STATE OF VERMONT

SENATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: Tuesday, February 13, 2007

COMMITTEE MEMBERS:
SENATOR ANN CUMMINGS, CHAIR
SENATOR CLAIRE AYER, VICE CHAIR
SENATOR MARK MacDONALD, CLERK
SENATOR BILL CARRIS
SENATOR JAMES CONDOS
SENATOR HULL MAYNARD, JR.
SENATOR RICHARD McCORMACK

CD No: CD 2007 43, Track

Esquire Job #889697
CD No: CD 2007 43, Track 1

SENATOR CUMMINGS: Call the meeting to order. Today is February 13, and it is 1:35, and we're going to be talking about prescription drugs. We went through the whole list with Sharon Treat and some other people during our joint hearings, and Doug and I went through and asked Robin to raft up for the purposes of discussion of a Committee Bill what we heard, so this is probably most of it, and I'm going to let her walk you through it and see where we go.

Okay. It's all yours.

MS. LUNGE: Robin Lunge, Legislative Counsel.
I think Rachel has already given you a section by section summary and then the actual draft, so what I'm going to do is walk through the draft, and I'm going to try and give you a little background information of where I got the text because it comes from various different spots, so most of the stuff in the beginning of the Bill are things that have passed the Senate previously in either H-524 -- there were several provisions in the Conference Report, or in S-288 from a couple of years before that.

So starting with Section 1, this is the section in current law which directs the Office of Vermont Health Access, which is the Medicaid Office, to establish a pharmacy best practices and cost control program, and this is the section where our current law on the preferred drug list is -- is in statute.

So on the first page, there's just a little technical change to make it clear that in addition to starting the program, the office should maintain the program, and then on page 2 -- I should mention that this text is not exactly the same as what was in H-524 because I took some of the suggestions from Sharon Treat and others that you've heard to update it. So I'll highlight that as we go through it.

So Section -- on page 2, line 3, Subdivision 1, we're clarifying in this section that the preferred drug list would be based on an evidence-based model, which I think actually is probably very -- about what they're doing now in terms of their practice and then --

FEMALE ATTENDEE: May I ask a question?
list through voluntarily eliciting health benefit
plans to participate. That hasn't really worked.
Also, this directs, the current law directs
the Commissioner of Human Resources to use the
preferred drug list in the state employees health
benefit plan and come back to committees with a
report on that, and the report that the
Commissioner came back with a few years ago to
help Access Oversight Committee was basically like
oh, we can't use the Medicaid preferred drug list.
It wouldn't work for us, and we can't get the
Medicaid price.
So this draft takes -- moves away from that
previous statewide preferred drug list approach
and moves to a different approach, which I'll be
talking about when we get to that language in that
a little bit, but basically moving towards a joint
purchasing consortium approach, the main
difference being that instead of specifying, You
must use this list and only this list, it creates
the concept that various state purchasers of drugs
can bargain together and negotiate together
without having exactly the same list.
So the next change at the bottom of page 3,
this language that's struck through was our
previous language on the counter-detailing
program, our evidence-based education program, and
I've moved that to a new section, so I'll talk
about -- even though it looks like that's
disappearing, it's actually moving.
So on the bottom of page 4, you can see the
next additional inserted language, which is from
H-524 and has the Office of Vermont Health Access
develop a plan to encourage Vermonters to use
Federally-Qualified Health Centers and
look-alikes, focusing on participants in Medicaid
and our Medicaid waiver program, state employees,
individuals under the supervision of Corrections,
et cetera, and including potentially contracting
with one or more of the FQHCs or look-alikes to
provide case management or record management
services, which was something that this Committee
heard about I think two years ago that was an
approach some other states were taking to increase
utilization of the FQHCs.
And again, the reason why that's important in
terms of prescription drug pricing is that these
entities are able to receive what's called the
340-B price, which you'll remember is one of the
lower prices, so it would save money if Medicaid
recipients, for instance, were able to access that
price. That would save money for the Medicaid
program.
And then 8 establishes a joint
pharmaceuticals purchasing consortium that is set
out in more detail in C-1, which is on the bottom
of page 5.
So what this section does is add language
which says -- and this language from a Maine Bill
that's currently pending in Maine or based on the
Maine Bill.
So for entities in Vermont, the Director
shall directly or by contract implement the
Pharmacy and Best Practices Cost Control Program
through a joint pharmaceuticals purchasing
consortium.
The consortium would be offered on a
voluntary basis no later than January 1st, 2008,
with then mandatory participation by state or
publicly-funded, administered or subsidized
purchasers to the extent practicable and
consistent with the purposes by January 1st, 2010,
and then there's a definition of who those state
purchasers would be.
FEMALE ATTENDEE: Well, this might be -- it
might be answering that, but do the state
employees come in? Are they considered state
funded?
MS. LUNGE: I didn't specifically --
FEMALE ATTENDEE: Or is that union?
MS. LUNGE: -- list them, although I think
that they arguably could be at least state or
publicly funded, but part of the reason why I
think the term, "to the extent practicable and
consistent with the purposes" is in here is to
give some wiggle room if it really wouldn't
work for certain groups of people.
Does that answer your question?
FEMALE ATTENDEE: Yes, thank you.
MS. LUNGE: And then on page 6 in the section
on the Drug Utilization Review Board, I've just --
again, this is modeled on some Maine Bill
language, included that evidence-based
considerations and added a couple of other
considerations that were included in the Maine
model which were including information on adverse
side effects and appropriate clinical trials, and
that's basically various things that the Board
would consider in making their recommendation of
what drugs should be on the preferred drug list.
In addition, I've added Subdivision 6, which is actually just reworking of current language that directs OVHA to encourage participation now in the joint purchasing consortium by inviting representatives to participate as observers in the Drug Utilization Review Board meetings. Part of what that Board hears would be information about which drugs are effective for certain conditions and clinical information that might be of assistance for our plans. Section 2 is a new section, and that would direct OVHA in collaboration with the Department of Health to enter into a contract with the Oregon Health and Science University Drug Effectiveness Review Project, and that project was spoken about by both Steve Kappel and by Sharon Treat in their previous testimony to you, and again, this is the project which looks at two drugs that are used to treat the same condition to compare those two. You'll remember that Steve I think talked about in the FDA approval process, the drug is compared to the placebo effect or nothing, and this would compare two drugs to each other, so it gives you a sense of yes, this one might be more expensive, but it's a lot more effective, so maybe that's a better choice for our list than this one which is cheaper, but not as effective for as many people.

On page 7, in Section 3, this language is from S-288 and H-524. This is our provision in statute right now which provides for pharmaceutical marketers to disclose certain information to the Attorney General's Office and currently, unrestricted grants for continuing medical education programs are an exception to what needs to be disclosed, so by striking that through, this would make these programs have to be disclosed and reported.

FEMALE ATTENDEE: I don't remember why we exempted that.

MS. LUNGE: I actually didn't -- Maria covered S-288, which is --

FEMALE ATTENDEE: Uh-huh.

FEMALE ATTENDEE: Do you remember?

MS. LUNGE: I don't remember either, so I don't know.

SENATOR CUMMINGS: I think it might have been something we didn't want to discourage.

MS. LUNGE: Uh-huh.

SENATOR CUMMINGS: Because continuing education is generally a good thing.

FEMALE ATTENDEE: Oh.

MS. LUNGE: And you'll see also that there's a D added, which would clarify the disclosures of these grants would be limited to value, nature and purpose and the name of the grantee, but not the individual participants in the program.

So that might be, for instance, UVM would be the grantee, and -- but the particular health care professionals who went to the education program wouldn't be disclosed.

SENATOR CUMMINGS: Just that a grant was given to UVM for continuing education.

MS. LUNGE: And I'm using UVM as an example. I don't know who receives these grants in particular so...

Section 4 on page 8, this provision was also in S-288 and H-524. It requires manufacturers of prescription drugs to disclose to the office of Vermont Health Access prices of drugs that are used in the Medicaid program, so it's limited to the OVHA and Medicaid program, and the two prices which must be disclosed are the average manufacturer price and the best price, and this again is the exact language from what passed the last time.

One thing I will note for you is that last year in the Deficit Reduction Act of 2005, there were some changes made in Medicaid around pharmaceutical pricing, and I believe that those changes will at some point in the future make the average manufacturer price more public than it is now.

Right now, it's confidential, so I'm not entirely certain if these two items are really the best prices to be disclosed to OVHA.

That might be something you want to ask them, but certainly, I think we will be getting, even without this provision, at least one of -- a little more information on one of these prices.

The rest of the section in B, starting on line 11 indicates that the pricing information are just again for the drugs under the rebate program and must be submitted to the Director following the submission to the federal government, and the cite is to Medicaid statute which talks about the pricing of drugs in the Medicaid program.

Subsection C requires the President or Chief Executive Officer of the manufacturer to certify to OVHA that the reported prices to OVHA are the
same as what was reported to the federal
government for the applicable rebate period.

And then on page 9, in D, this is a provision
which makes certain that the information disclosed
to OSHA is confidential and is not a public record
and does allow OSHA to disclose that information
to its contractees if -- as long as the contractee
would then keep that information confidential.

FEMALE ATTENDEE: What would be a contractee?

MS. LUNGE: Well, you know, I think it would
depend on how OSHA used the information, but for
instance, we have a PBM who works with us in
with the Medicaid program, so if what they were
trying to do was compare what they actually paid
to what the prices were, they would probably need
to share that to get the information from the
person that administers the program for us.

FEMALE ATTENDEE: Okay.

FEMALE ATTENDEE: 'C's a new idea though,

isn't it? I don't remember that.

MS. LUNGE: No. That was in --

FEMALE ATTENDEE: Was it?

MS. LUNGE: -- 524 and S-288 as well.

FEMALE ATTENDEE: Okay.

SENATOR CUMMINGS: I think some of these got
done more extensively in Health and Welfare, and
some of these, we're just taking kind of cursory

testimony on, but it will go to Health and Welfare
when it has to do with regulating health care
providers. We're going to be looking more at the
insurance aspects of this.

MS. LUNGE: And then E talks about AG

enforcement and basically allows the AG to enforce
under the Consumer Fraud Act rules and provisions.

Second 5 is Healthy Vermonters Plus. Healthy
Vermonters Plus, you may remember earlier in this
session, we talked a little bit about our discount

card. We have a discount card that's available to
certain folks under certain income levels that
allows them to access the Medicaid price at the
pharmacy.

These are -- it's only for people who have
either exhausted their pharmacy insurance or have
no pharmacy insurance, and you had enacted the
Healthy Vermonters Plus Program, which extended or
upped the income limits for one group of people
there.

There was -- at the time that you did this,
it was under litigation, and we weren't sure if we
needed a waiver or we didn't need a waiver.

ATTENDEE: The court case said.

MS. LUNGE: -- the court case said.

So with that said, the first section of this,
Section 9471 are the definitions.

And a Beneficiary is defined as an individual
enrolled in a health plan in which coverage of
prescription drugs is administered by a PBM, and
it would also include the beneficiary's
dependents.

Health Insurer, we reference another
statutory definition of Health Insurer in 94029.
We clarified that would include the state of
Vermont and the Medicaid programs.

Health Plan means a health benefit plan
offered, administered or insured by a health
insurer doing business in Vermont.

Pharmacy Benefit Management means an
arrangement for the procurement of prescription
drugs at a negotiated rate for dispensation within
Vermont to beneficiaries, the administration or
management of drug benefits provided by a health
plan or any of the following. And then there's a

list, A through F of specific services.

Pharmacy Benefit Manager means an entity that
performs pharmacy benefit management and that
would also include any contract fees or employees of the PBM.

9472, these are the requirements. A Pharmacy Benefit Manager that provides pharmacy benefit management for a health plan will have six duties.

1. This is commonly referred to as the prudent PBM standard, so discharge the duties with care, skill, prudence and diligence.

2. Provide all financial and utilization information requested by the health plan relating to the provision of benefits to beneficiaries, and also, all financial and utilization information relating to services for that health plan.

So the health plan could get information about its beneficiaries or its services so -- not someone else's.

Also, that information would be designated as confidential, with some exceptions. It could be disclosed with the consent of PBM, as part of a court filing under Consumer Fraud or pursuant to court order.

Third is to provide a notice of any conflicts of interest to the health plan.

Fourth is a policy about drug substitutions, so with regard to substituting a drug which costs more than the drug that's prescribed, the health plan would get information about the cost of both drugs, and also any benefits or payments directly or indirectly occurring to the PBM as a result of the switch.

B also requires that the PBM transfer that benefit or payment to the health plan instead of retaining it themselves, so it passes through.

5. If the Pharmacy Benefit Manager derives any payment or benefit for dispensing prescription drugs based on volume of sales that that benefit would be passed onto the health plan, unless the contract between the PBM and the health plan specifically provides otherwise. So people are allowed to contract around it if they'd like to.

6. Disclose to the health plan all financial terms, arrangements of any kind, financial terms and arrangements for remuneration of any kind that apply between the PBM and the manufacturer. And then there are some examples of what those might be, formulary management and drugs, which programs, et cetera. Again, this information is kept confidential under the same terms as we just talked about.

ATTENDEE: I just wanted to make sure.

MS. LUNGE: Also, in terms of enforcement, there's a presumption of validity for the Commissioner's determination, and there's a consultation requirement between the AG and BISHCA.

FEMALE ATTENDEE: Can you tell me what that means, the presumption of validity?

MS. LUNGE: It's basically a standard that the court would look at when they were reviewing any -- any interpretations of this subchapter, that BISHCA had made, for instance, in their rules.

Generally speaking, when courts look at an agency's interpretation of their own rules, they're given a presumption of validity, and they're given deference.

They're not necessarily given deference -- let's say there's a federal law. A state agency's interpretation of their federal law would not be given deference.

So this basically gives the court some guidance that in terms of BISHCA interpreting this statute that the legislature intends and recognizes them as sort of an authority on the
subject, so we assume that they know what they're talking about --

FEMALE ATTENDEE: Okay.

MS. LUNGE: -- when they go to court. That doesn't mean that they can't -- the court can't overturn them or can't decide the opposite way.

The court can. It's just that the court will, unless there's a compelling reason to believe that something else was meant by that regulation, they'll assume that BISHCA's interpreting it correctly.

Section 7 on page 16, this section was in S-288 but it was not in H-524 and this provides for Pharmacy Benefit Managers to register with BISHCA.

The other thing I would mention, as part of the multi-payer database project, BISHCA is doing a pilot project on PBM registration now, so I just wanted to mention that to you so you know that that's kind of starting to happen currently.

So that would require the PBM to register with the Commissioner and then gives BISHCA the authority to adopt rules and allows that for PBMs operating in the state that they must offer health plans a quotation for an administrative services only contract with full pass-through of negotiated prices, rebates, et cetera, which would include a reasonable fee payable to the PBM for their services.

That's just an option. It doesn't require that that's the only -- the only relationship, but that's -- that option must be offered in every negotiation.

C. In order to enable periodic verification of pricing arrangements, PBMs would allow access again in accordance with rules by BISHCA for the health benefit plan to receive the financial and contractual information necessary to do an audit, and then provisions 1 through 3 are the types of things that the health plan would be able to get information in order to verify, including that there is a full pass-through of prices and fees, a full pass-through of all financial remuneration and any other verifications relating to pricing arrangements and activities as required by the Commissioner.

D is a pretty standard bill-back provision.

BISHCA in certain contexts has the authority to Bill back certain expenses. That's modeled on similar authority and other laws.

And then in E, we have broad rule-making authority as necessary or desirable in carrying out the purposes of this section, and also a confidentiality provision to make sure that any proprietary information is kept confidential.

Again, definitions of Health Insurance Plan and Health Insurer and Pharmacy Benefit Management and Pharmacy Benefit Manager are all listed.

On page 19, Section 8, this basically says that the previous two sections about Pharmacy Benefit Management and contracts we just discussed would apply to contracts executed or renewed on or after September 1st, 2007. So it was clear when this law was meant to apply to contracts.

Section 9 is actually a technical section.

One of the things I took the opportunity to do in this Bill is to create a new chapter in Title 18, which is the health chapter on prescription drug cost containment activities, so I'm moving the generic drug chapter as Subchapter 1. That's what sections 9 and 10 do, and you'll see later on in the Bill there were some provisions in the Bill that were put in Title 33 in the Medicaid chapter which aren't really Medicaid related, so I'm moving them over here as well, so that when people go to look for things in the statutes, they're actually in a logical place.

Some of the things that are in the Medicaid chapter since they have nothing to do with Medicaid, you would never look for them there, and I've looked for them and looked for them and looked for them a number of times and then found them there, so I'm trying to clean that up a little.

So the next substantive section is Section 11. This is the counter-detailing program.

At the beginning, I said I moved some language from current law. I moved it to Title 18 because as you have heard, this was a program which OVHA hasn't implemented at this point, and it is actually the type of program that might make more sense in the Department of Health, so this would direct the Department of Health -- and again, first, I guess I should go through the definitions.

The department is Department of Health.

Evidence-based means based on criteria and guidelines that reflect high-quality, cost-effective care. This is from a Maine Bill on
evidence-based practices.
The guidelines shall meet recognized standards for systematic evaluation of all available research and be free from conflicts of interest.
Consideration of the best available scientific evidence does not preclude consideration of experimental or investigational treatment or services under a clinical investigation.
ATTENDEE: Robin, can I just ask you, because you said, and I don't remember from our earlier meeting that we had on this, discussion on this, what was the reason why OVHA has not implemented the detailing fees, aside from the money?
MS. LUNGE: I'm not sure. I don't think OVHA--
ATTENDEE: Or is that the issue?
MS. LUNGE: I don't -- I think that's the issue, but OVHA hasn't said that one way or the other that I've heard this year. That's what I recall from previous.
SENATOR CUMMINGS: We've -- Doug and I have actually sent a letter to Commissioner LeWare (phonetic) just saying we were very disappointed in the lack of detail in the testimony that day.
We had actually sent them twelve points we wanted them to talk about, and they didn't do that. Inoculations wasn't one of the twelve points, and I think that's where they spent most of the time, so we're waiting for a response.
ATTENDEE: It just seems to me that it's probably a combination of the Department didn't ask for the money and the administration --
SENATOR CUMMINGS: Didn't volunteer.
ATTENDEE: -- didn't volunteer it.
MS. LUNGE: Uh-huh.
ATTENDEE: Which to me, I don't understand since it's law why they would openly violate the law.
SENATOR CUMMINGS: It's not an unknown, actually.
MS. LUNGE: I mean they have had a lot on their plate too, OVHA has but --
SENATOR CUMMINGS: But that's part of the rationale to move it to the Department of Health.
MS. LUNGE: Right.
So in 4622, this establishes the education program and directs the Department in Collaboration with the AG, and the reason why the
AG is there is because you'll note, as we discussed earlier, they get certain information about marketing disclosures, so they have a lot of information about where marketing is being targeted among different physicians, so that could be very helpful in designing an education program to know what else is happening out there.
So those two entities would establish an evidence-based prescription drug program for health care professionals designed to provide information and education and therapeutic and cost-effective utilization of prescription drugs to physicians, pharmacists and other health care professionals authorized to prescribe and dispense drugs.
The Department may collaborate with other states in establishing this program.
That's to leave the door open for, for instance, collaborating with Pennsylvania, which has already started a program or other Northeastern states that might be interested.
FEMALE ATTENDEE: I think we have heard Maine and New Hampshire were looking at this seriously and starting.
MS. LUNGE: Yes, and I think at the next NLARX meeting in March, there's going to be a presentation on this issue and...
B. The Department shall request information and collaboration from physicians -- physicians, pharmacists, private insurers, hospitals, PBMs the drug Utilization Review Board, medical schools, etcetera and any other programs providing an evidence-based education program to prescribers on developing and maintaining the program so that they get lots of input about what would be helpful to doctors, what do doctors want and need, etcetera.
C. As provided for in 1998-G, that's the first section we looked at, the Department shall have clinical and technical support from the Oregon DERP Project.
And D has the Department and the AG collaborating and reviewing the marketing activities in determining -- as well as determining appropriate funding sources.
ATTENDEE: Robin?
MS. LUNGE: Yes.
ATTENDEE: We're dealing with 1.2. You're dealing with 1 point what?
MS. LUNGE: That's because when I went
through it last night and made all my notes, I
found some things I needed to correct, so I
corrected them. That’s why I have two versions.
ATTENDEE: Okay.
MS. LUNGE: Because I couldn’t write all
these notes on this.
ATTENDEE: That’s fine. That’s fine. That’s
fine. I was just trying to understand.
ATTENDEE: I think you ought to have three
versions, in case there’s a tie.
MS. LUNGE: I’m sure before I’m done, I will.
FEMALE ATTENDEE: As will we all.
ATTENDEE: Probably a 4 and 5 too.
MS. LUNGE: The next section of the Bill is a
prescription drug data confidentiality section.
This is based on a New Hampshire law that
passed last year that’s main purpose was to
prevent what’s called data mining, which is buying
information and data that then can be through the
federal drug prescribing code linked up to
particular physicians so that marketing activities
can be directed based on prescribing patterns.
So what this section does is, and this is
pretty closely based on New Hampshire, although
there is a lawsuit going on right now, so I looked
at the information I could find and tried to
tailor it to address some of the issues that were
raised in the lawsuit.
So subsection A is a finding/intent section
that explains why the state might want to pass
this type of law.
B are the definitions, and the definitions
include commercial purpose, which would include
advertising, marketing, promotion or any activity
that is intended to be used or is used to
influence the sales or the market share of a
pharmaceutical product, influence or evaluate the
prescribing behavior of an individual health care
professional, market drugs to patients or evaluate
the effectiveness of a --
FEMALE ATTENDEE: Robin, where are you?
MS. LUNGE: Sorry.
ATTENDEE: On page 22.
ATTENDEE: Where are you?
MS. LUNGE: 22.
FEMALE ATTENDEE: Okay. I moved too far
ahead. Okay. All right.
MS. LUNGE: 21 to 22.
SENATOR CUMMINGS: We’re double-sided here,
so you have to remember to flip to the back.

