the work that they are trained for and skilled at doing.

Now if you're familiar with the concept of the creative economy and its well documented contribution to sustainable economic growth in Vermont, you know that it is fueled by these dedicated individuals working either as sole proprietors or as leaders of small two to three-person businesses that make enormous contributions in the areas of design, marketing, entertainment, technology innovation, and cultural tourism, not to mention creating a lot of beautiful things that make life in Vermont really worth living.

If I had a dime for every time one of those creative, motivated, hard working Vermonters told me that they couldn't risk expanding their business or even devoting themselves full-time to their creative

work because they couldn't afford health care coverage for themselves or their employees or because they had to hold down an unrelated day job just because it provided some minimal health care coverage, well I could probably afford to pay for private health insurance myself with those dimes.

Please support the expansion of eligibility for Catamount Health care plan to include small businesses and the self-employed. It's an investment that will greatly increase the ability of our most creative citizens to contribute to Vermont's future. Thank you.

MR. MAIER: Thank you very much. Terry Vest from Hardwick.

MR. VEST: Hi. I'm Terry Vest from Hardwick, and I've taught school in Plainfield, Vermont, for 20 years, mostly middle school; you will be able to hear me. And I'm sorry I didn't bring any handouts; I didn't realize.

I wanted to talk a little bit about health care, though, not as an educator, but as a Vermonter. And up front, I did not grow up in Vermont; you may notice as I talk, I grew up in the south. I choose to live here. And I choose to live in Vermont because of the state that it is.

Page 46

Last year the Legislature made a bold move with Catamount Health care. A bold move nationally. And thank you. It's not good enough for me yet, and I want you to go farther, because of everything these people so far have talked about today. Particularly I want to talk a minute about disengaging health care availability from employment.

I'm a teacher; I've got a good insurance plan. The people in the community in which I work pay a lot of taxes for it. But I have good health care. And I have a good job right now in my life; I'll pay for all the health care I can. But many people around me don't.

I have a student right now who's a junior in high school who is not able to attend school because he has to stay home and take care of his sick mother because they cannot afford to have somebody come in. Dad works nights -- I'm sorry, dad works days; the child stays home during the day to take care of mom, and we try to tutor him. He's 16 years old. He's bearing the brunt of health care because they can't afford anything else. And they work.

We have so many people in Vermont that are the working poor, and they need health care. It is not

Page 47

fair, it is not right, it is not humane, it is not the principles on which this country was founded, to let people struggle and suffer. I like living in Vermont because we have people who are poets, who are independent business owners, who love being a logger. I like to live where those people are. But they can't afford to live in our culture anymore because they can't afford, as the poor gentleman said, to stay alive.

Health care is expensive for a number of reasons. It's not because people overuse it. I used to have a health care plan many years ago now that had no deductibles. I didn't use my health care more then than I use it now with higher and higher deductibles. It didn't do any cost containment; all it did was cost shift out of my rapidly dwindling budget with all the other costs that are coming to us in our culture.

Somebody else said there's enough money in this country to pay for health care, we just have to decide where we want to spend our money. And there are places even in Vermont where we can look at getting the money for this. This is not a desire. This is not something we want. This is something the people in this state need and need desperately.

Page 48

And it needs to be available to everybody, regardless of employment status, regardless of socio-economic status. I'm willing to pay while I have the money. But what if I'm in a really bad car wreck and I can't work anymore? I don't know what. It's something that's really scary. And I'm old enough now to consider that there's going to be a point in the not too distant future where I may not be able to work. What am I going to do?

And I'm looking to the Legislature now, not 18 months from now, now, to start looking at the issue. Help me out. Just help me out. I don't want anybody to give me a handout; I don't want anybody to get a handout. I want it to be affordable and available for everybody.

I'll use one quick example, and that's my sister. My sister was unemployed, and therefore without health care for two years. She worked, she worked part-time jobs, she worked what she needed to do to put together to scrape and stay alive. But she couldn't afford to buy health insurance. She finally got a decent job, got health care, went straight to the doctor, got her annual and had uterine cancer. Now thank God that over the next year the treatments that she received have appeared

Page 49

to probably cure her uterine cancer. It's not going to be a death sentence to her. But what's the difference in cost between a pap smear and treatment for uterine cancer? I mean because she had no access to health care, she had no wellness care.

This money is not only coming out of the public coffers, because my, my health insurance is paid by you all, by the people in the school where I live, that's public money; and the higher health care costs are, the more my insurance is, the more people have to pay for their taxes, they're paying for her.

What was the difference in cost because we wouldn't come to just the point where people could get basic available health care?

So I'm asking you to think about this is not a desire; this is a need. This is a priority. I don't really care at this point where the money comes from, except possibly from the education fund. But it's something that we have to take seriously, we have to look at, and we have to do it now.

So thank you very much for your efforts last year and I'm in Lucy's district; Lucy and I are great e-mail friends. She'll be able to tell you exactly what I think about this at any given moment. But I really appreciate the hearings, and I

Page 50

appreciate the opportunity to speak to all of you. I'm sure Lucy represents me well in this, but I like to see you face-to-face with this and to say thank you for what you've done and help other Vermonters. Help these other people. Thank you.

MR. MAIER: Thank you. Trinka Kerr.

(End of CD.)

MS. KERR: Hi. My name is Trinka Kerr; I'm the State Health Care Ombudsman, and my office assists as many -- most of you know, my office assists people with health care and health insurance problems. We operate a hot line and we talk to hundreds and hundreds of people every year with all kinds of health care issues.

And I want to say first off that I am not in favor of this piecemeal plan that the State has put together that relies so heavily on employer-based insurance. I really think health insurance should be decoupled from employment. Because of the ties to the employer-sponsored insurance, the system that's being created that will start up in October is going to be very complicated, and I'm anticipating that my office is going to get a lot of calls. I mean we're already starting to get calls with questions about am I going to be eligible for

Page 51

Catamount, how is this going to work. And it's not that easy to explain, and not everyone who thinks they might be eligible for it is actually going to be eligible for it, and not everyone who thinks they're going to be able to afford it is actually going to think that it's affordable.

So with that sort of negative being said, I do appreciate that we operate in a political reality and at this point we do need to see what is going to happen with Catamount, how many people are going to sign up, what it's actually going to mean when the State tries to enroll more people in its current programs and what, how that's all going to play out in terms of costs. But I am concerned that people are going to have trouble navigating this.

And there are still some serious holes in the system, and I wanted to mention a few of the holes that we see from the calls, kinds of calls that we get. And I've mentioned some of these categories of people to people on these committees in the past, but I'll go through them again.

One of the first kind of calls we've been getting lately in particular are kids who are, families who have kids who are on Dr. Dynasaur who are still in high school and whose Dr. Dynasaur ends

Page 52

because they turn 18. And so one of the groups that I'm hoping you'll be able to add on the coverage is kids who have been on Dr. Dynasaur and continue them at least through high school.

Another category of folks that we've been hearing from are families with young adults who are out of high school but still living at home because they can't afford to live on their own; and because of how their income is counted, it can end up that neither the youth nor their parents are eligible for any of the State benefits. Some of that may get addressed with Catamount, but it may not. And one way to address those kinds of issues would be to allow people to configure their home, their household either as parents and child or together, however would maximize the coverage for the family. And that already happens with some Medicaid programs now, so it is possible. But I would hope that the goal would always be that each family could maximize its coverage and who can get coverage.

The third group that we hear a lot from are folks who have bought individual plans because they don't feel that they can go without health insurance, and the cost of the plans and the cost of the health care that they're getting even with those

Page 53

plans is really expensive, and they realize that they're not going to be able to continue paying for those plans. And if they drop those plans, they drop them today, they're not going to be eligible for Catamount in October. So that speaks to the 12-month uninsured rule, which I'm hoping can be reduced. Or at the very least that folks who have purchased individual plans and feel, and have to drop them because they can't afford them, that those folks would be considered automatically to meet the uninsured requirement.

And then the other two categories of people that we hear from are folks that are essentially underinsured, and that's usually people who have insurance with very high deductibles, or in some cases have insurance that has very low maximums. And that really ends up not being very good insurance at all for those folks and they go without needed health care, which in the long term ends up costing everyone more. So thank you.

MR. MAIER: Thank you. Greg Richards.

MR. RICHARDS: My name is Greg Richards. I sit on both sides of the fence. I have an interesting background, both from the standpoint of health insurance and from the standpoint of health.

I've been a licensed health agent and have specialized in the small group market since 1990. On the other side of that equation, I've been chronically ill for 38 years. I've had almost 25 surgical procedures, major ones; cardiac bypass surgery, I've been on an insulin pump for 24 years. My prescription drugs are almost $14,000 a year. I have had many years when my overall costs have been 50-plus. So I know a lot about health care, unfortunately.

As far as the Catamount plan, I'm going to address the affordability issue; I'm not going to go into a lot of the other areas. But this is an area I think I have a fairly good handle on. One of the -- my specialty is the small group market. Many of the people that are in that small group market are not healthy, that's why they're in that small group market, it's the only way they could get affordable health care. If they were healthy, they would either go without, or they would be obviously getting some other type or high deductible type health care.

Now when I say unhealthy, I'm talking the group itself as a whole, I'm going to say probably 40 percent of my clients have health issues. The

health issues range from diabetes, heart conditions, the expensive stuff. And this is a real issue. The last person testified that they were dealing with very high prices on the individual side. The individual market and even the small group market has essentially become a high risk pool, and that's why the rates are what they are.

Because of the high rates, you're put in the situation where only the sickest are actually in these pools. If you are going to look at Catamount expanding it before you've even run one year of coverage, you really need to start looking at what it's going to really cost you. The rate right now for the individual market is over $350 a month for a $5,000 deductible. You're, you have a rate right now of 440 I believe, with $200 deductible. So that might put things in perspective as far as what type of costs you might face. You really need to be running the plan for a period of time to find out what it's really going to cost you, otherwise you could be in for a horrible surprise.

Right now health care in the U.S. is about 16 percent of the gross domestic product. You can put that into Vermont, and someone has the numbers here of the gross domestic product is here in Vermont,

you get a pretty good idea what they are dealing with. And you are actually talking about taking on some of the highest risk people that there are. So that's my concern.

Another area you can, you can really make an impact on cost containment through cost control is the cost shift. This has been brought up. But right now the numbers I see are between 95 million and 195 million on the cost shift, depending on what source you read. This year you added a $1 million bandaid to cover the cost shift. And that's, it's not even worth talking about at the point that you're dealing with a number between 95 and 195 million dollars. That's about 14 to 20 percent, depending again on which number you use, of the entire premium we're paying right now in any plan. So to put it in perspective, if you have a $500 a month premium, $100 is directly related to cost shift. That premium would be $400 if the State was paying its fair share. So that's something you really also need to look at.

As far as the rest of the things I have here, I could probably go on all night; I'm not going to. I'm going to pretty well cut it off right there. But I, I really want you to be cautious rather than

just jumping in and finding out that you can't afford what we have. Because basically the people who have the coverage are going to be the ones who suffer because they won't have the money to get the help they need. It will be universal across the board; you'll have universe health care then, but the problem is you'll have lack of care because you won't be able to afford what's going on. So you really need to approach cautiously and figure out how you're actually going to pay the actual cost. Because none of this here is contained costs; all of this is paper costs. Thank you.

MR. MAIER: Thank you. Sarah Albert, Plainfield.

MS. ALBERT: Thank you for listening to us tonight. I'm Sarah Albert. I am a freelancer, I am a sole proprietor, topography, design publications.

I want to say up front that I believe in universal coverage and single payer, but I'm focusing tonight on something which I believe is immediately achievable, and what that is is to ask to drop the 12-month waiting period for some employed people who meet the income requirements of the Catamount Health.

The self-employed, in particular freelancers,

are really at the mercy of their clients in regards to what they earn every year. I have clients that I've had for years, and I get along with them very well, but sometimes they have to make tough business decisions. And when the budget gets cut, the freelancers are usually the first people to be let go. It's really difficult to plan ahead of time for health care costs and for expensive health care premiums.

Also those of us who are approaching retirement, and I'm the first wave of the baby boomers, we, we're in an even more vulnerable place because those of us who have managed to save up some for our retirement, you hear all the time that that's a mutual concern, is how, how is this generation going to support themselves in retirement, to give up health insurance for 12 months is to put that all at risk. Even, even a brief hospitalization could drain something that you've been working years and years to save up. And also for those of us who are near 60, we don't have the potential working years ahead of us to recover from a loss like that and to save it back up again.

So I think what I'm asking is in light, or I'd asked you initially, to drop the 12-month waiting

period for the self-employed to meet employment, or the income requirements.

Secondly, if that isn't achievable, to at least drop it for people who are within, say, ten years of being eligible for Medicare; for those who are 55 and older, for instance.

And my very last straw that I'm grasping at is to say at least afford us catastrophic care so that those of us -- and I'm lucky enough to be healthy, the insurance premiums I pay now I, I pay out of my retirement savings; I'm willing to take out some of my savings in order not to put everything at risk, but I spend many more times in health care premiums what my health care costs are. And the only reason I do it is because of that fear that I will play Russian roulette if I drop insurance. That there just -- we all know too many people that have had unexpected cancer diagnosis or some other mishap. And, you know, I take risks, I travel alone, I ski alone in places where I wouldn't be found for days if a tree fell on me. But health insurance, our health care system is the most terrifying thing. So I'd appreciate anything you can do.

MR. MAIER: Thank you. Joan, Joan Leddy? Not here? Paul -- Must be a doctor.

DR. MANGANIELLO: Right. Good evening, and thank you very much for having this hearing tonight. My name is Paul Manganiello and I'm a gynecologist. I work at the Dartmouth Hitchcock Medical Center, but I'm a Vermont resident; I have a Vermont license. I offer care at the Good Neighbor Health Clinic in White River Junction and I'm also on the board of the Good Neighbor Health Clinic, and so I hear about not only the medical problems that our patients are confronted with, but also the psychiatric and the dental issues that also come out.

I'm here to speak in favor of House bill 304, the Vermont hospital security plan. The Catamount health plan in its present form is fatally flawed. It will not address the health care financing crisis that we're currently facing. And the longer we delay in instituting a meaningful change, the more painful that change is going to be.

One of my colleagues, Dr. Jack Winburn, who's at Dartmouth, he's a nationally renowned researcher, he's a consultant for Medicare, he was the founder for the Center For The Value Of Sciences, he published the Dartmouth Atlas of Health Care. And what he and his colleages showed is that there is a

large, a wide variation in how patients receive their health care in this country.

Some hospitals are characterized as being high utilizers; they consult more specialists, they order more tests, they administer more aggressive care; and parenthetically, often times outcomes are worse than in low utilizing areas. His team of researchers estimate that, and this is pretty amazing, that one out of three dollars of the more than two trillion dollars as that we spend actually is wasted on unnecessary hospitalization, unneeded and redundant tests, unproven treatments, over-priced drugs, devices that are not necessarily better than those that they replaced, and end of life care that doesn't really bring about a cure, and worse, no comfort. Add to this the estimated administrative costs that we see in our present system with third-party payers, Medicare, Medicaid, and the Veterans Hospital, and there is a lot of money is going into the pockets of the wrong people. Which has not to do with how one practices medicine, but how individuals are reimbursed by this present system.

High quality, cost effective medicine can be achieved only by eliminating unnecessary procedures,

reducing errors and avoiding redundancy. Ideally we'd have a unified system with a single risk pool. Everyone would be contributing to a unified health plan through either an income or payroll tax, and what is needed to ensure fiscal responsibility through a global budget. And these three elements are all addressed in House bill 304.

Decisions based upon good medical practices as determine by an independent medical board should determine reimbursement for those services. We need to get away from the concept of health care being delivered through traditional market forces. In an October 16th Washington Post article, Joshua Freed reported that the chief executive of the largest health care company, United Health Care Group, William Maquire, was stepping down because he was suspected of backdating $1.6 billion in stock options; not millions, but billions. This is while 45 million Americans are without health care insurance. I have to ask you, where is the world outrage?

So in summary, we need a unified health care system with one funding source, an independent medical board, and a global budget. Okay, you want to placate the insurers? The plan can be put out to

bid to be managed by a private insurer. House bill 304 is not ideal, but it's a step in the right direction. Thank you very much.

MR. MAIER: Thank you. Now here's, here's a doctor with very clear handwriting. Dr. Vasser.

FEMALE: Mr. Chair? Mr. Chair, can we get copies of that?

MR. MAIER: Of which?

FEMALE: The doctor's testimony.

MR. MAIER: You didn't get one?

FEMALE: Oh, she's making some? Okay, sorry.

MR. MAIER: Carol Vassar from Montpelier.

DR. VASSAR: Hi. I'm an internist in Montpelier, I've been practicing internal medicine for 20 years here. I've been before a couple of committees over the years, and this is somewhat spontaneous comments on the topic that has taken a lot of my time and interest in the past ten years. A lot of what I came to say has just been said.

The most important part, part of what I have to say is that the administration of health care really is not what's going to control the cost of health care. The cost of health care is going to be controlled when we control the research on how we're going to deliver care, what we're going to do, and

how we're going to do it. And if we have insurance -- not insurance companies, the pharmaceutical companies controlling 95 percent of the clinical research, and the quality of that research is notably terrible so that when reviewers try to do, come up with clinical guidelines, they throw out 85 percent of the studies that they find as uninterpretable or not valid for one reason or another and we now have, in case you haven't looked at it, the Institute of Medicine has just, there's a pre-release document on the web having to do with evidence-based medicine, which so far, as far as I've read, looks like an incredible distortion of it, which one of the primary things they want to do is get rid of the randomized controlled trial because it's too expensive and takes too long. It's something you might enjoy looking at this. I can give you the reference; it's you go to the National Academy of Science, they list it as something like the learning something or other in medicine.

So somewhat ironically, the most important thing we can do to control the cost of health care is accomplish the campaign finance reform that we tried to do and that the Supreme Court cut down. Until you get that campaign finance reform, you're

not going to get control of the pharmaceutical industry that has one, more than one lobbiest for every member of Congress and I understand has moved into the state, and get rid of drug detailing. There's absolutely no virtue in pharmaceutical companies doing drug detailing.

What, what sort of objective presentation of a new drug do you think you're going to get from the pharmaceutical industry? And is that the only source that we're going to provide for our physicians for learning about new drugs? I spend over a thousand dollars a year on sources of information, and I don't really have time to read through it all. But I'm not going to spend an additional $100 for the Medical Letter, an additional $100 for the journal of, International Journal of Obesity; I don't have that much money. Some of this should be available to physicians, practicing physicians automatically. You pay with your license, you get access to the medical literature. Why would you want to hide the medical literature from us? Instead, we're getting it from drug companies.

So get control, get your -- the best thing you could do for controlling the cost of health care

would be campaign finance reform.
Now I can't resist making a couple of other comments that Steve has already heard, Jim Hester has heard multiple times. There are things that we can do in the state to improve -- to reduce the cost of health care, and the Blueprint has some potential of really doing that. If you, if you assist physicians in learning how to run their practice, that when they have a chronic patient, a patient with a chronic disease, you don't send them out and expect them to call up on their own when they need another check. You don't let them go without having a return appointment.
That sounds so basic, but it wasn't anything I was taught; I didn't do it initially. It took me probably four or five years in practice before I, before I said you don't let them out the door until they have an appointment. Doesn't matter whether they have their appointment book or not, they can reschedule; get an appointment. And it's things that as basic as that and can be and are being taught in the micro systems management part of the Blueprint that are valuable.
A registry where you have physicians take their time to enter data that is already in the labs

or already in the insurance company computers is an incredible waste of time. With the, with the idea given that if we have this registry, the physicians can go and look at their patient records every three months or however you want to do it and find out what they did wrong. That's great; why don't they teach them to do it right in the first place? You can provide that report of how they're doing without reporting on every single patient. I've said enough I think.
MR. MAIER: Thank you. Marjorie Power. And Marjorie is our last witness that we have testifying; so if anyone else would like to speak when she's done, let us know.
MS. POWER: I'm Marjorie Power and I'm the newsletter editor of the Older Women's League and I have been coming before you, I figured it out while we were sitting here, for over 20 years and covering the health care efforts of the Legislature in our newsletter. (Sign) I, I have been very interested as you all have been listening --
MR. MAIER: You've been here longer than anyone else.
MS. POWER: I don't know, I think Doug was here. I've been watching as people have testified,

and noting the areas that you found interesting enough to make notes on, and I've been thinking about that. Tweakity, tweakity, tweakity, tweakity. One woman says oh, please cover the self-employed and don't make them wait without insurance for 12 months. Cover the 19-year olds who are still in high school. Cover the red-headed women with cervical cancer. Cover this; cover that. Tweakity, tweakity, tweakity, tweakity.
The ombudsman testified that there are holes. Well, yeah. There's -- the hole is that not everyone is covered. It's a great big hole. But others have said well don't meddle with the system now; you went and you put a big new system in effect, wait until you get data. Well, you know, we got 20 years of data. The data is that we don't cover everybody and that dreadful things happen to people who can't get health care.
You know, when you have a front step broken, you don't say we'll wait and get some data; we'll see how many people fall and hurt themselves, whether those injuries are significant, and whether it's just better to let our liability insurance cover any damage that may occur. We go out and we get a carpenter or a board and we fix it.

We know that what we have put into place, the Catamount, is not going to work. Every time a state does one of these major health care initiatives, it is ballyhooed from the housetops. Right, AARP magazine, the Governor with the cow. The last one before that was the Maine Governor with the D'Rigo plan. The D'Rigo plan was the best thing since sliced bread. Well it turns out it's a nothing burger. And, you know what? If you all don't do Catamount right, that's going to be the next, being Vermont it will be a veggie nothing burger.
But it isn't going to work because, as everybody has pointed out, it's full of holes. And until you have the one risk pool, you're not going to be able to deal with the costs, to deal with all the other multiple groups who are not being well treated. And for those of us who are well treated, like the teachers, in terms of the health care coverage that they have, everybody else is either begrudging it or paying through the nose for it.
It's, I mean we're faced here with a moral issue. I mean well we could do the financial issue. Well Blue Cross Blue Shield came in with a proposal that for the first level of people who will have to pay the entire premium, the lowest group that does

not get any subsidy, the self-employed logger, it's going to be 17 percent, that premium, which has since been turned down by BISHCA, but it represented 17 percent of that individual's income. That's not affordable.

Now we're talking here, this is a moral issue. We talked about we can't have everything, we can't have this. So the question is who are we leaving out? The freelancers? The micro business people? Who? You say, you raise your hand and say we are not going to provide health care for the red-headed woman with cervical cancer. No. It's a moral issue. We have to provide it for everybody if we're to call ourselves the state that we think we are.

And my son also, who's 36 years old and only had health care one or two years since he went off my insurance. It's not just the odd people; it's everybody. And if you have it yourself, you're related to somebody who doesn't have it or you're in the potential to lose it.

So until we cover everybody with a program that ensures that they can keep it whether they have a job, don't have a job, change a job, get fired from their job, then we don't really have a program at all. So let's be the state we think we are and

cover everybody.

(Applause.)

MR. MAIER: Do we have anybody else that would like to speak with us tonight? All right. Well thank you all very much for coming.

(Hearing concluded.)

TAB Q

STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: 5/2/07

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

CD NO: 07-162

PROCEEDINGS

MR. SLEN: Hello.

ATTENDEE 1: Hi, Josh.

ATTENDEE 2: Hello.

MR. SLEN: Hi. I'm Josh with Slen. Everyone knows me here, I think. I'm the director of the Office of Vermont Health Acces from Vermont's Medicaid office. And Senator -- Senator -- Representative O'Donnell and I talked yesterday and I raised some concerns about the notification provisions in Section 11 of the bill. I have not had the opportunity to speak with other insurers about their thoughts. I don't know if the committee has heard from them, but I -- I can't speak to how other insurers feel about the language that's written.

The way we read the language in OVHA, it appears to us to present some changes administratively and how we might have to do business that would potentially be cumbersome and costly. And after discussions yesterday we presented some language that is much more broad and could be implemented in a number of ways using existing -- using existing processes that we have and other insurers have available. I

know as far as newsletters and ability to let consumers know about the PDL and changes to the drug formula. We're not -- I'm not wedded to the language. It was -- it's a starting point. If it needs to be filled out or have additional pieces put in it I'm totally open to that. What -- what I --

ATTENDEE 3: Can you give us a minute or two on what sort of -- so everybody here what --

MR. SLEN: Sure.

ATTENDEE 3: What was the concern --

MR. SLEN: Sure. The -- our concern was the way the language was written. It appeared to us that we had to provide written notification to every beneficiary who would be affected by a change to the procured drug list. 30 days in advance of those changes being sort of boisted upon the individuals and there are -- and -- and it was broad language as far as what types of changes didn't -- didn't clarify, for example, that there were only changes that were not for chemically equivalent changes in the drugs or for new formulations in oral versus -- you know, a liquid versus a pill. And so we have dozens of changes every month to the preferred drug list,

many of which due to the fact that a drug has gone generic and so we put the generic as the preferred and the brand as the nonpreferred on the drug list and so when you go in you would -- you would -- you would see that switch.

There's a generic situation law in the state anyway and so that -- we also noted and I believe a legislative staff are looking at that to make sure that that -- the two -- the provisions in 11 don't conflict with the generic sustitution law, so that was the first level.

The second level is we may have changes because we signed, you know, in the middle of the year a new rebate agreement with a new -- with a new drug manufacturer. We may be adding a drug onto the -- to the formulary, which is very, very close. So we have the drug utilization review board and -- that looks at therapeutic classes and -- and often we have half a dozen things that are preferred in a complex class and we may add another one and we may add -- there's any number of things that could happen. You might take two off and add three new ones or take one off and -- and add two new ones and all of that information is instantaneously available to the

providers. You know, we have -- providers have -- we -- we support epocrates, which is a handheld -- we push out the handheld devices, the preferred drug list, we also post it to our Web site. It's available on our Web site and it's available to -- through member services, our 800 number to members. They can call and get updates on that at any point in time.

And so the -- the new thing that would have to happen is that under the way we read the -- I read the language is we'd have to send a written letter to each beneficiary whenever any of those changes happen and we're not set up to do that right now, and so that would require us probably to send several thousand letters a month out to people and that seems -- it seems like a burden that in many cases would not be necessary that -- for -- for many, many changes they are of little note. For some changes it's -- it might be of note for the individuals, but determining which ones those are is -- is -- is a challenge.

ATTENDEE4: What's your recommendation?

MR. SLEN: So what we've recommended is that we have language that requires us to inform beneficiaries that there are changes to the PDL

in a -- in a general way and to make sure that they know that the -- the preferred drug list is available to them totally in these different ways and that we -- and we believe we can do that with some of the regular mailings that we do to beneficiaries already. So it would be in addition to regular mailings as opposed to specifically targeted when we changed how -- the type of inhaler or -- that was preferred or when we -- when we added a new combined drug formulation to a specific therapeutic classes of preferred agent.

So instead of on each individual we would be providing a broader message, educational message to beneficiaries and making sure they know the resources that are available to them both telephonically and Web based information for their specific prescriptions.

ATTENDEE 4: So you would put that in your regular mailings, like a supplement?

MR. SLEN: That's correct.

ATTENDEE 4: How often do those mailings go out?

MR. SLEN: Well, we send -- we send mailings every -- every month. We the -- the agency of

human services and -- and the office of Vermont Health Access to different groups of beneficiaries. Every beneficiary gets multiple mailings a year now. Eligibility related mailings and then coverage and service related mailings including like the covered services handbook that's updated once a year, and so there's a number of things like that that we do today and we would integrate this message into that -- into that communication plan.

One of the complicating factors is that we have signed a contract with GMMB to do the outreach and enrollment and they're doing a full look at all of the mailings that are done in order to provide some -- a fresh look at consistency of messages delivered and not overwhelming people with detail, because it's a larger subject. So I will stop there, but there's -- there's a whole review that's ongoing that will be this summer about how we communicate to beneficiaries in a way that they -- in a way that people hear it, because you all know when you get -- some things you read you remember and some things just (verbal indication) right by you and there's -- there's an actual science to that,

so . . .

ATTENDEE 5: Well, I guess my question sort of relates to that. I mean, if -- if what I get in the mail is a ten-page list of -- well, I don't know how long, but, you know, you need the -- the PDL goes on and on and on and it says somewhere in here there's a change, you know, it's a little bit like the prospectus I get from the mutual fund company. I mean, you know, the --

ATTENDEE 6: Right.

ATTENDEE 5: -- recycling bin.

ATTENDEE 6: Sort of interesting.

ATTENDEE 5: It's a lot different than a letter that says, Dear Steve, we know you -- you know, we know you take Lipitor, whatever, we've now changed the status here and the next thing you go to the pharmacy you're going to see a different drug. Please call this number, you know, for further explanation.

MR. SLEN: The -- the -- Mr. Chair, the -- I agree with you and I think that in -- in some cases when Synergist became available, which is a new drug, it was available last year sometime or maybe the year before -- do you --

ATTENDEE7: I have no idea what you're talking about.

MR. SLEN: Okay. So it -- it's a drug for infants that stops influenza development in -- in infants and it -- it's a -- it -- it really was a leap forward, as my understanding, in the ability and it was way overprescribed, way, way over prescribed and very, very expensive, thousands of dollars. And it was supposed to go to high-needs -- high-risk infants, but the definition wasn't very clear.

So anyway, that's a good example of one where provider education was really important and we did a big push to providers along with other insurers to make sure that people had the better practices, that providers had the best practices in front of them.

In other instances when an individual is having a change in -- when we do a review of a class of drugs and we actually change a bunch of things, we have done specific mailings to beneficiaries that were impacted because we knew that these were an impact, that people would notice this, that this was a big deal.

In many instances, though, that type of

mailing isn't -- doesn't appear to be necessary and defining when it is and when it isn't a challenge.

And so do- -- I think this -- the first language that was in there was a sledgehammer and what we -- what we -- what we need is -- what -- what I think we try to do in the office of Vermont Health Access is to -- when we have a big change, when we do -- when the DOR board spends three months reviewing a therapeutic class and makes sort of 72 changes to it, that we -- that we go out to the beneficiaries if there's a thousand of them that are impacted by the changes at the top of that list and -- and do some beneficiary direct as well as provide direct education on that. That doesn't happen near as often as all of the regular changes that occur because of new formulations and one small change to a therapeutically almost identical drug, so -- but -- but the -- the medical clinical discussion about how therapeutically close is this substitution different professionals can disagree about how therapeutically close the substitution is. And so we're -- we are dependant on the professionals around -- that sit around the table

at the drug utilization review board to identify for the office if this is one that's a big change or not. And that's not a -- there's a lot of qualitative discussion, not quantitative discussion that goes into that.

ATTENDEE 7: You're going to -- all in five minutes, right? Are you -- are you okay with this?

ATTENDEE 8: Yeah.

ATTENDEE 7: Are you -- are you --

ATTENDEE 8: I think as long as we address the problem in some way. You know, like Josh said, that's a sledgehammer and a sledgehammer's going to cost a lot of money, and I don't want to do anything that's going to cost money to the Medicaid budget as you all know. So we could start out this way and if it doesn't work then we can go tougher, but my concern was just that patients be notified. And, you know, Medicaid it sounds like they are being notified, but they're not necessarily being notified for other health insurers. So, you know, I think if we start out this way and it doesn't work we certainly can come back and address it next year, but I certainly -- I don't want to -- I don't want to

start way at the other end. It costs everybody -- because even the insurers, if -- if it costs them a lot of money -- it's people who buy the health insurance, they're going to pay for it. So at least there's some recognition of change formulary that's going to the patients and I think that's real important.

ATTENDEE 7: Okay.

ATTENDEE 9: Josh, for clarification. Does this replace the whole Section 11?

MR. SLEN: Yes.

ATTENDEE 10: Yes.

MR. SLEN: That's the --

ATTENDEE 11: We don't have this.

ATTENDEE 12: None of us have this, so I don't --

ATTENDEE 13: What are you looking at? What are you talking --

ATTENDEE 14: Okay.

ATTENDEE 15: I guess we need to get the language.

MR. SLEN: Can I -- can I read this? Should I read this?

ATTENDEE 16: I need to read it.

ATTENDEE 17: Josh can read it if he wants.

ATTENDEE 18: Yeah, it's really short.

ATTENDEE 19: That's where you said it replaces this, I just wanted --

ATTENDEE 20: I'm sorry.

MR. SLEN: Would -- would you like me just to read it?

ATTENDEE 20: Yeah. Please.

ATTENDEE 21: Please.

ATTENDEE 22: So this is -- this replaces Subsection 11 --

MR. SLEN: It replaces Subsection 11 as it currently exists. The language would read, On a regular basis no less than once per calendar year health insurers have defined in subdivisions blah, blah, blah, blah, blah, of Title 18 shall notify beneficiaries of changes in pharmaceutical coverage and provide access to the full preferred drug list maintained by the insurer.

ATTENDEE 22: So the piece about if you didn't understand it or no -- when you go to the drug store and, you know, suddenly an inhaler's been change to something that's double the dose you've been taking and that's your only option, you don't have the month that we had in ours to get -- you don't have the opportunity to fill the

prescription and then do it new the next time?
MR. SLEN: That's correct.
ATTENDEE 23: So can I ask a question? I haven't -- I haven't heard you talk about the cost. I mean, I've heard you talk about concerns of the cost of mailing written notice to beneficiaries every time you make a change and I understand that, that makes a lot sense, but why not -- why not simply allow the pharmacist to alert the customer that their PDL -- that their drug is no longer on the PDL and allow them to fill one more prescription, that way giving them usually 30 days to get back to the their doctor to -- to get put on a different formula or to get more guidance?
MR. SLEN: Uh-huh. The -- the bottom line on that piece of the discussion is that in some instances there's a lot more money than the mailings would cost at stake in allowing -- and having as a regular pattern everyone that came in with a change to have another fill. So that would be one more -- one more time -- however many individuals, one more at the higher payment rate than at the lower. And so when -- when -- when a change is made, we want that implemented

from a fiduciary perspective immediately.
Beneficiaries always have the option in the Medicaid program to at the counter have that discussion with the pharmacist. The pharmacist can call their doctor, the doctor can override and require -- I mean, so we have an open formulary. The doctor can require the original prescription to be filled again, but that's a patient --
ATTENDEE 24: I hate to interrupt, because the house has just recessed and people are headed over to the governor's ceremonial office for those of you -- that's all of us that wants to be there for that proclamation related to the -- what is it related to?
ATTENDEE 25: Just related to soldiers. It's not related to anything that we did.
ATTENDEE 24: Not related to our documents --
ATTENDEE 25: No. No. It's not at all in any way, shape, or form, it's just to have to met -- we started the boxes after the debate and they were finished last week and, you know, they haven't had a chance to come and pick them up yet, that's the only other relation.

ATTENDEE 24: It sounds to me like we still have some questions around this and so --
ATTENDEE 25: I'm fine.
ATTENDEE 24: Well, we'll come back to this, I guess. So I would ask the committee to, I guess -- and go back on the floor at one, but I'm going to ask that we come back up here at one o'clock and we -- I should know more about where things stand with the amendment on the data mining event at that point and depending on what's going on in the floor per second and the third we may continue this conversation at that point. Thanks.
ATTENDEE 26: Because we could come here at 12:30, right?
ATTENDEE 27: Why not notify those people in writing so that they can get to their doctor and say don't put me on this because this is --
MR. SLEN: I think as a matter of public policy we could require the office to notify everyone in writing in advance, but we will -- there will be a cost to that.
ATTENDEE 27: But you just said that in many cases filling that one last prescription would be far more expensive than mailing the -- the --

we're talking about in the original language, so why not --
ATTENDEE28: They both cost money.
MR. SLEN: Yeah, they both cost money, so --
ATTENDEE28: We need a better way to do it that doesn't cost them that much money.
MR. SLEN: There's no way to do it without spending more money on both the mailings and on filing. If we do the mailings some higher proportions than currently we'll ask for the current drug to be maintained.
ATTENDEE27: And their doctor can override it anyway even if it has --
MR. SLEN: The doctor can always -- we have an open formula, so the doctor can always prescribe -- write -- prescribe -- on it and that's prescribed as written, meaning that they can't substitute -- that the pharmacist can't substitute.
ATTENDEE 27: And then OVHA picks up the tab?
MR. SLEN: That's correct. Yeah.
ATTENDEE 27: Well, I would like to save money too, but --
ATTENDEE 28: What would you -- what would

currently -- would I be right or wrong to suggest that this language -- what will essentially enable you to just keep doing what you have been doing, are there -- will this -- we actually do something different than the result of either this conversation that we had or this language.