MS. LUNGE: 2. Electronic transmission
intermediary is defined as an entity that connects
basically computer systems or other electronic
devices between health care professionals,
prescribers, pharmacies, PBMs and insurers, et
cetera, et cetera.
Health Care Facility has the same meaning
that we use in 9402 of current law.
Health Care Professional has the same meaning
as in 9402.
Health Insurer has the same meaning as in
9410.
And Pharmacy means an individual or entity
licensed or registered under Chapter 36 of Title
26.
Prescriber is an individual allowed by law to
prescribe and administer drugs in the course of
professional practice.
And Regulated Records is information or
documentation from a prescription written by a
prescriber doing business in Vermont or a
prescription dispensed in Vermont.
And one of the -- this is one of the areas
that I tried to tighten the language up a little
bit.
<table>
<thead>
<tr>
<th>Page 34</th>
<th>Page 36</th>
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<tbody>
<tr>
<td>4. Care management educational communications to the patient about their health condition or following a prescribed course of therapy.</td>
<td>prescribed in Vermont.</td>
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<td>5. It does not apply to the use or disclosure of information authorized by Chapter 84, which is our chapter in Title 18 that regulates drugs in general, or 84-A, which you may remember was S-90. That’s the Health Department initiative that’s looking for misuse of drugs by patients or misprescribing by doctors or other prescribers.</td>
<td>SENATOR CUMMINGS: Right.</td>
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<td>SENATOR CUMMINGS: I get my prescription at Kenny’s, and I decide it would be more convenient to fill it at Rite-Aid. This doesn’t prohibit Rite-Aid.</td>
<td>MS. LUNGE: You could get that information.</td>
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<td>MS. LUNGE: No.</td>
<td>You couldn’t get it tailored to doctors by prescriber number.</td>
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<td>SENATOR CUMMINGS: -- from calling Kenny’s and saying --</td>
<td>SENATOR CUMMINGS: Okay. You couldn’t get the doctor -- all right, you couldn’t get the prescriber number. All right.</td>
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<td>MS. LUNGE: No, this wouldn’t. I don’t know if they can do that now, but this wouldn’t change that.</td>
<td>MS. LUNGE: Right.</td>
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<td>SENATOR CUMMINGS: Okay.</td>
<td>SENATOR CUMMINGS: And you couldn’t get the patient.</td>
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<td>MS. LUNGE: Because what this would change again is it’s just the use for commercial use.</td>
<td>MS. LUNGE: So you could find out that in Caledonia County, more Oxycontin is prescribed than --</td>
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<td>SENATOR CUMMINGS: Okay.</td>
<td>SENATOR CUMMINGS: Tylenol.</td>
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<td>MS. LUNGE: So if Kenny’s was buying Rite-Aid’s information so that they could --</td>
<td>MS. LUNGE: -- Tylenol or whatever else.</td>
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<td>SENATOR CUMMINGS: If they would send me an ad that would be different.</td>
<td>SENATOR CUMMINGS: Tylenol III needs a prescription.</td>
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<td>MS. LUNGE: Exactly, and also, the collection, use, transfer or sale of patient or prescriber data for commercial purposes, if the data does not identify the person and there is no reasonable basis to believe that the data provided could be used to identify a person can be used. So there’s also an exception for commercial uses where those patient-identifiable or prescriber-identifiable information is removed.</td>
<td>MS. LUNGE: Right, so you could get that for a commercial purpose. You just couldn’t do it if it was in some way tailored that you could figure out exactly which doctor or which patient was receiving it or prescribing it.</td>
</tr>
<tr>
<td>SENATOR CUMMINGS: So they could find out that this doctor prescribes Oxycontin more often than Tylenol III.</td>
<td>SENATOR CUMMINGS: So pharmaceutical companies can find out general market information,</td>
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<td>MS. LUNGE: Who could? The Department of Health could.</td>
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<td>SENATOR CUMMINGS: Could.</td>
<td>what’s selling here, as opposed to what’s being prescribed here.</td>
</tr>
<tr>
<td>MS. LUNGE: As part of S-90.</td>
<td>SENATOR CUMMINGS: But not which doctors.</td>
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<td>SENATOR CUMMINGS: Okay, somebody doing research.</td>
<td>MS. LUNGE: Right.</td>
</tr>
<tr>
<td>MS. LUNGE: If you wanted to do market research to see what is the drug that’s most often</td>
<td>SENATOR CUMMINGS: Okay.</td>
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<td>MS. LUNGE: And then E provides for AG enforcement through the Consumer Fraud Act.</td>
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<td>Section 13 is a technical section related to this. This is the multi-payer database section and just clarifies that any of this information multi-payer database receives --</td>
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<td>SENATOR CUMMINGS: I don’t think this Committee did the multi-payer database, so can you--</td>
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<td>MS. LUNGE: Okay. The multi-payer database is the project that BISHCA is undertaking that is collecting -- I think the Bill -- there’s a similar law in Maine and New Hampshire where the purpose is to collect information so that you can use it for various I think noncommercial purposes such as researching different -- I’m actually not entirely sure what they’re going to use it for but --</td>
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<td>SENATOR CUMMINGS: Well, maybe we ought to</td>
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1 ask BISHCA to come over and talk to us.
2
3 MS. LUNGE: But I think consumer education is
4 one potential use. I think they're still
5 developing it, so I know more about kind of what
6 they were --
7
8 SENATOR CUMMINGS: Okay, because this is not
9 ringing a bell with me. I feel this was a Health
10 Committee initiative and...
11
12 MS. LUNGE: I think it was actually in a
13 budget a few years ago, to tell you the truth, but
14 it was --
15
16 SENATOR CUMMINGS: Oh, okay. So we will have
17 them explain it. It's not just me drawing a
18 blank.
19
20 MS. LUNGE: No. There were some revisions to
21 it last year I think through to Health and
22 Welfare, yeah.
23
24 But what this would basically do is make sure
25 that again, the identity of the patient or

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up-- 14 and 15 are related, and basically, this
has to do with if you go to the pharmacy and the
drug that you're prescribed costs less than your
copay, the usual retail cost is less than your
copay, you would pay the lesser of either your
copay or the usual retail cost of the drug.

27 So if your copay was ten dollars, and you go
to Wal-Mart and they have a four-dollar generic,
you pay four dollars. You don't pay your
ten-dollar copay.

29 And the first section applies to pharmacists,
and Section 15 would apply to health insurance or
other health benefit plans.

31 Section 16, this is the unconscionable
pricing section. This section is modeled on a
D.C. law that passed.

34 SENATOR CUMMINGS: And this is new?
35 MS. LUNGE: This is new, yep, last year, as
36 the two -- the three sections that we just talked
37 about were new also.

39 SENATOR CUMMINGS: I don't think the other
40 ones were quite as controversial as this one is.
41 MS. LUNGE: This section is based on a D.C.
law, although tailored a little bit more closely
to some of our -- "our" being Vermont's,

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4 initiatives like chronic care, for instance, so
5 this establishes a process by which the Department
6 of Health and the AG's Office could look at
7 specified health conditions and look at the costs
8 of drugs for treating those conditions and then do
9 a price comparison to see if the price being
10 offered in Vermont is within a certain benchmark,
or if it's over that benchmark, it would be
11 determined to be what we're calling in this Bill
12 unconscionable pricing.
13
14 So Section 4651 is the purpose, which is to
15 insure affordable access necessary to treat
16 certain health conditions determined to be a
17 serious public health problem in the state.
18
19 4652, this says that a manufacturer or its
20 licensee shall not sell, supply for sale or impose
21 minimum resale requirements for a prescription
22 drug necessary to treat a specified health
23 condition that results in that prescription drug
24 being sold in Vermont at an unconscionable price.
25
26 4653 is the process for specifying a health
27 condition.
28
29 The Commissioner of Health may issue a
30 declaration that a health condition is prevalent
31 in Vermont to such an extent as to constitute a

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serious public health problem.

3 The Attorney General has the ability to
3 request that determination from the Commissioner
4 of Health and if the AG makes the request, the
5 Health Commissioner will consider it.
6
7 FEMALE ATTENDEE: How is that different than
8 that's in statute today?
9
10 MS. LUNGE: None of this is in statute at
11 all.
12
13 FEMALE ATTENDEE: A Health Commissioner can
14 declare an emergency, can't they, a health
15 emergency?
16
17 MS. LUNGE: I suppose they can. I don't
18 actually know the details of what that means they
19 can do.
20
21 FEMALE ATTENDEE: Well, I don't know what it
22 means when they declare that, but it would be
23 interesting to me to know if this was not the case
24 before.
25
26 MS. LUNGE: Uh-huh.
27
28 SENATOR CUMMINGS: I know just reading stuff
29 on the flu epidemic when they did declare one,
30 they closed public gatherings. I know during
31 polio epidemics, they close pools and beaches and
32 places where people would congregate.
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1. This is a different thing, I think.
2. MS. LUNGE: Right. This -- this I think
3. is -- it's different in that it specifically, as
4. you'll see when we get a little bit farther along
5. that it has -- it directs a process that the
6. Commissioner of Health wouldn't necessarily be the
7. person, other than the person because they have
8. the public health kind of background.
9. The process is looking at prices, which is
10. not something that I think the Department of
11. Health currently has the authority to do.
12. FEMALE ATTENDEE: Oh.
13. SENATOR CUMMINGS: This is saying there is so
14. much, what, M.S. in the state of Vermont that it's
15. reached -- and the drugs are priced so high that
16. people can't afford them. We therefore have a
17. public crisis or a health emergency, something on
18. that line.
19. FEMALE ATTENDEE: Yep, that is different.
20. SENATOR CUMMINGS: Yeah.
21. MS. LUNGE: And I can check. I will see what
22. I can find on current law about public health
23. emergencies in terms of if there's criteria and
24. stuff like that.
25. FEMALE ATTENDEE: I was thinking in terms of

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1. the federal supply schedule or prices available
2. throughout Healthy Vermonters Program or the most
3. favored purchase price.
4. And I'm sorry. I skipped the definitions,
5. but the most favored purchase price is defined as
6. the price offered with all rights and privileges
7. accorded to the seller to the most favored
8. purchaser in Vermont, and that definition is based
9. on a definition in Wisconsin law which was upheld
10. as constitutional by the Circuit Court for that
11. area, and they -- and their comparison was
12. basically similar in that it said that any
13. purchaser must receive the most favored purchase
14. price in Wisconsin.
15. SENATOR CUMMINGS: Okay. That might be the
16. Veterans Administration price or...?
17. MS. LUNGE: The V.A. price --
18. SENATOR CUMMINGS: Is different?
19. ATTENDEE: That's a federal agency.
20. SENATOR CUMMINGS: That's a federal agency?
21. MS. LUNGE: I can't remember if they're a
22. federal supply schedule or if they're lower than
23. that. I think that --
24. FEMALE ATTENDEE: The V.A.?
25. MS. LUNGE: I think they're lower than that.

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1. international paper when we asked what the state
2. could do to protect people's health (inaudible).
3. FEMALE ATTENDEE: I think health emergencies
4. usually are communicable diseases, that there's a
5. danger to the public. This might be diabetes
6. which is not a communicable disease so...
7. MS. LUNGE: So in B, it sets out some
8. preliminary -- a minimum sort of floor of factors
9. that the Commissioner would consider when
10. declaring that a health condition was a serious
11. public health problem, and that would be how many
12. Vermonters suffer from the condition, the costs to
13. the state, employer-sponsored insurance and
14. private insurance of treating that condition with
15. prescription drugs, the cost of a prescription
16. drug or class of prescription drugs used to treat
17. the condition to the extent that that information
18. is available, whether a drug or class of drugs is
19. essentially for maintaining health or life and
20. other relevant factors.
21. 4654 establishes that in order to prove in
22. court a case of unconscionable pricing, the
23. wholesale price of the prescription drug in
24. Vermont would have to be over 30 percent higher
25. than prices available to federal agencies under

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1. SENATOR CUMMINGS: Yeah, I think V.A. is the
2. lowest.
3. MS. LUNGE: Right, so it wouldn't be V.A. It
4. would be the federal supply schedule.
5. SENATOR CUMMINGS: Okay.
6. MS. LUNGE: If we have that chart that Steve
7. did.
8. SENATOR CUMMINGS: Yeah, that's what I'm
10. MS. LUNGE: That would --
11. ATTENDEE: It sounds like the V.A. can
12. initiate prices where the rest of the government
13. can't.
14. MS. LUNGE: They do a very good job.
15. SENATOR CUMMINGS: Be glad that Senator Harms
16. (phonetic) isn't here, but he may come back to
17. haunt you.
18. MS. LUNGE: So 4655 would give the AG or
19. State's Attorney civil investigation power.
20. This is literally cut and pasted from our
21. Consumer Fraud Act in Vermont, so it gives the AG
22. the same powers that they would have under a
23. consumer fraud investigation.
24. And again, all of page 28 and page 29 is
25. literally cut and paste from the Consumer Fraud
<table>
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<th>Page 46</th>
<th>Page 47</th>
<th>Page 48</th>
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<tr>
<td>1. Act, so it goes through the process on how they can do an investigation before filing in court so that they can determine whether or not it makes sense to file in court.</td>
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<td>2. 4656, civil action, again, this describes the court process. This would allow any affected party, including the AG, to have standing to file a civil suit in a court of competent jurisdiction for a violation of this chapter.</td>
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<td>3. If the state is the Plaintiff, it may seek remedies on its own behalf or on behalf of all residents or both, and that's a combination of the Consumer Fraud Act and the D.C. law.</td>
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<td>4. If a prima facie case of unconscionable pricing is shown, the burden of proving evidence and the preponderance of the evidence shifts to the defendant, and then the defendant can show that the price is not unconscionable because of the costs of inventing it, developing it, producing it, global sales and profits to date, consideration of any government-funded research, and the impact of price on access to drugs in this state.</td>
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<td>5. Whenever an affected party, other than the AG, brings an action, a copy of the pleading would be served on the AG. That's again from the Consumer Fraud Act.</td>
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<td>6. And 4657 are remedies. Again, these are based on the Consumer Fraud Act and would allow a court if they found a violation to order a civil penalty of not more than $10,000 for each violation, temporary, preliminary or permanent injunction, which is a court order that says that you have to stop or you have to do something in a certain way or you have to stop doing something, an order of damages, which are usually money damages, an order requiring reimbursement to the state in its investigation or prosecution, costs and reasonable attorneys' fees and any other relief determined appropriate by the court.</td>
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<td>7. And then there is again, the Consumer Fraud Act also sets up this B, which is if you violate an injunction, then you pay a civil penalty of $10,000 for each violation.</td>
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<td>8. FEMALE ATTENDEE: Can you tell me two things? What does prima facie mean, and what exactly is an injunction?</td>
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<td>9. MS. LUNGE: And what's the second? FEMALE ATTENDEE: An injunction? MS. LUNGE: A prima facie case is the basic case that you have to prove in case.</td>
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<td>10. So I, the plaintiff, when I go to court, I have to show certain things in order to give the court enough evidence to see that I have a claim under the law.</td>
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<td>11. So in this case, it would be -- we talked about in order to prove unconscionable pricing, you have to show that the drug was 30 percent more than, so those are the elements. It's called the elements of the case.</td>
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<td>12. So basically, when you go to court, you break up your case into particular legal parts, and you have to be able to prove each of those legal parts in order to win, and the prima facie case is like the first basic showing that you're not going to get kicked out of court, so if you can't show that, you can kicked out of court.</td>
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<td>13. FEMALE ATTENDEE: Okay. SENATOR CUMMINGS: So if you go in and you say I'm sorry, but I, you know, I have to take aspirin for my arthritis, and I think 99 cents a bottle is an unconscionably high price, I'm not going to have a prima facie case unless somebody can show that the most favored status is ten cents a bottle.</td>
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<td>14. MS. LUNGE: Right. SENATOR CUMMINGS: So if I come in, and it may be a very high price, but if it is a new, experimental or only three people in the state have this condition, I'm not --</td>
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<td>15. MS. LUNGE: You wouldn't be able to prove it. SENATOR CUMMINGS: I won't be able to prove it because even though it was very expensive and I can't afford it, somebody else isn't --</td>
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<td>16. MS. LUNGE: That's not enough, right. ATTENDEE: Yeah, somebody else isn't getting it a lot cheaper.</td>
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<td>17. FEMALE ATTENDEE: Okay, and what's an injunction?</td>
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<td>18. MS. LUNGE: An injunction is a court order which tells somebody to do something or to not do something.</td>
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<td>19. FEMALE ATTENDEE: Okay, okay. MS. LUNGE: So for instance, if you are having a boundary dispute with your neighbor, and they keep coming onto one part of your boundary, you can get an injunction saying, Stay off my property. So it's an order from the court telling somebody stay off my property.</td>
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<td>20. ATTENDEE: With the force of law.</td>
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13 (Pages 46 to 49)
MS. LUNGE: With the force of law.
FEMALE ATTENDEE: Okay.
MS. LUNGE: So the next section of the Bill is based on a current law in Maine, and also it's sort of -- the Maine law is fit into our current law on labeling and advertising, so we've added two definitions. These are from the Maine law.
Manufacturer of Prescription Drugs is defined, and Regulated Advertisement is defined, and I'm going to go through regulated advertisement in some detail.
It means the presentation to the general public of a commercial message regarding a prescription drug or biological product by a manufacturer that is broadcast on television or radio from a station that is physically located in the state, broadcast over the Internet from a location in the state or printed in magazines or newspapers that are printed, distributed or sold in the state. So again, there's an effort to tie those activities to just in-state activities.
So on the next page -- actually, I should check and see if you're on the next page.
That's the problem with running two copies at the same time.

SENATOR CUMMINGS: Yes, 152 is on the same page.
MS. LUNGE: All right. These are the prohibited acts.
So a manufacturer of prescription drugs may not present or cause to be presented in the state a regulated advertisement unless that advertisement meets the requirements concerning misbranded drugs and devices and prescription drug advertising of federal law and regulations.
So right now, there is federal law and regulations which define what type of advertising is allowed, and this would prohibit ads that do not meet those federal requirements.
FEMALE ATTENDEE: Concerning misbranded drugs?
MS. LUNGE: That's the term used in federal law.
So basically, the federal law would be I think in more common usage, it would be misleading advertisement or fraudulent advertisement. That's kind of what I think most people would describe what those federal laws are trying to do is make sure that the ads --
FEMALE ATTENDEE: Oh, branded, not labeled.

I was thinking mislabeled I guess.
MS. LUNGE: I'm not sure why they use misbranded in federal law versus mislabeled but...
FEMALE ATTENDEE: Probably started doing it in 1821 for (inaudible).
MS. LUNGE: Probably. So this, this is tailored to just prohibit advertising if the ad violated the federal law or violates the federal law, and the way you can know that is that the FDA sends out letters to drug manufacturers if they've found that an ad violates the federal regulations, so you can go on the Internet and see some of these letters if you are so inclined.
FEMALE ATTENDEE: So that it's the federal government that determines when they are in violation of federal law when -- that they do now?
MS. LUNGE: Yes.
FEMALE ATTENDEE: This is just changing who can now enforce it.
MS. LUNGE: At the state level, yep, because right now, at the federal level, the FDA can send out what's called a warning letter, or quote, unquote, untitled letter, or they can yank the drug. And that's pretty much their options.
So the FDA doesn't really have an in between enforcement mechanism, so in Maine, what they decided to do was pass this law which gave their Attorney General authority to basically enforce removing an ad if the Feds had sent out one of these letters saying your ad violates our federal regulations, so it gives the state kind of a way to act on that.
The second piece in 13 is based on a Florida law which would prohibit pop-up or instant pop-up ads or instant messages built into electronic prescribing software or any other means used to influence or attempt to influence the prescribing decision of the health care professional.
FEMALE ATTENDEE: So there are programs that let's say doctors or prescribers use.
MS. LUNGE: Uh-huh.
FEMALE ATTENDEE: To help them prescribe?
MS. LUNGE: Yes. I think -- I don't actually know much about the details of them.
I think and I don't -- I think it may be that it communicates directly with the pharmacy or it may be it also checks drug interactions, so you could input what you're prescribing, as well as the other medication that the person is taking, and that will say oh, there is a drug interaction
you should know about or -- I don't know all the
details.

FEMALE ATTENDEE: By the way, purple is
better. I mean, that would be the pop-up.
ATTENDEE: (inaudible).
FEMALE ATTENDEE: Did you know that you could
get a free trip to Cancun?
MS. LUNGE: And this is something that did
pass.
FEMALE ATTENDEE: I used to get alligator
clogs. I win the lottery, and I've gotten free
alligator clogs several times, and I don't know
why.
FEMALE ATTENDEE: I could go for that.
FEMALE ATTENDEE: But I've won the Australian
lottery at least three times.
MS. LUNGE: Are alligator clogs clogs made
out of alligator, or are they clogs that look like
alligator? That's what I want to know.
(inaudible).
ATTENDEE: I never clicked that. I never
clicked that.
ATTENDEE: Just don't stick your feet in
them.
FEMALE ATTENDEE: That's right.

MS. LUNGE: Right. So the changes in the
next Section 4054 are technical changes, and
that's pretty much it.
FEMALE ATTENDEE: Okay.
MS. LUNGE: And 4068, again, this is all
current law. There are technical changes in that
section, and then we struck the current law on
advertising which says that whenever the Board of
Pharmacy determines that an advance in medical
science has made any type of self medication safe
to any of the above-named diseases, they can
date the advertisement of the drugs, since
the Board of Pharmacy at that point in time
probably doesn't have the authority to do that,
since there are now federal law and regulations
around that so...
In Section 18, this adds a funding mechanism
for the enforcement of the advertising section,
and also, for the evidence-based education
programs.
Again, this is from Maine law. It was passed
with the advertising provisions that you just saw,
so it may be something that you want to do or
don't want to do, but because that was the package
in Maine, I put it together in here.

FEMALE ATTENDEE: So this is 4068 we're
talking about?
MS. LUNGE: 1998-A.
SENATOR CUMMINGS: Section 18.
MS. LUNGE: Section 18.
FEMALE ATTENDEE: Page 36.
FEMALE ATTENDEE: Oh.
ATTENDEE: Page 36.
MS. LUNGE: 4068 is all technical.
FEMALE ATTENDEE: I was just looking at A on
my 14 on page 35.
MS. LUNGE: Yes.
FEMALE ATTENDEE: A cosmetic deemed to be
false, and I'm wondering about the 12-year-olds
that advertise wrinkle creams. Is that false?
MS. LUNGE: This is current law.
FEMALE ATTENDEE: We don't do anything about
that, do we?
MS. LUNGE: No, we don't.
SENATOR CUMMINGS: Well, that's because we
all want to believe that it's -- (inaudible).
MS. LUNGE: So there would propose a $1,000
annual fee for prescription drug manufacturers who
participate in Medicaid and Medicaid waiver
programs and allows the human services designee to
make rules for implementing that section.
Section 19 on page 37 at the bottom, this
provision just adds a section to the Consumer
Fraud provisions currently in law that kind of
summarize -- throughout the course of the Bill,
I've said this is enforced by Consumer Fraud, this
is enforced by Consumer Fraud.
This kind of summarizes that all in one place
so that you can find it either by looking at the
Consumer Fraud Statutes or by looking at the
particular -- particular subject matter.
The other thing that I -- that in B is it
establishes more clearly in our consumer fraud
area that it would be an unfair practice for a
health insurer to do particular marketing or
solicitation practices.
And this has come up in relation mostly to
Medicare Part D plans, and for the most part, the
state's ability to regulate in the Medicare Part D
area is very limited because that is a federal
prerogative, but the state is still allowed to
pursue our traditional areas against certain -- of
regulation around certain types of practices,
including marketing and sales practice.
So this would prohibit advertising which
FEemale ATTendee: So they're not getting paid?

SEnator CUMMINGS: We now pay -- we'll have testimony. It's my understanding that Medicaid gets paid within eight days if it's an electronic transfer, and so why do we let insurance companies have more than eight days if our notable -- the (inaudible) can do it in eight days.

MS. LUNGE: So B on the first pages applies to health plans.

C-1(a) on page 2, line 8 applies to a health plan that is a workers' compensation insurance policy. And then the rest is there just for context.

SENATOR CUMMINGS: But that one -- all right. Okay.

MS. LUNGE: That's that.

S-87, that would amend Title 8, which again talks about filling of prescriptions and would amend -- some of it is just moving current law into a different order.

But first of all, a health insurer, and this -- I'm starting on page 3, which is you see the first substantive addition, on line 7.

"A health insurer and PBM shall give clear

advertising of insurance products by nonlicensed insurance agents like (inaudible).

Thank you. Committee?

MS. LUNGE: I'm not done. I have two more bills.

SENATOR CUMMINGS: (Inaudible). We get two more. That's right, and those are my bills, but these are really short and sweet. Very sweet.

MS. LUNGE: Very short and very sweet.

SENATOR CUMMINGS: Very short.

MS. LUNGE: So I'm going to start with --

SENATOR CUMMINGS: I thought they might be appropriate to tack onto this mega Bill once -- if it stays in there as a Bill because they're similar in nature and very short.

MS. LUNGE: So I'll start with S-84, and this is prompt payment of electronic prescription drug claims.

This would modify Title 18, which is health -- to require that a prescription drug claim submitted electronically would be paid within eight days by electronic funds transfer unless the claim is contested or denied.

FEMALE ATTENDEE: Paid to the pharmacist?

MS. LUNGE: Paid to the pharmacist.
had to tell the pharmacies and the insurers that
they could do that, so this tells them that they
have to tell people what they're required by law
to do.
FEMALE ATTENDEE: You have to guess at it.
SENATOR CUMMINGS: At least, that's what it's
supposed to do.
MS. LUNGE: Right.
(End of CD 2007-43)

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 2007-43, Track 1,
the Senate Committee on Finance, Tuesday, February 13,
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 28th day of August 2007.

Katherine Milam, RPR
Esquire Job #889697
TAB G
STATE OF VERMONT
SENATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: Thursday, February 15, 2007

COMMITTEE MEMBERS:
SENATOR ANN CUMMINGS, CHAIR
SENATOR CLAIRE AYER, VICE CHAIR
SENATOR MARK MacDONALD, CLERK
SENATOR BILL CARRIS
SENATOR JAMES CONDOS
SENATOR HULL MAYNARD, JR.
SENATOR RICHARD McCORMACK

CD No: CD 2007 46, Track

Esquire Job #889696
A-555

1 - 5
2 PROCEDINGS
3 - 5
4 CD No: CD 2007 46, Track 1
5 SENATOR CUMMINGS: We're on the record. It
6 is 1:55, and this is the 15th of February.
7 The sun is out. The snow has stopped, and
8 we're going to work very hard because they were
9 saying there might be another big one coming.
10 FEMALE ATTENDEE: Yahoo.
11 ATTENDEE: When?
12 SENATOR CUMMINGS: Next week maybe. I don't
13 know, but there is an El Nino thing that's blowing
14 around. I wouldn't panic yet.
15 And this Committee always meets. So anyway,
16 we are working this through with folks that are
17 stuck in airports, so Andy --
18 ATTENDEE: Friedell.
19 SENATOR CUMMINGS: Friedell is first, and
20 we're going to put Brian -- he's next. We're
21 going to put Brian Quigley on first.
22 ATTENDEE: Okay.
23 FEMALE ATTENDEE: Okay. However you want to
24 do it.
25 SENATOR CUMMINGS: He was going to -- I

1 thought he was going to listen.
2 ATTENDEE: He is.
3 SENATOR CUMMINGS: And you guys -- okay,
4 we'll let --
5 FEMALE ATTENDEE: I think Andy's doing more
6 of the overview, so it might be good to let him
7 start.
8 FEMALE ATTENDEE: Okay. Are we on --
9 SENATOR CUMMINGS: Prescriptions drugs.
10 FEMALE ATTENDEE: Senate Finance. Hi, Brian.
11 I'm going to put you on the speaker phone.
12 We just convened.
13 SENATOR CUMMINGS: Hi Brian, it's Ann
14 Cummings.
15 MR. QUIGLEY: Hi, Ann Cummings, how are you?
16 MS. CUMMINGS: I'm good, and we have a quorum
17 of the Committee present. The rest will be coming
18 down as they finish voting. We had a special
19 afternoon session for UVM trustees that we hadn't
20 anticipated on today, so we're running a little
21 behind.
22 Andy Friedell is here and ready to testify,
23 and I have you on the phone. And I think you were
24 going to do more of the overview?
25 MR. FRIEDELL: Yeah. Brian, I have Peter's

1 deck, which is the overview slides, and I was
2 going to go through that first and then go through
3 some of our concerns briefly about the Bill, and
4 then maybe you can go into a little more detail on
5 some of the contractual issues.
6 Does that sound --
7 MS. CUMMINGS: Does that work for you?
8 MR. QUIGLEY: Yes.
9 MS. CUMMINGS: Okay. Can you hear, the other
10 end of the table?
11 MR. QUIGLEY: Andy was a little fuzzy.
12 MS. CUMMINGS: Okay. I'll turn you away.
13 Better you hear him, and I'll be fuzzy.
14 MR. QUIGLEY: Okay.
15 MS. CUMMINGS: Okay?
16 MR. FRIEDELL: Okay. I'll pass these around.
17 These are some slides that. I'm not Peter
18 Hardy, as you can see here. I'm sort of the sole
19 survivor of a group of folks that tried to make it
20 here one way or another.
21 ATTENDEE: You actually did it.
22 MR. FRIEDELL: And "Planes, Trains and
23 Automobiles." The automobile was the only one to
24 actually --
25 MS. CUMMINGS: I was going to say or dog

1 sled.
2 MR. FRIEDELL: Right. Dog sled was about
3 what you needed the last few miles to get up the
4 last stretch into Montpelier.
5 But Madam Chair, members of the Committee, my
6 name's Andy Friedell. I'm Director of Government
7 Affairs at Medco.
8 We met briefly a few weeks back, and I
9 appreciate the opportunity to come and speak to
10 the Committee. I just have one question.
11 Are you taking testimony today only on the
12 draft PBM Bill, or also on the 87 and 84 as well?
13 MS. CUMMINGS: Those are the two pharmacy
14 bills? We'll probably end up rolling this all
15 together so...
16 MR. FRIEDELL: Okay.
17 MS. CUMMINGS: So go through them all.
18 MR. FRIEDELL: Okay. Well, as I was saying
19 earlier, when we were talking with Brian, I'd like
20 to go through -- take a little bit of a step back
21 and give you an overview a little bit about our
22 industry, and then we can get into the specifics
23 of the Bill.
24 My boss, Peter Hardy, had this slide
25 presentation which I've given to you folks.
1. It's very thorough. I'm not going to go through it at all slide by slide. In fact, I'm just giving it to you as a resource, and I'd like to sort of speak generally about the industry, and then we can pull up certain slides if things come up of interest to you folks.

2. SENATOR CUMMINGS: Okay.

3. MR. FRIEDEL: So I think the best way to start probably is to take a look at sort of how the industry operates today and to get the best sense of how it operates today, sometimes, it's good to take a little bit of a step back and see how it worked before there was a concerted effort to manage pharmacy benefits.

4. And if you think back to like the late or early 80's, mid 1980's, when you got a prescription, at that point, you took it into the pharmacy, you went to your local pharmacy. You handed it to the pharmacist, you paid cash for the full amount of that prescription, and then you brought that prescription home with probably a receipt you got with some forms from your health plan.

5. You filled out sort of a reimbursement claim, mailed that in, and that, you know, then you got reimbursed for some percentage of that prescription drug cost, like 80 percent or something like that, if that was what your benefit was.

6. Then around that same time, you sort of had an explosion of new drugs coming into the marketplace in the mid eight 80's.

7. You had new cholesterol drugs, like Medecor and Zocor, and G.I. drugs like Tagamet and Zantac and others like Prozac, a whole variety of new and innovative products hitting the market, and you also had sort of that baby boomer bubble of people who were more apt to be taking prescriptions drugs to get to that age where they could be taking medications.

8. So you had sort of a storm brewing in the prescription drug marketplace where you had all the ingredients together whereby the actual cost of prescriptions drugs were going to be increasing significantly.

9. So the folks who paid the bills, most of the bills for prescriptions drug, employers, unions, the state of Vermont, state government, the federal government began to realize that they had this piece of their health benefit that they really didn't have any control over that drug benefit.

10. When the patient went into the pharmacy, the drug manufacturer was charging the pharmacy whatever it was going to charge.

11. The retail pharmacy was pricing its product how it wanted to price.

12. The patient wasn't really shopping around, and when the patient and the doctor were having the discussion about therapies, there wasn't any way to get information into that discussion about lower-cost alternatives.

13. So that is where the marketplace really saw a need to step in and have some kind of management of pharmacy benefits, and that's where the origins of PBMs really come from.

14. While there are stand-alone PBMs like Medco and Express, there are really -- pharmacy benefit management is a whole variety of techniques and tools that have sort of grown out of that need to manage that drug benefit.

15. You have formularies, which you've talked about in the past, mail service, retail networks, the whole works.

16. All of those things sort of fall under the umbrella of pharmacy benefit management, and while there are stand-alone PBMs like Express and Medco, there are -- those are by no means the only players in this marketplace.

17. It's a very competitive, very dynamic marketplace.

18. In fact, the FTC has determined that there's about -- somewhere between 40 and 60 PBMs across the country or entities that play in that PBM marketplace, and those are our competitors.

19. Those are folks like not only our stand-alone PBMs, but we have -- Aetna has a pharmacy benefit management arm of their health plan. Anthem, you may be familiar with has a pharmacy benefit management, and we will compete against some of those folks for carved-out business in addition to their business they have for the rest of their plans.

20. Beyond the health plans, there's also the large chains. CVS, Rite-Aid, Walgreen's all have pharmacy benefit manager subsidiaries.

21. In fact, CVS right now, as you may know is in a bid to purchase one of our largest competitors, Caremark.

22. In addition to that, the retail pharmacies
also are very involved in this space as well. The retail pharmacies came together and formed a prescription drug plan under Medicare Part D, and in fact, they're one of the largest PDPs right now in that market space. So you have sort of a variety of players in that, in that -- who have come into answer that market need and have stepped into that space, and what we have seen in our business and through our competitors is there is a demand as this has become more competitive to show that we're lowering the cost. When we bid on a piece of business, it all comes down to sort of the bottom line price. We can add as many bells and whistles as we want to that, into that offer, but repeatedly, what I hear from our folks in the sales department is what clients are asking, What is the state of Vermont and what other payors are asking is, What is your bottom-line price? And we're constantly under pressure to sharpen our pencils and lower and lower that price. And what you've seen is that's having an effect on the marketplace, and I know if you look at slide 9, you can see this shows what the prescription drug trend looks like now and that it's coming down significantly. In fact, CMS, the Centers for Medicare and Medicaid Services, the federal government's agency, estimated that prescription drug costs were rising at 5.8 percent in 2005. That's down from about 16 percent in the year 2000, and in fact, in 2003, this was the first year that prescription drug trend was below all of the other service sectors, hospital, physician, nursing care and the like. So this is having an effect, this competition in the marketplace right now, and there is a growing body of evidence that shows, and that's sort of what the next few slides of this presentation go through, but there is a growing body of evidence of studies that demonstrate the value that PBMs bring to the marketplace. If you look at -- I gave you folks a study when I was here last time. The General Accounting Office did a study solely on pharmacy benefit managers. It talks about the value that they bring and gets into specific discounts that PBMs can offer, and I also gave you a one-pager on that, and I can give you additional copies if you need them. The Federal Trade Commission -- Congress asked the Federal Trade Commission to specifically look at PBMs and their mail service pharmacies and whether or not there was a conflict of interest among PBMs. The FTC looked at this and specifically found that allegations of a conflict of interest are without merit. That's their words. ATTENDEE: Well, can I stop you for a second? MR. FRIEDELL: Yep. ATTENDEE: Because I don't know if it's the case today, but there have been, and I don't know if it's your PBM or not, but there have been cases where a drug company owns the PBM. MR. FRIEDELL: Yep. ATTENDEE: To me, that's a conflict. I don't care how you put it. MR. FRIEDELL: Well, there were cases. In fact, Medco used to be owned by Merck. ATTENDEE: Okay. MR. FRIEDELL: We were spun off three years ago from Merck, but the FTC looked at that relationship between Medco and Merck and set up very specific guidelines, and there was a firewall where we weren't allowed to share certain information between, you know, between the two entities, and Medco had to treat Merck's products as it treated all the other products that were on the marketplace. And, you know, so you're -- I understand your concerns, but there was specific rules that were set up around how that was, you know, how that needed to be handled. But more importantly, I would say the marketplace ultimately won out because our customers had maybe the same concerns that you had, and whether or not there was that firewall in place, customers may have said, you know, we don't, we don't -- we're not sure if we're still getting the best deal. Ultimately, Medco spun off and now, you know, we're alone in the marketplace, and we're competing for business on those terms. So I mean, really the marketplace in this -- in this instance has played out, and with the rules of the FTC has been able to look at this, and if you look at today's environment, that was what the FTC was looking at in this particular
study where they found that the conflict of interest allegations now are without merit.

But additionally, there's been other studies and one is going to be published in the Congressional Budget Office to show that PBMs save somewhere on the range of 25 to 30 percent for their customers.

And there is also additional quotes I have here on slides 17, 18, and they're from actual payors who -- 16, 17, 18 and 19 from payors who filed a brief in the challenge against PBM legislation in Maine, and here's some of the things that they said.

It cannot be doubted that employer-provided ERISA plans' reliance on PBMs to provide and administer prescription drug benefits has reduced the costs of those benefits significantly.

These are what our customers are saying in court challenges to PBM regulation.

FEMALE ATTENDEE: These three slides are all quotes from the same people, right?

MR. FRIEDELL: They're all -- they're all quotes from the same brief. There are several quotes because there are several people in there that are, you know, very strong arguments that are coming from the folks who are paying the bills for this drug benefit.

So, you know -- so it brings me to the question of this particular Bill before you which are you considering and how this would adversely affect the marketplace today, and if you think about the way it works today currently in the marketplace, what happens is you take, for example, the state of Vermont.

If the state of Vermont wants to put its prescription drug benefit contract out for bid, it will issue an RFP, a Request for Proposal, and generally, someone like the state of Vermont or an employer won't write this RFP themselves. They rely on a consultant who -- there are people who are very versed, they make a living out of knowing exactly what kind of discounts can be extracted from Medco and Express and others, and they educate the state on exactly how this RFP should be structured, so then they write that RFP, and they send it out to all the interested parties to potentially bid on this piece of business.

Then it ends up on our doorstep, and we evaluate all of the terms that you, the state of Vermont, have set out in your bid, and we decide whether or not we want to bid on this piece of business.

Business.

And it will say specifically things like, We want to have a formula that has maybe three tiers with a preferred brand and nonpreferred brand and generics.

It'll say we want to have mail service, or we don't want to have mail service. We want to have retail networks that are structured in a certain way. It will get into all those questions.

It'll talk about rebates. You know, how are rebates going to be shared?

In fact, in many cases, an RFP will ask us to bid a piece of business two ways.

It will say, We want you to bid the business as if you were going to pass through all rebates directly to us, and we want you to bid the business as if you just keep the rebates and give us a deep discount instead. And that allows the client to then make a decision based on the two what price is best for them.

But this Bill sets up sort of a standard that will affect that relationship, and it will create problems in the marketplace that don't exist today right now because currently, what you have, if you look at page 12 of the Bill, there's this new standard here that's established.

It's this prudence, diligence, discharge duties with care, skill, prudence and diligence.

This is an undefined standard in the marketplace, and Brian will get into this I'm sure in more detail when I'm finished, but currently, we're held to the standard of our contract between the PBM and our customer.

If our customer doesn't pay us what they agreed to pay us, or if we don't perform the services that we agreed under the contract, then they have a right of recourse under that contract, and it's perfectly well defined, and it's two entities that agreed and willfully entered into a contract that they felt best suited their needs.

This creates a third overlapping new undefined standard that is going to create confusion in the marketplace, and the confusion will lead to more litigation, and that will drive up costs because people won't know how they're going to have to respond to this standard, whereas entering into a contract is perfectly clear. We know what the terms are, and we can agree to it.

The second thing on page 13, there is a variety of disclosure requirements under this --
want to know exactly how many rebates you're getting, we want to see that, we want an unrestricted right to audit that information, and we want you to pass it off through to us. And when we got that bid from you, we would look at those terms, evaluate them and bid on them, and that's about -- right now, I would say 70 percent of the marketplace. There was a survey done by the International Federation of Employee Benefit Plans, which found that 70 percent of the marketplace operates that way today, that all rebates are completely passed through, they're fully transparent contracts. Medco, we file quarterly information with the SEC. In those documents that we file with the SEC, it says that 80 percent of all the rebates we received, are fully passed through to our clients, so that's the way we operate. But some -- some customers don't want to have that kind of relationship. There are those, and I think I talked about this the last time I was here, there are those customers who want to have a guarantied discount. They don't want to rely on the rebates because when you depend on rebates, you are at risk to get those rebates.

If a drug like Vioxx goes off the market, those rebates evaporate. If your PBM is not able to get the rebates for you, you may have counted on a revenue stream from rebates that may disappear, and then you have a budget shortfall. FEMALE ATTENDEE: But how could I buy a car, for example, if -- I mean how sensible would it be for me to buy a car if I said I wanted 20 percent off and I wanted a rebate on every -- you know, some feature, if you don't know what the price was to start with?

MR. FRIEDELL: Well, that's a good point. FEMALE ATTENDEE: What sense does that make?

MR. FRIEDELL: No, but that's a good point because we work exactly the way the market does work right now. When you go to buy a car, just like when you go to buy a PBM service, you know exactly what you're going to pay. We will tell you exactly what you're going to pay. When you go to buy a car, you don't know what they paid for rubber, you don't know what they paid for aluminum, you don't know what they paid for glass.
FEMALE ATTENDEE: But we do know what everybody else is charging in the marketplace because we can find that out.

MR. FRIEDELL: Yes, and you can find that out from your other PBMs too, but -- because when you put that RFP out, you know, when you folks -- the state of Vermont, when it puts that RFP out, it will bring in all the PBMs, and they'll all be bidding on that.

And today in the marketplace, what will commonly happen is they'll call -- they've have these best and finals where they'll call the highest bidders together into a hotel, and they will go back and forth, and they'll say PBM X gave us this rate on their discount. What can you do? And then they'll leave the room and then they'll go in the next room, and they'll say, Well, that PBM just gave us this rate, dah, dah, dah, down on this discount. What can you do? And they'll go back and forth.

Medco, I know back in the early 90s, mid 90s, we had most of this -- many of the state contracts were Medco contracts.

We lost many of those businesses over the course of the later part of the 90s. Many of our competitors came and sharpened their pencils and undercut us, and now we're in the process of trying to sharpen our pencil and win some of that back.

A good example is the state of California. That was a Medco client for a while. Caremark came in with a lower price. They moved the business to Caremark.

We then came back three years later, and we won the business back.

So the state of California knows that it's got significant leverage over its PBMs. It goes back and forth and competes and pits them against each other, makes them compete on price, and that's, you know -- and that's how they get a lower price, and that shows that the marketplace is working.

That's exactly how competition -- you would have a problem if there was only one PBM or if there was -- you know, but we have a very competitive marketplace now, and there are people who really want this business and we know when we get an RFP from the state of Vermont or anyone else, that if you've defined terms that we can't meet, we know that one of our competitors surely will, and so if we're choosing not to bid or to bid at a higher price, we know we're probably going to get undercut in the marketplace, and we'll lose that piece of business.

And that's exactly what I think happened here with you folks. Looks like you -- and Brian, who represents Express, can probably speak to this more than I can, but it sounds like they offered you a lower price, and I think that the PBMs' willingness to offer lower prices like that demonstrates that they know that there is someone else going to be knocking on the door.

SENIOR CUMMINGS: Okay. I'm still trying to figure out what the objection is, and the first thing I hear is that you object to is being told that you will discharge your duties with care, skill, prudence and diligence.

You don't do that?

MR. FRIEDELL: Madam Chair, what I'm objecting to is a new standard that the state implies over top of our existing contracts.

What we do today is we enter into a relationship, an arms-length negotiation where you, the employer, and Medco will both come to an agreement on a set of terms and negotiate payment for those terms, and then you both have remedies if someone doesn't meet their end of the bargain.

This would overlay a new standard over top of that, and it's not clear to me who would define care, skill, prudence.

I mean, those sound like great words, but those need to be defined somewhere, and they're not. It's not a standard that's established anywhere.

SENIOR CUMMINGS: I think they are under another term but...

MR. FRIEDELL: Well, there is a fiduciary obligation.

FEMALE ATTENDEE: Yes.

MR. FRIEDELL: Which -- which you're right, and that's very well defined under ERISA, but there, the problem with fiduciary, and Brian, again can speak to this in much more detail than I can, but there's a very specific definition of a fiduciary, and to be a fiduciary, you have to have discretion over the plan's assets, and you have to have discretion over the design of the plan.

We do neither. We don't design the plan for our customers.

A customer will say to us we want to have a
The contract says he'll put down your shingles, not that he'll replace the deck.

I think the problem here though, at least on my part is that the contract is set. We'll save you 25 percent of what? Because what seems to change on a daily basis, the testimony -- we haven't had an issue this year. We had it the last three years we worked on this Bill is use this average whole wholesale price, but the average wholesale price changes or can change daily.

We have had testimony in the past about the three months before a pharmaceutical goes off patent, it may zoom up 30 percent in wholesale price that -- and so that, I know, is outside your control.

MR. FRIEDEL: You know, those issues are not addressed, and that may be a concern to the Committee, but those are not issues at all addressed by -- in fact, we have to employ a lot of people just to keep on top of the changes in prices.

 SENATOR CUMMINGS: Right, so, you know, but -- you know, the person that hired your organization has to try -- if they don't know what -- how do they know that they are actually getting the 25 percent off if they don't know off of what?

MR. FRIEDEL: Yeah.

SENATOR CUMMINGS: And it can't be demonstrated off what, and then we get to if you are in fact getting an additional rebate for pushing -- I've picked on the purple pill enough, so the green pill, all right, you get an additional rebate if you could increase the market share of the green pill just before it goes off patent.

MR. FRIEDEL: We would never do that. That's not something we do. We have a policy that we would never switch to a product that's about to go off patent.

SENATOR CUMMINGS: A new one coming on.

MR. FRIEDEL: Right.

SENATOR CUMMINGS: All right? The new green pill, the improved green pill.

If I don't know what the base number is on a daily basis, and I don't know if you are in fact getting paid -- you encouraged me to use the new green pill, which may or may not affect the wholesale price, how do I know if, if --
MR. FRIEDELL: Yep.

SENATOR CUMMINGS: If we're all performing according to contract?

MR. FRIEDELL: Yep. Well, it goes back to the fact that first of all, you, the payor, have defined the benefit, so you've said you want the green -- because we sat down with you, and we said here's this formula we can offer you, and we can offer you, you know -- this could be a preferred brand, and this could be a preferred brand, and you've decided okay, we want the green pill to be the preferred brand because we can get a better price.

SENATOR CUMMINGS: Yeah, but it's going off patent six months into this contract.

MR. FRIEDELL: We would never put that offer in front of you because first of all, we have the incentive to prescribe generics, just as you do.

We share that incentive because we make money on generics at a much -- we have a much better margin on generics than we would on brands, and that's the same with all pharmacies, and that's the way it should be because we want the pharmacy to have the incentive to dispense the generic rather than the brand.

So then you have the rebate issue, which is the one you're talking about, and there, I guess your question was about whether or not the customer knows if it's getting that rebate, I think what you're asking?

SENATOR CUMMINGS: I think what I'm asking is does the customer know enough to know, have enough information to know if the contract is in fact being filled?

MR. FRIEDELL: Uh-huh, uh-huh.

SENATOR CUMMINGS: And if it is the best deal or -- you know, because the foundation of this deal is very murky.

MR. FRIEDELL: Well, it comes down again, that right to audit, and I said that about that same survey I mentioned to you before which looked at over a hundred large employers, PBM contracts, I think about 60 some percent had unrestricted right to audit that information.