MR. SLEN: Well, we don't necessarily do this now. So we don't -- OVHA doesn't. I mean, Signa did for me. As a State employee I got a notification in December or November, sometime, that the preferred drug list was changing next year and go look at this Web site. And OVHA just created this year a communications unit to help manage all this external communications and we have a contract with GMMB, as I indicated, that's reviewing how we communicate with beneficiary and providers and so we have -- we're sort of light years behind the other, you know, major insurance companies in the world as far as communicating effectively with beneficiaries and that's something that through the CCM, chronic care management program, that vendor also has communications strategies. And so we've got to combine all of those communication strategies along with synthesizing what we do with what the

Department for Children and Families to eligibility enrollment department does so that we don't send beneficiaries 16 things a month that are -- that result in 37 pages a month to every beneficiary that just go the circular file because it's too much stuff. Meanwhile we need to get messages like your PDL has changed and you -- you might want to pay attention to that across -- and across to -- I would -- I would say to specific groups of beneficiaries. So for many, many beneficiaries the fact that the PDL has changed doesn't affect them because they don't take any maintenance drugs --

ATTENDEE 28: Right.

MR. SLEN: -- you know what I mean? So if you're not on a maintenance drug where there's actually a change it doesn't matter to you that the PDL is changed, as a matter of fact most of our mailings don't matter to you for many folks. For the 60,000 kids, you know, 50,000 of them or so have a well child visit or a physical exam and maybe an ear infection once a year, that's it, and -- so most of our mailings don't -- don't -- don't impact them. So we need to get better and that's one of the goals for this coming year at

targeting communications effectively, and this fits into that pool of things that we need to do effectively.

ATTENDEE29: It seems to me that the aim of the communication needs to be to -- to encourage some good will between the payer, which is OVHA, and the prescriber and the patient who really could care less what's on the PDL because if that's the drug that I want to be on and I tell my doctor that's the only one I can stand, that's the drug I'm going to get, you know. And so sending out a -- you know, here's where you can find the PDL to find out what drugs are on it and what aren't means nothing to the -- to the OVHA recipient, right? I mean --

ATTENDEE 30: Excuse me.

MR. SLEN: I think -- I think it -- I think every beneficiary is different in that there are a number beneficiaries who know more about the drugs that they're taking than their doctors do because they've been -- their very strong self managers. They've done the research, they've had 12 different doctors in the last 15 years, they are very strong self advocates and so they -- they are -- they -- they don't even need to be

told to look on the PDL, they do it. You know, they keep -- they're managing their own -- their own medical care and that -- that is certainly true for a very small percentage of people.

There's other folks that really -- like me, like many other folks, who are really very dependant on the doctor. You know, you get sick and you go to the doctor and the doctor fixes it, right? And -- and in those instances the primary communication on most changes is really directed at the providers and thus the pieces of this legislation that have the counter detailing and the -- the ability for best practices to be discussed and talked about and advocated for -- on a broad basis across the system are important, they're important to the blueprint and other things.

I'm -- I don't want my comments here to be taken to say that I don't think that it's a good idea to inform beneficiaries directly. I do think it's a good idea to do that. I think that the language that was originally in the bill and this language sit at the two sides of that and that there may be some changes to either that would push more towards the middle which we may

be fine with. I -- I just think that what we -- if the intent is to inform people when there's a substantive change to the drugs that -- that they're taking, defining that is going to be very difficult and I would like the opportunity in OVHA anyway to -- to take a whack at that without legislative change -- without legislative language that says you must do it this way, because it's going to be pretty complicated to do well.

We may do it well for 70 percent or 80 percent or 90 percent but there's going to be some percent of folks where the DUR board docs and pharmacists didn't think it was a big deal and the doctors for these 20 people thought it was a big deal for the change or the people themselves thought it was a big deal for the change. And that's -- that's going to -- that's for sure going to happen no matter how we write the language.

ATTENDEE 31: Yeah. I think -- what you were saying about -- being able to identify and effectively communicate with segments of the entire Medicaid population made a lot of sense to me. For example, looking at people who are just

on maintenance drugs for -- you know, for doing these communications, I -- I agree with that. I think that's -- that's sufficient and it makes sense and I'm -- and you said that you were undergoing some system changes. I mean, I know you're undergoing some -- some systems changes with the help of CMS and stuff and I'm just wondering is this -- this -- it sounds like it's a goal of yours to get to the point where you can do this -- this kind of targeted communication with members. Do you have -- what is the time frame for that project? When do you expect you're going to be able to have that culpability?

MR. SLEN: Well, we're -- that's a great question. We're -- so the transformation of the healthcare system in Vermont and the -- the transformation of the Office of Vermont Health Access are sort of moving along at a lot of different paces and one of the things that we're sort of far behind on is having a communication plan with beneficiaries. We're very efficient if not effective -- potentially not effective but very efficient at communicating with providers for changes, to coding changes to payment levels changes. I mean, those things go out, the

providers know where to find those changes, they -- they hit them on a regular basis. And I say it may be not effective because we need to review how effective, you know, is -- is -- what percentage of the provider community is hearing those changes or understanding them, that's a different question from we're getting the message out repeatedly very efficiently.

On the beneficiary side -- and we have -- we -- we don't have the systems in place to be efficient or effective in communicating clinical changes to the covered services. That's not something that's been focused on in the history of the program very much and it's an area that with the chronic care management that's going on we need to get much, much better at. So pieces of this are going to get very -- are going to become very professionalized meaning systematized, efficient, and measured for their effectiveness over the next 12 months, very.

So for the 25,000 people or so that are going to be in the chronic care management program, they're going to get tons of very effective and efficient communication about their chronic conditions including the drugs and how

the preferred drug list impacts the drugs that they're taking. I mean, that's a coordinated concentrated effort that's going to occur. And for the -- for the people at the very top of the preparement the care coordination folks, that's also going to occur right now, you know, in the next six to -- six to eight months. The -- for the rest of the population it's going to be post that 12-month period because we just -- we just don't have the capacity to build that efficient and effective communication system for all 150,000 people all at once.

ATTENDEE 31: So I'm wondering, if we -- if -- how you would feel about us phasing in this kind of thing for -- for OVHA, so we -- we make a later effective date and maybe we just -- we specify only for -- for Medicaid patients who are on maintenance drugs, for example. I mean, if we did a little more fine-tuning with the language and -- and maybe did a phased in kind of thing and after a cert- -- another certain date you will include the entire -- or not Medicaid pop- -- just thinking kind of out loud about this. How -- how -- how do you react to it? How would you like that?

MR. SLEN: I think my preference over time would be that the state laws --
ATTENDEE 31: Stay out of it?
MR. SLEN: Don't di- -- don't differentiate between the public payer and the private payers and what we're required to do. And so I wouldn't -- I would prefer to have -- if we -- if we all have to notify individuals in certain time frames for changes at a certain level then we should all do that the same way, ideally with the same -- with the same materials. Very similar materials with a different logo at the top but the -- getting there is a -- we're a long way from there.
ATTENDEE31: Can I understand for a moment how -- do you have a question? How a Medicaid patients -- what would happen if say I was on a maintenance drug and I had a five-month refill and I came in after month three and found that my medication had been changed on -- on the OVHA preferred drug list, what would -- what would I find at the pharmacy?
MR. SLEN: The pharmacist would have a -- depending on your pharmacist a more or less informative conversation, but often quite

informative about there's a change to the preferred -- to the preferred agent here. This is the new -- this is the new agent that is preferred. It's, you know, similar, identical depending on what the issues are and they -- they walk through with the patient what that was and --
ATTENDEE 31: And if that was simply something coming off patent and it switched to generic, would that just be automatic and they --
MR. SLEN: Yes.
ATTENDEE 31: -- would get the generic and I say why does the box look different and that would be fine.
MR. SLEN: It might not be fine, but it would but -- that's what would happen.
ATTENDEE 31: Okay.
MR. SLEN: I mean, it might not be fine from a beneficiary perspective. I mean, we do get calls -- member services gets called, you know, my pills used to be --
ATTENDEE 31: Right.
MR. SLEN: -- purple, they used be larger, they used --
ATTENDEE 31: Yeah. Yeah. Yeah. Yeah. I

understand those differences, chemically it would be the same?
MR. SLEN: In that instance, yeah.
ATTENDEE 31: But what if it was, you know, the preferred drug used to be what I'm on and now it's something else, would -- what -- would I -- would I be handed a bill for the difference?
MR. SLEN: No.
ATTENDEE 31: So OVHA would pay the difference?
MR. SLEN: As a Medicaid beneficiary your co-payments are set so they wouldn't -- they wouldn't change --
ATTENDEE 32: You'd still get -- you'd still get -- from your example you'd get the new -- the difference drug.
ATTENDEE 33: The drug.
ATTENDEE 31: I would get the new drug?
MR. SLEN: Yes. Yes.
ATTENDEE 31: I would get a new formula.
ATTENDEE32: And if you didn't like it you'd have to go back to your doctor --
ATTENDEE33: Call your pharmacist -- call the doctor.
ATTENDEE32: And try to get the doctor to

overrule the substitution.
ATTENDEE 31: Right. Right. Okay. That would be different.
Now, you said that you wanted public and private payers to be treated the same, but in the case of an OVHA patient I'm completely insulated from price whereas she's on a -- she's got a -- you know, a pharmacy benefit manager. Her -- you know, her -- her co-pay for drug A might be a buck 35 and for drug B might be, you know, $18 and so she's price sensitive and I'm not, so I guess I don't understand why --
MR. SLEN: Well, I need to -- there's -- there's -- the Office of Vermont Health Access runs multiple programs and so it's not true that in ever instance a change -- some changes would result in different payments for a number -- for a big chunk of beneficiaries that's mostly not true. It's mostly -- what you're saying is true. For another -- for several other big chunks of beneficiaries there are changes potentially, but they're very small changes and it actually works backwards from how you might think about it. So our -- the folks that are extansion folks only pay premiums and not co-pays at the drug counter.

So the folks that we've -- that are not traditionally eligible for the Medicaid program pay these premiums and they don't pay at the drug counter for -- for the drugs.

The folks that are on the traditional Medicaid program pay co-pays in a tiered way, but they're still at the $5 -- they're still at the -- a very small amount based on the price of the drug. So when we -- when we make a -- when we make a switch it might often actually result in a lower co-payment.

One of the things we know too about those -- the small one, two -- or one, two, and three or two, four, and five, whatever the co-pays are now -- is it two, four, and five?

ATTENDEE 34: It looks like 5.35.

MR. SLEN: So is that -- from the survey we did that they're only collected a minority of the time at the pharmacy counter, so that -- in fact, that those -- those co-pays are not of the survey that we did a couple of years ago of pharmacies was that they were -- they were not collecting those, which is one of the things that was utilized, they were collecting them, let me be clear, less than 25 percent of the time and the

state was collecting premiums more than 85 percent of the time. I'm being careful because I think that was actually lower than 25 and higher than 85 considerably, but that -- this way I'm safe, because it was certainly higher than 85 we were collecting premiums and lower than 25 they were collecting co-payments at the pharmacy counter. And so that was one of the deciding factors when the legislature was considering moving to pure premiums for the majority of this -- the Medicaid programs.

ATTENDEE35: Two questions. Well, one question and one comment. The question would be, would it be hard to make your -- space in 13 months and have an overlap of one month? I mean, that's really effect- -- that's somewhat what we're asking for. So -- so did you -- so there's a month overlap where two drugs is kept the -- you know, preferred. And, you know, I'm just throwing that out as a possibility and that type, meaning a potential solution to this and then the second question asking your -- your -- my comment about -- well, maybe -- you're actually right, I think we all should be doing it the same way, all different -- and then maybe -- I hate to say

this, but maybe it says something -- people can work on and come back with a solution next week. It's a little more complex than it seems.

MR. SLEN: I'm not certain I understand the question.

ATTENDEE 35: The first one?

MR. SLEN: The first part, the 13-month question.

ATTENDEE 35: Well, I -- I guess the question is -- if -- if.

ATTENDEE 36: I think they're changing more often --

ATTENDEE 37: They change every month, though.

ATTENDEE 35: Do they change every month?

ATTENDEE 37: That's part of the issue, is it's so frequent and it's --

MR. SLEN: There's 500-and-something drug manufacturers. We have -- even some of the big ones we don't have supplementals with and we may have agreements with a manufacturer for just 15 of their drugs as opposed -- and then three months later one of their competitors may have a new drug competing against one of theirs that they don't have a supplemental with us and so we

add -- it's a very dynamic process that's constantly being managed.

ATTENDEE35: Okay. Okay. That's fine. That's answered my question. Thank you.

MR. SLEN: Thank you. And -- and I will be here if you need me at all today.

ATTENDEE35: I may need to get back with you at some point today or tomorrow morning.

MR. SLEN: Okay.

(End of track 38:25.)

- - -

CERTIFICATE

THE STATE OF FLORIDA
COUNTY OF DUVAL

I, Sherry Brazier, Notary Public, Certified Shorthand Reporter do hereby certify that I was authorized to and did listen to CD 07-162, the House Committee of Health Care, Tuesday, August 15th, 2007, proceedings and stenographically transcribed the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 16th Day of August, 2007

Sherry Brazier
My Commission #DD 458166
Expires September 9, 2009

STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: 5/2/07

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

CD NO: 07-162

PROCEEDINGS

- - -

ATTENDEE 1: You're doing -- no, you're not doing the -- I'll go through this. It will give me a chance to brush up on it. The first instance on the amendment on the appropriate amendment here is inserting the word confidentiality, which was -- is if -- if you recall the conversation that we had with the judicial committee regarding Section 19, judiciary wanted to be sure that it was clear in Section 19 that -- that the fees --

ATTENDEE 2: Administrative penalties.

ATTENDEE 1: Administrative penalties. Sorry. The administrative penalties were applicable if there was -- if anybody knowingly failed to comply with the confidentiality requirements or the confidentiality rules in that -- in that section. And that -- and that section is dealing with the administrative penalties of the multi-payer -- information. So if anybody knowingly misuses or releases data that violates confidentiality rules that's when those administrative penalties kick in.

ATTENDEE 3: Especially those larger ones.

You can only relate to confidentiality --

ATTENDEE 1: Right.

ATTENDEE 3: Compromises.

ATTENDEE 1: Right. Okay. Section 20 is changed to the fee, in -- fees is changed here.

ATTENDEE 4: Is the amount of the fees the same from what's happened here?

ATTENDEE 1: This basically just establishes a fund into which the fee is placed, right? The fee is the same and it's collected in the same way, establishes separate funds and designates that the secretary of human services will make rules for establishing that assignment and the fee. And then the third amendment is --

ATTENDEE 5: Let me just ask, so the idea of reducing the rate, that's talked about and then decided not to?

ATTENDEE 6: No, that was done in a way to move time.

ATTENDEE 5: Oh, so that's not final.

ATTENDEE 6: We haven't gone -- for the -- the ways, means to making amended -- they -- it's recording favorably on the drug.

ATTENDEE 5: Okay.

ATTENDEE 1: Yeah.

ATTENDEE 6: But they did take testimony yesterday on a lower fee and voted against the lowered fee and for the --

ATTENDEE 5: Oh, that's right. I'm sorry.

ATTENDEE 6: And so -- for appropriations, because now we have money, but we hadn't actually thought that we -- the appropriate -- included them in the appropriation part. And they -- they just tweaked a few sections on -- only because they were setting up funds from which they're going to appropriate the money. And so 20A is just the fund itself, is that right, Sara?

MS. COPELAND: That is -- 20A talks about the fund, what is coming into the fund. It's a revenue from the manufacturer fee. Any proceeds from grants, donations, that's just kind of a catch-all in the case. There's no more future money that wants to be put into the -- the fund. And then 24A, which is the fourth sentence of the amendment, simply sets up the budget of how -- how the fund is to be used. So 200,000 to -- to APAT (phonetic) for the evidence based education program, 300,000 for the generic sample pilot project, and then 500,000 to the attorney general for the collection and analysis of the

pharmaceutical marketing activities that -- sorry. In which section of the bill --

ATTENDEE 7: It's part -- it's prior law that they -- they claim --

MS. COPELAND: Right.

ATTENDEE 7: -- the data -- they had not had the ability to do anything but make a report at this point.

MS. COPELAND: Okay.

ATTENDEE 7: This would allow them to analyze it and decide where to target the evidence based education.

ATTENDEE 8: And the reason that you made it higher, you have estimated revenues of 400,000 originally or whatever, it's in case it's more so that you --

ATTENDEE 7: No. This is -- I believe what -- it was 550 is what we estimated it was going to be.

ATTENDEE 8: Okay.

ATTENDEE 9: I thought 438 too.

ATTENDEE 7: I think 438 was the flat $1,000 fee.

ATTENDEE 10: I thought they were comparable, but -- but -- but that's okay.

ATTENDEE 11: And we voted it out -- you're both right. When it was -- OVHA handed to us and said if we were to apply the $1,000 fee across all of our marketers -- we have 429- of them or whatever the number was, so that would prove $429,000 or 38- or whatever it was.

We feel it would have been easier just -- rather than -- and fairly that -- to do it on percentage and they pick the number, which would -- comparing them -- they sort of intended to generate around the same amount of money.

ATTENDEE 10: Right.

ATTENDEE 11: But it happens to generate by 50 and not 40.

ATTENDEE 10: Okay.

ATTENDEE 11: So -- but as it -- as we voted it out in doing it on that percentage basis the number was by 550.

ATTENDEE 10: Okay.

ATTENDEE 11: When it -- when it left here the revenue amount was 550.

ATTENDEE 12: And that was based on that half of percent of spent in --

ATTENDEE 11: The year before.

ATTENDEE 12: For last year's spent, which

if it grows as it has been growing will be more than that.

ATTENDEE 13: Did you go through this with the committee yesterday?

ATTENDEE 14: No. No.

ATTENDEE 13: So I thought it would be since -- does everybody have their little table here?

ATTENDEE 15: Somewhere.

ATTENDEE 13: This has been a work in progress. And I will let Harry -- but on -- on this -- yeah, the illustration of -- again, this is illustrations. There's no way of predicting. There's no predictive model in terms of effective this could be or not.

And the first thing is the effective percent -- and actually I may present something and then I'll lower predict effective -- effective percent. But 25 percent means that one in four people who get this card will stay on the drug that would have been on another drug. And -- and what I did was go through different disease categories, high cholesterol, depression, hypertension, acid reflux, go through drugs that are branded, go through -- generally accepted

guidelines what they consider equally advantageous that are generic and compare the prices. And obviously this -- this is the result I get, it's either -- pretty remarkable. The cost of the two-week generic voucher is -- I increased it to two weeks because I don't know how many people -- what people get, sometimes they get a week or two, sometimes they get a month, but we -- it's starting at two weeks. The -- now requires -- and then they analyze savings again at the effective percentage. That's one in four. And obviously if you -- you know, if you go -- if you have a lower effective percentage you still have -- you have a lower amount of potential savings to the system, but the numbers are --

ATTENDEE 16: But still, I mean, for the investment that we put in --

ATTENDEE 13: Still could be larger.

ATTENDEE 16: -- my God, amazing.

ATTENDEE 13: And underneath they're all explaining. I didn't put names in here because I didn't feel like we needed to target one drug or another. These are -- there's some examples of what's out there based on the research.

I told Steve the drugs and he did the research.

ATTENDEE 17: And about a quarter of -- I mean, assuming that number were right and it's probably a little bit high --

ATTENDEE 13: Up high. And for purpose of illustration I might even take it one in ten on it, you know, it would be perhaps more realistic.

ATTENDEE 17: But whatever the number is Medicaid will see about -- a quarter of that number would be the Medicaid savings?

ATTENDEE 13: I actually think now because of Medicare D it's covered about 15 percent.

ATTENDEE 17: Okay.

ATTENDEE 13: It was about 30, but now because of Medicare D a lot of that has gone away. But you can see there's considerable savings, again, to the whole health care system in Vermont.

ATTENDEE 18: Awesome. I love it.

ATTENDEE 19: And part -- and part of this had been (inaudible) report and with one of the requests of a representative held appropriates. One of the reasons he voted for it because it obviously looks pretty good, and let's give it a

year and see how successful it is.
ATTENDEE 20: Do we have an idea of how we're going to get those numbers?
ATTENDEE 21: I don't have it in front of me, but I think --
ATTENDEE 20: It's a little like finding a needle in a haystack, but I know Steve has magic and he --
ATTENDEE 22: There will be ways of doing it I think based on before and after generic (inaudible), that's probably the best you will be able to.
ATTENDEE 20: But it's mandatory for them to use generic medicines now.
ATTENDEE 23: Again, whatever that -- the discussion we had that was the different drugs, a generic drug in the same class is what we're talking about here or --
ATTENDEE 24: It's different than an actually biologically equivilent --
ATTENDEE 23: Right. They're not biologically equivalent, they're therapeutically equivalent. So when you -- when -- when -- when Medicaid makes a decision to change its preferred drug in a class, they -- it's not -- if -- that's

exactly what we're talking about here essentially, but we're trying to move to encourage it by the sampling of (inaudible) education program.
ATTENDEE 23: But what's man- -- the generic substitution manding (phonetic) is related only to the biologically equivalent. When a drug goes of patent and it's the exact same drug, the formulation intends to get produced --
ATTENDEE 25: There were -- number one, prescribes drug Lipitor. Three years ago number four, five, Zelcore. This past year Zelcore went generic, so many other manufacturers make it as in the name of Simvastatin. So R. Moss says if I write a prescription for Zilcore they will give you Simvastatin. What we're trying to do -- what PDL's tried to do, preferred drugs, is to try to -- both of these lower cholesterol and for any given person they're -- they're appropriate -- certainly an appropriate starting drug and an appropriate maintenance drug. They do the same thing. The side effect profiles may be a little different and so it doesn't work on everybody, but neither one works on everybody.
ATTENDEE 26: But neither one works on

anybody.
ATTENDEE 25: Right. Neither one, and you may want to go and -- what we would like to do is get people to start on that and then if it doesn't work go to that one or one of the other ones. So what -- what -- so what I'm doing with this and what they're doing with PDLs is trying to move people to use that first or to use that to see if it works because it works and the cost potential didn't (inaudible) one. So that's -- that's what this whole education evidence based agent supposed to do is to give you -- somebody with high cholesterol, what the numbers are, what your goals should be, here are the different drugs you can use that work, and here are the cost associated with those drugs.
ATTENDEE 27: But under Medicaid now if they get a prescription they would go directly to the Zelcore because that's what -- that's what the rule says.
ATTENDEE 28: That may be the preferred drug.
ATTENDEE 29: Simvastatin.
ATTENDEE 30: But Harry could write the prescription for Lipitor and if he writes it for

Lipitor your Medicaid patient's going to get Lipitor.
ATTENDEE 31: If it's on the preferred list.
ATTENDEE 32: No, they --
ATTENDEE 33: I -- I -- I believe that if I looked at Lipitor I -- it probably is -- I can look at my thing, but I think there are more than one -- more than just Semavastin is the preferred drug, because, again, Medicaid is overquoted. Did I confuse everybody?
ATTENDEE 34: No. I wanted to talk about it.
ATTENDEE 35: The question I have is gender identity in an amendment.
ATTENDEE 36: Do we -- we could -- is the committee -- I know we're talking about this issue more generally. Is the committee ready to vote on -- up or down and slightly like the appropriation committee amendment?
ATTENDEE 37: I am. I'm good with it.
ATTENDEE 38: Yes.
ATTENDEE 39: I'm good with it.
ATTENDEE 40: Yes.
ATTENDEE 36: Okay. Can we do that and then go down and vote?

ATTENDEE 41: Sure.
ATTENDEE 42: All right.
(End of track 14:41)
- - -

CERTIFICATE

THE STATE OF FLORIDA
COUNTY OF DUVAL

I, Sherry Brazier, Notary Public, Certified Shorthand Reporter do hereby certify that I was authorized to and did listen to CD 07-162, the House Committee of Health Care, Tuesday, August 15th, 2007, proceedings and stenographically transcribed the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 16th Day of August, 2007

Sherry Brazier
My Commission #DD 458166
Expires September 9, 2009

STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: 5/2/07

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

CD NO: 07-163

PROCEEDINGS

- - -

ATTENDEE 1: We'll have it in another five or ten minutes we hope. Robin was going to -- we're handing it out where -- quickly before going through it with the committee. She's going to give an overview of the court case in New Hampshire. So while we're waiting for the printing and final editing and whatever it's called -- copy editing and -- she can go ahead and do that, so take it away, Robin.

MS. ROBIN: I'm sorry, I'm just trying to get things squared away with downstairs. Okay. I know you talked about this a little bit yesterday I think, so what my plan was just kind of walk you through --

ATTENDEE 2: And do you have copies of the court case?

ATTENDEE 3: Oh, the full case? Not the whole committee, no.

ATTENDEE 4: I don't want one.

ATTENDEE 2: I thought that's what I called you to ask --

ATTENDEE 5: Don't need it.

ATTENDEE 3: I'm sorry, I misunderstood. I

thought you mean the --

MS. ROBIN: I don't need it. That's okay.

ATTENDEE 6: Don't need it.

MS. ROBIN: Well, we can make -- we can get a --

ATTENDEE 6: I'll get copies of --

MS. ROBIN: We can look at it later.

ATTENDEE 7: We just have the executive summary here.

ATTENDEE 8: Yeah, that's right.

MS. ROBIN: So a good part of the -- of the decision is findings, which is basically the judge summarizing the evidence or his take on the evidence that he heard, and I wasn't really going to go through that part of it because it -- it really has to do with the evidence that was before that particular judge. So what I was going to focus more on was the analysis. So the first step, as I think you know, the -- the New Hampshire statute was challenged on First Amendment ground. So the first step in making a First Amendment analysis is to decide whether or not -- what you're looking at -- if the law that you're looking at restricts speech. So the first step is deciding is it speech, that's restricted.

So the court looks at that issue and decided looking at precedent and other cases that this fell into the description of speech and particularly into what's called commercial speech. And generally speaking commercial speech there's more ability by states to restrict commercial speech than other kinds of speech like political speech, for example. So -- so that's sort of the first step was figuring out what is the -- and -- and then what does it look like.

So once you know what you're dealing with in this case, commercial speech that's tells you what level of what's called scrutiny that the court would apply. And the level of scrutiny means how much the court is going to look at the statute to decide if the state had a certain level of interest in their different levels depending on what type of speech you're talking about. In this instance we're talking about whether or not the court -- I'm sorry, whether there was a substantial government interest in regulating this particular area. So the test is, first, is there's substantial government interest, second, does that -- does the law directly advance the government into (inaudible)

and, third, is the statute not more expensive than is necessary to serve that interest.

So it looks at the scope of the statute and whether or not it's narrowly focussed on remedying the issue that the legislature was considering. One of the important parts of the division I think from our perspective is that the New Hampshire court was somewhat judgmental of the New Hampshire legislature's process. So one of the things the court indicated is that they were not going to give great difference to the New Hampshire's legislature's predictive judgments on what would be accomplished by the law because the legislature didn't -- didn't have findings in the statute and didn't illustrate that they had established a quality record. And just one quote from the case on that is when a quality record establishes that the legislature conducted an extensive investigation acquired considerable expertise in the regulated area and incorporated express findings into the approved statute, a court must accord substantial difference to the legislatures predictive judgments. So --

ATTENDEE 9: Predictive?

MS. ROBIN: Predictive judgment. So meaning that -- what the legislature said we're trying to accomplish X, Y, and Z with this statute. Their predicting the result of enacting the law I think that's what --

ATTENDEE 10: We're getting a brief -- it's like a 10-minute -- 10-, 15-minute summary of the court case in New Hampshire while we're waiting for the amendment to be copied.

ATTENDEE 11: Well, I apologize for being late, but the solders just showed up to pick up the boxes, so --

ATTENDEE 12: Great. Quality record.

ATTENDEE 13: So I'm going to --

ATTENDEE 14: That's awesome.

ATTENDEE 11: Yeah, it was pretty awesome.

ATTENDEE 15: Robin, can you check your e-mail?

MS. ROBIN: Sure.

ATTENDEE 16: Lori, can you do me a favor?

ATTENDEE 17: Yes.

ATTENDEE 16: Can you open 220658 and make sure Charlene and Nadine have access to it?

ATTENDEE 17: Yes.

MS. ROBIN: I did it on your computer.

220658. Thank you.

So the next part of the -- the court case looks at what the court saw as the potential substantial government interest and so they basically list three, protecting prescriber privacy, public health and cost containment. There's an analysis of the prescriber privacy interest in the court's division where the court basically goes through and says, well, the AG makes an argument that it was -- that pharmaceutical companies use prescriber identified data to pressure healthcare providers, but she didn't try to prove or even attempt to prove at trial that there was any improper coercion or harassment of healthcare providers as a result of having that information. So the court was critical of the evidence in front of the court about the provider privacy and why that was necessary.

So they -- the court -- the judge basically decided that they didn't accept the AG's argument that the law was justified based on provider privacy because they didn't feel like the evidence supported that.

ATTENDEE 18: I'm sorry, could you say the last sentence?

MS. ROBIN: He judge rejected the AG's argument that the law could be based on provider privacy of the justifiable reason because the judge didn't feel like the evidence supported that, the evidence that the judge had in front of him.

The next step was the court looking at public housing cost containment. And the court accepted the major premise by the attorney general in New Hampshire that pharmaceutical company views prescriber identifiable data to make detailing more persuasive, but then didn't really feel like the connection between that and either public health and proper prescribing or cost containment was proven in the evidence. So they -- the judge recognized that both public health and cost containment were legitimate and proper state interest, but then didn't feel like there was enough proof to show the connection between what the statute was doing by limiting the provider's identified data and those two goals.

So the next step in the case was then to look at -- at whether or not the law was narrowly

tailored enough to serve the state's interest. And basically the court went through and said, well, you know, I don't really buy that --

ATTENDEE 19: Which was sort of the sledgehammer or --

MS. ROBIN: Exactly.

ATTENDEE 19: Or small hammer question?

MS. ROBIN: Right.

ATTENDEE 19: So if you -- you might -- might well -- the state might well doc- -- in -- in any area you document a problem and you prescribe a solution that the sledgehammer -- you would be more likely to (inaudible) perhaps overturned by a judge. If you prescribe something that was more appropriate to the level of --

MS. ROBIN: And more -- exactly. And more focused on the specific problem and solving that specific problem as opposed to just, you know, saying outright band kind of thing.

So -- so the court basically found that the New Hampshire statute wasn't narrowly tailored enough because there are a number of other things that New Hampshire had not yet done but could have done to address some of the problems

including the court cited specifically to -- if the legislatures were concerned that pharmaceutical companies were improperly using samples, gifts, meals, or other inducements, they could address that by limiting gifts to doctors. Also they could do a counter detailing program and then it's on the cost -- I won't go you through all the different examples, but -- and then on the cost containment side the court pretty much focussed on Medicaid and what New Hampshire Medicaid law does in terms of cost containment. And basically said, you know, you could do all these other things in their Medicaid program, which would improve your cost containment and that would be more directly on point to what -- to cost containment than what you're doing here.

ATTENDEE 20: Can you give an example? I mean, to what -- what kind of detail do they -- are they trying to --

MS. ROBIN: Well --

ATTENDEE 20: That's okay.

MS. ROBIN: No. No. No. I'm laughing because the court, you know, basically goes through and says, well, New Hampshire's pharmacy

program might violate federal Medicaid law, which is an side, by the way, but they could do that better, you know, kind of thing. So I'm not -- I'm laughing just because the court made this little detour.

ATTENDEE 20: Yes.

MS. ROBIN: But they basically said, you know, the Medicaid law could -- in -- in New Hampshire I believe what their -- their preferred drug list and their Medicaid program is much newer than, for instance, ours. So that's one thing which they haven't, you know, sort of pursued as aggressively as -- as in Vermont.

So that's sort of the 15-minute version. If you have questions about that or --

ATTENDEE 21: I have one question. Were they to -- they had to demonstrate coercion? Was that -- did I understand you correctly, that if there wasn't coercion, that it was -- that was one of the standards?

MS. ROBIN: It's not that specific, so that was an example that the court gave. So the standard is the three-prong test that I said.

ATTENDEE 21: Okay.

MS. ROBIN: That you have to show a

compelling state interest -- I'm sorry, a substantial state interest.

ATTENDEE 21: I'm sorry. Law advance and interest in the stethoscope. So -- okay. So they weren't -- that wasn't one of the things they said -- it wasn't like a minimal req- --

MS. ROBIN: That was an example.

ATTENDEE 21: Okay. Okay.

MS. ROBIN: So -- so part of the way constitutional law kind of goes is that they give these broad standards and then they sort of look at the facts and if the judge feels like the facts meet that task. So there's a lot of -- it's not a very precise area of law.

ATTENDEE 21: Okay.

ATTENDEE 22: It's a fair amount of gray area, is that what you're telling us?

MS. ROBIN: Yeah. I mean, that you can argue things back and forth in most constitutional areas. I spent a long time in law school doing that.

ATTENDEE 23: I have one question.

MS. ROBIN: Yes.

ATTENDEE 23: The attorney general's going to appeal this, right?

MS. ROBIN: I don't know. I haven't heard one way or the other. You may know more than I do. I haven't --

ATTENDEE 24: They said yesterday that, you know, it was just a material -- a trailer on the story that they -- they hadn't decided yet whether they were going to appeal it, which is what they always say for at least a couple -- a few days until they've had a chance to read it and talk with people about it.

ATTENDEE 23: Okay.

ATTENDEE 24: Were you surprised that this came down as a First Amendment case as opposed to some other issues?

MS. ROBIN: There were other issues argued in the case, but it is pretty typical for courts when they're addressing an issue if they foun- -- if they decide an issue that strikes down the law they don't then go and decide all the other issues. They can, but they don't -- often don't do that. So I sort of thought they would address it on the commerce clause issue, but they didn't address that issue at all. So I guess I'm not super surprised but I was sort of expecting more than just First Amendment at least decision.

ATTENDEE 25: So on -- are there other questions about the case? And anybody that would like a copy of the case -- I didn't intend to get 7anymore, but what do I know. Why don't you -- we're looking at five minutes or less or what are we looking at?

ATTENDEE 26: Katy's sending me questions, so when she's done sending me questions then I can get it copied. So copying will probably take ten minutes. So I'd say 10 to 12 at this point, because I think she's probably done asking me questions. I can run down and check with her.

ATTENDEE 25: So the topper we're just whispering -- I mean, it's sort of obvious -- so obviously what the -- what the work has been over the last 24, 30 hours or so has been to try to understand the case and to try figure out whether the holdings in the case were so strict or, you know, so -- so -- so encompassing that we, you know, didn't feel like we could --

ATTENDEE 27: Move forward?