So that means that they have a third party who comes in and looks at our contracts with manufacturers, looks at the utilization for that customer and determines exactly what rebate dollars are then owed to that customer.

SENATOR CUMMINGS: So what's the problem then with provide all financial and utilization information requested by the health plan?

MR. FRIEDELL: Well, because that's -- because the way it is done currently is it's part of our contractual arrangement with, you know, with our customer.

This puts it in a statute, and under the consumer fraud protection, there's a private right of action, so anyone could sue to get that information. They don't have -- their suit doesn't have to win. They could get that information, and then if a -- if a pharmaceutical company has that information, then they know exactly how little they need to discount their product in order to compete with another pharmaceutical company.

That information is important because confidentiality drives rebates and discounts.

SENATOR CUMMINGS: This does require that it remain confidential, and I'll check on that.

We do have the Attorney General coming over or on the phone, coming over tomorrow, but it isn't my -- and I'm not an attorney, but if in fact, you can have a -- if you're not part of the health plan, you're saying I could sue?

MR. FRIEDELL: Yep. You have a right, a private party's claim.

SENATOR CUMMINGS: I have a private right of action?

MR. FRIEDELL: Yep, you have that here in -- here in -- I don't have it marked but...

SENATOR CUMMINGS: Okay, so the issue is somebody, not the health plan, that has the contract with you could, in fact, sue for the information?

MR. FRIEDELL: Could be -- and that could become public, and then beyond that --

SENATOR CUMMINGS: Okay.

MR. FRIEDELL: Also, it's also setting -- this is also setting up a standard whereby every contract has to abide by.

People talk about transparency in the marketplace.

We don't have a problem with transparency in the marketplace.

As I told you, 80 percent of all of our rebates are completely passed through to our customer.

70 percent of all contracts in the marketplace are fully transparent contracts, so...
that's the norm in the marketplace today. What we have a problem with is the state coming in and saying this is the way all contracts have to be set up. SENATOR CUMMINGS: Okay. I think we also though allow you just an administrative -- give me the 25 percent only in there. MR. FRIEDELL: Well, you have all this information. SENATOR CUMMINGS: So they just want, Give me the 25 percent off of AWP, period. Don't bother me. I don't want any more information. That's allowed. MR. FRIEDELL: On page 16, it says, it says, if you look at line 13, it says "shall offer." That's the first issue because we don't offer-- page 16, line 13. At the end there, it says, "The PBM shall offer." As I said earlier, we don't go around offering our services. We respond to RFPs, so if someone -- and you may think that's a subtle difference, but it isn't because it it's a fundamental misunderstanding of the way the marketplace works. It's not that offers these services and information to our customers. Our customers will set the terms under which we will compete, under which -- the terms under which that contract will be structured, so if anything, it -- you, know if the states wants to get into this place, it needs to tell the customers you have to demand this information from your PBM. And then you talked about these -- the administrative service only contract, but then line page 17, line 16, there, you say -- there's a very broad additional provision that says, "Any other verifications relating to pricing arrangements and activities of a pharmacy benefit manager required by the Commissioner." So it's not just the information -- so this, this information that's required under this section isn't just for those administrative only services contract. There is this additional broad piece here that says you can -- the Commissioner can require any information from the PBMs. SENATOR CUMMINGS: I think you can do that now, but okay, so that's the BISHCA Commissioner who is the regulatory authority. ATTENDEE: Excuse me. Madam Chair, sorry, having been absent for a couple of days, I wonder if I'm using the wrong draft. SENATOR CUMMINGS: No, we've only got one draft. ATTENDEE: I have found the language referenced just now where it was referred, but I did not find -- ATTENDEE: Line 13. SENATOR CUMMINGS: Line 13 is where the "shall" is. ATTENDEE: The "Shall," right here. SENATOR CUMMINGS: Okay. The intent, you know, this originally was proposed as a total transparent, but we heard the testimony that said some of us just want to say give me the basic black phone plan, you know, stick it in my wall, don't bother me, send me a bill once a month, and I'll trust you. And I think those were the two things. We said okay, you can offer that. We're not going to require you to do a transparent. You can offer either one. Now, I'm not sure if the language is incorrect with the RFP. MR. FRIEDELL: Madam Chair, I want to take a step back to what I'd said earlier about the marketplace. You know, I understand what you're saying what the intent is, but when you have two contracting entities coming to agreements that they're both willingly entering into and they both have recourse under, and a PBM contract is generally three years, so -- and there's, you know, you see opportunity, people moving back and forth, there's significant competition. You know that you're getting, you know, your PBM significantly discounted your price. My question is what is -- is there a need for this in the marketplace today? We have a very competitive, highly-competitive marketplace. You have contractual arrangements governing the information, the relationship. You have very skilled consultants who, like I said, know exactly the kind of discounts and rebates they can extract. They know the exact questions to -- to ask. We see the same consultants over and over again, and they're constantly honing their RFPs, they're
1 getting more aggressive in the kind of information they're asking.
2 So when you have all that information for the purchaser, when they've got that competitive marketplace, why does the state need to step in and set these kinds of additional rules?
3 ATTENDEE: Can I just ask a question a simple question?
4 MR. FRIEDELL: Yes.
5 ATTENDEE: Because you keep -- you said it over and over and over again, this is a highly-competitive market.
6 What if it wasn't?
7 MR. FRIEDELL: If it --
8 ATTENDEE: Would that change your -- your opinion?
9 MR. FRIEDELL: Well, it's a hypothetical. I don't -- I don't know. I mean, it is a competitive market.
10 ATTENDEE: Well, let's go back ten years. It wasn't a highly-competitive market then.
11 MR. FRIEDELL: That's ten years ago though. I mean, you're looking to regulate the existing marketplace right now.
12 If you were -- if you were looking to regulate a marketplace of ten years ago, maybe, you know, maybe you're right. Maybe at that point, maybe there were business practices ten years ago that maybe needed to be addressed.
13 But in today's marketplace is what we're talking about, and that would be what this legislation would apply to.
14 ATTENDEE: But isn't this part of just getting better at it?
15 MR. FRIEDELL: Well, what's getting better at it is the consultants are constantly asking us more detailed questions. We're constantly having to sharpen our pencil. That's the process of getting better.
16 This is sort of laying a layer of state control over it where the state's going to step into that relationship and say here's, How you guys have to set this up now, so the consultant doesn't have the freedom to -- to work with the plan to structure the contract based on their needs.
17 MR. QUIGLE: Yeah, this would limit the ability of the customer, either a health plan or a state organization or a large employer to set the parameters of their contract, so it would not help
18 the situation. It would hurt their ability to negotiate on terms that they find most comfortable.
19 If they want information now, they can get it. If they don't want the information, they can indicate they don't want it, and therefore, they don't have to pay for it.
20 SENATOR CUMMINGS: Brian, can I just have you identify yourself for the record so that we have a name that goes with the voice on the tape.
21 MR. QUIGLE: I'm sorry. Brian Quiagle representing Express Group.
22 SENATOR CUMMINGS: Okay. Do you want to chime in on this one? Because we are getting into detail here.
23 MR. QUIGLE: Yeah, I think on this specific issue, as Andy has stated it, that the financial disclosure, and I don't see that there's any exemption, whether it's ASO or otherwise, that the financial information must be disclosed, and we have clients who don't want the information. They want a very simple contract where they -- they decide they don't want rebates, they don't want the discounts, they just want a set fee, and therefore, you know, they don't have the capacity, they don't want to pay for the outside audits, and they just want a hard, fast contract and, you know, if they want to audit, they always have that right in the contract, but they don't want the information.
24 SENATOR CUMMINGS: Right, and we thought we allowing that.
25 MR. QUIGLE: And we can provide the information, which would do in most of our contracts, as Andy said, but if we have to provide it to someone who doesn't want it, there's an expense to that, and they're going to have to pay for that, and what we're saying is if in the client doesn't want it, then they shouldn't be forced.
26 If this provision, whether it's the disclosure -- there are a number of these provisions. If the provision was qualified by
27 unless the client specifies in their negotiation or in their contract that they don't want this, you know, be it the financial disclosure or whatever, we'd be more comfortable with it.
28 As Andy said, we're fine with transparency, but if the client simply doesn't want it, we don't see why the state would force this expense on a
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<td>1. health plan for a large employer.</td>
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<td>2. The example I use often when I testify -- I used to work for United Healthcare. They had their own PBM. They felt it was not one of their core businesses, so they sold it, and they hired I believe Medco. I believe, I think they're with Medco now.</td>
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<td>3. MR. FRIEDELL: Yep.</td>
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<td>4. MR. QUIGLEY: They don't necessarily want all the information. They had it when they owned it, and they decided they don't want it.</td>
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<td>5. To say that United Healthcare with 26 million members and hundreds of lawyers doesn't have the ability to figure out whether they want this or not, whether they want to audit or not, you know, kind of defies reality.</td>
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<td>6. So if these provisions, be it the standard, the duty, the financial disclosures, if they were all qualified by some statement that they that said &quot;unless the client specifies otherwise.&quot;</td>
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<td>7. SENATOR CUMMINGS: Okay. It was our intention and we thought we had it in here for an administrative only packet to allow customers to do that.</td>
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<td>8. Now, maybe we need to reword it or reorganize the structure, but we wanted to make sure that -- and it says information that the client requests, and so we want to make sure that the client has the ability to get information that they feel they need to understand that their contract is being fulfilled.</td>
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<td>15. SENATOR McCORMACK: Several thousand?</td>
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<td>16. MR. FRIEDELL: Yes. The very small employers, they typically will go to an aggregator like a TPA, and that'll become a health plan, and then that health plan would then contract.</td>
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<td>17. MS. CUMMINGS: What's a TPA?</td>
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<td>18. MR. FRIEDELL: A third-party administrator.</td>
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<td>19. MS. CUMMINGS: Okay.</td>
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<td>20. MR. FRIEDELL: And then party would then contract with Medco or Express or somebody.</td>
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<td>21. SENATOR McCORMACK: In other words, I guess if I might just jump in here, so my -- the company that I work for has 120 employees.</td>
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<td>22. We use Cigna as our third party, and then they use somebody as their PBM.</td>
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<td>23. MR. FRIEDELL: Cigna has its own PBM, but yes, that's the idea, right.</td>
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<td>25. MR. FRIEDELL: And they could decide, you know, they could decide, you know, if it was someone who -- if you had United Healthcare, then United Healthcare would then have a relationship with Medco. That would be how it would work.</td>
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<td>26. ATTENDEE: Who in Vermont is big enough to -- who are we talking about?</td>
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SENATOR McCORMACK: IBM.

ATTENDEE: I mean, does IBM in Vermont make their own health care arrangements?

MR. QUIGLEY: IBM would probably have a national --

SENATOR CUMMINGS: National.

ATTENDEE: Yeah.

SENATOR McCORMACK: It would be a national for all of them.

MR. QUIGLEY: With a TPA or with an insurer, and then they would -- and they're big enough that they might have a separate negotiation with a PBM.

If they were using, for instance, United Healthcare or Aetna or Cigna as their third-party administrator, they'd probably go with whoever their PBM relationship was.

In the case of Aetna and Cigna, it would be their own.

In the case of United, it would be Medco, but as they get very large, 10,000, 20,000 people in a plan, they can split that up, and in fact, you might have Cigna with the underlying health benefit, but if Express Scripts or Caremark or Medco had a more competitive bid on the PBM, then they would split that off from a Cigna, and it really does operate that way. And I would say for Express Scripts, similarly.

I mean, you know, we would be dealing with employers of say 500 lives to 1,000 lives or more, nothing smaller than that.

Obviously, the state of Vermont is our client, and a large part of our business is health plan.

MS. CUMMINGS: Health insurance companies.

Blue Cross uses a PBM.

MR. FRIEDELL: So we're talking about very sophisticated purchasers of health care, people, you know, who have divisions in many cases set up to look at the issue of the pharmacy benefit.

MS. CUMMINGS: The average consumer does not hire a PBM.

MR. FRIEDELL: Right, right.

ATTENDEE: Or even the small business.

MR. QUIGLEY: Not even the small business.

SENATOR CUMMINGS: Small business, right.

ATTENDEE: Does Caris Wheels (phonetic?)

ATTENDEE: No.

ATTENDEE: Basically, what you're doing is you're part of an association of a group, and it's kind of similar, like -- I don't know about the Vermont Chamber, but the Lake Champlain Chamber offers health insurance to their small business.

That's one plan, but it's offered through -- through the association of Lake Champlain Chamber Of Commerce, but they offer a health insurance plan to their small businesses who by themselves could not buy a health insurance plan at the rate that they could buy by pooling it.

ATTENDEE: Something like this aggregation of small businesses?

SENATOR CUMMINGS: Right, yes.

ATTENDEE: But then there's another tier.

ATTENDEE: But then go to a PBM?

MR. FRIEDELL: But yes, but then go to a PBM, yes.

ATTENDEE: But then you're dealing with the Chamber of Commerce.

SENATOR McCORMACK: Well, I don't know if they do, but NFIB, if NFIB offered health care and a PBM, it would be for small businesses across the country.

ATTENDEE: Yeah.

MR. FRIEDELL: Sometimes we'll deal with a union. A group of unions will come together and we'll...
MR. FRIEDELL: When you say we get our price, how, what do you mean?
MS. CUMMINGS: Well, you keep talking about sharpening your pencil.
MR. FRIEDELL: Well, I use that as a term of art. You're right. There's no price.
SENATOR CUMMINGS: Okay, but how -- how I mean, you don't buy pharmaceuticals and resell them.
MR. FRIEDELL: Well, we do in the capacity of a mail service pharmacy, so what we'll have, and here's a good example, in the testimony that Kathy gave, she said at retail, and she lists here your AWP minus 16 for brands. For generics, it was AWP minus 51.5, and then mail, it was AWP minus 24 for brands, and AWP minus 54.
MS. CUMMINGS: Yeah.
MR. FRIEDELL: So those are the prices. Those are the things we're talking about that get negotiated.
MS. CUMMINGS: Right, but -- so but if you want to get AWP minus 10, instead of minus 24, how do you go about that?
MR. FRIEDELL: Well, it's the other way around. You want a deeper discount.

ATTENDEE: I'll be the sales rep, and I'll call on you.
FEMALE ATTENDEE: How do you know what AWP is?
MR. FRIEDELL: Well, AWP is a published price, but it's a very -- it's a moving target.
We have to employ several people just to get a handle on what AWP is because you're right, it is a moving -- but it is -- it's a difficult moving target, but the federal government through the Deficit Reduction Act of 2000 is looking at making public this thing called Average Manufacturer Price, which is --
MS. CUMMINGS: Yes.
MR. FRIEDELL: -- in theory potentially going to replace average wholesale price.
SENATOR CUMMINGS: Because that has happened, yes, because average wholesale price seems to be what the manufacturers say it is on any given day, and it doesn't necessarily seem to be related to the price of materials, plus time, plus labor or whatever, but again --
ATTENDEE: I mean, their price will fluctuate.
At least as I understand it, their price will fluctuate as -- as the number of customers that are -- that they have as a pool of customers.
I mean, if they had only had 10,000 customers versus the PBM that had 100,000 customers, the buying power for that 100,000-customer PBM is whole lot more.
SENATOR CUMMINGS: Okay.
ATTENDEE: Than this guy.
SENATOR CUMMINGS: But I think that's what I'm asking you to lay out for us.
MR. FRIEDELL: Yeah.
SENATOR CUMMINGS: For the record is how do you go about negotiating?
I mean, if the manufacturer sets the wholesale price, how do you get 20 percent off the wholesale price, and if everyone gets 20 percent, what do you have to do to get 22 percent?
MR. FRIEDELL: There's a variety of different ways that's done, and -- okay, so if you look at these -- there's a variety of different factors that go into that price.
There's these components I'm talking about here, these discounts off AWP, and if it's at mail, we're the pharmacy at mail, so we're saying we purchase at this, and we can sell it to you at this, and it's then a function of our -- of our bulk, as a bulk purchaser how low we can go.
We're negotiating. We're one of the largest purchasers of generic drugs, so we're negotiating with a number of different generic drug manufacturers to get the best price on those generic products, and so that's why we can go that deep when you look at that.
MS. CUMMINGS: So the bigger the volume, the lower your discount?
MR. FRIEDELL: That's for mail, but on retail, it's a function of the network.
So at retail, we've gone around to retail pharmacies, and we said if you want to participate in this network, you can give AWP, and then we negotiate that retail discount, and the payor will say --
SENATOR CUMMINGS: Oh, that was perfect timing.
MR. FRIEDELL: Yeah, right. The payor will --
FEMALE ATTENDEE: He's talking about pharmacies, Andy.
MR. FRIEDELL: So the payor will say, in their RFP, they'll say I want to have a contract

14 (Pages 50 to 53)
with you that guaranties that every one of my members will have a pharmacy within X number of miles from their house, and then -- and then we will then create for them a network based on a network that has a number of pharmacies based on the terms that they've set forward, and so we have to then negotiate with those pharmacies.

And if there's -- if you got an outlier or a bunch of people who live in a place far off and there's not many pharmacies, we don't have much leverage to negotiate with the pharmacies, but if it's in a city, then we may only negotiate --

MS. CUMMINGS: Actually, we've heard that this is the negotiation where Senator McCormack's red flag might go up, where if you are the provider for the state in this town, where probably the majority of the people are on some form of state health insurance that you -- I mean, that pharmacist either takes your offer or loses a huge percentage of business, and so that be that's --

MR. FRIEDELL: But actually, in rural areas, it's all again dictated by --

MS. CUMMINGS: You're talking the state capitol here.

MR. FRIEDELL: Yeah. Well, wherever it is, it's again dictated by our contract with -- it's again dictated by our contract with the customer.

The customer will say they want to have either a broad network or a narrow network, and that's their decision, and those discounts that they're going to get are going to change based on their request for broader --

MS. CUMMINGS: Right, but you negotiate. You're not getting the lower price from the manufacturer. You are negotiating with the pharmacist on what he will sell it for, so it's -- it's the pharmacist's margin.

MR. QUIGLEY: And we don't run away from the fact that we do have that leverage on behalf of our customers.

As Andy laid out before, the growth in the cost of the drug benefit has gone from 18 percent to 5.8 percent.

MS. CUMMINGS: I think the concern is here that some of that growth may be coming out of and in fact putting our local pharmacists out of business, rather than coming out of the pharmaceutical manufacturing.

MR. FRIEDELL: But if you go back to my --

where I started, the earlier example, if you go back to the early 80's, when you got your prescription, you went into the pharmacy. You paid cash. The pharmacy charged the price that the pharmacy charged, and you went home, and then you had to go through this rigamarole to get reimbursed for it.

There was nobody there negotiating that discount on your behalf at that point. Employers have --

MS. CUMMINGS: Yeah, but all I ever bought was Amoxicillin, and it cost ten bucks.

MR. FRIEDELL: Okay, but now, in today's marketplace, where you've got a lot of prescription drugs, they're clearly wouldn't be a tolerance for just people charging whatever they want for prescriptions drugs at the pharmacy.

The employer is demanding. The state of Rhode Island --

MS. CUMMINGS: But that's the market Vermont.

MR. FRIEDELL: I mean the state of Vermont is demanding. All employers are demanding that their PBM goes in and exerts some influence over that price.

And we find that the people who pay the most, studies have shown are the people that have no insurance, the people who go in and pay that over-the-counter price is significantly higher, like sometimes the GAO has numbers, and I have them in here on --

MS. CUMMINGS: Yeah, but if -- if in order to get the contract, okay, from the big dealer, the pharmacist has to pay below his cost and overhead, then he's got a cost shift onto the uninsured, just like everybody else.

MR. FRIEDELL: He has to lower his prior is what it says. I mean, that's --

MS. CUMMINGS: No, he has to lower his price for the big guy, but if that price is not meeting his needs, his costs in overhead, all right, it's too low, but he has no choice because that's 90 percent of his business.

MR. FRIEDELL: But then you wouldn't participate in the network.

MS. CUMMINGS: But if you are the big -- you know, the 64,000-pound gorilla in the town, you control the bulk of the health care. And that's a real issue here.

MR. FRIEDELL: Right, but --

MS. CUMMINGS: Then that -- then that's a
concern. I'm just saying that is a concern. The
pharmacists will be testifying but --

MR. FRIEDEL: And I understand. I hear that
concern, but I would just point out to the
Committee, there are several PBM's, as I said, 40
to 60 PBM's.

We have requirements that we have to have
networks of a certain breadth to show off our
customers, and if we were cutting the market down
to below price and people weren't participating,
then we're not going to be able to meet the
obligations of our contract because we're not
going to have a network that's broad enough to
meet those standards, so we have to -- in many
cases, that's why in areas, rural areas, the
independent pharmacies often have more leverage
because we have to have pharmacies within a
certain distance of people's homes.

MS. CUMMINGS: I'll leave it to Mr. Otis to
respond to that one, but that's been a concern,
and it's reaching, my understanding, the national
level of independent pharmacies.

ATTENDEE: A lot of this is -- I guess I was
a manufacturer's rep for a Fortune 100 company at
one time in my life and -- for about 17 years, and

we used to have -- we had a wholesale price which
was set, and that was for up to 25 cases of
product, and if you bought between 25 and 50 cases
of product, you got a reduced price, if you bought
from 50 to 100, a reduced price.

Then there were the Wal-Marts of the world
that got their own price, which was negotiated
directly from Wal-Mart directly through the
manufacturer.

MS. CUMMINGS: Right, and I think we've seen
that --

ATTENDEE: Through the headquarters.

MS. CUMMINGS: -- that chart.

ATTENDEE: But my job for the most part was I
sold to mostly the wholesalers that existed in
Vermont and Upstate New York, and I would sell to
them at that price level, depending on what their
level was that they were purchasing at, but then
what would happen is they would turn around and
sell it to their customer, the retail customer.

Now, the retail customer, depending on their
volume would pay a certain percentage above that
cost.

SENATOR CUMMINGS: Right.

ATTENDEE: I mean, the marketplace has gone
to cost plus 30 years ago.

SENATOR CUMMINGS: Yeah.

ATTENDEE: 25 years ago, but I had some
accounts because they were parts of national
conglomerates that would receive the direct price
that would be paid otherwise, and it's just -- and
I see this as being I guess much the same way,
understanding how, how that marketplace worked.

Actually, the company that I worked for was a
pharmaceutical company, but it was not
pharmaceuticals that I sold, just to put that out
there.

MS. CUMMINGS: I don't think anyone has
difficulty with understanding volume discounts,
and the fact that wholesale -- when I was selling
wholesale, it was half of retail, because you got,
at least on hard goods, you got to cover --
everybody's got to cover their overhead.

The problem with this one is the wholesaler
sells to the retailer, and then the guy that
controls the customers comes in and says I'm
sorry, you can't do your 50 percent markup if you
want my business, and by the way, I control
70 percent of your customers. You've got to sell
at a 20 percent markup.

Now, if 20 percent doesn't cover my overhead,
then that cost has got to go on to the uninsured,
and the testimony -- and we'll have testify from
the pharmacists. You know, if you're Wal-Mart,
you got an equal playing field.

If you're Joe the pharmacist downtown, you're
in a whole other ballgame, and I think that's --
that's it. That's the concern.

ATTENDEE: But I guess I'm -- Madam Chair, if
I can just ask, are you suggesting that we come up
with some language that allows us to interject in
that relationship?