ATTENDEE 25: -- move forward with the provision or whether in -- we thought there were ways to -- to address the concerns that were raised by the court in New Hampshire. So suffice

it to say that, you know, we've got an amendment that's coming that we think does -- does address the concerns that the court expressed. And, you know, Robin sort of started to focus on -- in her analysis -- the background analysis, focussed on several of the areas that were important to that judge and that you'll -- you'll see when the amendment comes in. So one of the things we've tried to do, for example, is -- is go back to our testimony and to -- to the doc- -- some of the documents that were presented to us to create a stronger written record of what our findings were regarding, you know, the issues with detailing and with data mining and so you'll see there's several pages worth of findings that, you know, we'll -- we need to go through and --

MS. ROBIN: I can also sum- -- do you want me to summarize the other things that I did?

ATTENDEE 25: Yeah. Yeah.

MS. ROBIN: And this is the case. I have it here. So the things that I focussed on in doing this are a couple of different areas. First of all, the way -- the -- one of the things that the New Hampshire court had talked about on the bench, not if their decision so much, but on the

bench, was that they might look at an Austin kind of provision differently. So one of the ideas would be to move more to an opt in approach, which is more narrowly tailored because it's not an outright band on the information. It provides -- it would -- elect -- doctors could elect to provide the information. It's a more similar approach to the AMA approach, which hasn't been challenged, and it's -- it's definitely a different kind of program than -- than what New Hampshire did. So that would need a fresh look I think and this decision wouldn't be quite as easily transferable as sort of tweaking around the edges or, you know, kind of work on the New Hampshire text as such.

The other thing that I focussed on in making revisions was trying -- was that narrow tailoring other than just the opt in kind of ideas, but also looking at are there ways to tie the prescriber information and the use of that information more closely to cost containment and public health reasons, which were certainly part of why I think the state wanted to move in that direction.

So I think those are the findings and then

different we have a different approach and trying to tailor it more closely to the goal and not be quite as broad were sort of the three ways that I attempted to look the judge's decision and address some of the issues that were raised there.

I'll also just mention that the amendment has other smaller suggested changes that -- one of which was from the appropriations committee which has to do with the reports, but I'll just mentioned that to you or thinking that it's just focussed on this issue, so there's other issues in there too.

So I think those were really the three main things that I -- I did in addressing the case. I think part of the -- what the finding attempts to do is make a stronger case on the privacy issues than what the New Hampshire court sought.

ATTENDEE 26: You said the common (inaudible) is not address. If this were to be appealed, this thing in Vermont, maybe a different judge would have a different approach to this kind of thing conceivably the commerce? I know there's no way you could address some of those other issues and anticipate that

decision --
MS. ROBIN: One of the issues -- I -- one thing I did already address in the commerce clause area was that the New Hampshire case was not specific that it only regulated records in New Hampshire. So you may remember from the draft that you passed out we added that definition of regulated records to mean just prescriptions written by doctors in Vermont or records held by pharmacies in Vermont. So that hopefully would address the commerce clause issue.
ATTENDEE 26: Okay.
MS. ROBIN: I mean, to the extent that I can predict how a court would come out on that.
ATTENDEE 26: Good. Okay. Thank you.
MS. ROBIN: I just try to do that.
ATTENDEE 27: The speaker would like me to participate in a meeting she's having right now. So I'm -- continue with these questions in general and then, Loren, if could just call me when the bill gets -- when you get the bill here and you start to go through it give me a call and I'll come back up.
ATTENDEE 28: It should not be long, I don't

think. I think Nadine's making copies.
ATTENDEE 29: So the opt in -- can I just.
MS. ROBIN: Oh, yes.
ATTENDEE 29: So did you -- what did you use for miles for the opt in, was there something else out there that you drew from?
MS. ROBIN: I drew it from -- different pieces of different things. There is a main bill currently pending. Which looks at an opt in model through -- by allowing doctors to opt in through the licensing board, which seems to make some sense, you know, so that it would be easy for doctors to opt in as part of their licensure or renewals of licensures. So I based it on that although -- just roughly, because, of course, our licensing efforts are different than theirs too. And then -- and then others of it -- you know, I kept exceptions from the bill as it came out of this committee and other stuff I just sort of reworked from -- from the previous.
ATTENDEE 29: So the opt in -- what you used as a model is something that hasn't been tested in --
MS. ROBIN: No.
ATTENDEE 29: So there's no other kind of

opt ins outside from -- that -- I just thought there might be that.
MS. ROBIN: There are in the -- like in other consumer protection type --
ATTENDEE 29: Yeah, that's what I was thinking.
MS. ROBIN: -- models, but they wouldn't necessarily lend themselves to just copying and pasting because they aren't tied to licensure and that kind of thing.
ATTENDEE 29: Well, I'm actually glad it went this way, because I wanted the opt in to start with.
MS. ROBIN: Good.
ATTENDEE 29: Good. Because there's nothing like being hoisted on your old guitar. The best way to go.
MS. ROBIN: I know it's hard to ask me questions about something that you can't look at, but do you have any other questions? Maybe I should do this all the time. Okay. You ready to --
ATTENDEE 30: That's what I said --
ATTENDEE 31: Yeah, it works that way.
ATTENDEE 32: And apparently the

New Hampshire legislature as well.
ATTENDEE 31: Yeah. Does this mean we have to go through this whole process again on whatever the amendment is here from all sides?
MS. ROBIN: I think you do have testimony scheduled for tomorrow morning to get reactions to the amendment and --
ATTENDEE 31: Okay.
MS. ROBIN: -- get people's thoughts on it.
ATTENDEE 31: Okay.
MS. ROBIN: I think you are going to hear from people tomorrow morning on that.
ATTENDEE 31: All right.
ATTENDEE 32: Now, Robin, was opt in or opt our specified at all to the senate or --
MS. ROBIN: Yes. The senate -- let me see if I can recall. I believe senate health and -- one of the senate committees, I'm sorry I don't remember which one, and I don't have my full file with me, but -- and I -- one of the senate committees had looked at doing an opt in version so -- and their version of the opt in was a little bit vaguer and wasn't through the licensing process. So it was a little bit unclear how exactly it was going to operate. So

I rewrote it because -- so that -- I thought it actually operate better, but they did discuss the opt in and then that got kind of changed at the last minute.

ATTENDEE 34: Amendment Four.

MS. ROBIN: You know, I can't quite remember. I -- I don't think it -- it might have been on the floor. It might have been in the senate helping welfare version and then the senate floor amendment is what -- I can double-check on that tonight and tell you for sure how that happened. I just need to look back at my various versions from the various amendments. In fact, I can probably do that now.

Loren, do you want to go check with Dave to see if he has the copies?

ATTENDEE 35: I will.

ATTENDEE 34: At least enough for the committee? Hurry this along a little.

(Brief break.)

MS. ROBIN: So I needed to work on the leading language, but I normally when you -- because you're not -- I don't think you're officially getting the bill back. I think a member has to do it on behalf of the committee.

So I just picked you Harry, but it can be somebody else if you want.

So the first instance -- the first instance of amendment on page one I have renumbered the current section, one to be 1A and then inserted a new section, one with the findings so that it's at the beginning of the bill.

So I'll -- let me walk you through the finding. The first finding has to do with previous -- previous legislation and initiatives that Vermont has taken in the area of prescription drug cost containment and transparent fees. So there's the description that even after the pharmacy that practices in cost control program mandatory generic substitution and mail order purchasing and Medicaid in refarm (phonetic) in Vermont RX. Again, refarm in Vermont are after our prescription program and we've encouraged the Department for Human Resources to have a referred drug list in the state -- of health benefit plan in order to control cost while maintaining thus practices and drug prescribing.

Also the Medicaid program has been a member of multi-state purchasing tools for several years

and aggressively seeks supplemental rebates. We've also sought to control cost as a state in private and employer insurance by encouraging voluntary participation in the Medicaid preferred drug list requiring mandatory generic substitution for all prescriptions in Vermont providing members with pricing information about the drugs they are prescribed and assisting consumers for providing information about importation of drugs from other countries.

Three, and this is on page two, we sought transparency by requiring marketers of prescription drugs to disclose information about the amount of money spent on marketing activities in Vermont and also to require disclosure your pricing information to doctors during marketing visits.

This act is necessary to protect prescriber privacy, save money, the state, consumer (inaudible) protect public health.

Five, we're getting more into sort of summaries of the information that you've received. Most doctors in Vermont who write prescriptions for their patients have a reasonable expectation that the information in

that prescription including their own identity and that of the patient will not be used for purposes other than filling and processing the payment for that prescription. Doctors and patients do not consent to the trade of that information to third parties and no such trade shouldn't take place wouldn't their consent.

Six, according to the 2006 marketer disclosure report which was done by the AG's office as part of the marketing efforts pharmaceutical companies made direct payments of almost 2.2 million to prescribers in Vermont including fees and travel expenses. And those were all done in 2005, even though it's a 2006 report.

Estimates of total costs of marketing to prescribers in Vermont are 10,000,000 or more excluding free samples and direct to consumer advertising.

Some doctors in Vermont are experiencing an undesired increase in the aggressiveness of sales representatives and has reported this to be coercive and harassment. Prescriber identified prescription data show details of physicians -- sorry?

ATTENDEE 35: We have to take testimony tomorrow.
ATTENDEE 36: We're taking testimony tomorrow morning.
ATTENDEE 35: We're taking testimony tomorrow morning.
ATTENDEE 36: We have testimony on this tomorrow morning.
ATTENDEE 37: So no -- yes.
MS. ROBIN: So eight is a description of what prescriber identifiable data would be including details of the drug use patterns, both in terms of gross number of prescriptions and inclinations to prescribe particular drugs.
Prescriber identified databases is prescribing how to encourage pharmaceutical companies to increase the pro quo nature of relations between sales reps and prescribers. Pharmaceutical companies use prescriber identity data mining to target increased attention and harassing (inaudible) those doctors that they find are most profitable including high prescriber and grand loyal prescribers doctors willing to prescribe new medicines and doctors that are proven to be especially susceptible to

sales messages. Monitoring of practices also allows sales reps to assess the impact of various gifts and messages and select the most set of rewards added a portion and harassment (inaudible) doctors are informed by sales reps that they are being monitored either through positive or negative messages as with trading of consumer phone numbers linked to a spending pattern, trading prescriber information, it links to prescription data encourages harassing and unethical sales behaviors. Data mining also allows companies to crack prescribing habits of nearly every physician in Vermont and link those habits to specific physicians and their identities.
Coincident with the rise of data mining and the pharmaceutical industry increased its direct spending -- I'm sorry expending on direct marketing of doctors by over 275 percent (inaudible). There's estimated to be approximately one sales rep for every five office space physicians in Vermont.
ATTENDEE 38: Wow.
ATTENDEE 39: Where do those (inaudible) come from?

MS. ROBIN: It -- I have to double-check. What I should have done is write down all the stuff on my findings, but I will get that. Steve, you don't know off the top of your head, do you? You don't remember off the top of your head. Steve will look. Yes.
ATTENDEE 40: And there might be a reasonable time period for this 275 percent.
MS. ROBIN: Yes.
ATTENDEE 40: I think it was 1994 or something, 2005, something like that. I can't remember-
MS. ROBIN: In '04 the industry spent 27 billion in marketing pharmaceuticals in the U.S., a rate of five percent of drastic small doctors.
16 is the description of the AMA program and sort of an explanation why you might not feel like that is an accurate remedy for Vermont doctors.
17 on page five talks about in 2005 Vermonters spent an estimated 524,000,000 on prescription and over-the-counter drugs and medical supplies. That's from the big survey. In 2000 the spending was about 280,000,000. The annual increase during this period was 13.3

percent.
ATTENDEE 41: So your policy alternatives --
MS. ROBIN: Okay. Okay. So that's where the one and five -- well, if that's an actual number we shouldn't make that a national -- correct them.
18, nearly a third of the increase in spending can be attributed to marketing inducements in doctors prescribing from existing those effective lower class therapy to new and more expensive treatments. Public health is not served by (inaudible) information and information but that is doctors and other prescribers. The marketplace for ideas on (inaudible) effectively is frequently one sided and that brand named companies are the most expensive marketing campaigns to doctors and that can lead to imperfect or misleading information. And particularly for prescribers that lack the time to perform substantive research to assess domestically.
21 is about that issue. Physicians are able to take the time to research their supposed to be changing the pharmaceutical market and determining which drugs are best treatments for

particular conditions, because it is -- physicians frequently rely on information provided by pharmaceutical representatives.

Newer drugs on the market do not necessarily provide additional benefits over older drugs (inaudible) cost and as yet unknown side effects. One example of this would be Vioxx, which was removed from the market which potentially lead to side effects that were not adequately disclosed initially. 50 percent of all drug withdrawals from the market, quote, black box warnings are within the first two years of the release of the drug.

ATTENDEE 42: I'm glad that one's in there.

MS. ROBIN: Describer identified data increased the effects of detailing programs that support (inaudible) physicians to individual law, prescribers staff that's with an attitude.

The goals of marketing are at least often in complex with the goals of the state. Marketing programs are designed to increase sales, income, and profits at the expense of profit containment activities and sometimes health. Several studies suggest that drug samples clearly affect prescribing (inaudible) in manner of the sample.

The presence of their samples may influence physicians expensive to prescribe drugs different from their preferred drug source according to a study by Que (phonetic), et al, in the Journal of General Internal Medicine in 2000.

According to testimony by Dr. A. Horn, detailing effects of cost to medicines because it is generally complying to high margin, high profit drugs to which the main structure has substantially (inaudible) to increase sales. That's the work of the rep drives drug use toward the most expensive products and contributes to the strain on the healthcare budgets of individuals who's (inaudible) healthcare program.

Instance of amendment.

ATTENDEE 43: That was good stuff.

ATTENDEE 44: John.

ATTENDEE 45: I'm just curious, is there a rhyme and reason for the -- of ordering which these findings are placed?

MS. ROBIN: No. I tried to make them in somewhat of a rationale order, but I didn't, to be honest, go through and really think through the order after I -- I put them in there, so they certainly could be reordered.

ATTENDEE 45: Yeah. I -- I -- I just -- I was going through here --

MS. ROBIN: Yeah.

ATTENDEE 45: -- but jumping from the implications --

MS. ROBIN: Yeah.

ATTENDEE 45: -- of what it does to the doctor versus national (inaudible) versus the theft on Vermont. If there was some grouping relative to --

MS. ROBIN: Sure.

ATTENDEE 45: -- those three flavors.

MS. ROBIN: We can work on that.

ATTENDEE 45: -- of a doctor that's made --

MS. ROBIN: Yeah. No, it's true. Sorry. And if there's some particular order that people make sense, you let me know and I can work on --

ATTENDEE 46: And I also think it's helpful where in the last couple of the ones -- not that you have to do this every time, but when you cite the source I think it strengthens the argument and it makes it easier for me as a legislator to defendant it, because I can --

MS. ROBIN: Yeah. And we can try and -- of course, the first few are just my description of

the law, so I'm not going to put all the statutory sites in there, but --

ATTENDEE 46: But some of them like when you brought it up and --

MS. ROBIN: Right. So I think we can do that for the more factually based ones, but -- and some of it was more of like summary from testimony you heard, but to the --

ATTENDEE 46: Yeah. Yeah.

MS. ROBIN: For the ones that we pulled out of a particular source as opposed to a general testimony we can try and do that.

ATTENDEE 47: And this is while standing --

ATTENDEE 48: Nicely done actually.

ATTENDEE 49: That's true I. Think it's great you finding in here -- I mean, to put all that testimony in -- that we heard on this in -- in these findings I think is -- I don't know, I'd like to -- I think it's great. It's nice to see it in this form and up front and kind of remind us all why we're not giving up on this section.

ATTENDEE 50: Bill.

MR. KEOGH: Yeah. On three page, six lines -- subparagraph nine --

MS. ROBIN: Yeah.

MR. KEOGH: -- the last two lines.
MS. ROBIN: Yeah.
MR. KEOGH: Doctors that shoe themselves willing to prescribe new medicines and doctors that have proven to be especially susceptible to sales messages.
MS. ROBIN: Is proven too strong, you think?
MR. KEOGH: Well --
MS. ROBIN: -- based on the data. It's based on the data. So if you could look at somebody prescribing data and link it to when you make sales visits, you could tell that, okay, right after we visited --
MR. KEOGH: The sales of --
MS. ROBIN: The sales jumped up.
MR. KEOGH: Went up?
MS. ROBIN: Right. So you could potentially I think find that from the prescriber data, but proven may be too strong a word. So I can soften that.
MR. KEOGH: Okay. Soften that or substantiation that.
ATTENDEE 51: The testimony remember about the earlier doctors --
MR. KEOGH: Oh, I understand that. Yeah.

And I understand that. And that's testimony, but having testimony and having this in here might be a little bit different if it were challenged, that's all. Thank you.
ATTENDEE 52: So this is doctors that --
MR. KEOGH: Especially susceptible to sales messages --
ATTENDEE 53: Doctors that upon -- through use of the data are shown to be or something.
ATTENDEE 54: Shown to be susceptible.
MS. ROBIN: Sure.
ATTENDEE 55: Or -- or determined to be, because that's -- they determine that they're susceptible and they --
ATTENDEE 56: Or they demonstrate they go from one prescribing pattern to another.
ATTENDEE 57: Yeah.
ATTENDEE 56: -- after a salesman's --
ATTENDEE 58: But actually the process is -- is that they do determine that this one is an easy target, that one's an easy target.
ATTENDEE 59: Just for your information --
ATTENDEE 60: I'll extend the data.
ATTENDEE 59: Sean Glenn has sent four documents including studies of this blocking

pattern and they're copied there and (inaudible) --
ATTENDEE 61: Okay.
ATTENDEE 62: Well -- and in another instance -- I just -- I don't know.
ATTENDEE 63: We should go through the whole thing and then make comments.
ATTENDEE 64: Yeah.
ATTENDEE 65: Okay.
ATTENDEE 66: Otherwise we'll never get out of the findings section. There's a danger to findings.
ATTENDEE 67: I know, that's true.
ATTENDEE 68: That's one of them.
ATTENDEE 69: It's easy to get bogged down.
MS. ROBIN: Okay. So the second instance of amendment on page seven. This amends section 14 of your amendment which is the evidence base education program to add a sensus at the end to tie it to the blueprint for health. So to the extent practical -- practicable the evidence based education program shall use the evidence based standards developed by the blueprints for health. So where we have those standards as they're developed it would make sense to use

those as opposed to, you know, some other standard they find.
ATTENDEE 70: This is a suggestion --
MS. ROBIN: Yes. This is --
ATTENDEE 71: Well, it's a good suggestion.
ATTENDEE 70. Yes. No. No.
MS. ROBIN: And the third instance of amendment -- well, the third and the fourth -- the third is in, again, the same section evidence based education program. The fourth is in the pilot project for the generic sample and this would -- language would broaden the pilot from starting with high cholesterol, I think that's where we started, to just basically give more discretion for the department in APACS (phonetic) to pick what they would start with. So I changed it to just samples of generic medicines used for health conditions common in Vermont and the general description and then in the actual pilot language to establish a pilot project to distribute doctors for a sample of generic drugs frequently -- I'm sorry. Samples of generic drugs equivalent to frequently prescribe prescription drugs that are used to treat common health conditions.

ATTENDEE 72: And this was suggested by APACS?

MS. ROBIN: Yes. This is a suggestion by APACS. In the fifth instance of the amendment I've added a new section 15A, a report and this came out of discussions in the appropriations committee when we were going over an amendment for them. And this would require by January 16th, '09, so a year from next January that -- OVHA, Bishca (phonetic), and JFO would report to the house committee on health care you-all and the senate committee on health and welfare comparing the distribution of prescribing among generic drugs and brand named drugs for and after the first year of the generic sample pilot project. The comparison will review a year of prescribing data prior to the implementation of the pilot and a year after -- during the first of the pilot. To kind of look at is this program being effective at moving -- prescribing patterns from brand names to generic.

ATTENDEE 73: Just --

MS. ROBIN: And I worked with Steve Capell (phonetic) on developing that.

ATTENDEE 73: This says the comparison --

okay. Never mind.

ATTENDEE 74: Well, we have to do data mining to -- in order --

ATTENDEE 75: The answer is yes, but no. But it's exempt from public records.

ATTENDEE 74: So should -- should A have somehow the a part of this reporting, I wonder? I mean, it should be --

MS. ROBIN: They -- they.

ATTENDEE 74: They'll actually be doing it:

MS. ROBIN: They'll be doing the generic sampled pilot. They won't have the prescribing data, though, Bishca and OVHA will have that. OVHA will have it for Medicaid and Bishca will have it through their survey.

ATTENDEE 75: In one year of the project, though, might they have been more targeted or effective in any geographic area and, therefore, would want to advise Bishca and OVHA where to look?

MS. ROBIN: Yes. That's a good a point.

ATTENDEE 75: You know. I mean, we don't want an average state-wide data if they really only thoroughly covered central Vermont.

MS. ROBIN: Right. And you -- and that's a

good point. You would have to look at that and sort of control for what the pilot was actually doing.

ATTENDEE 75: Yeah, because we don't know --

ATTENDEE 76: I'm sorry. You're just saying that APACS might do more -- more detailing over here and less over there?

ATTENDEE 75:

MS. ROBIN: Therefore we wouldn't want it to be statewide --

ATTENDEE 76: Yeah. So it's consultation and -- yeah. Yeah. I think we need to ask for data of that, how many --

ATTENDEE 75: We need to consult on the report.

ATTENDEE 76: How -- how they went about implementing -- doing the kind of detailing, because I think -- you know, I think it's clear that the success of the generic samples -- sampling program is going to be related to the success of that -- the visits but are counter detailers.

ATTENDEE 77: Yes.

MS. ROBIN: Okay. I can add that.

ATTENDEE 78: It's a technical thing here.

It just says the comparison will review a year of prescribing data prior to the implementation of the project to a year of prescribing data and so forth, and just -- it seems awkward to me. The comparison will review this year to that year. Isn't -- are we comparing the two years?

MS. ROBIN: Yes, we are.

ATTENDEE 78: So if it said the --

MS. ROBIN: So I'll say the agency shall compare.

ATTENDEE 78: The report -- okay. Or the report will compare, whenever you want to do that. I think that would be clearer.

MS. ROBIN: Yes.

ATTENDEE 78: Thanks.

MS. ROBIN: Okay. So the next section will strike the current section 17 and replace it with a new sec 17 and it's just the confidentiality.

I rewrote subsection A. It's before -- had just some very general findings like (inaudible) literally of findings which I took out since we're adding findings to the act and focus this more on an intense section thinking that what this section can help you do is kind of clarify what are our substantial government interest that

we're trying to protect. So -- so I included protecting the public health, protecting the privacy of prescribers (inaudible) information and to ensure costs are contained in both the private healthcare sector as well as state purchasing prescription drugs through the promotion of flex (inaudible) drugs (inaudible) a information.

In B I have definitions and these are very similar to the definitions I used before except that I took out the commercial use definition and inserted instead a marketing and promotion definition and these are kind of a combination of what you had in there before and what I found if main bill that was pending.

So you can see, for example, under marketing advertising, promotion, or any activity intended to be used or if you used influence sales or market share, influence or evaluate the prescribing behavior of an individual healthcare professional to promote a prescription drug, so that's narrower than what you had before. Market drugs patients are evaluated effectiveness of the detailing sales force.

And then promote is an activity with the

intention of which is to advertise a public (inaudible) the drug, including a brochure, media, advertisement, or announcement, poster. You don't need (inaudible). Free samples detailing (inaudible) personal appearance.

ATTENDEE 79: Maybe advertisement would include only through e-mail.

MS. ROBIN: I think so.

ATTENDEE 79: No, it's not that.

MS. ROBIN: Let me make a question mark. C, if the --

ATTENDEE 80: Top of 11 --

MS. ROBIN: Now on page 11. Subsection C is the paragraph that would sort of establish the opt in programs. So the Department of Health in the office of professional regulation and -- in complication of the appropriate licensing board shall establish a prescriber data sharing program to allow prescribers to give permission for his or her identifying information to be likely transferred, used, or sold for the purpose described under subsection B of this section.

The department and office shall solicit the prescribers permission on licensing applications of renewal forms and shall provide a prescriber a

method for revoking his or her permission. The department and office may establish rules for this program. So they could, you know, do more details about exactly how you revoke your permission and give your permission in the role.

And then in D, this section is the section which talks about when you can and can't use the records. So a health insurer -- a self-insured employer electronic transmissions (inaudible) pharmacy or similar entities may use regulated records so -- it used to be more of a ban. It said you shall not use it except for the (inaudible). And I tried to make it more positive and kind of delineate what we were trying to accomplish would be use of the information. So the (inaudible) may use regulated records which include prescription information, and I took out the patients identifiable because they didn't really work with the new structure. So I think that -- that is an issue of whether or not we want to try and put that back in somewhere or we just leave it to what it protects.

So they use the records containing prescriber identifiable data for marketing or

promoting a prescription drug only if, one, the prescriber has provided their permission and the entity using the regulated records comply to the disclosure requirements or -- so one of those two things or, two, it meets one of the exceptions.

E, these are all the same exceptions that you had previously in the bill. So it's in the flight of this -- collecting the information et cetera, et cetera.

The change in the exceptions, there's one on page 13. In, seven, why I use -- commercial usage could be in there and I changed that to the new terms that we're using.

ATTENDEE 81: I'm sorry. So on the top of page 12, second line --

MS. ROBIN: Yes.

ATTENDEE 80: -- is that subsection --

MS. ROBIN: F. Sorry, that should be F. That's incorrect.

ATTENDEE 81: Oh, okay. I was like, huh?

MS. ROBIN: It would have to be E or E.

ATTENDEE 82: All right.

ATTENDEE 83: Wait a minute.

MS. ROBIN: No. That should be F. Sorry about that.

ATTENDEE 84: Now, the consent, this is an opt in?
MS. ROBIN: Yes. The prescriber is opting in to sharing their information.
ATTENDEE 84: And we haven't -- we haven't modified or described con- -- permission --
MS. ROBIN: We've left that to rule.
ATTENDEE 84: Is -- is that risky?
MS. ROBIN: Leaving it to rule?
ATTENDEE 84: Yeah. It just has provided permission. When we did all the stuff for financial services confidentiality, banking information, and so forth there were questions about informed consent, written con- -- you know, there's a lot of different ways to do it and if you provide your permission --
MS. ROBIN: Well, beyond the licensing --
ATTENDEE 84: I'm just trying to imagine.
MS. ROBIN: -- renewal or application. So we know it would have to be in writing.
ATTENDEE 84: Okay. And it -- and you would have to check it off that you want to do it?
MS. ROBIN: Presumably. That it couldn't say --
ATTENDEE 84: What I'm not -- check here if

you don't want to, it has to be affirmative because it's an opt in. All right.
MS. ROBIN: Correct.
ATTENDEE 85: So just give us -- every three years I get an, you know, eight-page application to renew my license and they ask me, you know, if I, you know, committed a crime, am I physically disabled, mentally disabled, you know --
ATTENDEE 86: And you can say yes to all the above?
ATTENDEE 85: Yes to all the above . The way -- if that's the --
ATTENDEE 86: It's getting late. I'm sorry.
ATTENDEE 85: So, anyway, that could be one -- one piece of it could be either one little section with an exclamation, you know (inaudible) or it can be a separate sheet of paper that you sign, but you really have a captive audience, everybody practicing in Vermont has to do it.
ATTENDEE 87: Could we have -- and maybe I can see it on page 11. On the third line I see where it says to allow our prescriber to give permission, could we see state affirmative permission or something like that?
MS. ROBIN: Sure.

ATTENDEE 87: So it's really clear, because you can give your permission or -- permission means the same as consent, does it not?
ATTENDEE 88: Where are you?
ATTENDEE 87: I'm on page 11 in C. After the third line, allow a prescriber to give permission and --
MS. ROBIN: If you like consent better we could use that.
ATTENDEE 87: Well, whatever it is I would like it to be affirmative.
MS. ROBIN: Yes.
ATTENDEE 87: Be -- just to be crystal clear.
MS. ROBIN: The other thing --
ATTENDEE 87: And then they can do it however they want.
MS. ROBIN: Okay. Yes.
ATTENDEE 87: But --
MS. ROBIN: All right. I will work on that and maybe I'll talk to Sam Borough a little bit about that in terms of how it's done in the consumer area.
MS. ROBIN: Okay. So on page 13 F. F describes the disclosures that would happen,

which, again, this -- the prescriber -- that it -- the information would be used -- the prescriber identified information could be used if the prescriber gives information and then the disclosures in F are provided. When a pharmaceutical marketer engages in prescription drug marketing directly to the physician of their person authorized to prescribe prescription drugs the marketer shall disclose to the prescriber evidence based information as provided for by rule describing the specific health benefit pro risk of using other pharmaceutical drugs including drugs available over the counter which patients would gain -- which patients would gain from the health benefits or be susceptible to the risk described and I should add a semicolon there that might be easier. The range of prescription drug treatment options and the cost of the treatment options. As necessary OVHA in consultation with Department of Health, APACS, OPR, and the AC would develop rules for compliance with this subsection including a certification materials (inaudible) evidence based as defined in our evidenced based evidence. Evidence based education program in which

conditions have evidence based treatment guidelines. The extend practicable to rules who use the evidence based standards developed by the blueprint. And then G is the same enforcement that was previously in the bill.

ATTENDEE 88: So --

ATTENDEE 89: But this is new? F is new?

MS. ROBIN: Yeah. What I did was bold -- in this section where I'm reproducing changes from something that was in your bill as opposed to completely new language I put bold where the major changes were.

ATTENDEE 90: So -- so I wanted to make sure I understand what you're saying. So, first of all, it's -- it acquires an opt in?

MS. ROBIN yes.

ATTENDEE 91: It's adopting that with licensure kind of with a (inaudible) -- with that -- a direct, you know, sign this form here, please or -- and then it allows -- well, first of all, marketing can go on as it normally goes now (inaudible) without a subscriber data. So anybody can walk into anybody's office and say here's a great drug, here's some samples, here's some information about it. So that still goes

off, right, as long as there's no prescriber -- prescriber identified data?

MS. ROBIN: Correct.

ATTENDEE 91: You can use prescriber identified data, if, A, the -- the prescriber has agreed to it?

MS. ROBIN: Yes.

ATTENDEE 91: And when you do use it you have to provide it in kind of a more less an evidence base format?

MS. ROBIN: Correct. And -- or it would be to toward the other --

ATTENDEE 91: Right. Or if it's accepted by one of these another things.

ATTENDEE 92: But we're not requiring that standard of evidence based presentations unless they use your --

ATTENDEE 91: Right. Right.

MS. ROBIN: Correct.

ATTENDEE 92: You basically -- if they are going to use it then they have to be held to a higher standard.

ATTENDEE 91: But if it's the regular marketing then they don't have to do it?

ATTENDEE 92: They can mislead and not give

you --

MS. ROBIN: Well, remember if it meets the federal definition for misleading we do -- there's an actionable way to solve that, so . . .

ATTENDEE 93: Right. It can be -- it can be one-sided, it doesn't have --

ATTENDEE 91: It can be one-sided. They can leave things out.

ATTENDEE 93: So they only give up this whole thing with (inaudible) should be a free speech. When I saw F I thought, what, are you taunting the courts, but --

MS. ROBIN: The court said --

ATTENDEE 93: But -- but then I--

MS. ROBIN: Using is different than --

ATTENDEE 93: Okay. So it's -- only your free speech is limited when you're -- when -- because the doctors presumably giving you information because they're saying I'll share this information provided you give me good information?

MS. ROBIN: And I should have mentioned I modelled the language in this section roughly in our current marketer disclosure law that requires certain types of (inaudible) law.

ATTENDEE 91: But it's similar to what?

MS. ROBIN: Marketer disclosure, price disclosure law, which is 33BSA2005A.

ATTENDEE 91: Some of the current law --

ATTENDEE 92: Wow.

MS. ROBIN: I looked at it recently.

ATTENDEE 93: So -- so if Harry doesn't opt in, then and let's say he operates out through the A M A as well, hold on to the A M A thing, the company -- the pharmaceutical company -- the info still goes to the data mining place and only the detailer can't see it, the higher-ups can with the AMA thing, does this opt in if somebody doesn't use it prohibit the manufactures from using all of that same information that they got from the AMA because their ope out only keeps the detailer from seeing and then they can get around this by using that information the way they do now --

MS. ROBIN: You said they -- the doctor did not opt it or did opt it?

ATTENDEE 93: The doctor did not opt in, so --

MS. ROBIN: He operated out through -- or she opt out through the AMA?

ATTENDEE 94: No. No. No . No.
ATTENDEE 93: -- what I'm saying, Harry doesn't check off the option.
MS. ROBIN: Okay.
ATTENDEE 93: So then --
MR. CHEN: I operated on both.
ATTENDEE 93: And then he also opts out on the other one but that one was meaningless because it just means the higher-ups give instructions even though the detailer has never seen -- according to the testimony we had, the detailer has never seen the stuff --
MS. ROBIN: Yes.
ATTENDEE 93: -- so they go there and the higher-ups say, okay, offer this, do that, are they still going to be able to do that if a Vermont physician prescriber doesn't opt in here?
ATTENDEE 94: Will they collect --
MS. ROBIN: Will they collect it?
ATTENDEE 93: Will they collect it?
ATTENDEE 95: Will they transcend it?
MS. ROBIN: What we say is that --
ATTENDEE 95: So the answer's yes?
MS. ROBIN: They will collect it because what we're prohibiting in B is the use of the

information.
ATTENDEE 96: So we really narrowed it, but I -- I -- from my perspective this better be crisis, because of --
ATTENDEE 93: Because of F for one thing.
ATTENDEE 96: Well, no, because of -- maybe because of F, but B because there's only -- only 20 percent of them left. They should belong to the AMA -- I think they know about that.
MS. ROBIN: Right.
ATTENDEE 93: Yes. So they're not going to be opting out of the other one, so they're going to have a --
ATTENDEE 96: Plus we'll have a list -- we'll -- we'll end up with a list of the -- of the opt in, correct, in Vermont and we'll able to know and Ann will be able to communicate with those people and other people will be able to say, you know, if you haven't opted in, you know, please know that you shouldn't be receiving this sort of -- this sort of detailing.
ATTENDEE 96: And if you have opted in and then there will be -- that's -- that's one of the questions there's an audit trail because you can go to these opt in people and see if they're

getting this second space format.
ATTENDEE 93: But -- okay. So if -- os if they haven't opted in, then they -- but how do they know the difference between somebody who's coming in and using it and not using it? How does a physician know that?
ATTENDEE 96: Well, I won't say to Harry, why aren't you prescribing my drug?
ATTENDEE 93: Okay.
ATTENDEE 96: You won't be able to say that to him, so --
ATTENDEE 93: Okay.
ATTENDEE 97: You could, it's a trick question. That's what --
ATTENDEE 98: But pharmaceuticals will still get --
ATTENDEE 99: There's no different than this law about whether you're 16 or 17.
ATTENDEE 97: No. No. No (inaudible).
ATTENDEE 99: Or whether it's midnight or what --
ATTENDEE 100: You can come into the emergency room at one o'clock, is that what you're telling me, that your most vulnerable --
ATTENDEE 99: No. No.

ATTENDEE 100: If they have a note from their mother. (Inaudible).
ATTENDEE 99: I'm sorry I started that.
ATTENDEE 101: Are pharmaceuticals going to be able to get the aggregate data that --
MS. ROBIN: Yes.
ATTENDEE 102: Yes.
MS. ROBIN: -- that includes the opt in --
MS. ROBIN: Yes.
ATTENDEE 101: -- or opt out -- I mean --
MS. ROBIN: Yes, because we still have that exception for -- for using the data for any purpose if it doesn't identify a person.
ATTENDEE 101: Okay.
MS. ROBIN: A prescriber or a patient, so that's -- the aggregate exception is still in there.
ATTENDEE 103: Well, this is interesting.
ATTENDEE 104: Isn't it delightful. Originally it suggested we try the opt in language first.
ATTENDEE 105: We wouldn't have had anywhere near as much fun. Sorry.
ATTENDEE 106: I didn't say anything.
ATTENDEE 107: I need that quote, what was

that quote again?
ATTENDEE 108: I bet it feels good as a freshman legislator to be one that was right in your own (inaudible.)
MS. ROBIN: There's one more to this amendment.
ATTENDEE 109: All right. I'm sorry.
MS. ROBIN: That's okay. Which is basically just an effective date that would have section 17 become effective no later than January 1st or it begins Department of Health in OPR time to do roles and all of that and get the forms together and it would allow them to implement it over time as people renew their licenses instead of time to get everybody in at once, so --
ATTENDEE 110: Well, that's good.
ATTENDEE 111: Now, what do you do with the marijuana?
ATTENDEE 112: I don't do anything with marijuana.
ATTENDEE 113: I don't smoke period, the records show --
ATTENDEE 114: All right. (Inaudible).
ATTENDEE 115: Here's the deal, folks around the room and other folks since you're -- maybe

Lori will be e-mailing if she hasn't already --
ATTENDEE 116: Oh, that's testimony --
ATTENDEE 115: I'm sure there are people that aren't here that might -- we'll make sure that -- (inaudible) got it. And we've lined up some -- or are lining up testimony in the morning. Do we already have a start time.
ATTENDEE 116: I need guests at 10:30 -- sometime between 10:30 -- I'll check --
ATTENDEE 115: We need to get started. I'm attempted to say 8:30. What does the committee -- does anybody -- I mean, I think we need to get going on this in the morning because I -- it is still my goal to -- by noon .
ATTENDEE 117: Okay. Some people probably won't get there first thing but they'll just probably filter in.
ATTENDEE 118: Is our resolution coming on the 14th?
ATTENDEE 119: Tonight.
ATTENDEE 120: So I can do my homework tonight.
ATTENDEE 121: Was it on notice today?
ATTENDEE 122: Yes, it was.
ATTENDEE 123: Yes.

ATTENDEE 124: I didn't read my calendar today because every time I went back to my desk -- still on my calendar and I had to keep doing it over by the time all that was done.
ATTENDEE 125: Distracting.
ATTENDEE 136: Just so that it's clear, why -- what -- I do think it's why -- I do think it's really important given the lateness of the discussion that we get this bill out of the house no later than tomorrow, so in order -- we would -- we have to -- I've asked the speaker to -- because this bill is on the action -- was on notice today, that action --
ATTENDEE 137: That's right.
ATTENDEE 136. So the idea then is that if she'll hold onto it for whatever afternoon, something we have tomorrow or -- and so we won't report it in the morning, we'll --
(End of track 38:25.)
- - -

CERTIFICATE

THE STATE OF FLORIDA
COUNTY OF DUVAL

I, Sherry Brazier, Notary Public, Certified Shorthand Reporter do hereby certify that I was authorized to and did listen to CD 07-163, the House Committee of Health Care, Tuesday, August 15th, 2007, proceedings and stenographically transcribed the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 16th Day of August, 2007

Sherry Brazier
My Commission #DD 458166
Expires September 9, 2009

STATE OF VERMONT
HOUSE COMMITTEE ON HEALTH CARE

RE: SENATE BILL 115

DATE: May 3, 2007

TYPE OF COMMITTEE MEETING: STANDARD

CD NO.: 07-164, 07-165, 07-166, 07-167

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 COPELAN-HANZAS
REP. LUCY LERICHE, CLERK
REP. PAT O'DONNELL
REP. SCOTT WHEELER

PROCEEDINGS

MR. MAIER: Good morning.

MR. HARRINGTON: Good morning. I'm Paul Harrington, the executive vice president for the Vermont Medical Society. I'm here to present the Vermont Medical Society's testimony regarding Representative Chen's amendments to the Bill S115 as amended by the Committee on Healthcare and Appropriations.

The Vermont Medical Society strongly supports Representative Chen's amendment on behalf of the Committee as articulated in Draft 1.3. I'm passing out a document that you received before, but it reflects a resolution adopted by the Vermont Medical Society regarding the privacy of prescription information adopted unanimously at its annual meeting in October. And that resolution being adopted unanimously was done following an educational forum on this issue where the members of the Medical Society heard witnesses from New Hampshire who had read the New Hampshire effort to enact their prescription privacy legislation, Attorney General Bill Sorrell in his strong support for a similar provision here in Vermont. Then we

also heard from the vice speaker of the American Medical Association. You may remember that the American Medical Association has a program allowing physicians to opt out of the database that it sells for approximately $44 million a year to IMS, the data mining company, and this speaker spoke on behalf of the AMA regarding that provision.

But notwithstanding that presentation, the Medical Society has detailed in its resolution resolved that the Medical Society work was appropriate for consumer groups, the Vermont Attorney General to enact legislation similar to legislation that was recently enacted in New Hampshire that would prohibit the disclosure of physicians prescribing information for any commercial purpose while permitting legitimate uses such as reporting requirements and research. And to that end the Medical Society has worked with the Attorney General's office and AARP in both the House and Senate in advancing this legislation.

We've done that for three reasons. Physicians in Vermont feel that the marketers having the prescription information particularly to that physician, many of whom have no idea that the marketer has that information, is an invasion of

the physician's privacy.

Secondly, the Medical Society over many sessions of the general assembly has worked with committees such as this and others to try to control the cost of pharmaceutical products, and we have -- I could remember when I first joined the Medical Society back in 2002, we joined in the press conference to support the development of a preferred drug list for the Medicaid program. And notwithstanding the additional administrative burden imposed upon physicians in complying with Medicaid's preferred drug list, it has certainly saved a lot of money for the state and we supported that goal.

And then finally most importantly probably for physicians who, you know, have many skill sets, but as I've come to learn, they in part view themselves appropriately as scientists. They want any information they get particularly around the treatment of modalities for their patients to be accurate and evidence-based.

So those three themes of privacy, controlling drug costs here in Vermont and ensure that any information they're receiving is evidence-based. So really the three pillars of the Medical

Society's advocacy.

There have certainly been other efforts that have been enacted nationally in Vermont. I was personally very pleased when the federal legislation created a Do Not Call List which allowed us to take our name off the marketer's phone list, we no longer had the phone call during dinner of somebody trying to sell us something that we had no interest in. And that seems to me to be an appropriate balance between an individual's right to privacy and at the same time striking a balance with the First Amendment rights to free speech. And my sense is that this initiative is in that same policy environment of basically trying to prevent harassment, particularly regarding information that the individual has no knowledge of but the party on the other line is aware of.

We have worked with the Senate and this committee to try to have Vermont pass the New Hampshire law. We were disappointed with the decision that was issued on Monday by the U.S. District Judge in Concord, New Hampshire, Paul Barbadoro in his key finding that the New Hampshire law restricts constitutionally protected speech without directly serving the state's substantial

interest, again, restricting the constitutionally protected speech without directly serving the state's substantial interests. And we feel that the amendment put before you addresses that flaw in the New Hampshire law identified by the U.S. District judge, and in fact, it does through its findings and through its alternative approach currently through opt in, does articulate the state's substantial interests in controlling costs, ensuring privacy and making sure that the information being disseminated to prescribers is accurate and evidence-based.

So with that sort of preamble, if you would like, I could probably walk through the Bill, talk about the various provisions and why we in fact support those. Before I do so, I would be happy to take any questions.

UNIDENTIFIED MALE SPEAKER: Paul, two questions. The first one is, is there any work being done or has been done so that physicians can get evidence-based information without getting it from detailers?

MR. HARRINGTON: Sure. You can't pick up the issue of the New England Journal of Medicine or the JAMA, the Journal of the American Medical Society,

or the publications for each specialty without seeing peer-reviewed articles surround medications and clinical studies around efficacy. So there's ample information available to physicians through their peer-review journals in articulating the results of tests. And then certainly as the FDA issues its determinations, you know, those are readily available to physicians. And in fact, many physicians I think carry around a PDA that allows you to, you know, download information about a particular drug, what its label uses are and any side effects and other issues. So there's information. As you also know, I don't know if you joined the committee when they took testimony from the senator in Oregon for value to science. There's an institute in Portland, Oregon that actually looks at the efficacy of different drugs and posts that information on the Internet.

UNIDENTIFIED MALE SPEAKER: I guess what I'm getting at, I'm trying to understand why a physician would want to see a detailer.

MR. HARRINGTON: That's a great question. Certainly detailers, you know, do disseminate information and, you know, for some physicians that information is valuable. They also provide free

samples. And for physicians that have a lot of low income patients, those free samples, you know, allow the physician to prescribe that drug that that physician knows by giving the free sample that the patient will actually be able to take the drug as opposed to writing a script, and then because the individual doesn't have any insurance, you're sort of offering the care, but the patient can't afford to receive the care because of the high cost of pharmaceuticals.

UNIDENTIFIED MALE SPEAKER: So if there was another mechanism of receiving free samples besides getting it through a detailer?

MR. HARRINGTON: Certainly the Vermont Society strongly supports the provision in S115 that you all have added providing for vouchers for generic drugs, for example. It would be -- we think that's a very good provision and we strongly support that as well.

UNIDENTIFIED MALE SPEAKER: And do you think there would be any discrimination from the detailers from seeing certain physicians that have not opted in relative to giving samples or information or...

MR. HARRINGTON: It's hard to say. I know

that -- I understand notwithstanding the New Hampshire law being overturned by the district judge, there had been a change in some of the practices in New Hampshire when the bill passed last June. I know that anecdotally, but I can certainly call my counterpart in New Hampshire and give you more information.

UNIDENTIFIED SPEAKER: Thank you.

UNIDENTIFIED FEMALE SPEAKER: With all the education you've done, you said and it's come up before that many doctors have no idea that the data is available to the drug company. I mean by now don't most of them know, or is it still -- no? Still a lot of people aren't aware of this whole thing.

MR. HARRINGTON: Well, we certainly publicized it through our newsletters. My sense is we have kind of a curious process of how we became such strong advocates for this provision. The six New England state medical societies get together once a year. We were in Portsmouth, New Hampshire a year ago last spring, and our president, then president Dr. Peter Dale, who is an internist here in central Vermont, was talking to his counterpart, a psychiatrist in New Hampshire, and he was telling

Dr. Dale about what New Hampshire was doing or seeking to do at that time. And you know, he had no idea. And that's been a constant comment from the physicians that they don't know that the marketers have this information. And almost all of them, and I say almost all of them, I have not heard anyone say that they want the marketers to have that information. So they are unaware of it. When they become aware of it, they don't want the marketing to have that information.

MR. MAIER: If I could, what I would like to suggest to the committee, we have a pretty limited time period here this morning. We -- our committee has taken a pretty strong position in favor of doing something on data mining. So I guess I would suggest that we not, at least during committee time, not ask general questions about data mining but try to focus our questions in particular on the amendment in front of us and whether or not we feel is -- I don't think it's a question for the committee of do we want to try to do something on data mining. We made that statement already. The question is do we feel that given what has happened this week, do we feel this is the right way to go and do we understand what's in this amendment. I

think it would be perhaps helpful to our time this morning if we could try to stay focused on that. Does that make sense?

UNIDENTIFIED MALE SPEAKER: Yes.

MR. MAIER: I don't mean to cut you off. Are you okay with that?

UNIDENTIFIED MALE SPEAKER: Yup, totally.

MR. HARRINGTON: Okay. I'm going to turn to page 9 of the draft, obviously section 17 is the section that we believe does clearly articulate the -- how this provision would serve the state's substantial interest and immunize it from the clause identified by the district judge in Concord, New Hampshire. And paragraph A I think identifies the three points I articulated initially, that this section would protect the privacy of prescribers, ensure costs are contained and ensure prescribers receive unbiased information. And then it goes on, you know, in the definition section, the key definitions as you probably heard are in our estimation definition of marketing, paragraph 5 on page 10. Advertising, promotion or any activity that is intended to be used or used to influence sales or the market share of a prescription drug. Influence the prescribing behavior of an individual

healthcare professional. And then further definition 8, promotion, activity to advertise or publicize a drug. And page 11 paragraph C is really the key paragraph in how this new section would be administered. And it's not an outright ban of this information for commercial purposes as was in the bill in New Hampshire and the one you passed out to the committee, but rather it creates -- the marketer would only have this information if the prescriber gave permission for his or her identifying information to be licensed, transferred, used or sold for purposes of prescribing in subsection D. And this would be done through the licensing application. So you don't have the marketers sort of administering the opt in, but you would have the licensing board through presumably its biannual licensing application include information on that licensing application through that licensing process to allow the prescriber to say yes, I do want to have the marketers to have this identifiable information regarding my prescribing habits. Absent that affirmative decision, the marketer would not have the information, and we feel that's an appropriate mechanism. If there are prescribers who want

markets to have this information, they'll make that decision, but absent that they will not.

And again, paragraph D, it allows the different regulated entities to use prescriber identifiable data for marketing or promoting, those two key definitions, a drug only if, and in 1A you have that express permission. And then in B the entity basically falls under the evidence-based information. There is -- I don't know if Robin is in the room. There is a mistake.

MR. MAIER: If should be F?

MR. HARRINGTON: Yeah, it should be F. And then you do have under C basically a series of appropriate exceptions.

UNIDENTIFIED MALE SPEAKER: D?

MR. HARRINGTON: E, you have a series of appropriate exceptions to that ban and, you know. I think important for the committee is on page 13, section 7. It does allow for the continued marketing and promotion as long as it's under paragraph 7 on page 13, the data does not identify the person. So we've got kind of a -- it's a ban, but it's only a ban of marketing when you have that identifiable information. And this kind of hits four square the whole privacy issue in our

estimation.
F I think establishes a new policy that the information disclosed be evidence-based and sets up opposing different branches of state government to develop the regulations regarding those evidence-based standards that would have to be a part of the promotion activities.
So in sum, the Medical Society again strongly supports this substitute language. We feel it does address the deficiency identified by the district judge in a different circuit. This New Hampshire is in the first circuit. We're in the second circuit, but I think it through the findings and then through this clear articulation of the state's substantial interests on the areas of protecting privacy, saving costs and then ensuring information is evidence-based, it would be a much stronger provision.
I think there is a strong interest in Vermont's efforts, certainly by -- made in New Hampshire. I was at a conference in Washington, D.C. last Thursday. I facilitated a panel discussion with the state senator from West Virginia who also happens to be a vascular surgeon, and he was very excited about what we're doing here

in Vermont. So a lot of other states are trying to address similar problems. I just saw this morning the press release from New York State. So, you know, paradoxically we believe the district judge's decision coming out as the legislation is being drafted probably was fortuitous and allows the Vermont legislation to build upon New Hampshire's efforts but also be drafted in a way that does address some of the concerns in the district court's decision.
So with that, I would be happy to answer any questions. And if you have any requests for additional information, I'll try to provide that through the course of the day.
MR. KEOGH: Paul, these pharmaceutical companies get similar information using ZIP codes instead of other educational numbers?
MR. HARRINGTON: Certainly they could get -- I know the legislation and they could get aggregated information and presumably, you know -- I don't think it would be appropriate for them to get information at the ZIP code level of West Charleston or, you know.
MR. KEOGH: Well, it wouldn't be as specific, but at least we get the Burlington area or -- you

can target --
MR. HARRINGTON: Yeah, I think certainly how it's aggregated as long as there's a sufficiently large number of prescribers in that ZIP code so that they couldn't say, well, in West Charleston there's only one prescriber, so you know, we know, but it certainly would be a different story in Burlington.
UNIDENTIFIED FEMALE SPEAKER: We talked earlier about how many physicians know what was going on and surprisingly you said not very many. So they get their license and it's an eight-page form and one of the lines is about opting in. I just wonder how many people are going to understand what that's about if they don't even know what's happening now. You have concerns about -- I mean I know that we haven't come up with how exactly that will be implemented, but what do you imagine will be the fallout from this? Would you guess 10 percent of the people will understand an opt in or a lot of people may not get it and just check it off?
MR. HARRINGTON: We're assuming and would be happy to work with our licensing board through the medical practice board under the auspices of the

Department of Health, and we would anticipate working with the physicians licensing board to ensure that there was backout information available to physicians, we would widely publicize it.
Physicians take their licensing form very seriously. This information, you know, is posted on the Internet. It's every two years, and they give thoughtful consideration on how they answer each question, because if they make an inaccurate statement, there are serious sanctions that could result from that. So my sense is that we don't publicize it independently. We assume the Department of Health, you know, through our licensing board would provide information in that application form.
And my final point again is physicians take that licensing application form very seriously because of potential consequences for an incorrect statement.
UNIDENTIFIED FEMALE SPEAKER: So with taking it seriously and looking at it six years from now, how many physicians would you guess are going to opt in for something like this?
MR. HARRINGTON: I would be surprised -- I would think it's going to be a very small

percentage. I have not heard any physician tell me, and we have widely publicized this and we've had, you know, public meetings around this, that they want the marketers to have their prescription information available to them for commercial purposes.

UNIDENTIFIED FEMALE SPEAKER: Can I continue follow-up on that?

I would have to say, when I read section F, and I said this yesterday, I said, you know, given the New Hampshire's ruling is based on free speech, I almost felt like it was flaunting the free speech because it was so, you know, saying so much what you can say. So I thought what if that were in there. I mean this is just -- I didn't talk to you guys about this before -- but I thought it was maybe pushing it, going out a little bit further than it needed to go, because if, you know, say 5 percent of people opt in anyway, and they're opting in. So they kind of know when they're opting, I would think they're going to get the slant. So I really wonder about the value of putting that. I'm concerned that it puts a rough edge to this that's just looking for a snag to (inaudible), do you know what I mean?

MR. HARRINGTON: That's a good question. However, I think F particularly on providing that any information be evidence-based is -- was drafted in large measure due to the district court decision and identifying that as an issue. Now, maybe when we're done, I'll try to find the sections of the decision, maybe Cathy could point you to that.

UNIDENTIFIED FEMALE SPEAKER: I've got it as well, sir.

MR. HARRINGTON: Okay.

UNIDENTIFIED FEMALE SPEAKER: So you don't feel it's more of a -- I'm thinking about karate or something -- it's more of a defensive block rather than an aggressive one.

MR. HARRINGTON: No. Again, my sense is that it is in its broadest terms the third layer of this (inaudible) to articulate the state's substantial interests and that, again, privacy cost and then accurate information, that we, you know, the prescribers are getting the accurate information as opposed to what may be in some cases biased information to try to push that particular brand name drug.

UNIDENTIFIED FEMALE SPEAKER: Thanks.

UNIDENTIFIED MALE SPEAKER: I mean it seems to

me that the legal, and I'm sure Julie or others can (inaudible) but the legal, this F doesn't restrict their ability to speak on their own, they're still going to present their own information.

UNIDENTIFIED FEMALE SPEAKER: But they have to present the other as well.

UNIDENTIFIED MALE SPEAKER: You've basically gone through the several hoops and you've done the data mining and you have prescribers' specific information, then it adds a requirement that same time as you give your own (inaudible). You got to provide evidence-based information.

MR. MAIER: Okay. Thank you, Paul.

UNIDENTIFIED FEMALE SPEAKER: Can I ask the last question? In your resolution, you use the word -- the strongest word I saw was intrusion, that this is an intrusion. In the proposal we have coercion, harassment, pretty strong words, unethical. So they're harassing and coercive practices, but the only -- but you never use words like that in yours. So I'm wondering, did seeing words like coercion to me, much further than intrusive, did that raise any concerns for you in terms of -- well, I'll just leave it at that.

MR. HARRINGTON: I got an e-mail from a

physician in -- highly respected physician who does a lot of research in Burlington area who directed a comment to Representative Keogh, and the words he used were "secret" and "manipulative." So I, you know -- the lady used the language in this resolution, you know, individual positions in corresponding with you all have used such terms as secret and manipulative activities by the marketers. So I didn't take the words you all used in this draft didn't -- seem consistent with the sort of comments you were getting from the individual physicians.

UNIDENTIFIED FEMALE SPEAKER: I'm sorry, you said they did seem consistent?

MR. HARRINGTON: Yes.

And you would corroborate my statement, Representative Keogh?

MR. KEOGH: Yeah. I just thought that was confidential, but that's okay. That's the risk you take when you do e-mails.

MR. HARRINGTON: Well, I didn't identify the physician.

MR. KEOGH: That's okay. He is well-respected. That's why I contact him on a regular basis.

MR. MAIER: All right. Thank you, Paul.
MR. HARRINGTON: Thank you.
MR. MAIER: We have the PhRMA person now or should we go to Sharon first now that she's here? Do you have a preference, Susan?
UNIDENTIFIED FEMALE SPEAKER: It doesn't matter. They're standing by, the PhRMA people are standing by right now.
MR. MAIER: Would you like to do that now then?
UNIDENTIFIED FEMALE SPEAKER: Sure. Do you want to take the chair while we're doing this?
UNIDENTIFIED FEMALE SPEAKER: Thank you.
MR. MAIER: Do you want to tell us -- Marjorie Powell? Have we heard from her before?
UNIDENTIFIED FEMALE SPEAKER: No. She's a senior assistant general counsel for PhRMA. You heard from Julie Corcoran. And I think Julie is actually going to be in the room with Marjorie.
MR. MAIER: Okay, thank you.
UNIDENTIFIED FEMALE SPEAKER: So they'll both be together.
(At this time, a phone call was made to Ms. Marjorie Powell.)
MR. MAIER: Good morning. Thank you for

joining us this morning.
MS. POWELL: Good morning. Thank you for having us.
MR. MAIER: Where are you geographically this morning so we can picture where you are?
MS. POWELL: I am in Washington, D.C.
MR. MAIER: Okay.
MS. POWELL: Halfway between the White House and the Capitol. And I'm sorry that I don't get to come to Vermont this morning.
MR. MAIER: It's a beautiful day in Vermont. So we only have a little snow left in the hills, but the rivers are full and it's a nice spring day.
MS. POWELL: It sounds like (inaudible) time to me, but I may be too late.
UNIDENTIFIED FEMALE SPEAKER: But you could buy it now though.
MR. MAIER: As you're well aware, we have an interesting decision in front of us from the New Hampshire Federal District Court, and I suspect, although I don't know for sure, do you have a copy in front of you an amendment that we are now considering on our -- on this drug data confidentiality issue?
MS. POWELL: Yes, I do.

MR. MAIER: Okay. So I would -- the committee welcomes your testimony. Thank you.
MS. POWELL: All right, thank you. For the record, let me start by saying that I'm Marjorie Powell, senior assistant general counsel at PhRMA which is short for the Pharmaceutical Research and Manufacturers of America, the trade association for the companies that are researching, developing and after approval bringing to market the new medicine.
I do have a copy of the Federal District Court decision on the New Hampshire statute. And I would like to, if I could, make five quick points. I realize that you have a long agenda this morning.
First, the Court opinion has just been issued. We believe it's a very well-reasoned opinion, but it is a fairly long opinion, and we anticipate frankly that the State of New Hampshire will consider appealing that decision. We recognize that the appellate court doesn't always affirm decisions made by district courts. So based on that we would urge the committee to consider putting the decisions off until later in the year or in the next legislative year, because the opinion is so new and it provides so much information that the legislators may want to

consider how they can best (inaudible) that opinion.
The second point I would like to make is that the Court was quite clear that physicians do not have an expectation of privacy as to their professional work. In fact, the New Hampshire Attorney General in defending the statute didn't even substantively make an argument that there is a physician right to privacy as to their professional work. Indeed every state licenses physicians and other healthcare providers, and physicians are subject to a variety of existing state regulations in their professional capacity, making a distinction of course between a physician's personal privacy and his professional -- his or her professional privacy.
The Court also made a clear statement that communication about prescription drugs is commercial speech, and as commercial speech it is subject to protection under the U.S. Constitution's First Amendment. The judge said that when legislators have concerns about commercial speech, the alternative should appropriately be more speech, not less speech. Of course that applies to political speeches as well as commercial speech,

but that I think the point is that legislators should look for alternatives that don't impose a restraint on speech.

There are a number of other alternatives that the legislators could consider if they are concerned about communications related to prescription drugs. The judge noted a number of those and I know that at least some of those are ones that Vermont applies or has considered in the past, but we would encourage the committee members to consider those alternatives and whether there are alternatives that would not impose special burdens on commercial speech.

My last point is, we think that the opt-out system proposed in this amendment also imposes a burden on commercial speech, because it in fact imposes a very real restraint on that speech, and that it may be appropriate to consider some of the other less burdensome alternatives, some of the alternatives that don't limit speech at all but perhaps propose more speech.

Let me stop and answer any questions that you may have.

MR. MAIER: This is a question from Representative Ojibway.

MS. OJIBWAY: So in the proposed bill on page 13, I'm not sure exactly what you're looking at, but I'm going to look at mine and hope that it somewhat corresponds to what you have. On page 13, section F it talks about the kind of exchange between a marketer and a physician or other person. So is that kind of when you refer to giving more speech, more information, so having this requirement to give evidence, is that the kind of thing that you might be referring to?

MS. POWELL: Well, that is certainly one alternative to imposed requirements on the kinds of information that a speaker including a sales representative would have to provide to physicians or other prescribers. One of my concerns with section -- with some of the details in section F is that the federal government already closely regulates what pharmaceutical salespeople can say about their prescription medicine and imposes limitations on what they can say about other medicines that they are not explicitly dealing with. And I've not had a chance to look at this and compare it with the FDA regulations, so I can't honestly say that all of this would be consistent with those regulations. It is clear that

pharmaceutical sales representatives are under the FDA requirements to provide information that is factually correct and that is based upon the research available about that drug for that drug. My concern would be whether they could provide information about other drugs that are not drugs that their company is licensed to sell.

MS. OJIBWAY: Okay, thank you.

MR. KEOGH: I thought there were five points that you wanted to make. I only have four, delayed decisions, doctors don't care about data and the prescription imposed commercial -- these are my words, I'm sorry, and opt out. What was the other point?

MS. POWELL: Let me go back and say, I wouldn't presume to speak for doctors. I think that doctors don't have a privacy right in their personal capacity. One point was that communication about prescription drugs is commercial speech.

MR. KEOGH: Okay.

MS. POWELL: Another was there are a number of alternatives available including the early alternative in section F but probably with some revisions to that and that we think the opt-in

system which is set forth in -- I'm not going to be as efficient as the prior questioner in identifying the page or the section number, but there is an opt-in provision here that we think may also have First Amendment problems.

MR. KEOGH: Okay, thank you.

MR. MAIER: Any other questions? Representative McFaun has a question.

MR. McFAUN: When I listened to you the first time, I thought you said opt out was a burden on commercial speech.

MS. POWELL: I'm sorry. If I did, that was a misstatement. I meant to say that we think that the opt-in provision imposes a burden on commercial speech that may be too much of a burden. There are opt-out provisions that are voluntary because of the AMA system, and of course there is the federally established mandatory opt-out system for individuals for telephone calls, but again, that's a system that is focused on individual privacy, not professional capacity.

MR. McFAUN: Thank you.

MR. MAIER: Representative Chen has a question.

MR. CHEN: Yes. Just following up on that, do

you think an opt out, if we put an opt-out provision in this, would it also go against free speech?

MS. POWELL: I think an opt-out provision that was voluntary like the AMA system which already exists, which the state doesn't have the burden of operating, would be a reasonable alternative. That's one that is already in existence and available to prescribers in Vermont already.

One thing that you might consider is making sure that every -- all the prescribers in Vermont are aware of that option. And I know that the medical -- at least the American Medical Association has been making major efforts to ensure that physicians are aware of the opt-out system. That is, however, one operated by a nongovernment agency, and therefore, the courts would look at that differently, but since I'm not a First Amendment lawyer, I would hesitate to give an opinion as a lawyer on whether a state mandated opt-out system would be constitutional.

MR. CHEN: Thank you.

MR. MAIER: Okay. I don't see any other questions. Does Ms. Corcoran have any comments that she would like to make?

MS. CORCORAN: No, I don't. Thank you.

MR. MAIER: Thank you very much for your time and information this morning.

MS. POWELL: All right. Thank you.

MR. MAIER: I think the suggestion was that we would now go to Commissioner Moffatt.

MS. MOFFATT: Good morning. For the record, Sharon Moffatt.

I'm going to speak to the amendment version and I guess follow up some of the comments that Paul Harrington made. And then I'll summarize with statements. I'll be fairly brief, because obviously you've done a lot of work. We testified both on the Senate side and also in this committee. And again, I'm going to kind of move through some sections fairly quickly. Certainly supportive of the section 1 in the legislative findings, I think you've added a lot more to that area and would note on page 5, number 19, again, I appreciate that you recognize the public health work that this bill is addressing in terms of protecting the health of the public and the optimal care for Vermonters.

I want to speak a moment, if I can, and then I'll speak to any particular area and I'll -- on page 8 you looked at evidence-based standards, and

again, as developed by the blueprint I think this is critically important that we continue to leave the work of our standard-based and evidence-based throughout not only the blueprint but this particular work. I just want to be sure that we're realistic in managing that what we're able to do.

As you know, we have a provider practice group that's really pushing on the clinical guidelines and has come a long ways, but has not taken some of these particulars around the prescribing aspects related to the clinical area. So that's work to be done. I just want to recognize that that's work to be done. It's not something we can take off the shelf immediately.

And in number 3 where we're talking, this is again on page 8.

MR. MAIER: Page 8?

MS. MOFFATT: Yes, page 8, number 3, to the extent permitted by funding, the program will include, distribution to prescribers of samples for generic medications used for health conditions in Vermont. So I think our only concern and it's actually a theme throughout here is related to the funding and appropriations of the -- and not only related to this particular area, I'll point out

some areas that we're just concerned about the ability in the first year, given the lack of funding for some of these areas. I just want to make sure that we're aware of that.

MR. MAIER: Have you seen the appropriations amendment in here, Robin?

UNIDENTIFIED FEMALE SPEAKER: The appropriation and the amendment are separate.

MS. MOFFATT: Okay. So I apologize then. Then that would help and probably would make Josh Slen a little more comfortable.

MS. MOFFATT: Okay. There, see. Ask and you shall deliver.

MR. MAIER: We try. I can't promise everyone in that chair today.

MS. MOFFATT: Then that speaks in part to certainly an area of concern that we have.

The next area is actually still on page 8 of the fourth A where we're talking about the collaboration with the Office of Healthcare Access and AHAC to establish pilot programs for distribution. So again, I'll look favorably towards that, and I believe the appropriations here will help us do that work with AHAC. We've already been in discussions, some initial discussions with

coding, but again need to flush that out. So that will be some of the early implementation work that we would need to consider as we go forward here.

Then if I could on page 9, this is in section 17, A, the intent of the general assembly, et cetera. We would agree as with the -- as stated by Paul Harrington on that particular section. And I know it's not -- well, I know it's language that you've added since the Senate version, but again, please see the electronic transmission aspect of it again, critical tool as we're developing those tools up there that we're using our electronic transmission whenever possible. And that actually ties into some of the work we're already doing on the prescription monitoring program and trying to look at that. So these things begin to all tie together.

The other areas though, only -- again, if I could move to page 11, item C, again, this is our work with the Office of Professional Regulation and Department of Health. This is C on page 11. I think just speaking with Chris Winters, part of this will be the complexities of putting the rule-making together and being judicious in the time that it takes to do that and the critical

public process that's necessary in doing the rule-making. So just -- and I think the only other thing I would say in regards to this particular section is, and Chris may want to speak to this also, each time we add something on to the eight pages of the licensure, we hear often that human cry from physicians saying, oh, my goodness, yet another detail to fill out in our application. So just want to acknowledge that each time we make this requirement, it adds further additions on to our application.

To speak to the Representative's earlier question about the notification and letting providers know what this opt in aspect of this is, we actually have done a lot with our Web site in terms of using that to help inform providers and then through licensure mailings which we do every two years. I could see us putting in a flyer to help inform a new item, and that's historically what we've done when we added a new item to raise their level of awareness of any new information we're requesting from them and what the implications of that are.

And obviously we'll work with the Medical Society and AHAC around the teachable moments to

further inform what we would be asking through licensure and I could see working with Paul at their annual meeting. It's often a good forum to get that out. So I think it's going to be a multi-prong area that we'll work on.

The next area if I could speak to on page 13, again, we're in agreement with item number 7 and then also item F as we were discussing earlier in agreement with what Paul Harrington and the Medical Society has put forward and I hope indeed that you're all going through the 50-page ruling out of New Hampshire in trying to understand all the complexities of that.

So I know in our first glance that we believe that this language would do that, but again, I think that's really more of the Attorney General's office final opinion. That's coming from our attorney -- Assistant Attorney General Bill Wargo. I think he's still working with the AG's office now to understand all of the complexities of that ruling.

And then I guess just to -- oh, if I could make one other point. On page 14, it's a continuation of item F. It's the certification of materials that are evidence-based, and to the

extent that rules should be evidence-based standards. Again, that certainly is our intent. The complexities and time restraints and costs around that will be critical. We obviously will be wanting to embed that within the blueprint. I think we actually will be working very closely with AHAC and the College of Medicine in this area and trying to draw on some additional resources to help us. So again, the appropriations to that end I think will help us along that way.

So I guess I would just summarize and finalize, I think this is an important piece of public policy that you have before you that is certainly critical in terms of helping Vermonters. There are some areas quite honestly that I think both Josh Slen and I feel are still a bit gray, maybe aren't fully defined in that. So the year ahead of us, assuming the bill goes forward and is passed, will take some work to further refine and solidify and actually get certain areas such as certification of evidence-based programs fully evolved. And obviously a critical amount of work to do with the Office of Professional Regulations and our other partners through the Medical Society. So work to be done. Appreciate the appropriations

that are there.
I do know that Josh Slen, I believe he testified yesterday, still had some reservations as he shared with you in terms of additional pieces of work that needed to be done.
With that I'll end and see if there's any particular questions.
UNIDENTIFIED MALE SPEAKER: Commissioner would you in your own words go to page 2 and the number 4. We're talking about the acts necessary to protect, save money, et cetera, public health. Can you just tell us in your own words how this act is going to do that.
MS. MOFFATT: Let me see if I can give you a couple different examples, and one is the I believe we talked about in the past was, and I think is perhaps a good evidence, is shortage of flu vaccine and when that comes into the state and all. So one of the concerns, for example, with flu vaccine and the shortages we experienced a couple of years ago was, and I think it actually gave a reality of shortages and what the pressures are. And quite honestly, what we find even in years of nonshortage, it's -- if there are -- if you have additional dollars to pay at the higher -- at a

higher price, you're going to be able to get that vaccine available sooner.
So let me give you a further example. We buy through the Center for Disease Control a flu vaccine. It's a very low price that we're able to purchase through. At the same time there are large conglomerates that often buy through the pharmacies, the Brooks, et cetera, that are able to buy at even a further reduced price, and they're actually able to bring their vaccine into the marketplace sooner than we're able to get through the Center for Disease Control. So it becomes an uneven playing field, if you will, that we hear repeatedly from healthcare providers who plan to use our CDC vaccine, and they're then competing with the pharmacy, the Costco or whatever who's got the vaccine that much earlier. And with individuals saying, well, should I go over to Costco, I'll just use them as an example, to get my vaccine sooner because yours hasn't come in yet. So we have an uneven playing field in that regard.
I think what this would do -- and I just used that as an example of the realities. I don't think this bill is going to necessarily help us around flu vaccine, but if we had a public emergency,

let's say we had a meningitis outbreak which has happened. I actually had one about ten years ago in Canada where it was very hard to get into the market the meningeal coccal vaccine that we all needed in a very quick way. So there could be a public emergency where something of this sort would be beneficial, that you would not be competing with then a vaccine going to the pool that's going to drive it faster. So that's a public example.
I think that's actually you take that up in the section -- not in this amendment but in the section around the public threat.
The other is, you know, when we talk about the public's health, I believe you had testimony on this is, we know that there are individuals that receive prescriptions for medications that cannot fill them because of the cost of that. If there were alternatives to a generic drug or, you know, another alternative than an expensive med, then we're going to get those individuals who are trying to take care of -- and I'm thinking of many of the cardiovascular meds, for example, can be extremely expensive, gives the individual a choice. But also what I think we're talking about through this bill is it gives the healthcare provider the

evidence-based and the information of what are the choices. And you speak to that in a couple of places throughout the bill, is that the provider becomes informed and actually required to have information that's not only evidence-based but also gives choices about generic and other options. So then a prescription is not being written for perhaps a higher end prescription that an individual quite honestly -- the provider could write the prescription, but it takes the individual getting to the pharmacy and getting it filled. And if it's a choice between that and paying the rent, buying the food. I think we know where the -- I don't know if you've taken testimony on that or not. I will tell you, we have individuals calling the Department at times in crisis because they cannot fill a prescription and are having to make those choices. We usually work back with the provider to help the individual work through the provider. Often they're embarrassed to go to their provider and tell them, I don't have enough money to fill the vaccine and then -- or fill the prescription.
The other thing that we try and do is see, oftentimes it's where it's, you know, are they --

do they have the right insurance, you know, are they -- we often see this in the underinsured. Not the uninsured, but the underinsured that have high deductibles and all. So it's not just the aging population, but it's what I might refer to more as the working poor that has an insurance, but it has a high deductible or whatever, and then they're put in a tight situation. That's a long-winded way of saying I believe this will address some important public health issues for us.