SENATOR CUMMINGS: I'm saying that that is
part of the concern that we've heard about PBM's,
that the state of Vermont, when they contract,
doesn't understand that 30 percent discount, that
10 percent of that is coming out of their local
pharmacist, not out of Merck Pharmaceutical
Company, and that's just one been of the concerns
that come up about PBM's and how they negotiate the
their price. Okay.

ATTENDEE: Yes. We're in a conflicted
environment. Is it the pharmacist or is it --
(inaudible).

MR. QUIGLEY: Yeah, Brian Quigley again, and
I would say that, as I say, we acknowledge that we have leverage, and that's why our customers hire us, but --

FEMALE ATTENDEE: Uh-huh.

MR. QUIGLEY: But they hire us, the insurance companies and employers, but I can speak for the insurance companies. I also represent America's Health Insurance Plan.

They are dealing with customers, particularly small employers who are struggling to pay their premiums, and the drug benefit is usually the first benefit that a small employer will drop as an optional benefit.

So the work we do enables many of those insurers to keep the cost of that drug benefit down, to keep those small employers in a position where they can continue to afford the drug benefit.

So it is a real policy question but, you know, independent pharmacies are threatened really more by the large-chain pharmacies and the Wal-Marts than they are by --

ATTENDEE: Yeah.

SENATOR CUMMINGS: Because they can --

MR. QUIGLEY: -- by our activity in the marketplace. I mean, that's well documented.

But as I say, our role is to take advantage of the leverage to get the best price for our clients so that they can provide the drug benefits to their small customers, small employers.

And, you know, as someone just said, that's the dilemma.

Who are you going to protect here, the small employer, whose employees want to have the drug benefits or the independent pharmacist?

SENATOR CUMMINGS: I think we're trying to find just a little balance.

ATTENDEE: Yeah.

SENATOR CUMMINGS: In the system to make sure that it's balanced and that everyone knows what the rules of game are going on.

MR. FRIEDELL: Because Madam Chair, I heard an interesting example, and I think you may have been there. It was an En Coyle (phonetic) meeting down in Boston. I think it was summertime.

SENATOR CUMMINGS: I was there.

MR. FRIEDELL: There was a gentleman who --

SENATOR CUMMINGS: I was there.

MR. FRIEDELL: There was a gentleman there who was representing the GIC. I can't remember what that stands for, but it was the entity in Massachusetts state government.

MR. QUIGLEY: Group Insurance Commission.

MR. FRIEDELL: Right, Group Insurance Commission.

SENATOR CUMMINGS: Yep.

MR. FRIEDELL: Who purchases prescription drug benefits for state employees.

And he made this same point that Brian's making is that, you know, it is a public policy struggle, but you have to -- as public policy makers, you have to weigh that balance.

There's the growing cost of prescription drugs that people paying for that bill, for those costs, and there's the pharmacists and, you know, do you support leg -- I mean, this legislation doesn't get into this issue in any way, but legislation that steps into that struggle is a real -- I mean, that's the issue you're weighing is those two, and do you enact public policy that favors one that over the other is the question to resolve because you have costs.

It's like squeezing a balloon. If you squeeze it one place, it comes out somewhere else.
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1  page 14.  I would just say that section on the top
2  of page 14, line 3, that's a provision there which
3  prevents the PBM from making any money from
4  substituting a lower-priced generic.
5  It seems as though that's the kind of
6  incentive that the customer should -- that the
7  customer wants their PBM to have.
8  I mean, when we contract with -- with an
9  employer, they want us to be favoring generics.
10  SENATOR CUMMINGS:  Okay.  You're looking at B
11  on the top of 14?
12  MR. FRIEDELL:  Correct, yes.
13  SENATOR CUMMINGS:  Okay.
14  MR. FRIEDELL:  So these are barriers to
15  therapeutic interchange programs, switching
16  programs, as they're commonly referred to, and
17  this is saying that any -- any money made by
18  substituting a lower price generic can't be made, so then you now --
19  ATTENDEE:  (inaudible).
20  MR. FRIEDELL:  Right, and basically, you
21  know, you're taking -- you're saying that the PBM
22  can't be paid to lower the prices for their
23  customers.
24  SENATOR CUMMINGS:  I think this was looked at
25  more as raising them, but we'll check it.

1  Utilization is going up, and that means more
2  people using more drugs, so whereas five years
3  ago, one person at this table was using one drug,
4  today, maybe three people are using three drugs.
5  That's a huge burden that's adding cost to
6  it.  Plus, you have a mix, which Steve I think
7  called intensity, which is a more costlier mix of
8  drugs.
9  So to say it's our fault and that we need to
10  be regulated in this situation I think misses the
11  point.
12  We are working to get these costs down.
13  There are external factors that are pushing
14  prescription drug costs up.
15  There are new, more expensive drugs coming on
16  the market, more people using drugs.  There's a
17  broader population of drugs.
18  But to -- to sort of regulate PBMs as the
19  cause because we have that contract and we're in
20  the marketplace to control the drugs, I think
21  misses the, you know, the issue.
22  We're in the marketplace right now trying to
23  control the costs.  Our customers look to us to
24  help them to control that cost, and that gentleman
25  from the GIC said the same thing, I think at En
1. Coyle.

- He said he's sort of amused by this PBM regulation debate because he in his position looks at the PBM as his ally. And that's the relationship we have with many of our clients.
- We're working with them to try to help them get the costs down.
- 
  MR. QUIGLEY: If I can address the question again, I also represent the health plans, 1,300 health plans nationally. I think there is a real difference.
- Certainly, the health plans work to control costs with Disease Management and Utilization Review, but the level of competition in some states and certainly in geographic regions is very different.
- As you know in Vermont, for instance, there are really only two insurers competing for business.
- The level of competition is significantly less.
- 
  FEMALE ATTENDEE: But we spend less per person here than most other states, don't we?
- 
  MR. QUIGLEY: Pardon?
- 
  FEMALE ATTENDEE: We spend less per person in the state of Vermont than most other states.
- 
  MR. FRIEDELL: Right. There are other factors, and the primary driver in increase of the cost of health care is the cost of the underlying service, and to the extent there isn't competition in local markets, either at the physician level or at the hospital level, you're going to rising costs that are harder to control and, you know, the other drivers are obviously the aging population, new technology and new drugs coming on the marketplace, those kind of things.
- So the ability of health plans to control those factors is in many ways significantly less than is the case on the drug benefit.
- Frankly, the health plans are subject to a very high level of regulation in terms of how they can develop networks and how they manage those networks.
- Obviously, there are a lot of mandated benefits that are on top of contracts.
- The state of Vermont has community rating, which affects the pricing.
- So there is a level of regulation that diminishes the ability of health plans to control costs that doesn't currently exist in the PBM.

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1. area, and what we're saying is let the customer decide what they want and let the customer determine how people will compete for their business.
2. The health plan business, unfortunately, is no longer that pure competitive model.
3. There's a great deal of regulation, some of which makes a lot a sense, and some of which we oppose, but it does restrict the ability of health plans to compete on all of the issues, and so there is that difference, but the underlying is the demographics of the population, and the costs of the underlying services is what primarily determines the costs of health care and is the reason why it's so expensive.

MADAM CHAIR: Okay.

(End of CD 2007-46)
STATE OF VERMONT

SENATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: February 15, 2007

COMMITTEE MEMBERS:
SENATOR ANN CUMMINGS, CHAIR
SENATOR CLAIRE AYER, VICE CHAIR
SENATOR MARK MacDONALD, CLERK
SENATOR BILL CARRIS
SENATOR JAMES CONDOS
SENATOR HULL MAYNARD, JR.
SENATOR RICHARD McCORMACK

CD No: 2007 47

Esquire Job #928012
PROCEEDINGS

CD No: 2007 47

MR. FRIEDELL: -- a benefit could just go away, if they couldn't afford it.

MS. CUMMINGS: I don't think anyone is arguing that you have a good, probably necessary service that the average organization couldn't do what you do, because it is a very confusing marketplace. I don't think anyone is arguing -- I don't think that's the issue, and I don't think anyone is arguing that you are the cause of rising healthcare costs. I think -- and there have been -- we started this six, seven, eight years ago, Robin? We have been working on this a long time.

When we started, PBMs were owned by pharmaceutical companies, and I think this is all -- but we are trying to make sure that information is available, so if -- for people that want it, so they can make informed decisions about their PBMs and where, you know, the discounts are coming from, and that's where this started.

If you have got boiler plate, we will be happy to take a look at that. We are not trying to force everyone to have a full disclosure program, but we are trying to make sure that -- I guess there has been, in the past, concern as to where the true loyalty lies.

You know, if you are, in fact, making a larger portion of your corporate income from rebates from pharmaceutical companies, are you working in their interest or are you working in the interest of your customers? That's been the on -- you know, the ongoing concern. You know, who do you work for? For whose profit and benefit? And I think that's because pharmaceuticals are not like clothing or camping equipment, they are a necessity of life for people that are sick, and so you have people at a very vulnerable position.

MR. FRIEDELL: I completely agree with you. That's our business. We are working with our employers to make sure that that benefit remains affordable for the population. In many cases it is the difference between offering and not offering. A lot of employee customers have said that, without these tools, they wouldn't be able to extend that benefit to those people, and they wouldn't have coverage, so I can completely understand.

MS. CUMMINGS: What would happen if no one had coverage and no one could buy pharmaceuticals and the market dried up, do you think the prices would come down?

Okay. Maybe we will just get --

FEMALE ATTENDEE: That was a good answer.

MS. CUMMINGS: Okay. And you said everything you came to say. I am not trying to cut anyone off.

MR. FRIEDELL: I know you have a full agenda. I know there are two other bills which we had concerns on. I can raise them another --

MS. CUMMINGS: No, no. You can do those.

MR. FRIEDELL: Okay.

MS. CUMMINGS: Those are two new ones --

MR. FRIEDELL: I would talk about the --

MS. CUMMINGS: These are two little pharmacy bills.

SPEAKER 3: Your contention is basically Subchapter 9 is unnecessary?

MR. FRIEDELL: Yes, that is our contention, that it is a competitive marketplace today. That we are partnering with our plans, we are contractual -- in the contractual arrangements is the standard that should apply to that relationship.

Brian, did I -- anything else on the -- before I move on -- the PBM bill that I didn't add?

MR. QUIGLEY: Well, either I can do that now or I can go back after you have discussed the other bills, whatever Senator Cummings would like.

MS. CUMMINGS: Why don't we let you just go through those bills --

MR. QUIGLEY: Yeah.

MS. CUMMINGS: -- and then we will give Brian, and then a break. I was going to try and get you a short break. Yeah, we are going to be here until 6:30 or so, it looks like, so...

MR. FRIEDELL: Okay. I would move first to S84. This bill is a bill that would establish prompt payment terms between the PBM and the pharmacy and with mandate electronic fund transfers --

MS. CUMMINGS: It doesn't mandate electronic fund transfers.

MR. FRIEDELL: It doesn't?

MS. CUMMINGS: No. It just says if you do
MR. FRIEDELL: Okay.

MS. CUMMINGS: -- you have to pay --

MR. FRIEDELL: If you receive a claim electronically, you have to pay electronically, right?

MS. CUMMINGS: No.

MR. FRIEDELL: Say again.

MS. CUMMINGS: You have to pay in eight days is what is the intent.

MR. FRIEDELL: Okay. It says prescription drug claims submitted electronically shall be paid within eight days by electronic -- so if we received the claim electronically, which we receive all our claims electronically, because you go and you swipe the card at the pharmacy counter, so if you are receiving a claim electronically, you pay it in eight days electronically.

Our main concern here is this is unlike prompt payment legislation anywhere else in the country. Eight days is an incredibly short turnaround time to be paying somebody. Standard contract arrangements across all business practices require 30-day payment terms. If you have a credit card bill or if you have, you know, a supplier, you have -- generally a 30-day turnaround period. In fact, I have a visual here that shows how we pay our customer --

MS. CUMMINGS: My contract doesn't give me 30 days from the time I got the bill.

MR. FRIEDELL: What's that?

MS. CUMMINGS: I know my car payment is due on the 26th, then I haven't gotten the bill yet, so --

MR. FRIEDELL: Generally you have a month to pay your bill.

MS. CUMMINGS: From the time I incur the debt, but from the time they send me the bill, I don't have 30 days.

SPEAKER 2: Verizon bills arrive two weeks beforehand.

MR. QUIGLEY: But those are repetitive bills here we are talking about.

MS. CUMMINGS: I am into ten days here, and the bill hasn't shown up yet, and it gets pretty tight sometimes.

MR. QUIGLEY: These are trans -- these are one-time transactions, not, you know, repeating payments like mortgages or car payments.

SPEAKER 3: From services incurred.

MR. QUIGLEY: You know what that bill is going to be every month, whether you get the bill or not. Here we await the bill to find out what is owed.

MS. CUMMINGS: I guess --

SPEAKER 3: Not when you have kids.

MR. FRIEDELL: Anyway, regardless, whether it is less than a month, you don't have to pay your bill in eight days.

MS. CUMMINGS: I think the request of the bill was requested because Medicaid pays eight days after --

MR. FRIEDELL: I have heard that comment made before, and I don't have any information about that. And Medicare -- Medicaid may be set up to pay that way, but I can tell you that across all of our business and our competitors, across all the business and across Medicare Part D, the payment terms I am about to describe are the same payment terms that are generally adopted by all pharmacy benefit managers.

In fact, the retail pharmacists have a Medicare Part D plan. They partner with Member Health, and they are actually one of the largest Medicare Part D providers. Their payment terms under Medicare Part D are exactly -- almost virtually identical as the ones I am about to describe to you.

What happens is, we have -- we batch plans, so basically as you go to the pharmacy, that claim is submitted, and all those claims keep submitting, and we pull them together and we batch them over a 14-day period. And then once that 14-day period is complete, we gather those claims, and that weekend after that period, our entire systems are absorbed by processing that 14 days' worth of claims. Then -- we then -- between the 15th and 16th day, that's when we batch it and pull those claims together and process them. Then we bill our clients, and then clients -- we receive payment from the client, and we mail a payment out to the client. Once we receive payment from the client, we then pay the pharmacy, and that payment is always out by the 26th day.

So that's the process.

Now, you are talking about abridging it to eight days, getting a payment out. I mean you would have to be doing these batch cycles -- it wouldn't be possible within our current system right now.
MS. CUMMINGS: Okay.

MR. FRIEDELL: And it is unlike any other prompt payment rule across the country.
Physicians, other prompt payment rules that are set up under -- I don't know Vermont's laws, but I know under Medicare, it is always 30 days, and that is generally accepted.

MR. QUIGLEY: In fact, most other providers are 45 days.

MR. FRIEDELL: Okay, 45 days, sorry.

Anyways, my point is -- the point I am trying to make, by setting this narrow standard for pharmacies and not other providers, you are opening the door for other people coming to the door and asking for similar terms. And I am just telling you that based on how our system works, it can't -- it cannot be done in eight days. And even when you abridge it below the 26 days, it requires you to run an extra cycle, which has extra payments. And that is a payment -- a cost that we have to pass back to the customer. And the other piece I would mention on that is the electronic fund transfer, it implies that if you are receiving electronically then you can pay electronically. But they are two totally different systems.

When you go to the pharmacy and you swipe that card, that's a system we have with the pharmacy. That is interact (inaudible). To have an electronic fund transfer, that's a totally different system, and that's not something generally done today under pharmacies.

Maryland recently passed a law requiring electronic fund transfer. We invested a significant amount of resources to build an electronic fund transfer capability for Maryland. It was hundreds of IT hours to build that, code that and make it capable. And then you have to have the bank accounts for all the participants, and you have to keep that updated.

We rolled that out to pharmacies in October. There is over 1,500 pharmacies in Maryland. We have one who signed up for that. It just shows you that there is not a huge demand for that service.

MS. CUMMINGS: Okay.

MR. FRIEDELL: That's on 87.

MR. QUIGLEY: If I can just comment on 84, just to amplify what you said. We were asked by the state to analyze this bill, and we did point out these points, that we batch claims on a two-week basis, and if we had to go to eight days, that would require four times the cycles that we currently use, and we would have to charge additional fees for that. Under the contract, we have the right to charge those additional fees.

In addition, the money going to the pharmacists earlier affects how much they are being paid. And we would probably renegotiate those fees with the pharmacist to reflect the fact they are getting money earlier. So that ultimately they would not receive any more value from getting these funds earlier, but the additional administrative expense would have to be paid by the state plan. So, you know, the customer, our customers, be it the State of Vermont or otherwise, are going to bear this additional administrative cost and, you know, at really ultimately no additional benefit to the pharmacist.

Because it may be that -- I don't know this -- that the Medicaid plans pays within eight days. It would be unlike many Medicaid plans I know. I have heard doctors say they don't even bother with Medicaid anymore, because they never get paid. But it may be that they do, but again, that's a single-state system set up to pay a limited set of providers. We are dealing with national systems where we have these administrative systems in place that control the cost of making those claim payments and to adjust that just for the State of Vermont is a significant expense.

MS. CUMMINGS: Okay, thank you.

MR. FRIEDELL: I will defer my comments. I know Brian used up my time. I appreciate the Committee's time.

MS. CUMMINGS: That's okay. You dog-sledded up here.

MALE SPEAKER: To sum up, either witness, are you objecting to the number of days or are you objecting to the entire concept?

MR. FRIEDELL: The way it is structured, we are objecting to the bill, the concept. I think the number of days is too narrow and building electronic funds transfer is a costly, additional expense that will need to be passed onto the customer. And we are not sure there is a huge demand for it, based on our experience in other states.
MS. CUMMINGS: Okay. Thank you, Brian, do you have something to add?

MR. QUIGLEY: On 84, no.

MS. CUMMINGS: No, on the big one.

MR. QUIGLEY: On the big one? Yeah.

MS. CUMMINGS: Yeah.

MR. QUIGLEY: On the big one, just to amplify a couple of points that Andy touched on. On the issue of the standard of care so to speak.

MS. CUMMINGS: Yeah.

MR. QUIGLEY: It is essentially a fiduciary standard. We have seen other states where I have pointed out that PBMs are not fiduciaries under the risk that they simply remove the word fiduciary and left the rest of the definition, and that's essentially what you have here.

MS. CUMMINGS: Yes.

MR. QUIGLEY: As Andy pointed out, I am a lawyer, and this does create a much higher legal liability for the PBM, well beyond the contractual liability. It is essentially a concept of trust law, where either an attorney or some other fiduciary controls the assets of the client. We are not doing that, and we would have to charge for that additional legal liability exposure to the client.

In addition, the client, in the case of an insurance company or an employer, they are the fiduciary. They have this obligation as defined here in words, but defined under federal law as fiduciary obligation. And they don't want us to have the same obligation they have. They don't want to give up that control or the control of those assets. So it is creating a legal standard that is inconsistent with a contractual relationship. It increases the cost.

It is not permitted under federal law, and we just think it doesn't make any sense. Again, these are contracts between sophisticated purchasers and sellers, and to create an ambiguous, at best and clearly inappropriate, at worst, standard doesn't make any sense to us.

On the enforcement provision, whether it is the registration with the insurance department for the consumer fraud, these are benefits that are regulated under the insurance contract. Fishka already has authority over the drug benefit, just as they do any other benefit, whether it's external review or network adequacy or disclosure.

All of those issues that control the insurance contract, control these benefits. So we do not see that there needs to be additional regulation by the department of the PBM, which is merely an administrator, and we are extremely concerned about the application of consumer fraud, punitive damages and private rights of action on what essentially is a contract relationship.

I have looked -- I have looked at the consumer fraud statute, and clearly it is directed towards individuals. Again, this is not a contract between an individual and the PBM, it is a contract between a very sophisticated purchaser and the PBM. And we think that all this, those provisions can do is create havoc in what our standard contract relationships, and again, increase legal liability.

So, you know, if the goal is to make sure the client understands what their rights and obligations are under the contract, both as to financial disclosure and their right to get rebates and the right to have audits, we don't have any quarrel with that, as long as they can choose that. But to impose a level of regulation that the PBMs would be assessed for, and again,
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PBMs will be submitting for that accreditation, which is both an initial review and an ongoing on-site audit of the PBMs to make sure they are living up to those initial standards.

MS. CUMMINGS: Okay.

Any questions?

Thank you.

MR. QUIGLEY: Okay.

MS. CUMMINGS: Thank you for being on the phone with us.

MR. QUIGLEY: Thank you for letting me.

MS. CUMMINGS: No problem.

MR. QUIGLEY: I was not looking forward to having to drive up to Montpelier.

MS. CUMMINGS: There are no parking spaces.

The meters are all under snow.

MR. QUIGLEY: It is good to know. I would have been parked down by the grocery store and trudging through snow.

MS. CUMMINGS: We are catching up, so Anthony Otis.

MR. OTIS: It is going to be quick.

MS. CUMMINGS: No, everybody gets their day in court here.

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MR. OTIS: Am I talking about 84 and 87?

MS. CUMMINGS: If -- yes or this, whatever the pharmacists would like to comment on.

MR. OTIS: Hello members of the committee, Madam Chair, I am Anthony Otis and I am an attorney, policy attorney, and I represent three pharmacy organizations in Vermont, the Vermont Pharmacy Association, Vermont Retail Druggist Association, and the Vermont Association of Chain Drugstores.

Thank you for having me speak a little louder.

I would like, if I may, defer testimony on the RDR, simply because when I received it yesterday, I sent it electronically.

MS. CUMMINGS: The RDR is the reimbursement?

MR. OTIS: No, the DR is PBM regulation, etcetera.

MS. CUMMINGS: Okay, okay.

MR. OTIS: So I am not prepared --

MS. CUMMINGS: You just want to talk --

MR. OTIS: -- immediately to speak on it.

MS. CUMMINGS: Okay.

MR. OTIS: Although I recall it, and I have files from previous years.

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MS. CUMMINGS: Okay.

MALE ATTENDEE: The big bill, it is the big bill.

MS. CUMMINGS: You may have to testify, and help (inaudible).

MR. OTIS: I am aware of that prospect and that's okay.

MS. CUMMINGS: And you may be more appropriate.

MR. OTIS: I have clients who are -- would you like talk to those, too? If not, I would be happy to give the chair so somebody else --

MS. CUMMINGS: No. The two, and I guess you can, you were the source for those bills.

MR. OTIS: Yes, and so I should explain it to the committee. Thank you. I will.

I guess I am just -- I don't want to say I am just a simple country boy, but I am trying to figure out --

MS. CUMMINGS: So is a fox.

MR. OTIS: I am trying to figure out how electronic transfers work, and unlike the gentleman who was on the telephone, who obviously is an expert and -- has a specialty in this area of the law, it seems to me that if the state Medicaid program will pay its vendors if they get the money by sometime on Wednesday, they get it within a week, it tells me that it is not impossible to pay more promptly.

Now, some would say that having a long period of time will allow someone to benefit from the float, but I think in reality, whether it is eight days or 30 days, it evens out for everyone. It is just a question of what is reasonable and fair, and frankly, the 45-day statute is, we already know is out of sync with some national standards, and I would be happy to talk the 26 days as a compromise. But I am thinking of a lower number, and I am not yet convinced by the testimony, and I will take time to discuss that with the lobbyists for various organizations.

MS. CUMMINGS: The reason maybe is I was hearing that -- you might check on it -- that sounds like the PBM bill their customers before they pay the pharmacists. I don't think Medicaid bills customers and that may be the extra step.