MR. MAIER: Great. Thanks very much.

MS. MOFFATT: Thank you.

MR. WINTERS: Good morning. My name is Chris Winters. I'm the director of the Office of Professional Regulation. We're a division of the Secretary of State's office and we license about 44 professions and occupations. And of the prescribers that we regulate, we have dentists, naturopathic physicians, nurse practitioners, optometrists, osteopaths, and veterinarians.

And I think what I should speak to today is section, I think it's 17 of the Bill, the very narrow portions of this Bill which is the opt-in provision, which this Bill would propose that there's an opt-in option on licensing applications

and renewal forms. We renew all of our professions every year. They're (staggered renewals, so they happen at all different times of the year. And of those professions that I just listed for you, it's approximately 3,000 licensees.

And I should tell where I'm coming from with this and why I might make the comments that I'm going to make. Several years ago I was counsel to the Board of Pharmacy when the regulation of pharmaceutical marketers landed in the Board of Pharmacy's lap, and that kind of took them by surprise. They're a board that's concerned with licensing professionals, and this put quite a burden on them to help regulate the pharmaceutical marketers. They really were inundated by the rule-making they had to do around that issue. Everyone came out in full force to put forth their opinion on how pharmaceutical marketers should be regulated. And thankfully after a couple of years the Attorney General's office sort of stepped in and took over. And that's where the regulation of pharmaceutical marketers lies is now with the Attorney General's office. So I just have a concern that this board of volunteers who are paid a modest per diem and meet once a month and have a

full agenda every month, that something like that doesn't happen to the other licensing boards, that they take on something that actually passes on the burden to the licensees, because these boards are specially funded. So all of their burden to regulate the profession comes from licensing fees. So any additional burdens we put on them actually is reflected in the licensing fees that get passed on to the individual licensees.

And so I'm a little bit concerned with how the mechanics of this will work, the opt-in provision once this information is gathered, what the boards will do with it. And also what sort of rule-making will have to be done. I'm a little unclear on that at this point.

And so I would echo the acknowledgement that Commissioner Moffatt made which was that the application process doesn't get too complex. We currently have all of these different check-offs for collecting taxes for the tax department, and you have to state whether or not you're in good standing, child support, unemployment compensation, and now this year it looks like the Judicial Bureau will have another provision that we have to put into our applications to help them in the

collection of unpaid parking tickets and traffic tickets. So it gets longer and longer.

UNIDENTIFIED FEMALE SPEAKER: Anything about (inaudible) driving in there at all?

MR. WINTERS: No.

UNIDENTIFIED FEMALE SPEAKER: How about being in the back of a pickup truck?

MR. WINTERS: So while I can fully support what this committee is trying to do, I just have some concerns about how this will be implemented in the Office of Professional Regulation, whether the burden gets shifted to the licensees and the licensing boards when that's really not something they're typically concerned with. They got their hands full, you know, judging applications and determining who should rightfully be licensed and then taking away the licenses of those who commit unprofessional conduct. So that's a full agenda for them already.

I would be happy to answer any questions.

UNIDENTIFIED MALE SPEAKER: First a comment. I appreciate what you're saying. I think the expectation is that people can work together and come up with a common form and common format, but I guess what I would ask is, do you have any

complaints from any of your -- that you're of aware of people being harassed by pharmaceutical marketers?

MR. WINTERS: It's not a conversation that I've had with any of these professions. And I would be really curious about what the veterinarians will say if they get marketed in any way for the drugs that they prescribe for animals.

MR. KEOGH: They do. I talked to a veterinarian. They're subject to all this stuff as well.

MR. WINTERS: I would suspect that the dentists are --

MR. KEOGH: I asked my dentist the other day. He said no, not really, not anymore. No samples. No sample of cavities.

UNIDENTIFIED MALE SPEAKER: He uses mercury amalgam.

MR. WINTERS: And then some of the other professions that are prescribers that we regulate, naturopathic physicians and nurse practitioners, they may prescribe a limited number of drugs in limited categories. And same with optometrists. So they may not be subject to the same extent of marketing that other prescribers are.

MR. MAIER: So is there a particular suggestion that you would like to make relative to the language here or is it more for the general uneasiness about how it would play out and wanting to know how relatively simple or complicated it would likely be?

MR. WINTERS: I think it's the latter, and I just want to just inform the committee that that has happened in the past, that some of these licensing boards that they had responsibilities put upon them that maybe were not rightly theirs to deal with. They're concerned with public protection and the regulation of the licensee. So putting other burdens on them that regulate marketers, for example, I just hope that the committee takes that into consideration however you decide to go forward with this bill.

MR. MAIER: In this case as opposed to several of the others that you mentioned in sort of passing, in this case it does seem to relate pretty clearly to the licensee. It would be asking them to opt in or not to something that affects them very directly.

MR. WINTERS: I think so. There's a direct connection there. I don't know -- I haven't -- I

really haven't been following this bill, but I don't know if there's any other place that's more appropriate to have that opt-in option. We do communicate with all the licensees.

MR. MAIER: I mean the licensee would be probably, I don't know what else is on the list, but of all the things you mentioned certainly this would be something that the licensee would be happy to have on the list as an option presumably or at least some of them.

MR. WINTERS: I presume that as well, although I haven't been able to speak to the boards about this.

MR. KEOGH: Okay. Let's say there's a check on the license form about opting in or out. What happens to that form? What happens to his office? Where does he go with that? Does he tell the pharmaceutical -- maybe Julie has some knowledge.

MS. BRILL: I could address that.

MR. KEOGH: Okay. Thank you.

UNIDENTIFIED MALE SPEAKER: I want to add a comment, maybe you weren't here for Paul's testimony, but for instance, physicians, the Medical Society unanimously passed a resolution that would do something more than this actually,

but based on the New Hampshire decision (inaudible). So I think they would probably be happy about it.

MR. WINTERS: I think no doubt the professionals want it. I just want to voice my concerns that we'll get the phone calls. We'll get the questions. We'll have to do the data entry of all of these check-offs. And then we have to do something with the list after that. And we do have to engage in rule-making is my understanding, and that's not free. You have to publish in newspapers across the state. It's at least a couple thousand dollars, and that gets passed on to the licensees through their licensing fees.

UNIDENTIFIED MALE SPEAKER: Well, in this case, again, you probably haven't seen the appropriations language.

MR. WINTERS: I have not. If I can get in on any of that.

UNIDENTIFIED MALE SPEAKER: Things like that would be appropriate to be paid out of appropriations, at least to some degree.

MR. WINTERS: I would hope.

MR. MAIER: Okay. Any other questions for Chris?

MR. WINTERS: Thank you.
MR. MAIER: I'm going to try to manage the time here.
Julie, we could try to be done with you about a quarter of eleven.
MS. BRILL: Okey-dokey.
MR. MAIER: And then Steve would be on next, and then we have Sean Flynn scheduled at 11:00. And that will leave hopefully leave about 45 minutes for the committee to consider what we've heard.
Is there anybody else in the room that needs to testify this morning?
Okay. I know there's some work that's been or needs to be done still on some parts of the Bill, some of the findings maybe. So hopefully we'll do that. And we have snacks on the table, so if we're not done by 12:00, we're going to keep going.
MS. BRILL: I'm Julie Brill from the Attorney General's office. I'm the Assistant Attorney General. And thanks for having me back. What I thought I would do is go through the Bill, because I've got some suggested language changes and I've also got some responses to questions that have come up thus far this morning, and I thought I could

just do it most easily by going through the Bill if that's okay, but Steve, if it's okay with you, if at any point anyone has a question about either something on or something else, please interrupt me. I would much rather respond to your concerns than walk through my issues.
I think it's important as a theme and I think the evidence is clear from the doctors who testified, that the purpose -- there are several purposes to the prescription privacy section, and they are articulated to a certain extent throughout the findings and then again in the special findings for this section which is going to be section 17. But in addition to protecting prescriber privacy, there's also this theme of avoiding prescriber harassment. And the reason why we want to avoid prescriber harassment I believe is not just because you want to, you know, keep doctors from being harassed which is of course an important state interest, but also the harassment leads to increased costs. Doctors spending time dealing with this issue. Time is money in the healthcare system, and costs is a very important issue, not only from the perspective of the cost that the state pays, but overall with the respect to the

cost that the sector is forced to pay. So I would like to see that as a theme, because I think it was -- I think you had testimony on that. I think the doctors talked about that.
So for instance, on page 2, finding number 4, this act is necessary to protect prescriber privacy, I think then you should add in, and I could give -- I'll just read it quickly because I could Robin the language assuming you all agree, to avoid prescriber harassment which leads to increased costs.
UNIDENTIFIED MALE SPEAKER: I'm sorry, page what again?
MS. BRILL: I'm sorry, I'm on page 2, finding 4. I just want -- I just think you need to reflect the record that you have in these findings which demonstrates that time is money and to the extent that doctors are being harassed dealing with marketers, that's money. That's money lost in the system, and that's something that I think is of concern to all of you. So 4 I think can better reflect that.
Going to Topper's question about how does this bill protect public health, you heard from Commissioner Moffatt with respect to the other

provisions in the Bill, so I would like to focus directly on the prescriber privacy issue or the data privacy issue. And the efforts -- this new revised draft has two prongs to it in terms of how it restricts marketing. One is it limits the use of data to those doctors who have opted in. That is the part that you heard Chris Winters testify to and whatnot. And then the other is that with respect to marketing that does occur, there needs to be evidence-based information also given. So it's a disclosure requirement. So you have both the opt in and the disclosure requirement. I believe that the way that protects public health is by limiting marketing to doctors who want it and requiring disclosures of fair and balanced information. It ensures that the FDA's requirement of doctors receiving fair and balanced information actually occurs.
And remember you heard a little bit from Marjorie Powell about, gee, she doesn't know. Is this preemptive? The FDA has all these requirements on what could be said to doctors and can't be said. The overarching theme of the FDA's requirement is that information be fair and balanced. The efforts to disclose to doctors who

are opting into the system of marketing, that they are getting fair and balanced information is what is contained in your mandatory disclosure requirement on page 13.

So I believe it is entirely consistent with the FDA's requirement of fair and balanced information. And I think that that goes directly to Topper's question with respect to public health. How does it promote public health? It's requiring the information be fair and balanced. And I have one other point to make, but please go ahead.

UNIDENTIFIED FEMALE SPEAKER: So are you actually recommending that we cite the FDA's requirement of fair and balanced within this amendment?

MS. BRILL: The way I would cite it if you do want to cite it, and that leads directly to the point I was just about to make, I think it may be and let me explain what the issue is. The FDA requires fair and balanced information to be given to doctors. However, the FDA has very little enforcement authority. These are the federal bills that are currently under consideration to improve the FDA's enforcement authority. There are thousands of detailers not in Vermont but out in

the nation that are out giving information to doctors. Who is out there policing it? It's a very difficult thing to enforce. So if you were to talk about the FDA's fair and balanced information requirement, I would put it in the context of the FDA requires this, but it is very difficult to enforce and very little enforcement actually happens.

So yes, it could be very helpful to add that finding.

UNIDENTIFIED FEMALE SPEAKER: Thank you.

UNIDENTIFIED MALE SPEAKER: I think we need to back up a little bit to be clear on what this amendment is doing.

MS. BRILL: Sure.

UNIDENTIFIED MALE SPEAKER: Because my understanding from Robin is this evidence-based requirement in F.

MS. BRILL: Yes.

UNIDENTIFIED MALE SPEAKER: Only applies --

MS. BRILL: If they opt in, correct.

UNIDENTIFIED MALE SPEAKER: If they opt in. And the rest of the marketers can do what they normally do.

MS. BRILL: That is absolutely correct. I

said that quickly. I'm sorry, I'm going a little quickly because of the time pressure. I will be happy to slow down, but that is absolutely the case as the amendment is written now, okay. But I really did want to address your question about how does this particular provision address public health.

I think -- sure. On page 3, the reference to fees, I think it should say consulting fees. Because it's not just -- I don't want there to be any confusion. The fees that we're talking about that are paid to doctors --

UNIDENTIFIED MALE SPEAKER: On the first line?

MS. BRILL: First line, sorry. Those fees are -- that's a lot of money. I mean we're looking now at the data that was just disclosed. You're talking easy $5,000, $10,000 a pop, sometimes a lot more.

And I see, for instance -- and I won't cite each one of these, but on finding 7 and finding 9, again, I think that the references to harassment of the doctors needs to then be linked up with, which leads to increased costs in the healthcare system. And that language could be added in 7 and 9 to really bring home why one of the reasons you care

about it is because you don't want doctors to be harassed, but another reason you care about it is because of the increased cost in the healthcare system.

UNIDENTIFIED FEMALE SPEAKER: Can I ask you quickly?

MS. BRILL: Sure.

UNIDENTIFIED FEMALE SPEAKER: So you're saying that and we're kind of nodding our heads, are you giving that language to Robin?

MS. BRILL: I'll be happy to give it to her. I just want you to understand the theme of it and where it would be added. For instance, in paragraph 4, paragraph 7, paragraph 9, paragraph 11. There may be a couple of other places, but wherever the harassment issue is mentioned, I think it should also say which leads to increased costs in the healthcare system. Does that make sense or would you like me to go through each time? I'm happy to do whatever you like.

MR. MAIER: I think it would be easy at the end of this we get a clean draft with Robin and she can indicate as she's going through where the language came from.

MS. BRILL: Sure.

In finding 12, this is the finding that's intended to link this issue to the Do Not Call List. I think that the beginning language of that should say something along the lines of, use of phone numbers -- as with the use of phone numbers for marketing, which is dealt with under the federal Do Not Call List, the trading of prescriber identity is linked to prescription data encourages..., et cetera. Because the Do Not Call List, it's not that the phone numbers are linked to spending. It's that consumers are allowed to either notify a state or notify the federal government that they don't want to receive any calls, and then they're not -- they don't get any calls. So this is a system that is designed to be now with this opt in. It's designed to be similar to the do not call effort that happens federally.

UNIDENTIFIED MALE SPEAKER: Wait a minute. I thought that system was an opt-out system.

MS. BRILL: It is an opt out. And I would like to address why opt out will not work here. My point is you're absolutely right. It is opt out under the do not call system, but opt out won't work in our view here for a couple of reasons. And let me just go right to that issue.

First of all, as you know the AMA currently runs an opt out which is not well publicized and in whose interest will it be to publicize that opt out, but much more importantly from our perspective that it, you know, if doctors fail to opt out, then they're just automatically -- inertia puts them into the system.

There was testimony on the Senate side and I testified as to what that person from IMS said here about three or four weeks ago. The IMS person was very clear that they don't need the AMA numbers to do their job for data mining. So if you have an opt-out system, a voluntary opt-out system, it is not going to stop the information from flowing if you're a doctor. If enough doctors start opting out, the IMS person was very clear that they could start linking the data to state licensing numbers. They could probably use DEA numbers. There are all sorts of identifiers for doctors, and these companies are extremely sophisticated and will be able to use other numbers.

So, you know, whenever you create -- when you opt out of one system, they're going to move to another identifying system. So that's why in our view opt out is not sufficient in this case to

ensure that a doctor who wants to choose not to have their information used in this way would be able to make a successful choice. Does that --

UNIDENTIFIED MALE SPEAKER: I have a follow-up, the concern earlier about how opt in it might be a First Amendment issue.

MS. BRILL: There are, you know, we have been -- and let me just say, you've heard that this decision is very complicated and it's long. This is actually a very straightforward First Amendment decision for people who are used to reading these things. It's not that complicated. The judge was very straightforward. The things that bothered -- there were a number of things that bothered the judge about New Hampshire's arguments. One was that there were very little findings. There was very little legislative history. The process that you've had here dwarfs, I mean it is a much more deliberative process than they had in New Hampshire. They had no findings. They had very little testimony. The bill raced through the legislature on both sides, both sides of the house.

So what you've done here will, I think, allow a court to defer to you all in a way that that judge was unwilling to do. Now, I'm not saying

that we are removing all the First Amendment concerns. There will undoubtedly be litigation if this were to pass. And in the event that we were to lose, there is always the threat that we have to pay the other side's attorneys' fees, because -- I won't go into why, but that's something that could happen. But we think what this Bill does do is, you know, it's designed to give us a better shot at the First Amendment argument.

Opt in does present some potential First Amendment concerns. However, there are other areas as I testified to a couple weeks ago where Vermont also has opt-in provisions.

Credit reporting, Vermont is one of the only states that requires consumers to opt in to allowing their credit report to be used.

Financial privacy, very small number of states require or -- yes, require people who are going to use financial information for marketing purposes to obtain the consumer's consent. In Vermont we are one of those states. So there's a very strong tradition in our view of requiring consent before information like this is used rather than allowing the system to go along unless a consumer says no.

Are there First Amendment issues? Yes. The

First Amendment issue is, does the restriction that the state is establishing sufficiently match up with the interest? And if we can show that the opt out is inadequate, then the opt in is a sufficient or is an allowable choice. I think here the evidence is quite clear from IMS themselves that the opt out is not sufficient. It just won't do it, because there are other identifiers for doctors that they can link up to. And you also have a finding on that which I think -- and I think that this issue should be mentioned in that finding. Let me see if I can find it for you.

UNIDENTIFIED MALE SPEAKER: Page 5, number 16?

MS. BRILL: Exactly. I just think that should say something like, finally, data mining companies could use other identifiers including state licensing numbers to track prescribing patterns of doctors. And again, I'll give that language to Robin.

So does that --

UNIDENTIFIED MALE SPEAKER: Yes.

MS. BRILL: Great, okay. That was it in terms of the findings that I had saw immediately.

With respect to page 11, requirement C, there's a couple of different points that I would

like to address. One I would like to address is the whole burden on the Secretary of State and how we envision this working. And I did speak with Chris Winters after he testified, and I think he felt a lot better after I talked to him.

The other point I want to address is, are the verbs that are used on the fourth line of C, it's kind of in the middle of page 11. So why don't I take those in order.

With respect to the Secretary of State, we actually envision this provision as being very easy for the Secretary of State to deal with. They would have to change their forms to provide for a place where there would be a check, you know, that, you know, I opt in to allowing my information to be used. Then the only other thing that the Secretary of State or the medical board would have to do is create a list of those who have checked that box. There needs to be added to this provision a sentence that would require that the data mining companies have to periodically review the lists from the Secretary of State and could only use the information about those doctors for those doctors who have opted in to the system. So you add a sentence here, and so the requirement, the burden

shifts to the data miners to have to check the list. And that is exactly the system that's used in the Do Not Call Registry. And I have -- unfortunately I only have one copy, but we can place it in the record if you would like. The Do Not Call Registry requires telemarketers to review the FTC's national Do Not Call List every 31 days. So basically every month. We could either -- you could either do it monthly. I'm not sure how often -- Representative Chen probably knows this -- how often the licensing, I think it's every two years, but is it staggered. I guess the question is if it's staggered, then you would need to have them review it more often.

MR. CHEN: Only the new applications are staggered. Different professions have different --

MS. BRILL: The naturopaths and others might have something else.

MR. CHEN: It's once every two years unless you're a new physician to the market.

UNIDENTIFIED FEMALE SPEAKER: Can that be done by rule?

MS. BRILL: That part can be done by rule, but I really think you could avoid doing rule-making here. You could probably say that they would have

to review it every six months, and I'm sure you would cover just about everybody at that point. You could do every three months if you want or you could follow the national Do Not Call List and do it every 31 days, because that is what they require.

So again, place the burden on the ones who want to use the information to go out and obtain the lists from the appropriate state entities. I would like to place this in the record, the information about the national Do Not Call List since that is something that you're modeling this on. I don't know who I should give this to. Is there like an official file? Lauren? Okay.

UNIDENTIFIED MALE SPEAKER: Just a question. Who is going to access this list? Is it the pharmaceutical companies or is it the --

MS. BRILL: That gets to my second question, my second point. I think it should be the data mining companies who should be required to access the list, because one of the things that bothered the New Hampshire judge was that the New Hampshire law prohibited the selling and the transfer as well as the use of the data. I think on line 4, I know that there were some discussions about that at some

point, but I would like to see that limited to just use so that it would say, shall establish a prescriber data sharing program to allow prescriber to give permission for his or her identifying information to be used for the purposes described in subsection D. I think that better parallels with what subsection D actually says, because that only refers to use down a couple of, I don't know, eight lines.

So, and I think the New Hampshire judge was bothered by the breadth of the New Hampshire requirement that he said it goes beyond what the purpose is, because the real purpose has to do with the use of the information. Whether they sell it among themselves or transfer it among themselves really doesn't need to be restricted. So you do want to try to narrowly tailor this as much as you can.

UNIDENTIFIED FEMALE SPEAKER: Does that set up the same kind of situation that exists with the AMA opt out which is that the data mining companies get the information. The detailers don't. The pharmaceutical companies do and the detailers never see the information, but according to the testimony we've had, they go to a physician's office and

somebody higher up calls them and doesn't say what the information was, but instructs them as to how to go about doing their detail.

MS. BRILL: That would be using the information.

UNIDENTIFIED FEMALE SPEAKER: That would be using?

MS. BRILL: Absolutely, there's no question. You don't have to say, you know, to the detailer, you know, Dr. Brill is down on her scripts on Lipitor, so you better get in there, but if you were to say go target Dr. Brill for Lipitor, I'm not going to tell you why, I mean they're using the information.

UNIDENTIFIED FEMALE SPEAKER: Okay.

MS. BRILL: Again, trying to address some of the New Hampshire judge's concerns about not being overly restrictive and really targeting in on what it is that you're concerned about with respect to the marketing practices I think would be helpful.

UNIDENTIFIED MALE SPEAKER: So going back to your comment about taking out license and transfer, I guess I sort of had it in my mind though that when -- if we were setting up this opt-in situation, that what the physician is giving

permission for should -- it just seems to me that it ought to be broader than just the use, you know, that at some point -- I guess the point I keep hearing Harry making in the beginning of the whole conversation about this issue is that the doctor and patient, that in the act of prescribing something, the doctor never envisions that that act and that relationship that he or she has with a patient is going to get used in the way that we have now figured out is happening. And that there's -- and so I think when you're giving permission for that information to go anywhere other than to the insurance company to get paid or to the pharmacy to get filled, that that's the point at which the doctor is giving permission for it then to get sent somewhere else for some other purpose.

MS. BRILL: That's it.

UNIDENTIFIED MALE SPEAKER: But -- so that seems logical to me, but maybe you're saying to us, well, it may well be logical, but that's part of what the judge was concerned about.

MS. BRILL: He was bothered about it. I mean there's no question he was bothered about it, and again, looking at C and D which I think go

together, the verb in D is use. A health insurer may use regulated records for marketing purposes only if one, A, says the prescriber has provided permission for the use. So again, I think there needs to be a match between C and D, that's important.

Also interestingly enough, the verb that you used when you were describing what was bothering Harry and others was "use" again. It wasn't sale or transfer. It was the "use." And if that's what's really bothering you, again, let's keep this as narrowly tailored as we can. Because that's going to be an important issue in any subsequent litigation, are we narrowly tailored. And, you know, if you think that it's simply the transfer of the data from the -- for instance, and now I'm getting -- I'm sorry it's taking so long to get to your point of who would have to check the lists, but if you want to get to -- you don't want to allow the pharmacies to transfer the data in the first instance, then it would be the pharmacies who would have to check it. But it strikes me that that's not really what is concerning this committee. What's concerning this committee is that it's being used for marketing purposes which

is increasing the costs that the doctors have to deal with this marketing. It's increasing the harassment factor and also the issue of not providing adequate information in that detailing moment, and that's why you want to have better information and more fair and balanced information given to the doctors. So, yeah.

The last point I just want to make is, again, if we add the adequate sentence that says that the data miners have to check this list every 30 days, quarter, six months, whatever you want, I don't think that the Department -- that the Secretary Of State's office will have to issue regulations. The sentence says they may issue regulations. I don't think they have to. And I think that if we make clear whose duty it is to check the list, they shouldn't have to at all. Okay.

UNIDENTIFIED FEMALE SPEAKER: Where was that particular reference?

MS. BRILL: It currently says, may. I don't have line numbers, so I apologize. End of C. It says may and that's right. Let's leave it that way.

Subsection -- so I've talked about opt in versus opt out and why in our view opt out, a

system of opt out would not be adequate and why opt in is necessary to do the purpose -- to meet the purpose that this committee wants to meet. And I think that's a very important issue under the First Amendment and will be important to any judge.

With respect to page 13, the mandatory disclosure, again, as Harry pointed out, this only comes up in the event that a doctor has opted in. And mandatory disclosures are treated differently than restrictions of speech to a certain extent under the First Amendment. A mandatory disclosure is usually given more leeway. In fact, you heard Marjorie Powell from PhRMA say that, you know, subsection F which is a disclosure requirement might be the kind of thing that would be appropriate here. She then mentioned a concern with respect to the FDA and whether or not it was -- it would conform with what the FDA would require, but the point that she was raising initially is disclosure requirements are, you know -- increase the dialogue and courts don't view them in the same way as they view a restriction of speech, because it's requiring more information to be given. Our office has had experience dealing with mandatory disclosure requirements. We have

litigated a couple of cases in the past ten years on this. One involved the -- some of you may remember if you've been around for a while -- the RBST, the little baby blue dot label that had to go on cheese products and milk products. We lost that case and I'll explain why in a minute, but then this --

MR. MAIER: Quickly.

MS. BRILL: Let me just say that we did then litigate the mercury labeling case, and we won that case. And I think the difference was the kind of information that had to be disclosed, what was the state requiring to be disclosed. And in this instance because you're being very careful that the information has to be evidence-based. It has to go through a regulatory review process. I think the likelihood that it will be upheld as an appropriate mandatory disclosure is much greater than if we didn't require that kind of rule-making process. So we're being very careful here to make sure as much as we can that the information is accurate, fair and balanced that would be given to the doctors.

You don't agree?

UNIDENTIFIED MALE SPEAKER: I'm just laughing.

Fair and balanced, I automatically thought of Bill O'Reilly.

MS. BRILL: You know, it's unfortunate but, that is the terminology that the FDA uses unfortunately. You're right. It would be nice if they come up with something different.

I think actually this section goes to your point of how do we get to doctors this evidence-based information. They are thirsty for information, there's no question. These doctors as Paul pointed out, JAMA New England Journal of Medicine has articles all the time. Doctors don't have a lot of time to read, because they are seeing patients. If someone can quickly come into their office and give them information, that might be something that they would want to opt into, but if they're going to opt in, let's get them fair information, information that presents all of the evidence. And that's what that section is designed to do. So it's a way for the state to make sure that that kind of information is getting out to doctors, that kind of balanced evidence-based information.

UNIDENTIFIED MALE SPEAKER: Too bad it's just going to the doctors who are opting in though.

MS. BRILL: We had some discussion about whether F ought to be a stand-alone, whether or not you opt in to the system.

UNIDENTIFIED FEMALE SPEAKER: One step at a time.

MS. BRILL: Right.

MR. KEOGH: What would that evidence-based information look like presented to a doctor? Would that be a 20-page document or an objective summary?

MS. BRILL: That's such a great question. I think I mentioned to you, again incredibly briefly, that we are spending -- that the group of AGs, 50 AGs are spending about $3 million to figure out the way to appropriately give to doctors the message about antiepileptic drugs, one classification of drugs that was involved in litigation that we did. We are trying to take a report that's about that thick and figure out ways to give the message to psychiatrists as to what the appropriate use for that medicine is and what is not appropriate use. It is something that we're spending a lot of time trying to figure out. And you heard Sharon Moffatt talk about teachable moments. She was talking about it in reference to the opt in, but it is an important issue as to what is a teachable moment

for the doctors. Is that detailing meeting a teachable moment? We think so. That's why the pharmaceutical companies are in there, and they're, you know, they've spent lots and lots of money figuring out how best to do this. So I don't -- I cannot tell you that I have an answer to that question.

MR. KEOGH: Okay.

MS. BRILL: I think it is a very important question you're answering, and I can say it may be giving them a document. It may be giving them some information, verbal information along with the document. It may be sending them to a Web site. There could be all sorts of ways to try to do it. It's a big -- that's a big question. Obviously we don't have time to address that now, but that's a big question.

MR. KEOGH: Okay, thank you.

MR. MAIER: Okay, thank you.

MS. BRILL: Thank you, and I will continue to listen and stay here.

MR. KIMBELL: Thank you, Mr. Chairman. My name is Steven Kimbell. I'm an attorney. I'm here on behalf of IMS Health which is a data miner pharmaceutical company as I testified before. And

heeding your admonition earlier, Mr. Chairman, I'm not going to re-argue the merits. I think this committee has made its decision about data mining, and I didn't make any prediction about or even discuss in my prior testimony the New Hampshire litigation, because I've litigated in federal court and the judges say they're going to make a decision in April, and then it comes out in October and it didn't seem relevant. But it's a reality we've got on our plate now, and that's what I'm going to focus my testimony on, whether or not you can fix it, fix the constitutional infirmities that New Hampshire judge identified with this or any other report.

But before I do that let me talk about process for a second. The New Hampshire District Court made its decision Monday of this week. The state's got 30 days to decide whether or not to appeal. They could probably get an extension of that period if they need more time to think about it. If they do appeal, they have got the option of requesting a stay from the Second Circuit. That means what this judge --

MS. BRILL: First Circuit.

MR. KIMBELL: First Circuit, thank you.

UNIDENTIFIED MALE SPEAKER: Are you going to testify, Julie?

MS. BRILL: No. This is such an important distinction. I apologize for interrupting.

MR. KIMBELL: It's okay. Whether or not to appeal to the First Circuit. And if they do appeal, they could ask for a stay. A stay just means this order doesn't go into effect until we finish reviewing this appeal. We don't know if any of that is going to happen. You move forward with this legislation and some of that does happen, you may be in a place you don't want to be. You might be able -- I'm arguing against myself here -- to pass your original law if the First Circuit stays the lower court decision, or maybe New Hampshire doesn't appeal and then you're faced with established precedent at the district court level which might alter your thinking about what you want to do. All of those factors and one other, the fact that you've got a January 1 effective date in this Bill, so you're kicking implementation off till next year anyway, all of those factors argue for you to take the section out of the Bill and wait and see. You're not going to have anything on the ground until 2008 anyway under this Bill. And

there's a lot of uncertainty out there and I tried to ignore the litigation in my earlier testimony and just talk about the merits, but as I say, now we have it, and those are the realities of federal court litigation that you're faced with. And I'm sure, because there's a good deal of passion about this issue in the room, that it really ticks you off that a New Hampshire federal judge is mucking around with your Bill, but that's the system. And I would suggest to you that you don't have to act now and take up a bill with thousands of words of new language on two days' notice and pass an imperfect product. So that's my first plea.

I would like just quickly, and I know that Lauren passed it out yesterday, it's a 54-page decision, but it's really an easy read because the judge actually had good clerks or learned how to write someplace, but it's fairly easy to get through this and understand it.

One of the things that the judge said here was that legislatures, state legislatures get huge deference from federal courts in most matters, but when you're dealing with First Amendment rights, any Bill of Rights right, but when you're dealing with First Amendment rights, there's a higher

standard. And he says, the state must demonstrate that the harms of the cites are real and that its restriction, the restriction of those harms will in fact alleviate them to a material degree. That's on page 36.

So you got to prove that your fears about the impact of the use of data mining information are real, and you got to prove that by passing this Bill it will alleviate the harms that you've identified. And then he goes on to say that that information you have can't be mere speculation or conjecture. And that's where I want to get back to the findings.

This trial in New Hampshire, I did look into a little bit after the decision came down, it wasn't a trial on stipulated facts. Often in federal court, at least in my experience, there isn't any argument about the facts, particularly in constitutional cases. It's a question of constitutional interpretation. So the parties stipulate to what the facts are, give the judge a set of facts, and then they argue the law. That wasn't what happened in this case. There was no agreement on the facts. There was a five-day evidentiary hearing in which witnesses testified

under oath and were cross-examined. One of the key witnesses for the state was Dr. Jerry Avorn, the expert upon whom the advocates of this approach to legislation based a lot of their -- hang their hat to a substantial degree. His testimony was essentially rejected by the judge who took the evidence, and I'll show you in his opinion where he says that. But you've got a different standard here in legislating. You can't just write findings that you believe are true. They have to be true, and they have to be based on some evidence that you can back up.

So with that in mind, just let me quickly --

Harry, can I get some glasses that I can read with and see you at the same time?

UNIDENTIFIED FEMALE SPEAKER: Trifocals.

MR. KIMBELL: I can't do trifocals.

Let me take it in order. Finding number 4, you've got on here, this act is necessary to protect prescriber privacy, save money for the state, consumers and businesses and protect the public health.

Now, if you go to page 44 of the judge's decision, he says, Accordingly, the attorney general has failed to prove that the prescription

information law directly promotes public health. He took five days of evidence. They tried as hard as they could to prove that it would do that, and he said no, you didn't prove it.

And then on page 45 he says, Because the attorney general has failed to prove that any reductions in healthcare costs that may result from a ban on the use of the prescriber identifiable data can be achieved without compromising patient care, I am unable to endorse their argument that the prescription information law can be justified as a cost containment measure.

So five days of sworn testimony under cross-examination and this judge says no, you didn't prove it. So I would say that finding, you need -- you're going to have to get some very strong evidence in your record that the State of New Hampshire and NLA-RX and others weren't able to produce. Sean Flynn, by the way who you're going to hear from later, was a participant in this case on their behalf. They couldn't prove it in five days of testimony.

Now, I would like also to go to finding number 5, and most doctors in Vermont who write prescriptions for their patients have a reasonable

expectation that the information in that prescription will not be used for other purposes. That's just not true according to the New Hampshire judge, that they know the information is going to be seen by other people including possibly their regulators and the pharmacist, and there isn't that expectation. One of the recurring themes in your findings, and it appears four or five times, is that Vermont doctors are experiencing coercive and harassing behavior by pharmaceutical marketers. Paul Harrington testified a better word might be manipulative, and the Vermont Medical Society resolution doesn't use the words harassing or coercive or even suggest that that kind of behavior is happening. And the New Hampshire in the footnote at the bottom of 41 says that, Thus, I do not find any credible evidence in the record that supports the notion that pharmaceutical companies are routinely using prescribed or identifiable data to coerce healthcare providers. No credible evidence in a five-day trial.

And so I would suggest to you that you don't have the proof to back up that assertion in your findings, and therefore, it's not going to do you any good. The strongest word I've seen used is

manipulating. And as I said, coercion and harassment appears four or five times in your findings.

Finding number 12 tries to make the leap to connect the privacy concerns expressed by the physicians with consumer privacy. And on page 39 in his opinion the judge rejects that linkage between commercial information and consumer privacy. He says in the footnote, Any argument that the state's interest in protecting business information is equivalent to its interest in protecting personal information would require a substantial extension of existing precedent. In other words, that's not the law. We have consumer privacy measures that we use for credit reporting and consumer solicitations over the telephone, but it's not the same body of law that applies to professional information.

Finally -- not finally but additionally in finding number 14, it says, Coincident with the rise in physician identity data mining the pharmaceutical industry increased its spending on direct marketing to doctors. Coincidence means at the same time, and that's just not true. Data mining as you heard earlier from Randy Frankel, has

been in place for about ten years as a part of pharmaceutical marketing efforts. And really in the second half of that period the last five years, the number of pharmaceutical marketers has declined somewhat. There was a great push in the '90s, but as one of the factors is data mining made marketing more efficient, that relationship has changed.

UNIDENTIFIED FEMALE SPEAKER: Can I ask a question? The number of detailers has declined. Has the spending on marketing declined in the last five years?

MR. KIMBELL: You know, I don't know the answer to that. I'm going to get to that study on spending that Sean Flynn -- I don't know if it's declined, if the spending has declined. You would have to factor inflation into account. I do know that one of the major pharmaceutical companies announced a 40-billion-dollar cost-cutting plan in the last couple months, and I think that included marketers. So, but I don't know the answer to that.

Page 5, finding number 18, nearly one-third of the five-fold increase in U.S. spending on drugs over the last decade could be attributed to marketing induced just to doctors. That's almost a

direct quote from Sean Flynn's memo that he wrote following the decision, and it's just simply not what this study which is his citation shows. As you can see, this study is for expenditures in 2001, revised 2002. It doesn't deal with the last ten years, for one thing. And it only studies -- and I'll be glad to leave this with you -- it only studies prices in that narrow period of time. And he additionally uses this study, you know.

The other thing that's in this study that I think it would be very useful for you to understand is -- and this is an institute -- a National Institute of Health -- National Institute for Healthcare Management study. They conclude at the end of the study, the prescription drugs have been enormous and valuable contributors to the improved treatment of many medical conditions, illnesses and diseases. Even so, many issues are raised by their escalating cost. Duh. They're too expensive. The most important from a healthcare financing perspective is whether the growing use of drugs will, over time, add to overall healthcare costs or yield savings as a plan and reduce the need for other more costly medical treatments. There is no easy or quick answer to that question, and the

issue bears close scrutiny in the years ahead.

So this independent study says, we don't know if more drugs is going to make the healthcare system cost more or not. It's an open question. And so there just isn't any evidence. What this gets to is to an assertion in your findings that this is going to reduce costs probably can't be supported by the evidence, and therefore, isn't going to be viewed in a friendly manner if this Bill passes and gets reviewed for First Amendment purposes.

There is an assertion in finding number 20 that the one-sided nature of marketing leads to doctors prescribing drugs based on imperfect, misleading and biased information. And I just wanted to point out to you on pages 45 and 46 of the judge's opinion where he says, the attorney general's argument also suffer from a fundamental flaw. Although the attorney general complains that pharmaceutical companies use prescriber identifiable data to manipulate healthcare providers, it is important to understand that she does not assert that the data is being used to propagate false or misleading marketing messages. She doesn't even try to prove it. I mean you would

think if you were defending this law, you would try to prove this if you had some evidence. This judge said, they didn't even try to prove it.

And I'm trying to wrap up, Mr. Chairman. I know you've got another witness here.

The findings aren't going to do the job for you in terms of making this law bulletproof in the courts. And I wanted to, since I'm referring to the Court a couple times, I got one last finding.

Assistant Attorney General Brill predicted litigation I assume from my client. There's no decision made on that. We're pleading for for reasonable legislative reaction to the New Hampshire decision, and any implied threat that she made about litigation on behalf of my client is simply not true. We haven't even finished analyzing the decision that came down in New Hampshire.

Finally, in finding number 27, you're laying yourself a trap, I think, by endorsing the testimony of Dr. Jerry Avorn, because he was a key witness in the State of New Hampshire's case in attempting to defend its law, and the Court didn't give any credibility to his testimony. So I think the findings need a lot of work which is something

that you could do over the summer or early next year, but I don't think they're going to achieve what you hope they'll achieve.

Secondly, I would like to address very quickly the opt in. It just -- the key point is whether the restriction on speech, which the Court said this would be, whether you carry it out yourself through passage of a law or indirectly allow it to be carried out by physicians pursuant to a state statute, the First Amendment outcome is going to be the same. You can either do it directly because you say it in a law or you allow physicians to do it, it's still a restriction on what's been identified as free speech, commercial speech by the Court, and it's going to get struck down for the same reasons I believe that are in the New Hampshire decision.

Julie referred to this and I'm glad she did, the part that requires disclosures from pharmaceutical marketers who are visiting a physician who has opted in, it would be interesting to see how we get all those connections made to determine who it applies to, but that's a separate issue, compelled speech is subject to the First Amendment. I mean laws compelling speech get

analyzed under the First Amendment as well as laws prohibiting speech. And as Julie said, it's a different standard, but you're creating somewhat of a trap here by telling a private sector marketer who is engaged in legal activity what he or she has to say when they engage in their activity. So I just wanted to raise that issue for your consideration.

I also wanted to call to your attention, since litigation seems to be so much on people's minds here, the fact that in the appropriations that just passed by the Vermont Senate, there's this provision, an amount not to exceed the amount available in other short-term general fund reserves is appropriated to the attorney general for payment of legal costs and charges arising from settlements of completed legal actions. I asked Bill Griffin today what that referred to. And he said, it's the campaign finance law, that the state may be on the hook for in excess of a million bucks, because that, like this, would be a free speech case. And if you lose -- if the state passes a law and it's successfully attacked on free speech grounds and you plead your case under certain federal statutes, you're on the hook for the attorneys' fees. So

it's real. I don't think Sue Bartlow would put this in the appropriations on the Senate floor if there wasn't some real liability, potential liability on the state's part with respect to this kind of litigation.

I have -- and I have a couple of practical questions or one I want to answer.

Mr. Chairman, you asked me when we -- you asked me if the Bartlow amendment when we first --

UNIDENTIFIED FEMALE SPEAKER: I never want to be confused with that.

MR. KIMBELL: It must have been a Freudian slip. I've been working on nuclear funding for all these weeks. You asked me, you expressed some surprise, and I had the same reaction, that this case was decided on First Amendment grounds instead of commerce clause grounds, and I asked my client about that. They pled commerce clause as well as First Amendment, that is, in their complaint they said, here's what the state is doing and we think it's illegal for these reasons. And they said First Amendment, commerce clause and they may have had others. The judge found in our favor on our first argument. So we didn't reach the other argument, but in terms of subsequent litigation

there may be commerce clause issues. And one of the interesting findings in the judge's decision is that clients, companies like mine get their data from computers located outside the State of New Hampshire. So if you're at all familiar with the commerce clause, you have to regulate transactions that take place in your state, and that law does go after people doing business here, but it's going to get tricky if, you know, the Rite Aid pharmacy on Main Street sends all that data on a regular basis to Pennsylvania, and then the transaction occurs that you're trying to ban. So I just wanted to answer your question. I think there are commerce clause issues here that the Court in New Hampshire just didn't get to them, because they didn't have to, and that the courts tend not to do that.

A couple other practical questions if you do decide to move forward with this which I hope you won't. How would this law work with multi-physician practices where some opt in and some do not? I don't know the answer to it, but it seems to me it's got to work on the ground if it's going to achieve your purposes. And the second question I have for you is, and I honestly don't know the answer to this, would it be okay for

pharmaceutical companies to pay Vermont physicians to opt in? I don't know the answer to that either, but it's something worth considering. If you're trying to achieve your legislative goals here, if pharmaceutical companies can just buy their way out of it, you haven't achieved anything. And I don't -- maybe you could ban that. I don't know if that would be an appropriate thing, but you don't ban gifts. It would be another form of a gift.

So I think I got done in about 15 minutes, Mr. Chairman. Maybe I ran over a little. I would be glad to take your questions.

UNIDENTIFIED MALE SPEAKER: I don't know if it's a question or a comment, but it's pertaining to this is, as usual sometimes I listen to various sides, and I feel like a ping-pong ball, but why can't -- and Harry might be able -- why can't you just -- why can't doctors just take the bull by the horns and just simply educate the doctors, as the saying goes, just say no. If they don't want to talk to detailers, don't talk to them, and then forego the benefits and get it elsewhere. Can you just do that?

UNIDENTIFIED MALE SPEAKER: What I would say to you is you absolutely can.

UNIDENTIFIED MALE SPEAKER: Right.

UNIDENTIFIED MALE SPEAKER: But it's not that simple.

UNIDENTIFIED MALE SPEAKER: I didn't think it was.

UNIDENTIFIED MALE SPEAKER: Because A, you your office staff that are in (inaudible) these people, and there's some degree to something there. And I think the most important thing is that there are very clear studies in the literature of if you ask doctors if they are influenced by marketers, the answer to that is usually no. The reality is if you're looking for behavior, that they are influenced. So there's a disconnect there.

UNIDENTIFIED MALE SPEAKER: Okay, that's what I wanted to ask.

UNIDENTIFIED FEMALE SPEAKER: Your suggestion just wait this out. I think about some court cases that have gone on ten, twelve years. So what does waiting it out mean to you? To me from cases I've seen and I'm not a lawyer, but enough, that I don't think -- you said next January we can take it up. If that were my approach to think, I'm going to wait until the waters are safe, it would be a lot longer than Joel's pond when that cinder block --

MR. KIMBELL: I didn't mean wait that long. You will know in a month or two probably whether or not the State of New Hampshire plans to appeal this decision.

UNIDENTIFIED MALE SPEAKER: Actually we know already.

MR. KIMBELL: Have they filed a notice of appeal?

UNIDENTIFIED MALE SPEAKER: We've heard that they are.

MR. KIMBELL: I didn't know this. I would be surprised if they had. They usually wait till the last day. Has that been in the press? Did I miss it?

UNIDENTIFIED FEMALE SPEAKER: The AARP in New Hampshire, New Hampshire Attorney General decided to appeal.

MR. KIMBELL: Okay. So they've appealed. Will they seek a stay, in other words, let their law continue to be in effect. We don't know those things. I was only suggesting waiting for those steps. So now you know. They're appealing this decision. You know, you've got some good constitutional scholars at Vermont Law School. This goes to my take your time approach too. You

could get a constitutional law professor up here from Vermont Law School, first ask him to analyze this decision and existing precedent, the First Circuit, and Julie's correct, different federal circuits. If this case does get to the U.S. Supreme Court, it might be as a result of conflicting decisions from two different circuits. That's sometimes the reason why the U.S. Supreme Court takes cases. But you've got time here, particularly given the the effective date that's in your draft, to get this right. I mean somebody said to me yesterday, and it seemed to ring true to this, if you want something really bad, that's probably the way you'll get it. In other words, take your time if you want something really bad, which I sense this committee does, I'm not arguing the merits with you, and try to get it right, instead of hastily putting together a multi-page bill in the last week or two, I hope week or two of the session.

MS. OJIBWAY: Can I make two comments? I did talk to a Vermont law professor yesterday, and he was the one who reminded me that cases often drag out ten or twelve years and that wasn't a good approach. And the other thing is, you know, we did

talk this opt in. This isn't completely new. This was talked about before, and I think you know that. So it's not --

MR. KIMBELL: No, no.

MS. OJIBWAY: It's not something that just came up in two days.

MR. KIMBELL: No, I was referring mostly in the findings, Representative Ojibway. I think they're really thrown together for the purpose of satisfying somebody's impression of what will meet the court's, the New Hampshire Court's standard, and they can't just be findings that you want to be true or believe are true or somebody's opinions are true. There has to be evidence that they're true or they don't do you any good.

MR. MAIER: Okay, thank you.

MR. KIMBELL: Thank you.

MR. MAIER: Good morning, Sean. How are you?

MR. FLYNN: Good morning. Good.

MR. MAIER: Are you in D.C. today?

MR. FLYNN: I am in D.C. today.

MR. MAIER: We spoke to someone earlier who was from D.C. somewhere between the White House and the Capitol. Where are you situated?

MR. FLYNN: I am as far -- almost as far away

from the Capitol as I could possibly be and still be in the district.

MR. MAIER: I see.

MR. FLYNN: American University.

MR. MAIER: Thank you for agreeing to speak with us this morning. We're running a little short on time, but I would welcome your thoughts on -- perhaps quicker thoughts -- on the decision itself. And then also I'm fairly sure you have a copy of the amendment in front of you, and maybe take a little more of your time testifying how or why you think this amendment either does or does not address the concerns of the New Hampshire Court.

MR. FLYNN: Okay, great.

MR. MAIER: Thank you.

MR. FLYNN: And I actually don't have the amendment right in front of me. If there's a staffer there, can they e-mail it to me now just so I can open it? I've seen a prior version but.

UNIDENTIFIED FEMALE SPEAKER: It's the same version.

MR. MAIER: It's the same version we had yesterday.

MR. FLYNN: Yesterday.

MR. MAIER: It should say 1.3 on it. It

should say on the right-hand side, page 1 and it should say 1.3.

MR. FLYNN: While I'm searching for that -- here it is. I have one from 3:00 p.m. Is that okay?

MR. MAIER: Yeah, I think so.

MR. FLYNN: Okay, great. Well, let me just start with the opinion and it's going to take me for whatever reason forever to open this document, but I have reviewed it, so we'll work from my knowledge of it and it should open soon.

So the New Hampshire -- a couple just quick points on the New Hampshire decision. And I'm happy to answer any questions, of course, but the first probably most relevant point from the New Hampshire decision is it doesn't actually bind in any way Vermont since it's just a New Hampshire District Court. Its only jurisdiction is within New Hampshire, and it will likely be appealed. So that decision offers some guidance on what one judge might think, but you shouldn't consider it binding on everything you do.

With that said, I think it's helpful to know what one judge thinks, and I think it can be helpful to respond to some of his concerns to the

extent you can.

The most troubling part of the judge's decision was his holding that New Hampshire did not adequately document a physician's interest in the privacy of their prescription records. It's troubling in two respects. It's troubling first because New Hampshire did in fact have a relatively full record of the voluminous and growing data and information and articles on the extent to which data mining is being used to harass and coerce physicians and to track their every move and use that information to tailor highly specific marketing messages and all of which has been leading to astronomical increases in drug prices.

It's been predicted that, or the conclusion of some experts is, that somewhere around a third of the five-fold increase in drug prices over the last 15 years or so is because of marketing induced shifts in prescribing practices from doctors and other prescribers from cheaper often generic medications, to highly marketed more expensive brand name drugs. So there's been a fairly direct link between marketing of more expensive drugs and the prescribing practices of physicians as well.

So getting back to the decision, he did not

find an adequate privacy interest of doctors and their prescription records. And he specifically noted that the legislation lacked findings on that issue and didn't find enough of a record.

So one of the things that the Vermont legislature can do is include fairly specific legislative findings that refer back to its own record documenting some of those interests on the part of patients.

His second and third holdings were that he didn't find that the legislation directly advanced its cost and public health goals. So I jumped ahead of myself a minute ago and mentioned some of the evidence that marketing in general towards physicians in general has led to increased drug prices, and there's quite a bit of other information that I believe is already in the record. I submitted some of it to a staffer yesterday, including some recent articles that have come out including one in the New England Journal of Medicine that describes in quite detail how data mining is used to persuade doctors to prescribe more expensive drugs. And the public health side of that is related to the cost. The problem here is that pharmaceutical marketing is a flawed

market. There's only incentives to spend the very high cost of pharmaceutical marketing, very high cost because it's done through individual person-on-person marketing efforts. The incentives are only there for the most expensive most profitable medications. So lower priced drugs which may be equally efficacious, there's no financial incentive for the sellers of those drugs to try to compete in the marketplace of ideas and offer counter-advertising through financial incentive. So you end up getting one-sided marketing towards doctors that's always pushing the most expensive drug regardless of whether it's the most effective or the most cost effective drug. So the state has a very strong interest in countering that through a number of ways.

So I'm aware, for instance, that Vermont has already either passed or considering a counter detailing or academic detailing program and other programs that try to raise awareness of generic alternatives, but the fact is that Vermont probably doesn't have enough money to actually go head to head with the pharmaceutical companies in marketing. So one of the -- this Bill fills in one of the key gaps and attempts to restrict the most

abusive uses of prescriber data, the same way states around the country have attempted to restrict the most abusive uses of consumer data, whether those be phone calls for Do Not Call Lists and other kind of consumer data that is sometimes traded between companies for marketing purposes. So I think it's important to make that link and show that the interests are similar between doctors and protecting other consumers.

And then the final point the Court made that needs to be on the tip of the mind any time there's a speech case, is that the law needs to be narrowly tailored to the interests that the state has set out for itself in the legislation, and essentially the New Hampshire Court found that the New Hampshire law was painting with too broad of a brush in that respect. It was banning both the good and the bad uses of prescribing data. And by doing that, it wasn't -- it wasn't using the least restrictive means possible to the good kinds of speeches, speech that society doesn't have as strong of an interest in and curb it. So that's the -- that's the basic summary of what the Court said.

Now, my understanding of the amendment to the

Vermont legislation in front of it, so first of all, it includes a number of findings upfront that attempt to respond very specifically and attempt to document the various interests of the state. So I think those are a very direct and desirable answer to the paragraph in the New Hampshire Court that criticized the New Hampshire legislature for not including specific and detailed findings in its law.

The second major change in the bill is to really concentrate on the uses of the prescribing data as opposed to just its disclosure. So it attempts to carve out a new exception for data that is used in a way that's backed by evidence. So this is responding to the judge's analysis that the New Hampshire Act suppressed the bad as well as the good. The Vermont bill attempts to respond to that by focusing more narrowly on the use of prescriber data for marketing that it is not backed by evidence.

And I believe the third component, although I haven't gotten that far, is that there is a -- now an opt out, is that correct, or opt in?

UNIDENTIFIED FEMALE SPEAKER: Opt in.

MR. FLYNN: It specifically requires the

doctor's permission in order to use data for marketing purposes. Now, this I think responds very closely to the narrow tailoring arguments and attempts to tailor one part of the tools, one part of the remedy, which is allowing doctors to express their preferences to not receive the data or alternatively express their preferences to share their data with pharmaceutical companies, and then allows the use of that data in nonharmful ways as long as the doctor has consented to it. So it's the most kind of narrowly tailored remedy to the state's interest in allowing doctors to protect their own privacy through a consent mechanism.

So that's kind of my analysis of a very general overview of the bill and how it responds to the act. And my general opinion is that the Vermont bill as it stands now is a much more defensible bill should it be litigated. My own opinion is actually that the New Hampshire Court is wrong. That decision is under appeal and I still believe that the New Hampshire Act should be upheld. However, on the grounds where there are some debate, I think the Vermont bill has set itself on firmer legal footing constitutionally. So I'm open to any questions you may have.

MR. MAIER: Representative Keogh.

MR. KEOGH: I have two. This could have been asked by previous attorneys, but do findings have to have some degree of accuracy or basis for facts presented?

MR. FLYNN: Yes, absolutely. I mean the findings should have a basis either in testimony that was actually given to the Vermont legislature or backed up by evidence that's in the public record that, you know, is readily accessible to the Vermont legislature.

MR. KEOGH: Thank you. My second question, we've heard testimony that this bill should be -- the action on this bill should be postponed until some of the New Hampshire issues have been resolved either -- through the appeal process. What's your response to that?

MR. FLYNN: Well, I think that depends on how long you want to wait. So it will probably be five years or so before there's a final appeal that's appealed all the way through the Supreme Court process. And if Vermont believes that there's a real problem in this area in its state that requires a response, then I would not advise it to wait until all the appeals are finalized.

In addition, you know, the way these things normally go is that so there will be an appeal for the First Circuit, that will take quite a bit of time. The First Circuit will review it. Either Vermont could pass something and have an alternative that could be considered by courts through the appellate process and perhaps have rival decisions that could go before courts as it gets appealed up through the process. And that could help the judicial deliberations by having different alternatives in front of it.

So in some respects you would be doing a service to the courts by passing something now before all the appellate processes are finalized.

MR. KEOGH: Thank you. And one final question, and that is, the New Hampshire Court did not address the commerce clause with respect to the issue before it. How long a street would that be in the litigation process?

MR. FLYNN: I'm not sure I understand your question. You mean if it was --

MR. KEOGH: Let me try to make it simpler. The Court did not deal with the commerce clause. How valid is that in this respect?

MR. FLYNN: How valid is the commerce clause

arguments against the bill?

MR. KEOGH: Yeah, in the New Hampshire case, yes.

MR. FLYNN: In the New Hampshire case. Well, the Court -- actually there was an oral argument. The Court dismissed orally and fairly out of hand the pharmaceutical industry's or IMS, the data mining industry, I suppose, challenges on the commerce clause aspects of the bill. He basically ordered, I don't remember if it was a formal order from the chair but he clearly informed the parties that he did not think that that -- that he essentially thought that that argument against the New Hampshire bill was frivolous. So he didn't address it in his opinion partially for that reason, and I agree with the Court on that basis. I think the New Hampshire -- the New Hampshire law and the Vermont law as well is carefully tailored to only regulate the sale and exchange and trade in prescription data that either originates from or is destined for Vermont commerce. It's clearly Vermont commerce. Of course Vermont has the ability to regulate out-of-state actors that are engaged in commerce in Vermont. It's only not permitted to regulate out-of-state commerce that is

not engaged in commerce in Vermont, and I don't believe that the Vermont bill or the New Hampshire bill for that matter crosses that constitutional threshold.

MR. KEOGH: Thank you.

MR. MAIER: Any other questions?

All right. I think we need to say thank you. We need to move along. We're trying to get something done here on this amendment in the next hour or two.

MR. FLYNN: Great. Thank you very much. Feel free to call back with any questions.

MR. MAIER: Thank you, sir.

UNIDENTIFIED MALE SPEAKER: Mr. Chairman, could I get a request on the record, please? I'm pretty sure I know what the answer will be. Was that a yes?

MR. MAIER: Sure.

UNIDENTIFIED MALE SPEAKER: You just heard from the losing lawyer in the case or one of them and I request that Tom Jullen who was one of the plaintiffs' attorneys, lead attorney for the plaintiffs in the case had an opportunity to address the committee. I know from doing federal litigation myself it's a lot of work, and when you

lose, it stinks, and I think until you get away from it a while, you might not have the most balanced perspective on the case.

And I assume the answer is no, but I felt like I needed to make that request before you vote.

MR. MAIER: If he can get it to us in an hour.

UNIDENTIFIED MALE SPEAKER: I doubt he can get something in an hour. I suppose I can get him to e-mail us his brief in the case (inaudible).

MR. MAIER: Julie.

MS. BRILL: I don't need to sit in the chair, but just briefly. First of all, Sean was not the losing attorney. He filed an Amicus brief. Actually the New Hampshire Attorney General's office was the party that represented the party that lost in that case. But really what I wanted to address was this whole issue of evidence and what evidence you need versus what evidence a court needs. And Steve does a very nice job of presenting his client's case, and I don't think he goes into court much anymore, but he would do a very good job in court. I think it's really important though for you all to understand, and I think Sean touched on this, but he hadn't heard what Steve was doing. You don't need to have so

much evidence that you met the standard of the preponderance of the evidence. You don't need to have so much evidence to show that the fact is more likely true than not. You need to have some evidence in the record to support your findings, okay. There can be conflicting evidence in your record and that's okay. You can credit, that is believe, who you want to believe. There might be one doctor who came in here and you all found very, very credible and there might have been ten doctors who came in and said something different. If you found that one doctor more credible, that is okay.

So when Steve was showing you your findings and weighing it against what the Court in New Hampshire found, those are totally different standards. It's okay that the Court in New Hampshire ultimately decided in weighing all the evidence that he was going to find in one direction. You can still say that your recommendation was something else. I just really want to make that clear, because I think that can be confusing by Steve talking about your findings and then holding it up against the Court's findings, okay.

The only other thing I want to mention, I know

you're in a rush, so I will do this as quickly as I can, is I think the entire New Hampshire judge's perspective on the New Hampshire law was very much colored by what's footnote twelve. And in footnote twelve he says, I'm not going to give the New Hampshire AG's office arguments or the New Hampshire legislature's argument any deference, because the record in the legislature was very bare. It's true that in the court case they had a much bigger record, but the question was what deference would they give to the legislatures, and there he said, I'm not going to give it to them because that record was bare. What your findings do -- and actually what all of the testimony you've taken does is it helps to address that concern and whether you should be given deference in the policy interests that you're putting forward. And that's what we're doing here with the findings.

So I mean that's your 30,000 feet what's going on here and the difference in terms of standards and why we're doing what we're doing. We're not arguing the court case here. You don't have to have so much evidence that it would satisfy a jury or satisfy a judge for the ultimate conclusions. I just wanted to make that clear.

MR. KEOGH: On these findings, I don't want these findings to be the Achilles' heel of what happens here. On these findings I agree with the face of what the findings say, but if this has to go to litigation, and I'm just thinking with my gut reaction.

MS. BRILL: As I said I predicted.

MR. KEOGH: I'm not saying your client, but someone goes to court, there's no basis for this.

MS. BRILL: Absolutely.

MR. KEOGH: As I said, on the face I agree with 99 percent of it. If the Court says, show me, we got to show them. I'm not sure. We are essentially --

MR. MAIER: We need to move as soon as possible --

MR. KEOGH: We haven't had that testimony.

MR. MAIER: Yes, we have.

MS. BRILL: I think you had a lot of testimony.

MR. MAIER: We had, substantiating a lot of findings, but that's where we need to move and we need to have that conversation right now, if that's okay with the folks here.

So I would like to ask Robin, I think.

UNIDENTIFIED FEMALE SPEAKER: On the findings I'm going to point to Steve because he and Lauren have been documenting the basis for the findings and I haven't reviewed that yet. I can try and do that on the stand while I'm going through that if you want.

MR. MAIER: What's the best way to do this at this point? Do you have something in writing?

UNIDENTIFIED FEMALE SPEAKER: Partially done, I think he's standing right outside.

(Committee members holding several conversations at once.)

MR. MAIER: Okay. Let me ask the committee members let's take five or ten minutes, not have a full conversation yet at this point, but let me ask committee members which of the findings you -- if you had a chance already -- which of the findings you find to be most -- more troubling or less substantiated so that -- then we're going to take a break. Harry met with Steve and Lauren this morning in trying to go to Bill's question on a number of the findings, just so you understand what it is that she's working on. She's going back to our testimony, going back to our record to be able to substantiate where that finding came from or in

some cases going to a particular journal article or other document. So that's what is going on over here, because I heard that yesterday. We all heard that yesterday even still. So we're doing that work, but it may be that we've already addressed some of the findings that you have, but I guess I would ask if there are particular ones that the committee members are concerned about, then we can be working on that over the next little bit as well.

UNIDENTIFIED FEMALE SPEAKER: I'll just say for myself, and I've said this before, I think that language is really important. I understand why harassing and coercive in my mind, not going back through, Frank Landry (phonetic) testified on Friday, April 20, he had pretty strong language and I'm guessing I remember Frank Landry had pretty specific complaints, and I don't remember the doctor's name.

UNIDENTIFIED MALE SPEAKER: The ophthalmologist.

UNIDENTIFIED MALE SPEAKER: The one that phoned in.

UNIDENTIFIED FEMALE SPEAKER: That was very colorful.

UNIDENTIFIED MALE SPEAKER: They actually told her, they said they won't give her any more samples because of something. I can't remember. It was very strong.

UNIDENTIFIED FEMALE SPEAKER: And then the third person was I think she was a pediatrician who testified at the public hearing last Monday. At the public hearing, remember her?

UNIDENTIFIED FEMALE SPEAKER: Oh, yeah.

UNIDENTIFIED FEMALE SPEAKER: And she was very -- she was complaining about -- she was out there with her comments about pharmaceuticals. And then afterwards came up and said, oh, well, we're doing this bill, because she was so strong on that. She was near the end. I can't remember. She was from Montpelier. She was a pediatrician I thought. But anyway, if you need -- I don't know that we have to put that in here, but as long as you're doing it, that's the one that, I think her language was too harassing and coercive, those exact words, but that for me is in the findings, because, frankly, and I hate to say this but, you know, you hire people on either side and put them on the stand. One expert will say one thing (inaudible) you can always go back and forth, but to me

essentially the biggest complaint is this harassing and coercive and unethical or however it's perceived and is experienced. And like Julie said, the cost of that to the system is to me is the biggest thing that jumps out at me, so...

MR. MAIER: Findings that are concerning.

UNIDENTIFIED MALE SPEAKER: I just have a concern about on twelve.

UNIDENTIFIED MALE SPEAKER: Me too.

UNIDENTIFIED MALE SPEAKER: I guess the encouraging. I don't know that -- I guess I would say maybe enables instead of encouraging.

UNIDENTIFIED FEMALE SPEAKER: We've had testimony that it happens, so it actually results in. It doesn't enable. It sounds like it could happen and we've actually had testimony that it happens.

MR. MAIER: Okay. I'll buy that.

MR. KEOGH: Let me just offer something in this same document that Paul and others have referred to. Also some of the assumptions or the affects of the detailing are not totally correct. Though it's clearly influenced choice of ages, this is based on available options we see in the sample closet when we would like to do trial of a meds

before committing them to buying an agent. That's why I've been saying for years that any means of counter-detailing needs to have samples of cheaper meds for docs to try with patients.

I also question that folks that push to the wrong drugs as a result of detailing, in general I decide what class of agent I think a condition requires and choose a drug from that class. If I don't like the available choices of sample meds, I write a prescription instead of something else. I don't give a lesser or worse class of agent because of the details. That's another view, a view that we probably have not heard much about.

UNIDENTIFIED FEMALE SPEAKER: It is, but as Harry said before, doctors say that they are not influenced by marketing, yet the studies show that their prescribing habits are influenced by marketing.

MR. KEOGH: Show me.

MR. MAIER: Oh, yeah.

MR. KEOGH: I'm just troubled by this whole thing. Okay, let it go at that.

MR. MAIER: With the whole thing of what?

MR. KEOGH: I'm troubled by some of these findings that could be our Achilles' heel. We get

Page 118

perceptions and we never heard from a physician that said, detailers are the third person with less triunity and some believe that. I don't.
MR. MAIER: What I'm asking you to do or the whole committee at this point is sit and put your finger down on the ones that are more troubling to you, and we'll try to resolve your concerns.
UNIDENTIFIED FEMALE SPEAKER: We already voted out the bill. It's not like we're going to go back and redecide.
MR. KEOGH: We're talking about this.
MS. O'DONNELL: I have a problem with a few of them and I spent the time reading the bill and going through it. I was kind of surprised that Steve and I had seen a lot of the same problems. And when you look at number seven, some doctors in Vermont are experiencing an undesired increase in the aggressiveness of pharmaceutical sales. We've only taken testimony from two people on this list. So could I go out in Vermont and find 15 people that would say the opposite? I know I could, because I've talked to my doctors about it, and they said, you know what, I don't see them. If I don't have the time, I don't see them. If I don't want what they're giving me, I don't take it. And

Page 119

then when you go to the findings, it says in the findings, page 41, thus, I do not find any credible evidence in the record that supports the notion that pharmaceutical companies are routinely using. Two people are not enough evidence. And then when you go to page 46 that Steve didn't even mention, it says right here in the findings and I believe this wholeheartedly, healthcare providers are highly trained professionals who are committed to working in the public interest. They certainly are more able than the general public to evaluate truthful pharmaceutical marketing messages. Accordingly, the state simply does not have a substantial interest in shielding them from sales techniques (inaudible) effectiveness of truthful and nonmisleading marketing information. Are there maybe a couple people out there? Yes, but I don't believe it's the whole industry, and I don't believe that every doctor in the state is saying save me from myself.
MR. KEOGH: But Patty this just says "some doctors." It doesn't say all doctors.
MS. O'DONNELL: But the perception you're giving in these findings is it's happening enough that we're writing legislation about it, not that

Page 120

two doctors have testified in front of this committee.
UNIDENTIFIED FEMALE SPEAKER: And you actually believe it's a very small problem.
MS. O'DONNELL: I believe that there are a lot of doctors in the State of Vermont that don't even see the marketers anymore or the detailers anymore, and I've always had a huge concern about sales because I've watched it with people I know very well that don't have -- that's another whole issue.
MR. MAIER: I'm trying to work the findings here so that -- to make them better. I don't doubt that we won't necessarily agree when we're done, but I would like to make them better.
MS. O'DONNELL: In 27 you refer to Dr. Avorn. In the findings on page 47 it also dismisses what Dr. Avorn had to say, but yet we're addressing it in our findings again. I know it's New Hampshire, but it's a federal court, we're going to have to go in front of a federal court, and I don't -- I mean (inaudible) comes from money. To be spending money and to pass something right now that we know could end us up in court at over a million dollars to me is just ludicrous.
UNIDENTIFIED FEMALE SPEAKER: That was the

Page 121

Vermont campaign was $1.3 million.
MS. O'DONNELL: It was the same issue.
UNIDENTIFIED FEMALE SPEAKER: But you know. Does the state reap money from the entity that sues it if the entity loses in the case where the state has to pay fees or is it a one-way street?
MS. O'DONNELL: Let me answer it.
UNIDENTIFIED FEMALE SPEAKER: I would like to ask Julie.
MR. MAIER: Let me ask, are there other particular findings that you find more troubling as opposed to --
MR. KEOGH: I don't remember the one I referred to yesterday, Robin. You said you were going to rewrite it, and I haven't seen the rewritten version. We'll see the rewritten version.
MR. MAIER: All right. It will be here in a little bit.
UNIDENTIFIED FEMALE SPEAKER: Number fourteen, I think this correction was already made. It says, the pharmaceutical sales representatives in Vermont are one for every five, and I think we said that that was a national figure, not Vermont. So that was going to be corrected, right?

MR. MAIER: Yes.
UNIDENTIFIED FEMALE SPEAKER: Okay. I have a concern, and I'm not sure if it's addressed and that is we keep talking about how the detailing affects the patterning behaviors of physicians, and I'm concerned that there are physicians, and I haven't done a survey, who very readily any new drugs that come in start giving them out to patients for samples before we know of any side effects. So I'm concerned about patient safety. Now, I don't know, I can't remember if there's a specific one that could cover that. I know there's something in here about public health good, but that's a consequence that concerns me, because particularly in some of the older generations people do what their doctors tell you. The doctor is unduly -- simply takes the stuff and starts handing it out, because it's available and because all the information isn't provided about side effects or problems or the fact that they don't know yet, I think that's a hazard that is of concern to the state. So I don't know if that --
UNIDENTIFIED FEMALE SPEAKER: Number 23. Who is making the notes?
UNIDENTIFIED FEMALE SPEAKER: I'm making the

notes. It says, 50 percent of all drug withdrawals from the market and so-called black box warnings are within the first two years of the release of the drug. And so I just think there might be another sentence that says so what, that's why that finding is important. So it's just a little again to say why that -- showing how that connection adversely affects public health and cost. I mean it might be obvious because it just seems that it could use a little bit more there. Because I didn't really know what black box warnings were. I was just guessing. I had to deduce what that meant.
MR. MAIER: Okay.
UNIDENTIFIED FEMALE SPEAKER: The other suggestion I would say Steve can very quickly run you through and give you the numbers. He has the cites for the numbers so he could do that quickly.
MR. MAIER: Even though we don't have it in front of us.
UNIDENTIFIED FEMALE SPEAKER: Even though you don't have the --
MR. MAIER: You're going to tell us which ones there have been citations added that Lauren is working on?