MR. OTIS: That may be the step that takes another eight days. Eight days a week. Huit jours par semaine as they say in French.

MALE ATTENDEE: (Inaudible) seven days a week.

MR. OTIS: Well, you know, I am in a business,
and we pay all the bills that come in during the week on Friday, and we wait for our money, and I think it is not a good business practice to pay with the money. I think people should pay promptly if they receive the money promptly.

The other bill that I have before you, but it was assigned to the Health and Welfare Committee, has to do with the mail order law. We do have a law in Vermont that requires pharmacy benefit management companies and health insurers to allow their insureds to purchase a 90-day supply on the same terms as they would through US mail service pharmacies, the term of art in the legislation.

I think the easiest way for you to make a decision on that would be to simply call up your PBM, if you have one, and ask them the question directly, as I did, or take longer to get the paper. And I am apologetic that I don't have it all with me today. The answers I got show that at least one major insurer in this state is not following the law, and -- because they are offering you to go to mail order, you get -- you only pay two co-pays, but if you get a 90-day supply from your local pharmacy you have to pay three co-pays, and I didn't think that was what the statute said.

MS. CUMMINGS: I believe the statute said you had -- the issue that came to us was that the PBMs who own the pharmacies would give a three-month supply and you got one -- well, you get two co-pays. You get one co-pay, but in a contract with the pharmacy, they said you are only allowed to sell on one-month supply, and therefore, you have to pay three co-pays for the same amount of medication, which is a definite incentive for people to leave their local pharmacists. So we said you had to allow it at the same -- with the same terms. You can't give yourself the benefit.

MALE ATTENDEE: Does that refer to people who are on state plans or to everybody?

MS. CUMMINGS: Everybody.

MALE ATTENDEE: I get a 90-day supply, and I pay three months co-pay.

MS. CUMMINGS: If your pharm -- if that's what they do to the pharmacy -- okay, if they -- if that's the term when you go to the pharmacy, then it has to be the same term if you do it mail order -- with mail order. They can't say you can buy mail order and only pay one co-pay, but if you go to your pharmacy, you have to pay three.

SPEAKER 5: Most -- I think the terminology, you are saying one co-pay. I don't know of any mail order that allows you to pay the one-month co-pay for a three-month supply. Most of the mail order you pay two.

MS. CUMMINGS: Okay.

SPEAKER 5: You pay two monthly copays, the equivalent of two.

MS. CUMMINGS: Two and you get three.

SPEAKER 5: And you get three months.

Now, the question just that I would ask, to further the question is, are the pharmacies willing to accept the same payment for the drug for the PBM as --

MS. CUMMINGS: PBM owns the mail order.

SPEAKER 5: I understand that.

MS. CUMMINGS: Okay.

MR. OTIS: We made the formulary in the pharmacy --

MS. CUMMINGS: You will have to ask Anthony. That's the law now. The law says that you cannot discriminate between what you offer -- you can't tell the pharmacy you can't offer the same thing.

SPEAKER 5: But can the pharmacy decide it wants to do it differently?

MR. OTIS: Yes, if the pharmacy doesn't want to pay the formulary price, then the law doesn't apply to them. They have to accept the PBM or health insurer's formulary price, the price that they would pay, and then they get the benefit of being able to handle the 90-day supply.

SPEAKER 5: But if they decide not to --

MR. OTIS: Yes, then they don't.

SPEAKER 5: How does the client know?

FEMALE ATTENDEE: That's the question. That's the issue.

MS. CUMMINGS: Let's let Anthony let out the present issue.

MR. OTIS: The pharmacist knows and the pharmacist will tell them, because if they are not accepting that formulary price, then they are probably not accepting the insured from that plan.

MS. CUMMINGS: Right.

MR. OTIS: But the president of the association will be here tonight, and (inaudible) I believe, the executive director, and I will run that by him again just to ensure that I have that right.

And then there is a question, the folks
that are on the telephone to answer questions from the insureds, and at the end, one of the major PBMs, it is the state’s -- as a matter of fact, when I called on behalf of my father, who is not well and is taking a lot prescription drugs these days, about it, the customer representative did that, well, you know, we can get a better price than the pharmacy can, so, therefore, you will be getting a better price, which, of course, is not accurate according to the law. So I think it bears some -- it bears some investigation, and the easiest way to do it, because I will guess -- I will have time since the bill -- we won’t have time to fully consider it here.

MS. CUMMINGS: Actually, we have got someone on the phone in about 30 seconds.

MR. OTIS: And we can -- you can call in yourself and ask for the paperwork, and then look at it and see if you think they are following the law. I don’t know that they are doing it intentionally, but it is happening, and let’s make sure that everyone is doing it right.

MS. CUMMINGS: The issue is that they may not be telling people that you can buy -- if it’s two co-pays or one, but you can buy at the pharmacist

that you know has agreed to take your plan and your formulary price, that you can’t then say okay, but you can save a co-pay if you buy through our mail order.

MR. OTIS: And the statute --

SPEAKER 6: Are they saying co-pay, or are they saying cheaper price?

MALE ATTENDEE: Both, they would say both.

SPEAKER 6: Because cheaper price would be to the insured -- to the insurance company or to the employer.

MS. CUMMINGS: Right.

MR. OTIS: It implies that they can give you a better deal, because they get a better price.

Where it’s -- the formulary price --

SPEAKER 6: (Inaudible) individual, it is a (inaudible) plan.

MS. CUMMINGS: It should be.

MR. OTIS: It may very well be, but we are talking about -- this was a consumer protection provision originally, and I am just amending that to make it clear that everyone should follow the requirements of law.

This particular section of law came in during a conference committee on the general appropriations bill, and it gave the right for the pharmacy to compete, but it didn’t put any provisions to make sure that the insured and PBM, and I am sure that they wouldn’t disagree, that they ought to be properly informing their insured about what the law allows them to do.

MS. CUMMINGS: Maybe if you get your executive director, you can -- I know you weren’t really planning on testifying on this today, so see if you can get us the backup information.

MR. OTIS: Sure.

MS. CUMMINGS: Okay.

MR. OTIS: Thank you.

MS. CUMMINGS: Thank you.

Okay, we have Sean Flynn.

SPEAKER 6: Can we ask Andy about this very issue since he is sitting here? I don’t know if he wants to answer.

MS. CUMMINGS: I thought he already testified on this bill.

MALE ATTENDEE: He didn’t testify on that bill.

MS. CUMMINGS: Okay. Right now we have got about 30 seconds, but yeah --

FEMALE ATTENDEE: He can do that.

MS. CUMMINGS: Identify yourself for the record here.

MR. FRIEDELL: Andy Friedell at MEDCO.

I know that in our case -- I know that in our case there are no retail pharmacies that have agreed to accept the mail network rate in Vermont, and so you are going to have a list like this, the problem would be it can’t be a blanket list that you send out to members that say you can go to any retail pharmacy. It would have to be some kind of a list that is fluid, if you will, that identifies the pharmacies who have accepted that rate. Like a list maybe on a Web site that says these pharmacies have accepted that rate or something like that.

FEMALE ATTENDEE: Why can’t you tell people they can check with their pharmacists? Some of them do offer it.

MR. FRIEDELL: I guess they can ask their pharmacist.

MS. CUMMINGS: It sounds like that we have got a problem with things being taken out of these bills, being stuck in the appropriations bill, being dealt with by people who haven’t been dealing with the issues, the appropriation committee, and it sounds like (inaudible) needs to
work on this one some more. It sounded real simple.

SPEAKER 6: If I can just ask one question, and that is, if I understand what you are saying, your PBM will offer the local pharmacist, if they are willing to accept all --

MR. FRIEDELL: They would have to accept the terms and conditions and rate, and their rates, you can --

MS. CUMMINGS: It's lower because you are doing mail order, and you don't have the overhead of the store.

MR. FRIEDELL: And you can look at those rates that Kathy, from your human resource, put in --

MS. CUMMINGS: Right.

MR. FRIEDELL: Those would be the rates that they would have to accept at that retail --

FEMALE ATTENDEE: One of the issues that was brought up --

MS. CUMMINGS: Okay. I got -- I got -- this bill was actually in Health and Welfare, and I am going to let them deal with it. And I am trying -- we have Sean Flynn. Hello, Sean, can you hear us?

MR. FLYNN: Yeah, I can hear you. I am here, thank you.

MS. CUMMINGS: Okay, it is Ann Cummings, Senate Finance Committee in Vermont, and I have you are the Associate Director, Program on Information Justice and Intellectual Property at the American University College of Law.

MR. FLYNN: That's right.

MS. CUMMINGS: Okay. And you have a copy of the bill before you, so just let us know what parts of it you are going to testify on.

MR. FLYNN: Great. Let me first further introduce myself. I also serve as litigation and policy counsel for the National Legislative Association on prescription drug prices, and I do some work also for the forum on democracy and trades that represents states in relation to trade policy advocated before USCR and Congress on those issues.

MS. CUMMINGS: Okay. So I was going to ask you who you represented, but you really are the National Legislative Conference on prescription drugs, Sharon Shreet's (phonetic)?

MR. FLYNN: That's right.

MS. CUMMINGS: Okay.

MR. FLYNN: What I want to talk about, two sections, the section 4651 dealing with unconscionable prices of medicines, and 4621, dealing with the confidentiality rules as applied to relief of prescription data.

MS. CUMMINGS: Okay.

MR. FLYNN: Let me just say a few things about some of my experience in these areas, and then I will open it up for questioning.

MS. CUMMINGS: Okay.

MR. FLYNN: So as the committee may or may not know this, there has been some litigation around each of these areas, and I have represented the DILA (phonetic), the legislative association, in some of those areas filing (inaudible) on behalf of states.

And so I can testify to you a little bit about some of the things we have learned in that litigation, some of the pit holes that we found, some of the way the Vermont legislation responds to those areas, and then I can open it up for any further questions.

MS. CUMMINGS: Okay. That will be helpful.

MR. FLYNN: First, let me address the unconscionable pricing legislation. So as the committee probably knows. I mean one of the main problems this attacks is not just the high rates of medicine, the high price of medicine, but the increasing prices of medicines that are already on the market.

So since 1990, you have consumer spending for prescription drug prices have increased over five fold. The medicine prices increased over five times over the last, you know, slightly over a decade. We now spend $235.8 billion on drug prices. Those are $2005 dollars. That's about the equivalent to the amount the US spent on the entire healthcare sector in 1980.

The medicine prices have risen about twice as fast as the rest of health spending and four times as fast as inflation as the economy as a whole over this period, from 1990 on.

Spending per capita on prescription drugs in the US is the highest in the world. It is about twice as high as the OEC medians. If you compare our price to other wealthy countries, we still pay about twice as high -- our price is about twice as high as that average.

So several factors account for the increase drug spending in the US. About 40 percent of the increase is due to the price
increases of existing medicine. And primarily those are patented brand-name medicines.

Another 30 percent is the other section of the bill I want to talk about, about 30 percent of increased spending shifts to more expensive products from less expensive products, mostly caused by marketing of drugs to doctors. So I will talk about that specific problem next, but right now I want to talk about the unconscionable pricing part of the bill, which I believe is primarily aimed at the 40 percent of increase that can be attributed to drug makers raising the price of existing products over time.

So there has -- the District of Columbia passed a similar piece of legislation. There are some significant differences between the two pieces, but D.C. also passed a specific bill attempting to attack the excessive pricing of medicine. That bill was quickly sued by the pharmaceutical industry, specifically the Pharmaceutical Research and Manufacturer Association, Pharma, Pharma brought a lawsuit against the District of Columbia, and they alleged a couple of key legal arguments.

So the first argument that they raised is federal preemption by the patent laws. They argued that the federal patent act preempted the ability of the District of Columbia to regulate the price of patented medicine.

A second argument that they brought forward was that the law was unconstitutional as applied to out of state manufacturers that weren't within the jurisdictional boundaries of the District.

And those were essentially the two main arguments. They also brought a third argument that the bill violated the foreign commerce laws, because that bill, which the Vermont bill does not, asks courts to compare the prices of -- in the district with prices in other high-end income, foreign countries, mainly Canada, Germany, the UK and Australia.

That provision, especially, is not really triggered by the Vermont law at all, because the unconscionable pricing provision in the Vermont law makes no reference to any foreign countries.

So you are not likely to see any arguments either in the legislative process or later in litigation at the foreign commerce clauses in anyway implicated by the Vermont effort.

But you are, however, likely to encounter arguments both in the legislative process and probably in litigation, after this bill is passed, both on the patent preemption, and on the dormant commerce clause aspects of their argument that were bought in D.C.

So I want to explain those two areas a little bit, and also explain why the Vermont statute is different than the D.C. statute, and I will first say that we still believe and are defending the D.C. statute in the court of appeals at the moment.

The district court in that case did find that the D.C. act was unconstitutional in various parts in a complicated way on those three grounds.

That decision has been appealed, and we don't have the final ruling in the appellate courts on that issue. So the fact that the arguments of the (inaudible) of the D.C. case doesn't mean that those arguments will necessarily prevail in the Vermont case, but in any case, the Vermont bill is different in several particular ways that I think should be dispositive, even if the D.C. act were to go down.

So first the patent preemption issue.

This is a kind of complicated, technical issue that requires thinking and analyzing what are the powers that the federal patent act grants. Many people will kind of lay early to the, you know -- early to thinking about patent law, might think that a patent grants some kind of right to price a product at whatever the patent holder chooses.

That is not, however, what the patent act in actuality grants to the patent holder. The patent act grants a right to exclude others from use of the invention. The invention is what people file with the patent act. It is a piece of paper usually that describes a particular invention in its various details, and in return for disclosing that invention to the public, the patent holder becomes the only person that can sell that product or license it to others for the time of the patent. What the patent does not grant is any affirmative rights to use or otherwise commercialize that invention, contrary to any generally applicable state or local law.

Now, that distinction that the patent protects the right to exclude others from making the invention, but does not prohibit any regulation of the products of the patent
invention, is trite issues of constitutional law that -- and patent law that go back to the 1800s, and I will be happy to provide the committee with relevant Supreme Court cites to that effect.

And this is a key distinction that is being litigated in the D.C. case, but the key difference between the D.C. law and the Vermont law, which could be dispositive is that the D.C. law only regulates the prices of patented products. The Vermont law regulates the prices of all medicine products, regardless of whether they are patented or not.

Now, it is possible that that can become a key distinction in the D.C. litigation. Although states have the right to regulate patented products, just as they have the right to regulate any other product, no court has really decided whether a state can single out patented products for special regulations.

So that's an open question right now. It is not clear how that is going to come out, but the Vermont law has finessed that distinction by not targeting only patented articles.

So I think that is a key response to arguments that you may hear that the patent act somehow preempts this or that you should be following the D.C. district court ruling, is that this legislation is different in a key way, and that this law impacts (inaudible) unconscionable practicing of all medicine, not just patented medicine.

Now, that's extremely important, because many states already regulate the prices -- unconscionable pricing of medicines through a number of different legislative enactments.

Many states have general unconscionable pricing regulations that some of them specifically and some of them implicitly apply to medicine regardless of whether they are patented, and in fact, a few states actually used those laws to sue the suppliers of flu vaccines not too long ago when they were spiking their prices in response to shortages of flu vaccine.

Indeed those lawsuits were prompted, promoted and supported by the US Department of Health and Human Services, which asks State Attorney Generals to use their unconscionable pricing legislation to punish flu vaccine suppliers that were spiking their prices, because there is no federal law that bans the unconscionable pricing of medicine. This is a uniquely state authority, and so Vermont indeed should have some kind of ban on unconscionable pricing, so they can follow the federal lead in this area and actually attack unconscionable pricing of medicine where they exist.

I think -- oh, so the second -- the second area that came up in the D.C. case that you are likely to hear in this case is the commerce clause question. So the commerce clause is a kind of famously complicated and difficult to interpret area of constitutional law.

They call it the dormant commerce laws, because it is not stated anywhere in the actual -- in the actual Constitution itself.

The Constitution simply says that Congress has the authority to regulate interstate commerce.

There's a series of cases through the years that have attempted to define a negative aspect of that commerce clause, banning the states from regulating certain kinds of interstate commerce, even where Congress has not explicitly preempted the field.

The area that the -- the area of the commerce clause doctrine that the pharmaceutical company raises in almost every regulation of pharmaceutical practices is the aspect of the couple of cases, supreme court cases that have said that a state cannot regulate practices that take place wholly outside of the state in question.

Now, the key cases in that area were cases where a state in regulating the prices of alcohol, in both of these cases, append their instate prices to the prices of neighboring states.

The law has essentially stated that in state F, be it whatever it was, you cannot charge a price higher than the price that you sell in state Y. So it tied the in-state price to an out-of-state price.

And what the supreme court said in those cases that in effect what you have done by forcing a manufacturer to look at its practices in other states before it decides what its practices in your state will be is in effect to control the prices in both states.

So both -- you're not just controlling your own prices in state X, you are also effectively controlling the prices in state Y, because the company will now have to look at both
states, and have a common commercialization strategy, and state X is not allowed to set the prices in state Y, because that's outside of the state's jurisdiction. So Vermont cannot decide what prices are sold by medicines or any other product in New York any more than New York can set the prices for medicines in Vermont. Fairly elemental concept.

Now, what the pharmaceutical companies have been saying is, well, we don't have very many sales directly into Vermont. We sell most of our products to wholesalers. Wholesalers then sell into Vermont. This is a fairly untested argument in -- with commerce clause jurisprudence.

We don't really know what the outcome is going to be. There have been a series of lower court cases that have said that a manufacturer or supplier that is coming from out of state and supplying goods that are bound for commerce in that state are subject to the regulation of that state, and there are other cases that have said that a supplier cannot intentionally skirt the laws of the state in which it's ultimately selling a product by consciously and intentionally fashioning its contracts so that the contract executes themselves outside (inaudible).

I think those cases are the best laws. Those cases have not been brought all the way up to the Supreme Court. It is still an open question as to where the bounds of this are, but surely Vermont has the ability to regulate prices and other terms of sale of any commercial transaction one side of which takes place in the state.

And I think that the law sufficiently gets to that now. If there is some areas that you may want to look further in to comply with the kind of commerce laws dictates, it would be making sure that there is an explicit in-state nexus for every commercial transaction that you regulate. I think it is fine to leave that somewhat vague, and let the enforcement process take care of that over time, but for any kind of facial challenge, the key is just to make sure the commercial transactions that are being regulated are the commercial transactions that take place in some manner in Vermont.

That doesn't mean that one of the parties cannot be situated outside of Vermont, engage Vermont, regulates transactions with people that have their domiciles outside of Vermont every day, especially since most corporations have their official domicile in Delaware. Delaware is not the only state that can regulate interstate commerce.

Okay, so those are the basic legal issues surrounding the unconscionable pricing legislation, and I alluded to some of the policy issues about why it might be an appropriate area for legislation.

Let me just do briefly the same thing with the part of the legislation that governs the confidentiality prescription record.

SPEAKER 7: What's the section number on that?
MR. FLYNN: I believe that is 4621, yeah, section -- let's see, I don't know if I am reading this correctly. I am looking at page 19 of my draft. It says section 11 and the definition section starts at 4621. Is that correct? Did I --

SPEAKER 7: Page 21 on the copy that you have.

MALE ATTENDEE: The definition starts on page 19.

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SPEAKER 7: Page 21 on the copy that you have.

MALE ATTENDEE: The definition starts on page 19.

MR. FLYNN: The definitions I think start on page 19 and the text that I am reading, by definition --

MS. CUMMINGS: Okay.
MR. FLYNN: Hold on, I am sorry, that's not right. It starts on page 20. Those are definitions from a different section.
MS. CUMMINGS: Okay.
MR. FLYNN: That's actually section 4631. I was mistaken.
MS. CUMMINGS: Yeah, okay.
MR. FLYNN: The title is called confidentiality of prescription information.

Now, first, as I did in this area, let me just briefly canvas the policy reasons why this section of the bill is appropriate and needed, and then I will turn to some of the legal issues.

So as I said, about 40 percent of increased spending over -- since 1990, the five-fold increase has been attributed to rising drug prices of existing drugs. About 30 percent of the increase in US spending on drug prices over the last decade or so can be attributed to a shift effect, of doctors changing their prescribing habits to new and more expensive treatments that
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<td>are heavily marketed to both doctors and consumers.</td>
<td>amount of money trying to shift doctors</td>
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<td>Although deregulation of to direct-to consumer advertising in 1997 has led to a substantial increase that we have all seen of direct-to-consumer advertising, the Super Bowl advertisement, etcetera. It indicates today that over 80 percent of pharmaceutical marketing spending is directed at doctors, not patients. In 2004, the pharmaceutical industry spent $27 billion on drug marketing. Over 80 percent -- closer to 86 percent of which was devoted to promoting drugs directly to physicians. That's -- that's more money that was spent on media advertising or sales force than any other industry in the country. The pharmaceutical industry, taken as a whole, spends more money on its sales force and more money on media advertising than any other industry in the country. Now, the reason it does this is, of course, is that pharmaceutical marketing is incredibly effective. They make approximately $10 in increased sales and the ability to increase the price of product for every dollar that they spend</td>
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<td>on marketing.</td>
<td>into their pharmacy. They give the prescription to the pharmacist. The pharmacist types that information into the computer and electronically -- electronically processes the claim, and gets an instant readout about whether that drug is covered or not or whether they should shift to another drug, etcetera.</td>
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<td>Their own industry publications and analysis have indicated that if they can win, and I quote, just one more prescription per week from each subscriber, then that will yield an annual gain of $52 million in sales. Now, of course the drug industry and who they are marketing too is also unique, in that the ultimate consumer of the product is not one who normally makes the most important decisions. And you can think for a moment to see how the pharmaceutical industry thinks about it, pretend for a moment that there was someone whose job it was to prescribe you your next car, and how much advertising would be directed at that person by General Motors and Toyota, etcetera. That's essentially what's happened with the drug industry. They spend most of their money marketing directly to doctors, because doctors' jobs is to prescribe what your purchasing choice will be, and very few people are willing to go outside of that prescription and consume a drug that is different, and you know, including a generic equivalent, etcetera. So drug companies spend an exorbitant</td>
<td>In addition, the transfer of that information into computer data has facilitated an easy sale of that data to other third parties. So IMS, which is the number one largest pharmaceutical marketing firm in the world, in the mid 1990s began to purchase that information from pharmacies, insurance companies around the country. Input that data into massive spread sheets, if you will, into massive computer programs, sort the data by doctor, and then they can -- they can shoot that data out, and sell it back to pharmaceutical companies who are then able to tell exactly what each doctor is prescribing. The second component of this story is that every prescription is required to have a DEA number on the prescription, and so high enough in these other companies purchase from the American Medical Association data that link those DEA</td>
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numbers to the name and address of every doctor in
the country.
That AMA contained, has a data set on
every doctor in the country, whether or not they
are AMA members. They do not get permission from
those people to transfer and sell that data off to
IMS and other companies. They do, however, make
many millions of dollars a year through those
sales. So the IMS --
MS. CUMMINGS: We have one question at this
point.
MR. FLYNN: -- identifying information at this
point --
MS. CUMMINGS: Sean?
MR. FLYNN: Yes.
MS. CUMMINGS: We have a question.
MR. FLYNN: Yes.
MS. AYER: Sean, this is Claire Ayer from
Addison County.
You are saying that all these
prescriptions are sorted by DEA number?
MR. FLYNN: That's right.
MS. AYER: So even things like -- I thought
that was only for controlled substances.
MR. FLYNN: Oh, it would have to be -- I

believe that any prescription medication is a
controlled substance for DEA purposes.
I suppose if you had a prescription for --
well, any medicine that requires a prescription is
required to have a DEA tracking. That's my
understanding.
MS. AYER: Okay. I didn't have the same
understanding. I will check on that.
MS. CUMMINGS: We will have (inaudible) here,
so we will find out.
MR. FLYNN: Okay.
MS. CUMMINGS: Yeah.
MR. FLYNN: So, in any case, the upshot is that
computer -- that detailers, which are the sales
reps from pharmaceutical companies, can carry with
them laptops or consult information in their
offices that can sort on a weekly or even daily --
what the individual prescribing doctors' habits
are, so this, of course, is extremely valuable
information from a sales prospective.
You can visit a doctor one week and
perhaps give them a gift or buy them lunch or just
give them a sales pitch, and in the next week,
find out whether that pitch was successful and
whether their prescribing habits have shifted away
from the generic or older medicine that you do not
sell towards the newer more expensive medicine
that you do sell.
So this information is used to target
gifts, it is used to target sales pitches. It is
sometimes used to target who should be doing the
sales pitch.
Some companies have reportedly shifted
their sales people from (inaudible) based on what
they know from that data for selling to this
particular doctor.
It brings the process of detailing, of
pushing drugs to doctors to almost a scientific
level, and it has been extremely effective.
Indeed, since the introduction of this kind of
tracking of doctors information -- the sales for
pharmaceuticals (inaudible) --

CERTIFICATE
STATE OF FLORIDA
COUNTY OF BROWARD

I, Sara Glazer, Notary Public, do hereby
certify that I was authorized to and listen to CD
2007-47, the Senate Committee on Finance, Thursday,
February 15, 2007 proceedings and stenographically
transcribed from said CD the foregoing proceedings
and that the transcript is a true and accurate
record to the beat of my ability.