UNIDENTIFIED FEMALE SPEAKER: I haven't added citations yet, but he could tell you where we're going to add citations.
UNIDENTIFIED MALE SPEAKER: There's different kinds of findings, the ones that are hard numbers, journal articles, we could do that. I could either tell you the ones that we have or whatever works best for the committee.
MR. MAIER: Isn't that in part what she's doing right now?
UNIDENTIFIED MALE SPEAKER: Yeah.
MR. MAIER: There are other findings typically, and correct me if I'm wrong, but if we have testimony that we deal with and make a finding, we don't -- we just make that as a finding. We don't say -- we don't quote them.
UNIDENTIFIED FEMALE SPEAKER: We don't usually cite findings anyway even if it is from a journal article. I'm doing that because that's at your request. That's not something I would normally do in a finding.
UNIDENTIFIED FEMALE SPEAKER: I don't find it necessary.
MR. MAIER: I think the most productive use of our time right now is to let her finish -- several

of you finish like a cleaned-up version or the next version of the findings and then walk through them, and if there are additional concerns that we soften this word or strengthen that phrase. And then I would ask if anyone has concerns about sort of -- I'm not hearing the committee say, I'm concerned about the general direction that the committee is heading in the other parts of the amendment. Let me know if you've got other concerns that you have about it. Let me know and we'll take about a 30-minute break here, and we'll come back and see where we are.
Before we all leave, I just wanted to read into the record or note in the record there's a -- where were the copies?
UNIDENTIFIED FEMALE SPEAKER: Right here.
MR. MAIER: The attorney from AARP submitted these written comments in support of this amendment and you can read the language there and the written testimony that will get submitted into the record. She couldn't be here this morning. All right. Thank you.
Good work this morning. I know it's hard, we're going to get there.
MR. MAIER: Patty might actually appreciate

it.
UNIDENTIFIED MALE SPEAKER: I saw the pictures.
MR. MAIER: Every time they tried last year to explain the global commitment to our committee the two of them would sit there and they would start going, the cap here and the other cap and they start going like this.
UNIDENTIFIED FEMALE SPEAKER: It took two of them.
UNIDENTIFIED FEMALE SPEAKER: Every time they tried to explain global commitment to me, I went like this, right, Steve? I sat over there in the pink (inaudible) --
UNIDENTIFIED MALE SPEAKER: It still has that effect on me.
UNIDENTIFIED FEMALE SPEAKER: Yeah, but I don't have to do it anymore.
MR. MAIER: We are -- the speaker knows we're not quite ready, but the plan here is we've got a few other things we're going to try to do, and I told her we would try to be done by 2:00 or before so we can vote this amendment out by 2:00. Then Sarah and Harry, all of us should at that point we can go down to the floor. They'll report the bill.

Remember, this is an amendment. So they'll go through the original report of the bill while the amendment is being finalized and copied and ready to be handed out, if assuming there is an amendment.
UNIDENTIFIED FEMALE SPEAKER: And all members will receive a copy of this amendment?
MR. MAIER: Yeah.
Are these extra copies?
MS. LUNGE: So what I handed out to you -- this is Robin Lunge -- are the first eight pages of the next version, page 9 and on are currently being copied because I wasn't able to finish that during the break, but this is the findings. So we were going to start here, and I thought what I would do is I will -- the changes from your last version of the findings are in bold. So I thought I would be responsible for saying where that came from since Steve wasn't necessarily here for the testimony.
MR. MAIER: And you also reordered them at John's request?
MS. LUNGE: Yes, Steve actually did that. We reordered them. I tried to do some -- like Harry gave me some suggestions and Hilde gave me some suggestions. So I tried to incorporate that all as

you can see it and take from there.
UNIDENTIFIED MALE SPEAKER: What we tried to do is kind of put the same idea stuff together instead of one here, one here and make it sort of flow from what we know to what we believe and why we're doing this. So I think there is some -- there's more of a straight line flow as my mind is trying to organize things and not usually working properly.
If I can make one more comment. When I was sitting listening this morning, I got confused a little bit about what a finding actually is, and maybe -- some of the conversation I heard was the differences of what the idea of a finding is, because some of these are clear statements of fact that I can cite to specific documents. Some of them are things that you clearly heard in testimony and some of them are conclusions that you came to as a committee. And I think by keeping those things separate in your heads may help with this conversation.
MS. LUNGE: And it's fine for findings to be all of those things. I think the most important thing about them is you feel that they reflect what you heard and stuff like that. And some of the

citations are things that we found, Steve and I did in research, and we'll make sure the copies of the journal articles are available in the record. That is something which we normally do when we create findings is look out there in the world of journal articles to see what we could find to find, so to speak.
So the first two findings actually are new and they were I think conclusions from -- to try to sum up that Steve wrote I think after kind of trying to reorder in a logical fashion.
So I'll let you speak more to those.
UNIDENTIFIED MALE SPEAKER: I think this was my idea of trying to start at the root and that the state has an interest in maximizing the well-being of its residents in containing healthcare costs. It's kind of a nice simple course. And there's a strong link between pharmaceutical marketing activities, spending and the health of Vermonters. So the two really fundamental points that I heard at least in all the conversations. Here's the interest and here's the connection, and then we start building up from those.
MS. LUNGE: So in three the change was based on your discussion and Hilde suggested that we add

the word "often" in the goals of the state. And this is also, you know, more of a conclusion, that based on what you've heard about marketing, the goal of marketing, which is generally selling the drug and making a profit, sometimes that leads to conflict with the goals of the state of cost containment and evidence-based practices.

Four, I think this finding pretty much -- I didn't make any -- I didn't make any changes in this finding. I know this was one that you probably wanted to have some discussion on, but I think this was meant to kind of also summarize some of what you either received in writing or heard through testimony. So we don't have a specific cite for this one as well. This is again something that's more of a conclusion from the evidence -- I mean the testimony and different articles that have been handed out.

MR. MAIER: I'm comfortable perhaps if we took the second to last line, I mean I think it's clear to all of us that the information is imperfect by itself. I'm not sure that it's always intentionally misleading. I might be more comfortable taking out the word "misleading."

UNIDENTIFIED FEMALE SPEAKER: I was thinking

about incomplete instead of imperfect. Imperfect sounds like there's an expectation that it's going to be perfect. Incomplete means something that got left out. Just a suggestion.

MR. MAIER: I think the basic message isn't lost by making either of those changes. Anybody want to object? Okay.

UNIDENTIFIED FEMALE SPEAKER: The difference between misleading and biased, you're leaving biased in?

MR. MAIER: We're leaving biased in.

MR. KEOGH: Isn't that kind of redundant between being one-sided in nature and being biased?

UNIDENTIFIED FEMALE SPEAKER: Would you be comfortable saying that -- the word misleading is I think descriptive of what the end result is, is that doctors are misled, but if there's a way to not attribute it to the person but somehow get to the fact that, you know, it's like doctors when they eventually find out feel like it's incomplete and biased information, but I don't want to bog us down. So whatever you want to do.

MR. MAIER: I think it will be a little redundant. So we say incomplete and biased.

Anything else in this section?

MS. LUNGE: Five is a new finding suggested by Julie Brill this morning to basically state that there are these FDA requirements about marketing and advertising that it needs to be fair and balanced, however, they have limited enforcement of that requirement.

UNIDENTIFIED FEMALE SPEAKER: Could we say, or limited ability to enforce it or limited resources to enforce it?

MS. LUNGE: Well, they actually have little legally. They can send a letter or they can yank the drug. So it's not that they have other -- they don't have options.

UNIDENTIFIED FEMALE SPEAKER: That's limited ability to enforce.

UNIDENTIFIED FEMALE SPEAKER: Do you have a sledgehammer or a feather?

UNIDENTIFIED FEMALE SPEAKER: If that's what it is. Limited ability.

MS. LUNGE: Yeah. So I mean my thinking behind that was based on the legal requirements, not whether or not they had their resources, because I don't know what their resources are in this regard.

UNIDENTIFIED FEMALE SPEAKER: If you want to

state limited legal ability.

MS. LUNGE: Yeah. All right. Sorry I'm multi-tasking. I'm trying to make the changes as we're discussing them.

Six, again, this is something that would be a conclusion based on testimony that you've heard about the effects of marketing to doctors resulting in prescribing perhaps newer drugs that may have more problems that are yet undiscovered, et cetera. So this is again kind of a conclusion more of the factual stuff that's listed in eight, for example.

UNIDENTIFIED MALE SPEAKER: Eight, we've got a specific article in the journal --

MS. LUNGE: Oh wait, we have to do seven.

UNIDENTIFIED FEMALE SPEAKER: Richard just did seven.

MS. LUNGE: No, that was six. I mentioned seven in describing eight. Seven was -- and Harry may have -- I summarized this based on a conversation with Harry, so he I think may have the sources for that. I think Vioxx is a commonly known example.

Okay.

UNIDENTIFIED MALE SPEAKER: If it would be helpful, we can certainly find a couple of journal

or news articles about Vioxx and have them just add to the record.

UNIDENTIFIED FEMALE SPEAKER: I've got a series of citations and articles on that for that one.

UNIDENTIFIED MALE SPEAKER: Okay. So eight, this is the 50 percent of all drug withdrawals. We have a specific article from the Journal of the American Medical Association about five years ago for that fact.

MS. LUNGE: What's in bold was -- came out of a conversation that I had -- the second sentence came out of a conversation that I had with Harry. And the third sentence came out of someone on the committee and I can look back in my notes who suggested that in this finding -- I think it was you Hilde -- that describing why this matters, what does it mean in the context. So the third sentence is my attempt to explain why we care that 50 percent of all drug withdrawals from the market and black box warnings are within the first two years.

UNIDENTIFIED FEMALE SPEAKER: Would it read better to say one-fifth rather than one in five of all drugs?

UNIDENTIFIED FEMALE SPEAKER: Well, with this one I guess for me it was taking the other -- I don't know how to quite say this -- extra step that when these warnings occur, it's because significant -- the public health has been adversely impacted. I mean it's really bad when they pull it off the market. A lot of damage has been done in my mind, never taken lightly. So it -- I kind of want that extra step somehow to say, you know, because of the serious adverse impact on public health, these products are withdrawn.

UNIDENTIFIED FEMALE SPEAKER: Instead of "for safety reasons," "because of serious adverse effects."

UNIDENTIFIED FEMALE SPEAKER: I'm not sure about the wording, but partly when I said so what, it was saying they're subjected to warnings and withdrawals is to take the extra step, because of the public health, because that's one of the issues is these drugs and this marketing can have a bad effect on public health, and so this is one of the findings that demonstrates that, you know, experimenting with the general population is a bad thing to do.

MR. MAIER: The point she was trying to get

at, maybe that we could say a little bit more, but the point that Robin was trying to get at with this last sentence is making a connection between that concern that you just expressed and the marketing that we're actually addressing in this bill. So what is it about marketing that is related to these, and the issue is that these marketing efforts specifically is much more oriented towards new by definition with respect to the newer branded drugs.

UNIDENTIFIED FEMALE SPEAKER: Yes, because there's enough in here that I think especially with the Vioxx as an example you get the idea. Never mind.

MS. LUNGE: I could also change that sentence to read, one-fifth of all drugs are subject to black box warnings or withdrawal from the market because of serious public health concerns. Does that get it a little more clear?

UNIDENTIFIED FEMALE SPEAKER: Yeah.

UNIDENTIFIED MALE SPEAKER: Number nine, probably the most easiest and most directly factual, straight out of the (inaudible) analysis. My main contribution is to calculate the 13.3 percent.

UNIDENTIFIED FEMALE SPEAKER: Steve, what was the increase in hospital costs or doctors' costs in comparison?

UNIDENTIFIED MALE SPEAKER: The aggregate, I don't know the specific sector stuff, but the aggregate was probably in the seven or eight range.

UNIDENTIFIED FEMALE SPEAKER: For hospitals?

UNIDENTIFIED MALE SPEAKER: For healthcare in general. Hospitals if I remember right were around eight.

Yeah.

UNIDENTIFIED FEMALE SPEAKER: But this also isn't just prescription drugs, just over-the-counter drugs and medical supplies. What are medical supplies?

UNIDENTIFIED MALE SPEAKER: Medical supplies are non -- well, specifically nondurable medical supplies. So it's equipment, things like that that you only use once. So wheelchairs which are durable medical equipment are in a whole different category, a wrist brace or something like that.

UNIDENTIFIED FEMALE SPEAKER: A syringe maybe, is that a medical supply?

UNIDENTIFIED MALE SPEAKER: I think so.

UNIDENTIFIED FEMALE SPEAKER: Should we say

nondurable?
UNIDENTIFIED MALE SPEAKER: We could, but the vast vast bulk of the categories are prescription drugs.
UNIDENTIFIED MALE SPEAKER: Are supplements included in this?
UNIDENTIFIED MALE SPEAKER: Over the counter is in there, so yeah.
UNIDENTIFIED MALE SPEAKER: It says over-the-counter drugs. I don't consider supplements to be drugs.
UNIDENTIFIED MALE SPEAKER: Right now can I give a precision piece to one of these things?
UNIDENTIFIED FEMALE SPEAKER: Sure.
UNIDENTIFIED MALE SPEAKER: On number eight, the study was between 1975 and 2000. Let's just use that time frame. This is what the study was.
UNIDENTIFIED FEMALE SPEAKER: You're talking about 50 percent of the --
UNIDENTIFIED MALE SPEAKER: Yeah.
MS. LUNGE: During, what did you say?
UNIDENTIFIED MALE SPEAKER: Between 1975 and 2000.
UNIDENTIFIED FEMALE SPEAKER: That's good. I mean it's bad, but it's good to know.

UNIDENTIFIED FEMALE SPEAKER: But wouldn't that depend on -- so for the 25 years before that how many new drugs came on to the market compared to the 25 years after that and the different kinds of drugs? I mean sometimes when we quote percentages and numbers and stuff, we're not always comparing apples to apples. I mean 25 years before this the drugs that came out on the market didn't do nearly what they do today.
UNIDENTIFIED MALE SPEAKER: I mean this isn't a vacuum. It says most of the bad things happen in the first two years, and that drugs have bad side effects. So we have to be careful about that. That's all it's saying. It's not saying it's better now, worse in my mind. All I'm saying is the first two years are the most dangerous time, that's really the time to watch drugs.
UNIDENTIFIED FEMALE SPEAKER: Was that the case 25 years ago?
UNIDENTIFIED MALE SPEAKER: I have no idea.
UNIDENTIFIED FEMALE SPEAKER: My fear is that 25-year span thing really necessary, because what we are saying is --
UNIDENTIFIED MALE SPEAKER: I'm trying to be precise though. I don't want people to say

one-quarter and one-fifth of every drug out there has a black box. I want to take what's in this study, that's all.
UNIDENTIFIED FEMALE SPEAKER: I'm trying to get to where -- never mind. Okay. It's just -- it doesn't feel good to say every drug.
UNIDENTIFIED FEMALE SPEAKER: The detailing didn't go on in the fashion it goes on today with the precision and so forth. It's a little bit different on how it goes on today.
UNIDENTIFIED MALE SPEAKER: Yeah, I think the market has so completely changed. Remember that graph, drug spending and healthcare spending, where it started high and went down. That was 25 years ago when drugs were not the major tool and the arsenal that they are today. And it's coming back up again because drugs do a whole lot more, they're a lot more powerful, they're prescribed a lot more, but they potentially have a lot more consequential side effects.
UNIDENTIFIED MALE SPEAKER: So if we added about the highest, the greatest increase of categories under nine?
UNIDENTIFIED MALE SPEAKER: The 13.3 percent was the highest in any of the categories.

MS. LUNGE: Okay.
UNIDENTIFIED MALE SPEAKER: Ten, eleven and twelve are the three statements of what Vermont has done and we pretty much built these by going through the statutes and identifying all the things you guys have done, which is a very long list by the way.
MS. LUNGE: Thirteen I think was again a summary of --
UNIDENTIFIED FEMALE SPEAKER: I've got about thirteen or fourteen documents that have been submitted to the committee for that one.
MS. LUNGE: Okay. Do you want to briefly --
UNIDENTIFIED MALE SPEAKER: No.
MS. LUNGE: Okay, never mind. We'll get it in a written form. We'll get the list.
UNIDENTIFIED MALE SPEAKER: Back to you, fourteen. Thirteen is what Lauren was talking about.
UNIDENTIFIED MALE SPEAKER: Fourteen is a direct cite from a publication by the National Institute of Healthcare Management. This is also the same kind of distribution. I think we talked about it with this committee a couple times. It's definitely around a third, no matter who does the

analysis. It's driven by this shifting of new drugs and the change in intensity of prescribing.
Fifteen according to testimony from Dr. Avorn, that was already cited. Sixteen is actually a two part and the first is directly out of the --
UNIDENTIFIED MALE SPEAKER: I'm sorry. Patty raised a point. I don't think so much about the language of this section, but the fact that it isn't here at all.
UNIDENTIFIED MALE SPEAKER: It's already cited in the New Hampshire case. That's -- his testimony was irrelevant. You can turn to the page and read it yourself.
UNIDENTIFIED FEMALE SPEAKER: This is our bill. It has nothing to do with -- I mean this is not New Hampshire care. This is our bill.
UNIDENTIFIED FEMALE SPEAKER: Well, if we're trying to change this bill so we don't have the problems they had in New Hampshire, the fact that he cited his testimony and his research as irrelevant in their bill, I think we maybe have a case in our bill too.
UNIDENTIFIED FEMALE SPEAKER: A different cite.
UNIDENTIFIED MALE SPEAKER: It says heavily --

this shift effect resulting in use of new drugs contributed to a 30 percent rise in retail prescription spending in 2000 and 24 percent in 2001. This is a National Institute for Healthcare Management Research and Education report.
UNIDENTIFIED FEMALE SPEAKER: Well, I think that it certainly, you know -- when this bill gets out on the floor and people have read the New Hampshire case and they read this, it's going to raise a flag. It's totally up to you guys what you do, but I wouldn't be citing research from somebody who is clearly named in the New Hampshire case.
UNIDENTIFIED MALE SPEAKER: What are you referring to?
UNIDENTIFIED FEMALE SPEAKER: According to testimony and studies.
UNIDENTIFIED FEMALE SPEAKER: I would refer to the other study. I just wouldn't refer to his.
UNIDENTIFIED MALE SPEAKER: But I'm looking at the case, the finding for that study, maybe that's better. What I'm looking at in the New Hampshire case says, he is a renowned expert on the effects of pharmaceutical marketing and drug utilization. And then it says that he is quick with knowledge that is of beneficial usage and should not be

banned of practicing (inaudible) generally, but our bill doesn't do that. It's actually moved away from the ban. I'm just sort of picking on something here. Is there something you want to refer to?
UNIDENTIFIED FEMALE SPEAKER: I can't even actually find the notes as to what I had in them.
UNIDENTIFIED MALE SPEAKER: I mean from the standpoint of, I mean it seems to me there would be several levels of whether or not we find a figure which is persuasive, you know, their credentials, their experience and then, you know, what we thought about what they actually had to say, and it seems as if this particular judge is acknowledging his credentials and his experience.
UNIDENTIFIED MALE SPEAKER: Both sources?
MS. LUNGE: Actually what Steve is pointing out to me is that the facts in fourteen actually came from the same study, so I could add this bit to fourteen if you like, if you want to keep both sources instead of -- that will save me renumbering.
UNIDENTIFIED FEMALE SPEAKER: It saves problems on the floor.
UNIDENTIFIED MALE SPEAKER: I'll look more

carefully too.
UNIDENTIFIED MALE SPEAKER: I thought you said it was around 46 or 47. In one reference I found on page 47 the footnote.
UNIDENTIFIED FEMALE SPEAKER: It seems like most of what they send is not going to be a difference to the legislature, because they didn't have any record of taking testimony and stuff.
MR. MAIER: Okay, 16.
UNIDENTIFIED MALE SPEAKER: We decided to add that other language.
MS. LUNGE: I'm adding it.
MR. MAIER: Collapse them together or something, have we decided?
MS. LUNGE: Yes.
UNIDENTIFIED MALE SPEAKER: Okay, 16 is a two-parter. First part, the $2.2 million is directly in the Attorney General's most recent report. The second half, the estimate of total cost in marketing to prescribers in Vermont, that's my analysis from a New England Journal of Medicine article about five years. And what I basically took was the national marketing spend estimated in the article and applied the famous two-tenths of one percent factor which is the Vermont population

as a percent of the national. So the number was around $10 million in 2000. So it's clearly more than that by now.

Okay, 17, this one comes from two sources, the Yale Journal of Health Policy and the Kaiser Family Foundation, same kind of thing. We can make sure the actual documents are in the folder, but that's where those two are from.

Eighteen, again, Kaiser Family Foundation trends and indicators in a study called Pharmaceutical Innovation and Cost, Yale Healthcare Policy Journal.

Nineteen, this is a new one. This specifically talks about the amount of time prescribers spend with pharmaceutical reps. This was based on a survey from the New England Journal of Medicine, the recent paper and we just cite the fourteen times a month figure, 16 times a month figure, from that study. What I was --

UNIDENTIFIED MALE SPEAKER: Did it say about how long each one is?

UNIDENTIFIED MALE SPEAKER: It didn't say. One of the things I was a little nervous about is automatically saying every minute spent with a rep comes away from spending time with a patient. So I

tried to say there is probably some swapping of time there. We don't know how much. So that's why it's to the extent the meeting time comes at the expense time spent with patients.

UNIDENTIFIED MALE SPEAKER: I don't know about substantial. I would be more comfortable with significant in the very beginning.

MS. LUNGE: In 19, yeah.

UNIDENTIFIED MALE SPEAKER: Okay.

UNIDENTIFIED MALE SPEAKER: Because at least a scientific sense.

UNIDENTIFIED MALE SPEAKER: Okay.

UNIDENTIFIED MALE SPEAKER: It doesn't necessarily mean a huge amount. It means not insignificant.

UNIDENTIFIED MALE SPEAKER: It means it matters.

UNIDENTIFIED FEMALE SPEAKER: That's right. It has consequences of some sort.

UNIDENTIFIED MALE SPEAKER: Well, pure statistician reading it's not zero.

Okay. Twenty some doctors in Vermont are experiencing an undesired increase in the aggressiveness of pharmaceutical sales representatives and have reported this to be

coercive and harassing and also leads to increased costs.

That would be yours.

MS. LUNGE: That one --

MR. MAIER: Are we still on 20?

MS. LUNGE: Yes.

UNIDENTIFIED FEMALE SPEAKER: I thought he said 20 something doctors. That's what I heard too.

UNIDENTIFIED FEMALE SPEAKER: Have reported this to be coercive and harassing, are we saying that the -- just if you could fix the awkwardness at the end of the sentence.

MS. LUNGE: So this finding would be again a summary or conclusion from information that you heard. You heard testimony from two doctors from Vermont and the Medical Society and there's an opinion piece that you received and then the Medical Society Resolution.

UNIDENTIFIED MALE SPEAKER: Are we comfortable with this language or do we want to suggest ways to change it?

UNIDENTIFIED FEMALE SPEAKER: Number 20?

MR. MAIER: Yes.

UNIDENTIFIED FEMALE SPEAKER: We have a list

of physicians that we heard upfront who have said --

MS. LUNGE: Frank Landry (phonetic) and Caro (phonetic). So you heard from two physicians and you heard from the Medical Society, and I don't think we have a list from the Medical Society per se.

UNIDENTIFIED FEMALE SPEAKER: We also heard from that one physician in the public hearing about who said this (inaudible).

UNIDENTIFIED FEMALE SPEAKER: Some doctors in Vermont, well, doesn't strike me as --

UNIDENTIFIED FEMALE SPEAKER: And Deb Bricker (phonetic) brought it up in her testimony. I mean if we went back and looked at it, it came up. It wasn't in her primary testimony, but it seemed to come up -- like I said, I remember Deb Bricker bringing it up and that wasn't the main point of her coming. She was talking about the Social Security bill and yet she brought it up there too.

UNIDENTIFIED FEMALE SPEAKER: Frank Landry also has a sign on his door in his office (inaudible) that says no marketers except for Wednesdays from 11:00 to 12:00. So I don't see how that makes having reported this to be --

Page 150

UNIDENTIFIED FEMALE SPEAKER: Patty, why would you put that sign up?
UNIDENTIFIED FEMALE SPEAKER: Because some doctors don't schedule their time that way.
UNIDENTIFIED FEMALE SPEAKER: The Vermont Medical Society has told us this. They represent the physicians and we hear on all kinds of issues from the representative of that industry without everybody coming here pitching it and singing it. If I could just ask Paul in talking about some doctors in Vermont are experiencing an undesired increase in the aggressiveness of pharmaceutical sales reps and have reported this to be coercive and harassing, and we had actually only two doctors that testified plus Debra too mentioned it, she's a doctor, is it fair for us to construe your testimony to be representative of this language or should we say that we had --
MR. HARRINGTON: All I can, what I represented was the discovery of this issue, you know, by talking to their counterparts in New Hampshire, they are agreeing with New Hampshire will adjust the problem. The date at our annual meeting in this court where that resolution was handed out this morning, I have not gone out surveying

Page 151

physicians asking them to describe those. Frank Landry is somebody whose testimony we rely on heavily, and we have him testifying frequently on. Dr. Richter has been a member of the medical society, she's a physician leader in the state. The ophthalmologist that testified by telephone, I doubt if she's a member or not. So certainly our resolution, you know, describes the problem and the solution. Those adjectives are in our words. I'm sure if I did a survey of the membership, I would probably get some physicians characterized in those terms. Other as, you know, the letter I perhaps inappropriately described to Keogh talking about "secret" and "manipulative." I've not heard the exact terms that you are using. I think it's a fair inference that physicians in Vermont do not want detailers to have information about their prescriptions when they are marketing. They feel that that is a violation of their privacy and gives the marketers a leg up in how they're going to push their drugs.
UNIDENTIFIED FEMALE SPEAKER: Okay, thank you.
MR. MAIER: We did something that was a step beyond. We have -- we had a continuing medical education program prior to the meeting on this

Page 152

topic, so we heard all sides on the issue.
UNIDENTIFIED MALE SPEAKER: (inaudible) a unanimous vote for this resolution.
UNIDENTIFIED FEMALE SPEAKER: Can I just say some wording on that, getting back on number twenty to finish that up? Just some ideas. Reported this to be coercive and harassing, comsuming doctors' time which leads to increased healthcare costs. Instead of "and also leads to increased costs," saying, "consumed doctors' time which leads to increased healthcare costs."
UNIDENTIFIED FEMALE SPEAKER: It's not just the time. It's prescribing expensive new drugs is the big cost.
UNIDENTIFIED MALE SPEAKER: It's trying to be too much.
UNIDENTIFIED FEMALE SPEAKER: I thought Julie Brill's point was time is money.
MS. LUNGE: We could add a second sentence after that to say, this type of behavior also leads to increased costs and pressure on doctors to prescribe more and more costly drugs.
UNIDENTIFIED FEMALE SPEAKER: Yes.
MS. LUNGE: Then you get both concepts.
UNIDENTIFIED FEMALE SPEAKER: And we just up

Page 153

above addressed "to the extent that this meeting time comes at the expense of time spent with patients," so we did address that. Access quality of care.
UNIDENTIFIED FEMALE SPEAKER: It's not a big deal. I just thought if we left that, people would say, well, what could we do at this point.
MR. MAIER: I guess I just want to see whether there is any language changes that we can make here that's going to make any one or several of you that may be still uncomfortable with this language okay with it. Is coercive worse than harassing? If we took coercive out would manipulative be better, or are we all just sort of, I'll look over here on this here, I've been hearing more concerns from Patty, Bill, Scott is raising his hand.
UNIDENTIFIED MALE SPEAKER: You know, I will canvas my thoughts, Bill. I haven't heard any coercive or harassing. I haven't. I've talked to them.
UNIDENTIFIED FEMALE SPEAKER: About this?
UNIDENTIFIED MALE SPEAKER: Oh, yeah, and I haven't heard, you know -- I'm not saying it doesn't go on, but I haven't heard any of it. I've talked to them and they're saying if we don't want

to talk to them, we don't talk to them and it's -- none of them raised the flag saying it was a -- of course I didn't talk to many of them. I talked to more than we did here, like five or six of them, and not one of them had any harsh words to say.

UNIDENTIFIED FEMALE SPEAKER: Could we say --

MR. MAIER: You're saying you don't agree with the whole finding itself?

UNIDENTIFIED MALE SPEAKER: I will be honest, I feel like if I had to vote now, I would vote no.

MR. MAIER: For number twenty?

UNIDENTIFIED MALE SPEAKER: At this point I feel like I --

MR. MAIER: You're saying that your vote is specific to number twenty or more generally on the whole?

UNIDENTIFIED MALE SPEAKER: Probably more generally at this point.

MR. MAIER: Okay.

MR. KEOGH: Just one comment. I don't think we can substantiate this unless it's based on the Medical Society survey, but I think those words are kind of harsh, but if you want -- my gut reaction is to strike it, but to accommodate some of the feeling around the table. I just would soften

those two terms of coercive and harassing, but that would be, I think, very difficult to substantiate.

UNIDENTIFIED FEMALE SPEAKER: Would it be at all helpful if we said "and a few have reported this to be coercive and harassing"?

UNIDENTIFIED FEMALE SPEAKER: Some?

UNIDENTIFIED FEMALE SPEAKER: A few. If not, just another because --

MR. KEOGH: If a physician felt harassed, they would say get your butt out of here. I don't want to see you.

UNIDENTIFIED FEMALE SPEAKER: Not necessarily. But it is a fact that we did hear -- we did hear at least two doctors testify in here using these words. At least harassment I remember. I don't remember coercive.

UNIDENTIFIED FEMALE SPEAKER: When I asked that question of my pediatrician, he said they know that if they do that, I won't talk to them, and that doesn't say to me they've never done that, and that doesn't say to me that if he was a 30-year-old doctor instead of a 58-year-old doctor that he wouldn't feel differently about that kind of pressure.

UNIDENTIFIED MALE SPEAKER: There are some

people that handle pressure like that better than others, and so you're going to have -- they're counting on getting to those that don't have that level like the doctor that testified to us, she's probably a very good doctor, but she has a hard time.

MR. MAIER: Let me ask whether you feel better about or worse about the putting a few having reported this to be coercive and harassing.

UNIDENTIFIED MALE SPEAKER: I'm fine with it.

MR. KEOGH: It softens it somewhat.

UNIDENTIFIED FEMALE SPEAKER: I would actually say here reported that they felt coerced and harassed. That's the most accurate way to say it. It's putting it on the doctors, and it's not saying they were. It's saying how they felt.

UNIDENTIFIED FEMALE SPEAKER: That's true. That's true, that softens it.

UNIDENTIFIED FEMALE SPEAKER: But if, you know, if it's important to people to take this out and it makes a difference, then I'll go along with the committee.

MR. MAIER: So what did you propose as your final suggestion?

MS. LUNGE: And a few have reported.

UNIDENTIFIED FEMALE SPEAKER: And that a few have reported.

MS. LUNGE: That they felt coerced and harassed.

UNIDENTIFIED FEMALE SPEAKER: That they felt coerced and harassed.

MR. MAIER: I'm sorry. I don't know who asked the whole stuff about "and also leads to increased costs."

MS. LUNGE: That was Julie.

MR. MAIER: I don't think that's what this finding is about. We have other findings that deal with costs.

UNIDENTIFIED MALE SPEAKER: I just feel very strong getting that in any time that's the right place.

MR. MAIER: It just seemed out of place here.

UNIDENTIFIED MALE SPEAKER: A few means something to me. If I were going to be the one that was going to draft this to get some meaning to it, I would just simply say and use the words two-thirds of an organization that represents two-thirds of the doctors. Then you've got something to hang your hat on. Otherwise what we got here is, I could just see myself in front of a

judge or anybody and they say how many people did you actually talk to? Two, three.
UNIDENTIFIED FEMALE SPEAKER: Out of.
UNIDENTIFIED MALE SPEAKER: Out of 300 doctors in the state of Vermont.
UNIDENTIFIED FEMALE SPEAKER: No, no, out of how many people who testified? Anyway.
Use the exact words on the resolution. Use the word "intrusive." Use what they actually used. Why not? I think the intrusive issue is, I'm just saying if you do as Topper suggested saying that an organization that represents two-thirds unanimously approved instead of it was intrusive, that's the word they had on the resolution, then use that.
UNIDENTIFIED MALE SPEAKER: Fine. That you can hang your hat on. Otherwise forget it.
UNIDENTIFIED FEMALE SPEAKER: Do we have a finding in here about their resolution anywhere?
UNIDENTIFIED FEMALE SPEAKER: Well, he gave it to us this morning during testimony.
UNIDENTIFIED FEMALE SPEAKER: He told us about it before. He didn't have the resolution with them, but in prior testimony he actually did.
UNIDENTIFIED FEMALE SPEAKER: I know this wasn't the first time it came up. I don't remember

actually getting it. I remember talking about --
MR. MAIER: All right. We need to make a decision here and move on. Topper has an idea on the table to use the word or -- well, I feel comfortable with harassed. We've heard about people feeling harassed.
MS. LUNGE: Again, you could do both. You could add the Medical Society reference to their resolution and their statement with your summary of the testimony that you heard.
UNIDENTIFIED FEMALE SPEAKER: I'm actually leaning in that direction.
MR. MAIER: So you would put a comma after "representatives," take out the word "and" say "a few have reported this coercive"?
MS. LUNGE: I would just make a second sentence and say, "the Vermont Medical Society, an organization representing two-thirds of Vermont doctors passed a resolution stating," and then quote the resolution.
UNIDENTIFIED FEMALE SPEAKER: Unanimously passed.
UNIDENTIFIED FEMALE SPEAKER: Those present at the meeting.
UNIDENTIFIED FEMALE SPEAKER: Yeah, I mean if

this makes a difference?
MR. MAIER: Can we agree here? Can we move on?
MS. LUNGE: I need a copy of the resolution. Thank you.
MR. MAIER: Twenty-one.
UNIDENTIFIED MALE SPEAKER: Twenty-one, several studies suggest that drug samples clearly affect prescribing behavior (inaudible). That comes directly from a study from the Journal of Clinical Pharmacy of Therapeutics that actually surveyed 20 or 25 other studies. So that means another one of those nice hard fact-based findings.
UNIDENTIFIED MALE SPEAKER: Twenty-two, prescriber identifiable prescription data showed details of physicians, drug use patterns both in terms of gross numbers of prescriptions and the inclination of the prescriber of particular drugs. That's pretty much, yeah, the point of it.
Twenty-three, prescriber identity data mining allows pharmaceutical companies to track the prescribing habits of nearly every physician in Vermont and link those habits to specific physicians and their identities. So 22 and 23 are really first cousins saying the same basic thing.