Dated this 8th day of April 2008.

Sara Glazer
Esquire Job #928012
STATE OF VERMONT
SENATE COMMITTEE ON FINANCE

Re: Senate Bill 115
Date: February 15, 2007

COMMITTEE MEMBERS:
SENATOR ANN CUMMINGS, CHAIR
SENATOR CLAIRE AYER, VICE CHAIR
SENATOR MARK MACDONALD, CLERK
SENATOR BILL CARRIS
SENATOR JAMES CONDOS
SENATOR HULL MAYNARD, JR.
SENATOR RICHARD MCCORMACK

CD No: 2007 47
Esquire Job #928012
PROCEEDINGS (continued)

CD No: 2007 47

MR. FLYNN: (continued) The sales force that pharmaceuticals retained have increased by over 275 percent, that's between 1996 and 2004, and --
I am sorry, let me take that back. The amount of money that they spent on direct marketing to doctors increased by over 275 percent, and over a similar period, it doubled its sales force to something around 90,000 drug reps at present.
That's about one drug representative, one sales representative for every office-based physician in the United States. So that's the state of where we are today.

MS. CUMMINGS: Sean, I am going to ask if you can kind of condense it a little bit, because we have got witnesses for the next bill starting to congregate in here.

MR. FLYNN: Sure.

MS. CUMMINGS: So if you can just kind of condense comments on this section of the bill.

MR. FLYNN: Yes. Let me just jump to the legal arguments you may encounter.

So this bill was first passed in New Hampshire, and the main challenge to that bill has been a claim that it violates the free speech rights of the data mining companies to regulate their data in this manner.

That case is still in the district court.

It has been argued. We expect a decision in the next couple of months. Most commentators, but I am probably biased on this, believe that we will win at the district court level.

It is unclear whether the buying and selling of data will be classified as speech et al. under the first amendment, but even if it is, it is likely to be considered commercial speech, and the state has a fairly substantial interest in regulating it.

If there is anything that is struck down on the bill, there may be a question about whether the ban on the sale of speech is the most narrowing hayward way to reach the state's interest.

The alternative would be for the state to adopt some kind of opt-in mechanism where doctors explicitly agree to transfer this kind of data over to IMS, and prohibiting its transfer without a doctor's explicit agreement.

So that case is still being decided, and we are waiting for the outcome on that, and with that, I will just pause, and I am happy to take any questions.

MS. CUMMINGS: Any questions?

FEMALE ATTENDEE: So this information, I must have missed a detail, but this information goes to the insurance companies, and the insurance companies sell it?

MR. FLYNN: Actually, usually a number of different entities could be selling the information. It is not always the same one. It can be the insurance companies. It could also be the pharmacy that sells, which would be more common when it is a large chain pharmacy that can negotiate with IMS on a fairly massive level.

Your normal, you know, mom and pop owned pharmacies probably do not have a deal with IMS to sell the date, in which case the insurer could be another source of where the data is sold. So it can be either pharmacy, it could be a pharmacy benefit manager, which are the intermediaries between the pharmacy and the insurer.

They are the ones that process the claim on behalf of the insurer, or it could be the insurer themselves. One of those three, the pharmacy, the PBM or the insurer.

MS. CUMMINGS: Okay, thank you.

Any other questions?

Thank you, Sean.

MR. FLYNN: My pleasure.

MS. CUMMINGS: Very enlightening.
CERTIFICATE

STATE OF FLORIDA
COUNTY OF BROWARD

I, Sara Glazer, Notary Public, do hereby certify that I was authorized to and listen to CD 2007-47 the Senate Committee on Finance, Thursday, February 14, 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 9th day of May, 2008.

Sara Glazer
Esquire Job #99012
STATE OF VERMONT
STATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: Friday, February 16, 2007

Type of Committee Meeting: Standard

Committee Members:

Senator Ann Cummings, Chair
Senator Claire Ayer, Vice Chair
Senator Bill Carris
Senator James Condos
Senator Mark MacDonald, Clerk
Senator Hull Maynard, Jr.
Senator Richard McCormack

CD No: 2007 - 49/Track 4
Esquire Job No. 889730A
PROCEEDINGS

SENATOR CUMMINGS: Robin --
MS. LUNGE: I'm on first?

SENATOR CUMMINGS: No, you're on first --
no, wait. That's my mistake. Okay.
First one I have -- I'm jumping ahead. I
skipped the first two.

Peter Martin, WCAX, going up.

ATTENDEE 1: Now, what does TV have to do
with prescription drugs? I think we're going
to hear. (Inaudible)

MR. MARTIN: Good afternoon and thank you
for having me. I'm Peter Martin. I'm in
charge of WCAX in Burlington County.

SENATOR MAYNARD: I'm Hull Maynard.

MR. MARTIN: And if you've done your duty
and bought your high definition set, you can
get us on channel 52.

I want to talk a little bit about this
amendment to the prescription drugs because in
looking at the amendment I noticed that this
set of amendments amends a statute that was
last amended in 1959 and 1961. It was a very
different world in 1961 from a television and a

media and advertising point of view.

In 1961 there were two television stations
in the state or serving the state, WCAX and
WPTZ in Glasgow (phonic). There was no
cable, there was no satellite, and there were
three networks, ABC, NBC, CBS and for a little
while Dumont (phonic) for any of you -- for
some of you who remember.

ATTENDEE 1: And CBC coming out of
Montreal fuzzy.

MR. MARTIN: So now we're in 2007. 85
percent of all households in Vermont receive
their television service by cable or satellite.

What that means is that 85 percent of Vermont
households have available to them 150 or 200
channels. There are now five commercial

11 television stations in the state. That's a
fairly small percentage of 150 or 200.

So now we get to prescription drug
advertising. I need to say right off the bat
we're a CBS affiliate so we get programming
from CBS. (inaudible) CBS. They provide us
with prime time programming, new programming,
sports. We do not control the commercial
content in those programs. We might be able to

object to something but it's a difficult and

strenuous process to get through.

We do, however, sell commercials in our
own programming like those in the breaks
between network programming and the like.

What's interesting about prescription drug

advertising is that local TV stations like us
see very little of it. Last year we had one.

It was for Ambien, Pfizer, I think -- no,
Synofene (phonic) and that's a sleep aid,
sleeping pill -- for about $6,300. This was
the only prescription advertising that we had.

Was there prescription advertising on CBS?
Yes, there was. There's quite a bit of it
actually.

Like the news, drug companies both local
encounter prescription like the news programs
because dare I say it, it's an older
demographics. As well we have a cable system,
The one big one in the state is Comcast, they
have 130,000 subscribers. They, too, sell
advertising locally but most of the advertising
that you see which is cable is sold by A&E,
TNT, MTV for those of you who watch MTV, and
all Disney channel (inaudible). Once again,

they do not control the commercial content of
these programs. And there is just an awful lot
of that programming flowing in. So with that
as background, think a little bit about what
this Bill proposes to do.

Well, it defines a regulated advertisement
as a spot which is broadcast on television or
radio from a station that is physically located
in the state, broadcast over the Internet from
a location in the state or printed in a
magazine or periodical.

Well, there aren't that many of us that
are in the state. And, in fact, we have a Web
site, www dot -- WWW6.com that some of you may
look at on occasion. That is actually served
out of New Jersey.

We have an arrangement with a company
that's putting one of these things together.
It makes a great deal of sense that somebody
aggregates them, operates them (inaudible).
And if you go deep into that site on the health
issue, you will find advertising -- banner
advertising mostly for prescription drugs. I
looked before I came over. That Web site is
not physically located in Vermont. It's in New
Well, if somebody should object to a commercial that ran on our air from the network and they asked us to provide the information, we go to the network and say, may we have the information. The network is under no obligation to provide it to us. Where are we? Are we subject to penalty? And as well it draws a distinction between the in-state media with five TV stations, the newspapers, the locally originated Web sites but cannot get at where most of this material is coming from which is out of state.

What's interesting in all of this is that the issues that seem to have given rise to this Bill are not confined to Vermont. I believe Senator Kennedy has a Bill in the Senate that would tighten up on direct to consumer advertising for prescription drugs. And Senator Dodd has one that would require the FDA to affirmatively approve ads before they are run. I think the current situation is that the FDA like the FTC will act, if it acts, on the point.

And it seems to me to get at what is fundamentally a national problem the state
in-state nexus because we as the State of 
Vermont cannot regulate out of state.

MR. MARTIN: Right.

MS. LUNGE: So I don't know if their 
cable -- I don't even know -- I know nothing 
about TV or cable so I don't even know what you 
would call the cable company and if they're -- 
if that programming is an in-state thing or if 
it's always from out of state.

So in terms of adding other entities to 
that language, the distinction would be whether 
you're in state or out of state and you can 
only include people in state because that's the 
only -- 

MR. MARTIN: Well, the cable company has a 
location in state.

SENATOR CUMMINGS: It does.

MR. MARTIN: And it provides programming 
that it receives from -- by satellite from out 
of state in much the same way that we do.

ATTENDEE 1: Just the fact that the wires 
hook up to the house -- 

ATTENDEE 2: Well, they receive it by 
satellite just the way he receives it by 
satellite.

MR. MARTIN: If you have cable, you 
receive us with a cable. So there are very 
practical details that are very important.

And, you know, it's very interesting that radio 
licensees and then it says that (inaudible) 
interesting between the two commas there -- of 
residing in the State of Vermont.

MS. LUNGE: And that's existing law.

MR. MARTIN: That's very ambiguous in -- 
in the context of the entirety.

SENATOR CUMMINGS: We'll have to look into 
that (inaudible).

MR. MARTIN: I'll be happy to answer any 
(inaudible). I apologize we're going through 
very quickly but there's some very -- I mean, 
it's a pretty complicated business.

SENATOR CUMMINGS: They all are.

MR. MARTIN: Yes.

SENATOR CUMMINGS: Okay.

ATTENDEE 1: Oh, I see. Okay. Existing 
law says no publisher, radio broadcast, 
licensee or agency of the media and you're 
saying there's no mention of TV in there.

MR. MARTIN: Or cable.

ATTENDEE 1: Or cable. But you also have 
an issue of you don't control what comes across 
from New York or wherever.

SENATOR CUMMINGS: Right. And I don't 
think anything expects you to control.

MR. MARTIN: Well, then you go back up to 
the definitions. What is a regulated 
advertisement? The presentation of a 
commercial message that is broadcast on 
television or radio from a station that is 
physically located in the state.

ATTENDEE 1: Yeah, that was the point I 
was making was that -- 

MR. MARTIN: And then -- 

ATTENDEE 1: They don't -- they don't 
govern what's coming across from New York.

SENATOR CUMMINGS: Right.

ATTENDEE 2: (inaudible).

SENATOR CUMMINGS: But this is -- and 
we'll have Julie up. The intent was to try and 
establish a legal nexus so that we could go 
after the producers of the Bill, not the 
broadcasters.

ATTENDEE 1: That's what that -- 

SENATOR CUMMINGS: Well, that (inaudible).

We'll take that one out. We have to.

MR. MARTIN: And then residing in the 
state, I mean -- 

ATTENDEE 1: It's on page 35.

SENATOR CUMMINGS: We may just update that 
statute. Okay. Good questions. Is it a good 
time to do this and then if it is, how do we do 
it. And again these were Sharon Treat's 
suggestions. They are out there for 
discussion.

ATTENDEE 3: Maybe this is a question for 
Julie.

First of all, where is cyberspace? You 
know -- 

SENATOR CUMMINGS: We will give you Chris 
Campbell's phone number, e-mail and the two of 
you can have the most fascinating discussion 
ever. I'd love to be a fly on the wall.

ATTENDEE 2: Is he alive?

SENATOR CUMMINGS: If anyone can tell you 
what cyberspace is, it would be Chris.

I'd like to know because I've heard 
ocasionally state money disappears into there.

ATTENDEE 2: Right.

SENATOR CUMMINGS: It's being transferred 
to New York (inaudible).
I think that's beyond our -- that must be -- (inaudible).
ATTENDEE 2: Except we're looking at advertising.
SENATOR CUMMINGS: Okay. Thank you. You opened a whole new world of discussion for better. Okay. I'm going to go as we have -- we've got Julie on last but I've got Madeleine Mongan and then Steve Kimbell and they're all going to talk I think about the same areas.
So, Madeleine, why don't you come up and then Steve. That will give Julie the time to finish those law books.
Okay.
MS. MONGAN: Good afternoon. I'm Madeleine Mongan from the Vermont Medical Society, and I'm here to express support for (inaudible) medical society on two sections of the Bill and there may be others that we, you know, have (inaudible) later but Section 11 which is the academic or counter detailing Bill describing the creation of an evidence based educational program, this is something that as some of you know we've been working on for years that from -- was it from the S90 524,

288? At least twice you passed the requirement that OVHA set up a counter detailing program.
SENATOR CUMMINGS: Yes. It hasn't happened.
MS. MONGAN: It hasn't happened. And we're -- we're happy -- we think it's a good idea to move it to the Department of Health in particular because the area of Health Education Centers are working on a counter detailing program now and you might want to talk with them as you go along about it.
They -- they had some grant funding which they got through the Attorney General's lawsuits against the -- the pharmaceutical manufacturing companies. I think that's where it came from.
SENATOR CUMMINGS: Yes.
MS. MONGAN: And they -- they are doing three different sessions on three different drugs in this year, hypertension, cholesterol and heartburn drugs. So that we support.
And we think that moving it to the Department of Health is good because they have a good relationship with the area Health Education Centers and work with them all the time.
The other Section that I want to speak about is Section 12, the prescription drug data confidentiality section. And I'll start out by giving you a little background. We -- the medical society first heard about this issue through the -- the New England medical societies, that all the New England states get together and meet twice a year. And New Hampshire was presenting about the law that had just passed in New Hampshire. And what it regulates is the ability of pharmacies to sell prescription information to data mining companies which -- and -- and -- so that's one piece of it.
The other piece is the American Medical Association sells its master file of physician information to the data mining companies.
The data mining companies puts -- put the information together to -- if -- if you don't need me to go through this I'll be happy to --
SENATOR CUMMINGS: No, no.
So they -- the data mining companies put those two pieces together and create profiles of physicians and their prescribing.
Then the data mining companies sell those profiles to the pharmaceutical manufacturing companies for purposes of developing specialized marketing strategies to particular physicians or particular regions.
So what we think is that these practices may lead to increased prescribing of more expensive drugs; may -- you know, more expensive brand drugs when equally effective generics are available.
Now, the American Medical Association developed an opt-out program which allows physicians to opt out for a three-year period but what they are opting out of is quite limited.
The information would still go from the pharmacy to the data mining company and from the AMA to the data mining company and the profile would be created and it would go to the pharmaceutical manufacturing company. Then what the physician would opt out of would be whether the pharmaceutical manufacturing company could allow the -- the individual detailers or pharmaceutical manufacturing
representatives to have that information to go and talk to particular doctors. So it's not opting out of the whole picture. It's just opting out a small piece of the picture.

ATTENDEE 1: Their information is still merged --

MS. MONGAN: Yeah, the information is still merged, the profile is still created. It still goes to the pharm -- it's still sold to the pharmaceutical manufacturing companies but those companies set up firewalls so that the detailers in Vermont who are going out to talk to the Vermont physicians don't have access or are not supposed to have access to the identities of the physicians who have opted out.

SENERATOR CUMMINGS: All right. But can the home office send them letters, advertisements, free samples, whatever?

MS. MONGAN: Yeah, I -- I -- I have limited information about how it actually works, and that might be a better question for PhRMA how -- how that would work. But I'm just telling you that the opt-out is kind of a limited opt-out.

SENATOR CUMMINGS: The record is still there. You just can't transmit it to the -- back to the groups in the field.

MS. MONGAN: To the detailer. Anyway, that's not --

ATTENDEE 1: So it's not an opt-out. It's not --

MS. MONGAN: It's not a complete opt-out. It's an opt-out of the bottom of the chain.

SENERATOR CUMMINGS: You still know my name, my address, my phone number and everything I buy at the grocery store. You just can't call me.

ATTENDEE 1: Yeah.

MS. MONGAN: Well, certain people don't know it.

SENERATOR CUMMINGS: Yeah.

MS. MONGAN: The people who are going to visit you at your office shouldn't know it.

That's -- anyway, that's my understanding of how it works, so... Then after the New England Medical Society meeting at the Vermont Medical Society annual meeting, we had a panel on this issue and it included the legislator from New Hampshire who had been instrumental in introducing the Bill, the president of the New Hampshire Medical Society, a psychiatrist, the vice speaker of the American Medical Association who wanted to talk about the opt-out program, and Bill Surreal (phonetic), the Attorney General.

We then adopted a resolution unanimously to ask the medical society to introduce this legislation draft and ask that a Bill be drafted sort of in tandem with what you are hearing I guess from NLaRx. So what the Bill does -- now you've had a walk-through of this, so if I'm going into too much detail --

SENERATOR CUMMINGS: You know -- you know, we get a very general -- I think it was very late in the afternoon so we haven't gone through this in detail.

MS. MONGAN: Okay. So anyway feel free, if you've heard it before, to let me know.

What it does is it prohibits the use of patient identifiable or prescriber identifiable information for any commercial purpose. And commercial purpose is fairly narrowly tailored. It includes advertising, marketing, promotion, and similar activities, activities designed to influence sales or the market share of the drugs, to influence the evaluation, prescriber behavior, and marketing drugs to patients and evaluating the effectiveness of the sales force. So the definition I think is kind of narrowly tailored to get at a commercial presence.

There are broad exceptions to allow things that are happening now to continue to happen including pharmacy reimbursement, prescription formulary compliance with all the insurance formularies, patient care management, utilization review by health-care professionals and insurers, health-care research. That's very broadly stated. And then any other purposes otherwise provided by law such as Medicaid fraud investigations. The auditor -- the former auditor Brox (phonetic) audited the Medicaid information. This information would be available.

And then there's a list of specific exemptions in the Bill such as dispensing medications, transmitting information between prescribers and pharmacies, in between pharmacies about prescriptions, care.
management, education, communications to
patients and those drug inserts in the -- with
the prescriptions, and disclosure to the
prescription monitoring program, which is a
program that you set up last year that requires
all prescriptions of controlled substances in
schedules two, three and four to go to the
Department of Health which was going to create
a database -- sort of getting started on it
now -- so that we'll be able to see if -- if
patients are -- are going to two or three
physicians to get controlled substances, and
that information can be fed back to the
physicians -- see also if physicians are
inappropriately prescribing controlled
substances. So this would not prevent that.

It would not prevent the access to law
enforcement that's permitted under current
law -- there's a study about that that was just
done -- and would not prevent access to
information that does not identify or lead to
or allow the identification of either
individual prescribers of patients supported by
us, AARP, the AG's office and the Drug
Utilization Review Board which is the group of
doctors and pharmacists who review and manage
the prescription drug formulary to the Medicaid
program.

Other states are -- well, New Hampshire,
you know, has passed the Bill. Massachusetts
Medical Society is introducing the Bill, also
being introduced in New York and Washington and
probably other states that --NLARx would know
about it. I don't anyway.

I think you might hear that there are some
possible unintended consequences from this
legislation such as law enforcement or Medicaid
fraud, overprescribing -- finding out about
overprescribing. I think what I would say to
you is that the insurance companies now know
about overprescribing and the Medicaid program
knows about that and there are systems --
other -- other ways -- I guess other ways to
get at that.

You might hear that public health research
that is enabled by the profit that the data
mining companies and pharmaceutical
manufacturing companies are making would --
would dry up, and I think there are other ways
to -- to do that public health research.

So in New Hampshire the Bill passed on a
voice vote in the House. It was unanimously
passed in the Senate. It was signed by the
governor. There's a lawsuit pending in --
in -- I think it's in New Hampshire Federal
District Court and we don't have a ruling. At
least I don't think we do yet but there --
there was a hearing on it.

There's also a Federal Bill introduced
that would probably have to be reintroduced so
that -- so there is some effort to work on this
issue at a national level. Oh, and I brought
you our resolution from our annual meeting.

SENATOR CUMMINGS: Okay. Question.
And my apologies, I stepped out for a
minute so if you covered this, just stop me.

We had a witness on the phone yesterday
from a -- from a PBM who said that the
prescribing activities of physicians were
sorted by DEA number and then, you know,
they -- they use -- they use that to find their
other information, what kind of practices they
are in, where they were and so on. And I
thought that the DEA numbers were only used for
narcotics and things like that, that's what's
considered controlled substances. But the
person on the phone said any prescribed drug is
a controlled substance and that's -- and that's
so that the DEA -- the implication was the DEA
number goes with that.

So if you get birth control pills, if I
have to call in for you, I don't want to have
to give the DEA number for that.

MS. MONGAN: No. The DEA number was
created by the DEA as a -- as a registration
number for prescriptions for controlled
substances.

Over time it has -- like the Social
Security number it has started to be used for
other purposes. The DEA does not favor using
it for those other purposes and for other types
of drugs other than the five schedules of
scheduled drugs but -- but it's happened and so
that is the number that some insurance
companies use for all prescriptions.

SENATOR CUMMINGS: So then you have
physicians --

MS. MONGAN: There -- there is though
going to be a national provider identifier that
is -- I think it's by May that all insurance
companies will start using. It's going to be an individual identification number -- it's part of the HIPAA law so that once that goes into play, I don't think there would be a need to use DEA numbers.

ATTENDEE 1: But it will still be an identifier by doc.

MS. MONGAN: Right, it will still be an identifier by doc. Yeah, that was designed for the controlled substances but there will be this other identifier that -- this national provider number.

ATTENDEE 1: But that will also be an identifier.