UNIDENTIFIED FEMALE SPEAKER: Should you combine them?
MS. LUNGE: Please do not make me renumber them.
UNIDENTIFIED FEMALE SPEAKER: Sorry. I realized that as soon as that was --
UNIDENTIFIED MALE SPEAKER: If we combine them, we'll have to say 23 reserved.
UNIDENTIFIED MALE SPEAKER: Put a dot dot dot.
Twenty-four, monitoring or prescribing practices allows the sales representatives to assess the impact of various gifts and messages on a particular physician to help him select the most effective set of awards.
MS. LUNGE: I think you had testimony on sort of the description of the process. You had a bunch of different people testify about that description.
UNIDENTIFIED FEMALE SPEAKER: You've got articles too.
MS. LUNGE: And articles too, yeah.
Prescribing identified data increase the effect of detailing programs. They support the tailoring of presentations to individual prescribers' preferences and attitudes. Again, that's the same set of articles. Prescriber

identified database, prescriber habits encourage companies to increase (inaudible) relations between pharmaceutical sales reps, and prescriber companies use prescriber data mining to increase -- to target increase the (inaudible) -- again, there's the same harassing and coercive language -- practices toward those doctors that they find would lead to increased prescriptions and profitability, that was suggested by Julie, including high prescribers, brand loyal prescribers, doctors that show (inaudible) to prescribe and doctors were shown to be especially susceptible to sales practices. And that change was from your discussion.

UNIDENTIFIED MALE SPEAKER: Would it help --

MR. MAIER: People are stumbling on harassing and coercive. Anybody? Would manipulative be better in place of those two?

UNIDENTIFIED FEMALE SPEAKER: Yes.

MR. MAIER: Increased attention and manipulative practices.

MS. LUNGE: Okay. Anything else on this one?

Again, added coercion and harassment occurs when doctors are informed by sales reps they are getting monitored. (Inaudible) or disappointment, and I think this was from that --

UNIDENTIFIED FEMALE SPEAKER: We had testimony from somebody on this.

UNIDENTIFIED FEMALE SPEAKER: Yeah, we did.

MS. LUNGE: There was an article that you received as well that you have on the record.

UNIDENTIFIED FEMALE SPEAKER: Is this added pressure is put on to doctors? Would that be the same if we don't want to use coercion and harassment?

MR. MAIER: Where are we now?

MS. LUNGE: 27.

UNIDENTIFIED FEMALE SPEAKER: 27. Added pressure and manipulation.

MR. MAIER: For added pressure, period.

MS. LUNGE: Yeah.

UNIDENTIFIED FEMALE SPEAKER: Where are we?

MS. LUNGE: 27.

UNIDENTIFIED FEMALE SPEAKER: Instead of coercion. Pressure occurs.

MR. MAIER: Add "and unwanted."

UNIDENTIFIED FEMALE SPEAKER: Yes. We can pull that out of the resolution, can we not?

MS. LUNGE: Okay, 28, I reworked this based on Julie Brill's comments about the consumer federal Do Not Call List to make it more correct. So as

with the use of consumers' phone numbers for marketing, the trading of prescriber identity is linked to prescription data. And this was from your discussion, results in harassing sales behaviors by pharmaceutical sales representatives for these doctors.

UNIDENTIFIED MALE SPEAKER: Can result?

MS. LUNGE: Can result?

UNIDENTIFIED MALE SPEAKER: Yeah.

MS. LUNGE: Okay. Okay. I think this is a suggestion from Hilde. Healthcare professionals in Vermont, since we are talking about health prescribers, not just physicians, who write prescriptions for their patients have a reasonable expectation that the information in that prescription including their identity will not be used for purposes other than filling processing payments. Doctors and patients do not consent to the trade of that information and no such trade should take place without their consent.

MR. MAIER: Do you want to say prescribers?

MS. LUNGE: Yeah, prescribers of patients. And I think this sort of idea probably would -- you can also refer to the Medical Society Resolution and some of the testimony that you heard about what

doctors perceive themselves.

Thirty, this is a description of -- well, it's an explanation really of a wide AMA opt out may not be perceived by this state as an adequate remedy for Vermont doctors based on how it's set up and also based on the --

MR. MAIER: Can we change it to, and approximately 23 percent of Vermont, because we don't have the exact number here, which is one of the lowest rates in the nation. I don't know. It may be lower.

MS. LUNGE: Approximately 23 percent.

UNIDENTIFIED FEMALE SPEAKER: So we say only approximately 23 percent?

MS. LUNGE: No. We'll take out the only. And approximately 23 percent of Vermont physicians belong to the AMA which is one of the lowest rates in the nation.

UNIDENTIFIED MALE SPEAKER: One other criticism I've heard on the AMA opt out is it's only a three-year opt out. So you opt out and then you've got to --

UNIDENTIFIED FEMALE SPEAKER: You have to remember to opt out three years?

UNIDENTIFIED MALE SPEAKER: Right.

UNIDENTIFIED FEMALE SPEAKER: Gee, 44 million at stake, who would have thought?
MR. MAIER: Thank you, but I don't want to add that.
UNIDENTIFIED FEMALE SPEAKER: We no longer prohibit the sharing of the data.
MR. MAIER: Where are you now?
UNIDENTIFIED FEMALE SPEAKER: I am in 30 is not an adequate remedy for Vermont doctors because the program does not prohibit the sharing of data but merely requires manufacturers to assure that they are not using the data, and ours doesn't prohibit the sharing of the data either, does it?
MS. LUNGE: It depends on what you decide to do in that section. What's actionable is the use. The way the opt in was worded in the last version 1.3 was the physician was opting in to not -- to sharing the data as well as the other things. And then you had testimony from Julie that you should consider changing that to use which I reflected in the draft, but you haven't made a decision on yet.
UNIDENTIFIED FEMALE SPEAKER: So if we go with use, does this argument hold water here?
MS. LUNGE: If you're not comfortable with that, we can also change it to reflect the other,

you know.
UNIDENTIFIED FEMALE SPEAKER: I just want to have -- if we're going to have an argument here about why the AMA database is not adequate, I want it to work.
UNIDENTIFIED MALE SPEAKER: And I think it's not adequate because people don't know about it. It doesn't cover other healthcare professionals.
MS. LUNGE: And the other thing that you heard from Julie that was different in our law from the AMA opt out was that her interpretation of use would be any use by the manufacturing company as a whole, whereas the AMA opt out is a firewall within the manufacturing company for using it by the detailers.
UNIDENTIFIED MALE SPEAKER: Say it again.
MS. LUNGE: I think -- what my understanding was that at the AMA level what was prohibited was the detailers getting that information.
UNIDENTIFIED FEMALE SPEAKER: Right.
MS. LUNGE: We used the word "use --"
UNIDENTIFIED MALE SPEAKER: It's less restrictive.
MS. LUNGE: Right. We used the word "use" more broadly than just detailers.

UNIDENTIFIED FEMALE SPEAKER: Okay.
MS. LUNGE: But I think it makes sense, you know, because that's kind of a fine distinction for a finding. So I think it makes sense to change it.
UNIDENTIFIED FEMALE SPEAKER: Could we say that manufacturers to assure that their detailers are not using the data, or is that --
MS. LUNGE: Sure. We can just take that and go with your other reasons for why you don't like that option.
UNIDENTIFIED FEMALE SPEAKER: I just don't want -- I mean I don't want somebody standing on the floor and asking these questions.
MR. MAIER: I think we can get rid of that.
MS. LUNGE: Okay.
MR. MAIER: We can say it's less restrictive.
MS. LUNGE: What I've done is say, the physician data restriction program offered by the AMA is not an adequate remedy for Vermont doctors because physicians do not know about the program and other healthcare professionals who prescribe medications may not avail themselves of the AMA program.
UNIDENTIFIED FEMALE SPEAKER: We'll probably have to say many physicians don't know about the

program because there are some that do.
MS. LUNGE: Many, thank you. And then I'll add, in addition, approximately 23 percent of Vermont physicians belong to the AMA which is one of the lowest rates in the nation.
MR. MAIER: Keeping in the "finally" sentence.
MS. LUNGE: The finally was suggested by Julie this morning.
MR. MAIER: Right. I like that.
MS. LUNGE: Okay. So thirty-one --
UNIDENTIFIED MALE SPEAKER: Finally thirty-one which is sort of the (inaudible) on the whole thing.
MS. LUNGE: It's sort of a summary. A summary of the findings.
UNIDENTIFIED FEMALE SPEAKER: So would that be, again, I'm looking at the restriction where it says -- anyway, it's broader than doctors. So I'm wondering if it should say again, by limiting marketing to healthcare professionals who choose to receive that information, because I don't know who would like to receive it. I mean I don't think it sounds like anybody would like it, but they choose it just because they're choosing to. So if you said, by limiting marketing to healthcare

professionals who choose to receive that type of information.
MS. LUNGE: Right.
UNIDENTIFIED FEMALE SPEAKER: So you want healthcare professionals, is that defined?
UNIDENTIFIED MALE SPEAKER: Prescribers.
UNIDENTIFIED FEMALE SPEAKER: Well, we used it earlier because when we ban it, we say it's prescribers, and then we talk about -- we don't always -- okay, prescribers then, that's fine. To avoid harassment of prescribers which leads to increased costs.
MR. MAIER: Okay, can we move on.
UNIDENTIFIED MALE SPEAKER: Shall we say pharmaceutical costs?
UNIDENTIFIED FEMALE SPEAKER: It's the same structure.
MS. LUNGE: So leave that just as costs?
UNIDENTIFIED MALE SPEAKER: Yeah, that's fine.
MS. LUNGE: Okay. Should I run downstairs and get the rest of the copies?
MR. MAIER: Yeah.
MS. LUNGE: Lauren will get them. I'll sit here and lounge while everybody else runs around.
(The committee members have discussions

amongst themselves.)
MR. MAIER: No, you can start. All right.
MS. LUNGE: All right.
UNIDENTIFIED FEMALE SPEAKER: So this is the substance?
MS. LUNGE: This is the rest of the amendment. So it starts where you --
UNIDENTIFIED FEMALE SPEAKER: The part that does something?
UNIDENTIFIED FEMALE SPEAKER: Where's the beef?
MS. LUNGE: You said it, not me.
Okay. So the second instance of amendment is -- would strike section eleven which is the notice about the preferred drug list changes and insert language suggested by Ova that on a periodic basis no less than once per calendar year a health insurer as defined -- and this references the PBM regulation section -- shall notify beneficiaries of changes in pharmaceutical coverage and provide access to the preferred drug list maintained by the insurer.
Third, there's been no change between 1.3 and this version, but what this section of the bill does is we added in the reference to the blueprint

for health. It's not bolded, because I only bolded changes from your last version. So that's the second to the last sentence. So they added in evidence-based education program in reference to the blueprint. That's also what -- I'm sorry, in the fourth instance of amendment I clarified, this is still in the evidence-based education program that what we're distributing to prescribers -- distribution to prescribers of vouchers for samples. So we're not distributing the actual samples. We're distributing a voucher.
And then fifteen you can see I changed sample to voucher just so that that is clear. And I think that's the only change in that section fifteen. I may have -- in 1.3 there may have been -- oh, the change in 1.3 was the last sentence, used to treat common health conditions. It broadened the pilot beyond just starting with the high cholesterol drugs.
The sixth instance of amendment, again, the same sample of voucher language change. This is the report on the pilot, and you could see I added the area health education centers as one of the entities reporting back. And I broadened it to include a description, general language to say that

the report -- the point would be to describe and evaluate the effects of the generic drugs voucher pilot program. Let me just make sure that reads right. Shall provide a report describing and evaluating that.
B talks about what would be in the report. The report shall describe how the project is implemented including which health conditions were targeted, the generic drugs provided with the vouchers and the geographic regions participating. The report shall compare the distribution of prescribing among generic drugs provided through the vouchers brand name drugs before and after the first year of the project and will review a year of prescribing data prior to implementation of the project to a year during the first year of the pilot. The data shall be adjusted to reflect how the pilot was implemented. And that language I put in because you wanted to make sure that we were comparing what the pilot was actually doing and where it was, so we're not taking like statewide data and then comparing it and having the pilot actually be lost because it was only a regional thing or something like that. So say reflect where and how the pilot is implemented. When you say

how, that confuses me.
MS. LUNGE: Sure.
So then the seventh instance -- before I move off the report, is there anything else on the report?
Okay. So the seventh instance of amendment is in the opt-in program. And again, I only put in bold the changes from yesterday's version. So yesterday's version the intent language in A was all new on page level. The marketing definition on twelve had some changes in it. And the definition of promotion on thirteen was new.
Then in C1 you've got a couple different suggestions from -- either your discussions were mostly -- I think it was AG that provided specific language. You had suggested changing permission to consent, so I did that. I didn't do a search, so I'll do a search before you vote on it to make sure I caught all the instances, but I tried to do that in every instance where "permission" occurred.
Also there is a suggestion that you just use the word "used" in C1 as opposed to the license transferred, used or sold.
In two, this is new language that would direct the department and office to make a list available

of prescribers who have consented to sharing their information and those who wish to use the information as provided for in this section shall review the list at minimum every six months. I just picked six months because it was the in-between date, you know, obviously you might want to state a period.
And then I didn't make any changes in D, although that language was -- most of that was new and in yesterday's draft.
E are the exceptions. On page 15 I changed person to prescriber, because we had sort of tailored this more towards prescriber identifiable data and patients. Oops, "person" appears another time, and that should be changed to "prescriber" as well.
In F I wanted to just -- I just added that what we're talking about in F is when the marketer engages in marketing directly to a physician or other person authorized to prescribe as provided for under this section, the marketer shall disclose to the prescriber evidence-based information.
MR. MAIER: This only applies to the update.
MS. LUNGE: Yes, just to clarify that a little bit.

And then on page 16 I also added to this section a reference that the rules would be consistent with the FDA regulations regarding false and misleading advertising, because I think you heard a little bit of testimony about that. That would have to happen anyway because it would trump us otherwise, but it can't hurt to say it if you want to make that.
UNIDENTIFIED FEMALE SPEAKER: It acknowledges that we are aware of it.
MS. LUNGE: Yup. And then there's a technical change in the eighth instance. I needed to add the Office of Professional Regulations one more spot.
MR. MAIER: Okay.
UNIDENTIFIED FEMALE SPEAKER: Excuse me, Mr. Chairman, you don't what roll call was, do you?
MR. MAIER: No. Here's what I'm going to suggest. We need at least a few minutes to get a clean copy. There have been too many changes to vote, try to vote without a clean copy in front of us. So let's go vote and maybe in about 15 minutes she'll have clean copies.
Why don't you say it out loud for the committee to hear?
UNIDENTIFIED FEMALE SPEAKER: It's wrong, I'm

trying to listen and write at the same time. On page 8, thirty-one, this is what ties all our arguments into why we have to do this in the first sentence. First part I don't have any problem with, but at the end where it says, to avoid harassment of prescribers which leads to increased costs, I was trying to figure out how to title. This is what I have. It is also necessary in order to save money for the state, consumers and businesses and to protect public health by reducing the frequency of prescribers prescribing more expensive potentially dangerous brand name drugs when less expensive generics known to be safe and effective are available and by requiring evidence-based disclosures, because I think --
MR. MAIER: I think it's going to be too much in one place.
UNIDENTIFIED FEMALE SPEAKER: I thought that was the strongest connection in there, but whatever.
UNIDENTIFIED FEMALE SPEAKER: The last finding does kind of wrap up everything. It's kind of a final statement.
UNIDENTIFIED FEMALE SPEAKER: But the harassment one just doesn't --

UNIDENTIFIED FEMALE SPEAKER: I kind of think that her suggestion wasn't all that bad. I agree with her suggestion.
UNIDENTIFIED FEMALE SPEAKER: Oh --
UNIDENTIFIED MALE SPEAKER: More expensive brand name drugs.
UNIDENTIFIED FEMALE SPEAKER: I mean it is more words. Maybe it is not as concise as we would like it to be.
UNIDENTIFIED MALE SPEAKER: That may have yet unknown --
UNIDENTIFIED FEMALE SPEAKER: I'm not married to the words.
UNIDENTIFIED FEMALE SPEAKER: Yeah, or health -- negative health consequences.
UNIDENTIFIED FEMALE SPEAKER: I'm not married to the words. It's the concept I thought was important. And to say "to avoid harassment of prescribers which leads to increased costs," the real issue is --
MR. MAIER: All right. Give it to Robin.
Robin, if you can work on trying to make it shorter.
MS. LUNGE: Yup.
MR. MAIER: I wouldn't want to imply that

brand name drugs aren't safe.
UNIDENTIFIED FEMALE SPEAKER: For which the side effects are less well-known.
MR. MAIER: And you'll bold it, right?
MS. LUNGE: Yes. With a shorter safety record.
UNIDENTIFIED FEMALE SPEAKER: For which the consequences --
MS. LUNGE: Can I ask one question? The license -- do you want me to just leave in the "license transferred, sold" stricken right now or do you want to --
MR. MAIER: Where are you talking about now?
MS. LUNGE: This is in C.
MR. MAIER: Not the findings.
MS. LUNGE: Not in the findings.
UNIDENTIFIED MALE SPEAKER: Why would you leave it stricken?
MS. LUNGE: Leave it stricken?
UNIDENTIFIED MALE SPEAKER: Why would you leave it stricken?
MS. LUNGE: Because I'm not sure -- I haven't -- I haven't heard enough to know what you decided on that. So I guess I'm asking for you to make a decision on that.

MR. MAIER: Page where?
MS. LUNGE: Hold on. I'm getting it.
UNIDENTIFIED FEMALE SPEAKER: Page 13, C1. License transfers.
MR. MAIER: There's other licenses. We have to be more narrowly tailored.
MS. LUNGE: That's what Julie suggested.
MR. MAIER: To be more narrowly tailored, that's fine.
MS. LUNGE: Okay. It's gone. All right, I'm going to take out all the stricken stuff so that it will be very easy to have it ready to go.
MR. MAIER: So please come right up after we vote and we'll get a clean copy. We'll vote on it, and then we'll report the bill on the floor right after that.
MS. LUNGE: So the bold reflects all the changes since 1.3. I needed to keep it in so that the proofers know what to read, but I will point out the changes you just discussed.
So on page 1 in finding four you changed some words "imperfect and misleading" to "incomplete."
On page --
MR. MAIER: I'm sorry, where are we?
MS. LUNGE: Page 2 and 5 and actually all of

five should be bold, but that's okay. All of five should be bold. You don't care so much. It's just for the proofers, but the bold change in that sentence is what we did. We changed it to "limited legal ability to enforce."
In finding eight we added the "between 1975 and 2000."
UNIDENTIFIED FEMALE SPEAKER: Should that be were?
MS. LUNGE: I'm sorry?
UNIDENTIFIED FEMALE SPEAKER: Black box warnings were or came within the first two years?
MS. LUNGE: Yes. "Were" I think makes sense.
We added nondurable in finding nine. And then we added the phrase at the end of page 3 which Steve Kappel is also going to check and make sure.
The next change in the findings were on page 4. We added -- I'm sorry, I'm trying to prepare two things while we go along here. We added that sentence in bold in finding fourteen before the Avorn quote.
On page 5 I don't believe we added anything on this page.
On page 6 there was -- we changed "substantial" to "significant" in the first

sentence. And then we did some substantial rewriting in finding twenty.

And then I think we also made changes in finding 26 on page 7. Those were in bold. Some findings in number 27, added "unwanted pressure."

Finding 28 we changed the "can result in."

In 29 we rewrote that sentence so that we took out language about the previous rationale and added "many physicians" that should be "do not know about the program and other healthcare professionals who prescribe may not avail themselves." I made the next sentence a complete sentence standing alone.

Then in thirty-one, thirty-one I tried to kind of incorporate some of your discussion at the end without adding a lot more language. So I rewrote it. I took out the confusing language about the harassment leading to increased costs and changed it to "to save money for the state, consumers and businesses by promoting the use of less expensive drugs and to protect public health by requiring evidence-based disclosures and promote older drugs with a longer safety record." I thought those were kind of the two most important points that you were trying to get at.

Then -- go ahead.

UNIDENTIFIED FEMALE SPEAKER: Just promoting older drugs rather than promote older drugs?

UNIDENTIFIED FEMALE SPEAKER: I didn't hear what you said.

UNIDENTIFIED FEMALE SPEAKER: The very last line of 31.

MS. LUNGE: Yeah.

UNIDENTIFIED FEMALE SPEAKER: Promoting older drugs rather than promote.

MS. LUNGE: Yes, promoting, thank you.

MR. MAIER: People good with that?

UNIDENTIFIED MALE SPEAKER: Usually the word older drug, I don't know what else to say. Older sounds like they've been around too long.

MS. LUNGE: We could probably just say promoting drugs with longer safety records. That should be records, not recon. Whatever a recon is.

MR. MAIER: That will be good.

MS. LUNGE: Okay, all right. So then in -- I don't believe we just made any changes in section -- in the second instance of amendment, again, this was the over language. The third and fourth are the evidence-based education program and pretty much was just changing vouchers, samples to vouchers and adding references to the blueprint.

We didn't make any changes in those just now.

Fifteen, again, broadens the pilot beyond just starting with the high cholesterol.

And sixteen we added some language, although I didn't actually add it, where and how. So in fifteen this is the report that the discussion that we had about adding language was in B at the bottom, the data shall be adjusted to reflect where and how the pilot was implemented, but I forgot to actually add the "where."

Then in seventeen this is the new opt in. I took out all the stricken language that was in the last version so you can see on page 13 and C1 we used the word "consent" instead of "permission." I took out the licensing, et cetera, et cetera, so that it says "used" in both C and D. I did find one other instance where we used "permission." I changed that to "consent."

Two, talks about the list that that will be made available by the department and office and that it's the (inaudible) responsibility to check it a minimum every six months.

Again, changes to consent. And then on page 15 in seven, this is one of the exceptions. We changed person to prescriber just to conform with

the rest of the language in the section. As I clarified, we're talking about marketing as provided for in this section. There's the reference to the FDA rules. And then there was a technical addition in the eighth instance to add "office."

UNIDENTIFIED FEMALE SPEAKER: Just to a little technical thing on page 14.

MS. LUNGE: Yes.

UNIDENTIFIED FEMALE SPEAKER: Bolded 2.

MS. LUNGE: Yes.

UNIDENTIFIED FEMALE SPEAKER: Could we simply it to say prescribers who have consented to sharing their information?

MS. LUNGE: Sure.

MR. MAIER: Are we all the way through?

MS. LUNGE: We're all the way through. And I'm going to make those few typo changes that we just discussed.

MR. MAIER: We need to do that before we make a motion?

UNIDENTIFIED FEMALE SPEAKER: The motion can include those changes.

MS. LUNGE: It can, and it would be 2.2.

UNIDENTIFIED FEMALE SPEAKER: We accept

favorably the amendment offered by Chen.
MR. KEOGH: Can we talk about that briefly?
MR. MAIER: Yeah, sure.
UNIDENTIFIED FEMALE SPEAKER: I move so that we report favorably on the amendment offered by the representative --
MR. MAIER: Can we be -- can you help me be clear, Robin? This is an amendment, Harry offers it because the bill is no longer in our committee.
MS. LUNGE: Correct.
MR. MAIER: But it still says on behalf of the committee?
MS. LUNGE: I'm pretty sure we can do it that way if you want to or we can just do it --
MR. MAIER: Does that affect the motion? Is that right, that we're reporting favorably on this amendment or do we --
UNIDENTIFIED FEMALE SPEAKER: Consider it friendly or is that semantics?
MS. LUNGE: That's a good question. I don't know. I mean in the Senate that's how they do it. Recently I just went over this with the Senate and they do when it's an amendment like this where the bill is not in the committee, an individual offers it and they opt to do it on behalf of the

committee. I have to check with the clerk's office about that, but I think it's a semantic.
UNIDENTIFIED MALE SPEAKER: Are they really a good example of that?
MS. LUNGE: I will refrain from answering that question.
UNIDENTIFIED MALE SPEAKER: I have one technical question.
MR. MAIER: Yeah.
UNIDENTIFIED MALE SPEAKER: The amendment the way it's reading is as amended by the committees on healthcare and on appropriations.
MS. LUNGE: Because it will come after those two amendments.
MR. MAIER: So here's what will happen. They'll report on the original bill. Then I think they'll report -- I don't know what order they'll do it in, but there will be three amendments. There will be the ways and means committee basically just -- I guess they don't have an amendment. They will just report favorably. Appropriations has an amendment. They'll report on that. And then Harry will report on this amendment, although they may do that one first. I don't know which order they will do them in.

UNIDENTIFIED FEMALE SPEAKER: In fact, even the bill is an amendment.
MR. MAIER: That's right. Then we're going to break for caucuses, because some people have asked for caucuses on this bill. So I'll talk with maybe I'll suggest to Harry and Sarah and I will somehow maybe try to split ourselves up.
UNIDENTIFIED FEMALE SPEAKER: Ooh, can I do the progressives?
UNIDENTIFIED MALE SPEAKER: I think Sarah's motion should be to report favorably Representative Chen's amendment on behalf of the committee on healthcare is the appropriate motion. Otherwise if Harry is just offering this on his own, you don't need a committee vote.
UNIDENTIFIED FEMALE SPEAKER: Right, that's right.
UNIDENTIFIED MALE SPEAKER: So your committee is voting to support Harry's amendment.
MR. MAIER: Whether or not they'll support it essentially.
UNIDENTIFIED FEMALE SPEAKER: Okay, what he said.
MR. MAIER: Okay. I would invite comments or explanations at this point.

MR. KEOGH: I'll be voting no on this amendment. I want to appreciate all the work that Steve and Robin did on the findings and supporting those findings but I think we need more time to address some of the issues that we're trying to address here. And we just haven't had the time -- devoted the time to do that. I think we have to allow time for educating doctors and what their responsibilities are and see if some of the counter-detailing to be done by the Medical Society is effective. The kind of support this type of legislation which could very well be faulty could be the subject of litigation down the road, and I certainly would not like to be part of any legislation which would cause us to go to court and be costly to the taxpayers.
And we have not addressed the commerce clause which while that has been discounted by New Hampshire, I think that is another element that another judge might look at, and I don't think we've addressed that as well. So I hope that my position is clear about this. I don't for one minute condone the abuse, if you will, of detailers. I think they are -- they don't serve the patient's interests and they don't serve the

healthcare interest. They serve the singular interest of the pharmaceutical companies with no adjective that I would like to put in, but I just want this committee to know I will not be supporting this amendment.

MS. BRILL: Thank you. Comments?

UNIDENTIFIED MALE SPEAKER: I feel the same way as Bill. I will be voting no, and one of the big reasons is there's a court case that was just finished that's under appeal. What I'm concerned about is the findings in this case. I don't feel comfortable with them.

The other thing that I'm really concerned about too is I felt as if I was trying to write legislation to get around a decision that was made by a judge as opposed to writing legislation to solve a problem. So that's my vote, no.

UNIDENTIFIED FEMALE SPEAKER: What I would say is I appreciate the committee's work on this. I think this is an important bill. I think that in terms of what we're looking at in healthcare costs, a thousand dollars a person for every (inaudible) prescription drugs, we're paying 38 percent of other costs. I see that things in this bill have the potential of really making dents in that. I

think it's -- we're not going to solve all the ills of prescription drugs and marketing prescription drugs, however, but just by comparison putting that $250,000 versus the $10 million.

MR. MAIER: We're on the amendment.

UNIDENTIFIED MALE SPEAKER: Well, it has generic stuff in it.

MR. MAIER: We're all clear.

UNIDENTIFIED MALE SPEAKER: I understand the concerns about the court case. I think that's why we're sitting in this room to try to figure out how to achieve our goals, achieve the ultimate end and working within the legal system. The opt in was something that was I believe first proposed in the Senate on the floor. So this is not a new thing, and I believe the findings are things that we've heard throughout the testimony. So I support the vote.

UNIDENTIFIED FEMALE SPEAKER: I think that we have responded well to the uncertainties that the one judge has ruled in New Hampshire. As much as I would like to stick with our original language, given that there is, you know, a lot of different possibilities, I think this is acceptable to me, this compromise, and I think we're still doing

something, and I think that it's a way of beginning to reign in the excesses that happen in detailing that contribute in a significant way to increases in prescription drug prices conservatively looking at, you know, what the rulings were in New Hampshire and backing away from, you know, going as far as they did.

So again, I think the work we've done today on the findings and the work that was done overnight by whoever stayed up and did all that research really make a difference. I think we've got a lot of stuff in here that's supportable. I think we've toned down the language. I think we've identified even to the extent of saying a few people said this, I think it's very accurate, and so I will support it.

UNIDENTIFIED MALE SPEAKER: I'm going to ask a freshman question since I'm still getting my feet wet.

MR. MAIER: Yeah.

UNIDENTIFIED MALE SPEAKER: I know the end of the session is coming, and I probably won't know how I'm going to vote until it comes out of my mouth, to be honest, and that's how close I am. Why does it have to be today versus tomorrow?

MR. MAIER: On this particular --

UNIDENTIFIED MALE SPEAKER: I'm just asking a freshman question.

MR. MAIER: There is no technical -- I mean I can't say because we have to technically. So it just becomes one of when are we going to truly end the session. And the date at this point my best guess is that we have tomorrow and next week, and it just takes -- you started to hear a lot of motions on the floor to suspend rules and all that sort of stuff. And so it's certainly possible the bill -- we don't always do that even at the end of a session. So there's -- you start counting back days and things like that, then it becomes necessary to pass a ruling a little sooner. I don't know if that's the case with this or not.

UNIDENTIFIED MALE SPEAKER: I can get on the floor and when I'm out on floor, that's easy, you know, in the last couple days. Making this vote is my hardest vote whichever way I go because I've never voted. It's hard in this group to vote any which direction so, it's a --

MR. MAIER: Well, what you're voting on here is an amendment to the bill. You made one vote already on the bill. This amendment will now

change the bill, but it's not your vote on the whole bill, so that would be a different vote.

UNIDENTIFIED MALE SPEAKER: Right.

MR. MAIER: John.

UNIDENTIFIED MALE SPEAKER: I guess I can agree with the fact that this bill or this amendment is not perfect. It's pretty darn good. We've done some good work on it. The legal system is not perfect either. One judge making one finding about what they had in New Hampshire and us making an adjustment, where we're towards perfection, whatever perfection might be. I think we've done some good work here to look at the fact that I personally think the drug companies are abusing their rights in making profits hand over fist and abusing the system. This is just making a tiny little dent in trying to get them to say, well, let's calm this extra marketing down to a point whereby we're spending more reasonable amounts of money towards what we need for our society. It is just a tiny step and it isn't perfect, but it's better than having nothing. And I wouldn't want to wait. If you have say wait now, how long do you wait? I don't want to wait. I would like to have more perfection, but I don't

know how long that would take. I would rather go with this now. So I'm very supportive of this amendment.

REPRESENTATIVE O'DONNELL: I think it comes as no surprise that I'm not going to be supporting the bill either, but I have huge concerns when our Attorney General's office sits here and says we could end up in court, and she believes, she thinks that maybe this bill is okay. So that's telling me that we don't know we're going to win in court. We don't know that we're not passing a law that is unconstitutional. And I think one of the most important things for me is when we're sworn in for office, we take an oath to uphold the Constitution of this state and the Constitution of the country. And to sit here last minute like this, and I have to say, I've been in this building for nine years, I've never sat with a committee, sit here and pass a bill at a committee that they're waiting to deal with out on the floor, and I don't feel I even know what's in this bill. It's being pushed past us way too fast. There's been way too many changes made and for us to be voting on a bill that they're going to take up on the floor in ten minutes is something I've never seen before, and I don't think

it's fair to the people we represent. It doesn't have anything to do with the drug companies. It has to do with the fact that we have a legal responsibility to follow the law, and one judge is a very serious judge when it's a federal judge, and our case would go in front of a federal court. And when you start getting into these lawsuits, you can easily spend millions of dollars. So what we may save on one end, if we even save anything, we're going to spend on the other in lawsuits and that's not fair to the people we represent.

MR. MAIER: Lucy.

MS. LERICHE: Yeah, I don't know. I guess I can't move away from the intent of this. I mean this is about improving quality, saving money and doing what is our duty as legislators and what I see as our job in this committee, improving quality, decreasing costs, improving transparency. I think that this is a legitimate problem and this is a legitimate solution to that problem. And speculating and being afraid of whether or not it's going to go to court or not I don't think should be clouding our judgment in what we believe is right or wrong. And this is the right thing to do, and that's why I'm voting for it.

MR. MAIER: I just want to say a few things addressing a couple of the comments that have been made, because I think it's important before we vote. We haven't talked, I think it was Bill, somebody said that we haven't talked about the commerce clause. We haven't talked about the commerce clause because the judge in New Hampshire didn't bring it up and this week's focus has been on what that judge brought up, but we did -- Robin very carefully drafted language in the bill from the very beginning over in the Senate because she knew that the commerce clause was an issue that was being raised in New Hampshire. So I just want the committee to understand that the commerce clause issues have been very carefully addressed by our counsel in a way and you also heard testimony today regarding that. So I don't really -- I don't think that's an issue that we need to be terribly concerned about.

I actually like the fact that as uncomfortable as I've been at times this week, I think we have a better amendment. We have a better bill in front of us now because of the judge's decision in New Hampshire. And I think we have guidance from that decision. And while I agree with several of you

that some of the people we heard from today that have said, well, it's not our district. It's only one judge. I think nonetheless it is guidance and that we now actually have a stronger bill in front of us.

We've had Robin explain and perhaps others explain to us about constitutional law cases, and what I understand about them is that almost, you know, almost as a rule they're not black and white cases. They're cases that as Robin explained go back and forth. It's largely fact based and for us to be able -- so I do feel like I'm upholding my best sense of what the Constitution is in passing a bill that I think is stronger on the Constitution than perhaps the one we had that we passed out of this committee several weeks ago, whenever that was. So those are my comments. And two or three of you haven't commented yet.

UNIDENTIFIED FEMALE SPEAKER: Okay. From a global perspective, yes, I took an oath to uphold the Constitution. People are actually dying because of these practices. It's not just about money. That's what gets me. People for profit motive are pushing drugs out before they're well tested and (inaudible) people with animals, with

any creatures, our products, drugs, pushing them out, pushing them hard and experimenting on people to see if they really work. And when they don't work, huge amount of effort to suppress that information about how they don't work.

So for me this is a global thing. This is a practice that is significantly hurting people's health. So I think we need to stop that, and this is a way to stop it. It's pushing drugs and it can be a good drug pusher, and there are bad drug pushers, and we make a difference in this society, and these are bad drug pusher practices.

MR. MAIER: Are we ready to vote?

UNIDENTIFIED FEMALE SPEAKER: Okay. The amendment is moved by Sarah with changes. I'll start to call the roll.

Representative Maier?

MR. MAIER: Yes.

UNIDENTIFIED FEMALE SPEAKER: Chen?

MR. CHEN: Yes.

UNIDENTIFIED FEMALE SPEAKER: McFaun?

MR. McFAUN: No.

UNIDENTIFIED FEMALE SPEAKER: Copeland-Hanzas?

MS. COPELAND-HANZAS: Yes.

UNIDENTIFIED FEMALE SPEAKER: Keogh?

MR. KEOGH: No.

UNIDENTIFIED FEMALE SPEAKER: Leriche?

MS. LERICHE: Yes.

UNIDENTIFIED FEMALE SPEAKER: Milkey?

MS. MILKEY: Yes.

UNIDENTIFIED FEMALE SPEAKER: O'Donnell?

MS. O'DONNELL: NO.

UNIDENTIFIED FEMALE SPEAKER: Ojibway?

MS. OJIBWAY: Yes.

UNIDENTIFIED FEMALE SPEAKER: Wheeler?

MR. WHEELER: No.

UNIDENTIFIED FEMALE SPEAKER: Zenie?

MR. ZENIE: Yes.

UNIDENTIFIED FEMALE SPEAKER: Okay.

(The hearing was concluded.)

CERTIFICATE

STATE OF FLORIDA
COUNTY OF PALM BEACH

I, Denise Sankary, Registered Professional Reporter, State of Florida at large, do certify that I was authorized to and did listen to CD-164, CD-165, CD-166, CD-167, the House Committee on Health Care, Thursday, May 3, 2007, proceedings and (stenographically transcribed) from said CDs the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 15th day of August, 2007.

_____

DENISE SANKARY, RPR