MS. MONGAN: That will be an identifier by doc, too, both of them.

SENATOR CUMMINGS: You can't keep track of them.

MS. MONGAN: And, I mean, we don't have any problem with the insurance companies having that information. It's that when it goes to the data mining companies, to the manufacturing companies and gets into the whole marketing and commercial use, we don't think that's real good.

SENATOR CUMMINGS: Senator Condos.

SENATOR CONDOS: Madeleine, who is the AMA?

MS. MONGAN: The AMA is the American Medical Association just like the national physician organization.

SENATOR CONDOS: Right. So it is a physician organization?

MS. MONGAN: Yes.

SENATOR CONDOS: Okay. And you spoke about the opt-out.

MS. MONGAN: Uh-huh.

SENATOR CONDOS: But let me -- if I'm a doctor and even if I go and opt out -- let's just say I go and opt out. Do I have to see a drug rep?

MS. MONGAN: No, you don't have to see --

SENATOR CONDOS: They call up and try to set an appointment with a -- with the doctor.

Is that how it works?

MS. MONGAN: Right, right. They do not have to see the --

SENATOR CONDOS: So they can say no.

MS. MONGAN: Yeah. And some doctors do and some institutions do and some institutions

say no logo pens, no -- I think Fletcher Allen (phonetic) is just about to establish a policy on that -- no pens, no pizzas.

SENATOR CONDOS: The reason I ask, I'm just trying to understand because you have the national physician organization is saying one thing and the state organization is saying another and there is a provision for opt-out and the doctors have also the ability to say no as well. So I'm just trying to understand all this in my mind.

MS. MONGAN: Right. We think as I -- that the opt-out provision is a little on the weak side and doesn't really prevent the -- the information flowing along those lines. It's a complicated world that we're living in as the previous witness pointed out and getting more complicated and so it's hard for us to get our arms around it. But I think we're thinking that having this information by prescriber going to the companies is going to lead to them targeting their -- their marketing them.

SENATOR CONDOS: Why wouldn't the AMA -- why couldn't the state organizations, the Vermont Medical Society and the New Hampshire Medical Society and all the other states medical --

MS. MONGAN: Massachusetts --

SENATOR CONDOS: Right. Why couldn't they tell the AMA, look, we don't want you involved in this?

MS. MONGAN: Well -- well, that's a separate track that's going on in a separate discussion among the states. We have different -- we have the doctors and lawyers in Florida and Texas and we have the doctors in Vermont and New Hampshire.

ATTENDEE 2: But the AMA is also in a financial at some point --

MS. MONGAN: The AMA gets paid by the data mining companies because it sells its master file of -- of physicians who's -- what physicians so that means the data mining companies can match information that they buy from the pharmacies so then they can get -- put it together and do profile.

SENATOR CUMMINGS: Okay.

MS. MONGAN: Okay.

SENATOR CUMMINGS: Other questions?

Thank you.
MS. MONGAN: Thank you.

SENATOR CUMMINGS: Steve Kimbell.

Something tells me it's going to even get more complicated.

ATTENDEE 2: Steve, it gets more complicated, believe me.

MR. KIMBELL: (Inaudible) My name is Steve Kimbell. I'm an attorney and lobbyist from Onterio (phonetic). I'm here today on behalf of IMS Health Incorporated which is a Pennsylvania based corporation.

And just let me very briefly tell you what they do so you'll understand who my client is. IMS purchases and repackages and sells health data. Just as an aside, the witness down from the NLARx yesterday described my client as a pharmaceutical -- pharmaceutical marketer.

That was either a mistake on his part or --

Anyway, it's not accurate. They're not a pharmaceutical marketer. We -- we acquire data, either public domain data or we buy it like from the AMA, and we repackage it. That's the matching that Madeleine was talking about.

And then we sell it.

One of the things I love about this business -- the business I'm in, I get to testify about things that didn't exist when I started because this is a business that didn't exist. In fact, it's the kind of business we're trying to make Vermont a comfortable place to do business in, but that's sort of an aside. We're sort of new and I -- I understand Madeleine's hesitancy about where this is going and so on. So that's -- that's the business that we're in.

And she described accurately one of the components of that business is to purchase from the national doctors group, the AMA, their doctor list with ID numbers and then to purchase from retail pharmacies, wholesale pharmacies, other sources prescriber --

prescription information that has the number on them and do a match and so then we can tell that IMS has the information to tell you what Dr. Jones in Smithfield, Rhode Island prescribes, broken down by category of medication.

One point I want to make very early on is I'm not sure why, except for sales purposes, but the language of the legislation refers to patient identifiable information as well as prescriber identifiable and that's not what we're talking about here. Federal and state law prohibit already the dissemination of information that has a patient identifier on it. So the reference on -- on the page 23 of the draft Bill, the patient identifiable information, I'm not sure why it's there except to try to make the Bill look more attractive than it really is. That -- that's on line seven.

And this is the guts of the Bill, page 23, line four through eight -- line four through seven contain the prohibition that you're being asked to enact.

ATTENDEE 3: Give me the reference again.

MR. KIMBELL: It's page 23, line four through seven. A health insurer -- a self-insured employer, an electronic transmission intermediary which is defined earlier, a pharmacy or other similar entity, so that's the catchall -- shall not -- there's the prohibition on line five -- license, transfer, use or sell regulated records which include prescription information containing patient identifiable or prescriber identifiable data for any commercial purpose. For any commercial purpose.

I would submit to you we're here to talk about prescriber identifiable data today, not patient identifiable data and I'm not sure -- I didn't draft this. I don't know why it's in there but -- unless you just want to repeat existing law about the privacy patients are entitled to.

This Bill is about what level of privacy prescribers -- prescribers are entitled to, prescribing physicians. It's not about patient privacy.

So that's what IMS does. It is a large company and it negotiates with other large companies, the pharmaceutical companies, for the sale of this data. It's not a pharmaceutical company itself and it sells lots of other health-related data. We're in the cyberspace business wherever that location is if you're trying to find it.

The other point I'd like to make, Madam Chair, by way of introduction is a lot of the language in the draft you're working on, all 38
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MR. KIMBELL: -- and they don't want people to know what they're doing. Well, there are very good reasons for people to know what they're doing. Overprescribing is one. Health-care research is another.

And I would like you to consider the notion that unless this data can be sold for commercial purposes, it won't exist. Private sector data, which is 50 to 60 percent of the prescription market -- by private sector I mean prescriptions written under insurance plans that are private sector plans, the big company we were joking about earlier or the State of Vermont or whatever, those are private sector plans. And the reason the data exists today and the reason it can be used for research regarding health-care safety; pay for performance plans, which is part of what the health-care reform last year was trying to encourage; consumer driven health-care initiatives, what we're trying to let consumers through Web sites choose providers and clinics and hospitals because of what they can see.

That data won't exist for those purposes if there isn't a commercial reason to collect and package and refine it.

And I -- and we've seen some evidence of that. This -- this state has on the books a thing called the Unified Health Care Budget and a Unified Health Care Expenditure Plan designed within the last 10 years, put on the books by the legislature to be data driven resources for government to do all kinds of functions about health-care. I think that if you had folks in here from BISHCA, they would say those plans haven't lived up to their expectations, they haven't been the robust tools that we hoped they would be because we don't have the data.

The government is not able or willing to pay for collection of the data and there's no commercial purpose in Vermont to collect that data. So we don't have the planning tool we need. And that's just an example of what I mean -- when I suggest to you, my main point, if you take the commercial purpose away for collecting this data, which is what this Bill will do, then the data won't exist or at least it won't exist in as robust a form. You might be able to get it from the Medicaid and

reduce the prescription of high-end drugs which doctors are induced to prescribe because they're given expensive gifts, we've already got a reporting mechanism that would presumably unearth that practice.

If we were -- if Dr. Jones was being flown to Jamaica for a two-week gig so that he'd prescribe a more important drug -- a more expensive drug than a generic drug, we'd see that in the reports.

SENATOR CUMMINGS: No. I think the issue I heard on this one was more that a detailer calls up and says, Jeez, you know, I came in and talked to you last week but I see you haven't prescribed any of the meds and am wondering what the problem was, why you weren't prescribing my meds. It was more of a subtle, arm-twisting or --

MR. KIMBELL: Well, I think you're probably right. To the extent that physicians are driving this is that they don't want to be bothered by the marketers --

SENATOR CUMMINGS: That's right. Well, they don't want people knowing what they're doing.
1 Medicare program or from the VA but you won't get it from the private sector described.
   It's been suggested that the -- the availability of this data raises prescription drug costs because it drives prescribers to prescribe more expensive medication.
   There's no research to support that assertion. There is research to say that prescription marketing -- prescription drug marketing by the pharmaceutical companies is effective but there's no research to show that effective marketing has driven up the cost.
   In fact, let me give you an example of how it might work just the opposite. There was a drug that treated muscular sclerosis that came on the market a couple of years ago, maybe a little more. And it was approved by the Food and Drug Administration. And once it was on the market for a few months, it turned out that the side effects were much worse than had been predicted and the drug had to be called back off the market.
   And the FDA reviewed it again and said, okay, this really helps with MS but it really has to be prescribed under very careful circumstances, and worked with the pharmaceutical company that developed the drug to train its marketers to go to physicians who prescribed -- who treat MS patients and train them how to use the drug.
   Now, that required knowing who prescribed the drug and it was -- it's an example of a positive use. We could have had to send marketers out to every physician in Vermont, say, do you have any MS patients and we did not. Instead we had a target population to -- to contact but for a positive purpose.
   And I would submit that most physicians if treated that population would welcome that kind of contact.

SENATOR CUMMINGS: Question.

ATTENDEE FEMALE 1: What kind of doctors treat MS patients?

MR. KIMBELL: What kind of doctors?

ATTENDEE FEMALE 1: Well, not obstetricians, not pediatricians, probably not family doctors for initial diagnosis. It's not that easy to weed out. It's not that hard to weed out who would prescribe a new drug for a very specific neurological condition.

MR. KIMBELL: I wouldn't be surprised you could find a specialist who treats MS. But that's just an example -- a generic example of where there might be a positive use for these.

The -- the other point that I'd like to emphasize is this is not like trying to protect consumers from 6:30 phone calls to sell them a vacation in Hawaii that they only get if they buy a new car. We're talking about a sophisticated audience here, physicians who are allegedly the targets of this inappropriate marketing by pharmaceutical companies.

They have a tool at their disposal endorsed by their national association to not be called by these marketers. And I think the narrowness of that tool that Madeleine described actually makes it better because the prohibition in the AMA program is on the marketers. So they've got the ability to opt out of that.

And most importantly -- I forget -- Senator Condos may have it out -- they don't have to see them. All the physician has to do to take himself out of this loop and exercise his or her own best judgment without interference from the pharmaceutical companies is to say to their office assistant, I don't want to see them, I don't want to talk to them on the phone, I don't want to see them.

So the physician have the tools in their hands to accomplish what they're asking you to pass this somewhat broadly affecting legislation would do.

And I just close with this: In general, more information is better than less information, particularly in health-care if we're going to get a handle on this system.

And I think physicians in this state have the tools at their disposal to protect whatever privacy they're entitled to without taking away a database that can be very useful for a variety of purposes and a database, notwithstanding the exceptions in the Bill, that won't exist if it can't be used for promotion purposes.

So I'll stop there and be glad to take any questions.

ATTENDEE FEMALE 1: Are there any other commercial purposes other than informing detail
people on how -- how their -- their offices
have prescribed?
MR. KIMBELL: Sure.
ATTENDEE FEMALE 1: What percentage of the
business is others? What percentage of the
business is that -- this kind of stuff?
MR. KIMBELL: I don't know that but I'll
ask a percentage -- a percentage for detailing.
An example I can give you the --
ATTENDEE FEMALE 1: That uses this kind of
data mining.
MR. KIMBELL: No. I--I got your
question.
ATTENDEE FEMALE 1: Yeah.
MR. KIMBELL: An example -- another use
might be for research, you know, what -- if you
want to know what a physician is doing and what
new drug should we try to develop, it might be
used for that purpose.
Variability research, what -- what -- in
one Section of the country what's the practice
versus another Section of the country and which
is better so that we might start to get a more
uniform method of practicing medicine.
SENATOR CUMMINGS: But my understanding of
what this -- this legislation proposes to
curtail is the use of this kind of information,
this mining information to promote drug
detailing. You know, companies that pay for a
lot of -- who are apt to put on more expensive
detailers are the ones that have -- they're not
out there detailing generic drugs. They're out
there detailing their latest best product.
And the other thing is that detailers in
a -- in a doctor's office establish
relationships just like lobbyists. So over the
years we've agreed on a lot of things, you've
given me some information, we disagree on a lot
of things but if you come -- if you came to my
office and said, Steve Kimbell, I'd really like
to see you, we have a relationship that we've
established. But if you've gotten some -- if
you've mined some information about me that,
you know, is going to make me spend more money,
you're going to be using a couple of -- I'm
not -- I'm not putting this together very well
but it's not just -- it's not just the -- it's
not that doctors refuse to see people. I
wouldn't refuse to see you, Steve, even though
I don't agree with or I might not agree with
you on a lot of issues because we have a
relationship and I respect the information you
give to me. So it's not -- it's not as if you
can come to my office and ask to sit in, I'll
say no because I know you'll want to talk to me
about not prescribing your drug.
Does that make any sense?
MR. KIMBELL: Well, I understand --
SENATOR CUMMINGS: There's a lot more to
it.
MR. KIMBELL: -- I understand the analogy
you're drawing. It strikes me there's a huge
difference between an elected official's
willingness or lack thereof to see a
representative of their constituents, which is
basically what I am or some of your
constituents, and the refusal of a physician to
see a salesperson when it's the physician who
has to prescribe -- has to decide on what to
prescribe. I -- I just see a huge difference
there and, you know, it's up to the doc.
ATTENDEE 3: Yeah, but if you've got a bag
of tricks besides just one pill, you're going
to want to see him or you value the knowledge
he has. You may disagree with what's going on
but it's hard to say no to a rep and miss
something.
ATTENDEE 2: With all due respect, what it
sounds like to me is the doctors would like us
to protect them from themselves.
SENATOR CUMMINGS: I'm -- no, I'm just
saying if there's someone that we've worked
with in our office for a long time comes in and
says, you know, I would like to see Helen,
we'll make some time for that person because
we've built a relationship and it's sort of an
unfair trick I think to say, well, Alex, I saw
you last week. I thought everything was
hunky-dory and you're not prescribing
Ortho-Novum. What's up with that?
MR. KIMBELL: Well, that's not a trick.
The docs know that this information is out
there. They --
SENATOR CUMMINGS: We'd like -- we'd like
to make it not out there so that I come in and
say, well, gee, Al, I -- I hope you're using
our product that does these three things and
then doesn't do these three things that you
don't like. (inaudible).
ATTENDEE FEMALE 1: I think there is some
analogies. Lobbyists are a prime source of information. Drug reps are a prime source of information, direct information. I don't have to sit down and read through formularies. They're probably the ones that know the fastest, quickest, what's new, what's out there and they might help my patient. I want access to that information. Okay? But I -- it's -- it's -- I think there's just a reticence in using -- whether or not I decide to use your drug. You know, I want to be able to take the information and make a decision and not have that person come back and say, gee, you really hurt my feelings, you didn't decide to use my drug, or we note that you're not using this and why aren't you? And I think that's -- that's the issue. It's not an all or nothing, just go away because in going away you lose something valuable.

MR. KIMBELL: I'm sure that physicians have to discriminate. There are salesmen and there are salesmen. If I come in and misuse the data I hope you wouldn't see me again if I'm a -- a drug salesman.

If I'm somebody you've got a good relationship with, presumably that relationship was built over time and you began to trust each other and not abuse the relationship.

The point I hope you won't lose is I understand the comfort this might give some physicians but question how much privacy they're entitled to when they're prescribing drugs. The patients are entitled to a lot of privacy but the physicians, I question that.

And they've got control of the situation by opting out, in which case the friend who comes to your office will have the information, or by refusing to see certain pharmaceutical reps who abuse the privilege.

And it -- what you'll lose by this ban is the availability of that data for a broad range of government and research and other legitimate and good purposes to advance the health-care system. So I -- it's like this is the old hat of -- a solution and search of a problem.

SENATOR CUMMINGS: But you haven't given any -- any -- given us any information that says this piece of data mining is critical to the -- all the other -- is critical to supporting all the other good uses, this
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 2007 - 49 /Track 4, the Senate Committee on Finance, Tuesday, Friday, February 16, 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 28th day of August 2007.

Dona J. Wong, RPR, CSR
Esquire Job No. 889730A

ESQUIRE DEPOSITION SERVICES
STATE OF VERMONT
STATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: Friday, February 16, 2007

Type of Committee Meeting: Standard

Committee Members:

Senator Ann Cummings, Chair
Senator Claire Ayer, Vice Chair
Senator Bill Carris
Senator James Condos
Senator Mark MacDonald, Clerk
Senator Hull Maynard, Jr.
Senator Richard McCormack

CD No: 2007 - 50/Track 1
Esquire Job No. 889730B
PROCEEDINGS

MS. BRILL: We do -- we do from a policy perspective support section three and also we don't think that it will cause us to -- to have the litigation as a result over removing this exemption. And I think that's fair for you to ask me to point out is not only from a policy perspective doing pharmaceutical pricing do we support it but also do we see any potential litigation on the horizon as a result of the change. So that's a very fair point.

ATTENDEE 4: I was sitting over in Gov ops 10 years ago --

SENATOR CUMMINGS: Uh-huh.

ATTENDEE 4: When we called in the attorney general's office campaign finance and they said we'll defend you.

MS. BRILL: They -- we -- we knew it was going to be an issue, we knew. I mean, there's no question.

ATTENDEE 4: Yeah.

MS. BRILL: So yeah. Okay.

So Section three, I don't see any litigation on the horizon as a result of that,

and we do support it from a policy perspective.

Section four is the -- it would require a disclosure of prices to, if I'm remembering right -- is this to OVHA? Is that right? To OVHA. And it is following on Maine law, a law that has been enacted in Maine. There is a similar but slightly different law that was enacted in Texas. The -- this is, I believe, identical or substantively identical to the Maine statute.

On line 10 of page eight in Texas rather than requiring the best price be reported to the governmental agency, it would require the price that each wholesaler pays the manufacturer for the drug would have to be reported to the governmental agency. And I -- to be fully honest with you, I have heard through various conferences I've been at the Texas law it is really quite effective and quite good and I'm not yet fully able to tell you whether I think the Maine law or the Texas law would be better for us in terms of what we're trying to do here. So we -- we're fine with this, we're fine with Section four but it might be that on line 10 there might be another

or maybe you can make it line 10.5 and maybe -- excuse me, I'm so sorry. There might be another disclosure that might enhance the robustness of this data and the richness of this data going to the state, and that would be the price that each wholesaler pays the manufacturer.

And Robin and I have been looking at that and she actually e-mailed me the cite and we went and looked at the actual Texas law. And it is interesting. So I think that we might want to consider adding that.

SENATOR CUMMINGS: From the local state of Texas.

MS. BRILL: That's right.

ATTENDEE 2: When you say the price of the manufacturer --

MS. BRILL: That the wholesaler pays the manufacturer, right.

ATTENDEE 2: Is that the invoice price?

SENATOR CUMMINGS: So it's the AWP.

ATTENDEE 2: Or the rebated price?

MS. BRILL: I'm not certain looking at the Texas statute. It should include the final price with any rebates. I don't know that wholesalers get rebates. I think that the -- you know, the ultimate --

ATTENDEE 3: They will if it doesn't.

MS. BRILL: Anyway -- anyway, it should be the ultimate price. It should be the ultimate final price.

ATTENDEE 2: No. The reason I ask is I work for a manufacturer, not a -- well, it was a pharmaceutical manufacturer but I didn't work for a pharmaceutical division. And a very large company that actually exists in Southern Vermont, grocery wholesaler --

MS. BRILL: Right.

ATTENDEE 2: -- would ask manufacturers to -- if you had -- if you had a promotion, they would ask you, can I get it off invoice --

MS. BRILL: Uh-huh.

ATTENDEE 2: -- or can I get it as a bill back.

MS. BRILL: Right, okay.

ATTENDEE 2: Because what they show their customers is what's off invoice.

MS. BRILL: Right.

ATTENDEE 2: They're required to show their customers. They don't have to show their
MS. BRILL: And that's exactly the issue with respect to PBMs, that -- we would be focusing on in that -- in this next section. That's exactly right, is this issue to what extent does the middleman that you're describing get a different price that they're not disclosing to others. That's absolutely right.

The bottom line with respect to this little issue here on page eight, we would want it to be the final price so it -- we would want it to include rebates if you were to -- to change this so that it would also incorporate the Texas data.

ATTENDEE FEMALE 1: So you and Robin help us --

MS. BRILL: Yes. And I want to speak to my contact who I was unable to reach in Texas to try to get a better understanding. And I'll try to do that. Unfortunately, Monday is a holiday but I really want to understand from him as to why that data is especially effective or is that data especially effective. So I will definitely endeavor to call him and ask that. Okay. And I see that our office enforces this on page nine and we are fine with that. Okay. I think the next section that affects our office or the consumer protection laws or anything along those lines is on page 11, Section six. And this is the PBM regulation (inaudible), just what we were talking about.

SENATOR CUMMINGS: Okay. The testimony yesterday in short summary was that the market has changed, it's a highly competitive market and that this sort of legislation is no longer available, that --

MS. BRILL: No longer needed.

SENATOR CUMMINGS: No longer needed. That it is a contractual relationship, if we put the fiduciary thing in it, it brings it up to a trust and not a contract level of law, that because it's highly competitive, these are highly sophisticated customers, they get everything that they ask for, that if they ask for all the information, they will get it or they can is just the -- give us the 30 percent off, that's what we guaranty, that's what we'll do. (Inaudible) was in the room but I think that was what I heard yesterday.

MS. BRILL: Well, our position -- we -- we do a lot of work with respect to PBMs. We've entered into a consent judgment with one of the largest ones and we're currently working on other issues involving PBMs. The market has changed since first we looked at this kind of statute but the market is not necessarily more competitive. And there is some consolidation going on in this marketplace. Right now -- and you'll probably here this through testimony -- Caremark is on the selling block. Caremark is one of the largest PBMs. And one of the potential bidders for it through a hostile bidding situation is another PBM, one of the large -- other of the largest three is ESI, Express Scripts, Inc. And if that consolidation were to take place -- and believe me there will be antitrust issues that would have to be examined before anyone would allow that to take place, but if it were to take place obviously we'd see huge consolidation.

But even leaving that aside, the -- this market is really an oligopoly in the sense that -- and I apologize for using that ridiculous word but it means that it's concentrated at the top. There are three very large players and then there's a bunch of others that are smaller and have a much smaller market share. So the total number of players in the PBM market might be, you know, 15, 16, 20 but the top three really have the lion's share of the market.

I do think that as a result of the work that the states did, Vermont and a few other states did in the MedCo case, I do think that the PBMs are more sensitive now to what they do with their rebates, for instance, just what Senator Condos was just talking about, how they disclose those to their customers.

The problem from our perspective is still that there are sophisticated customers and then there are not unsophisticated customers. Not every customer of a PBM is GM or even the wholesaler you were just talking about who might potentially be somewhat sophisticated.

There's some very small businesses that have to operate and deal with PBMs. And we don't think that every -- every one of these customers
The State of Vermont had relationships with PBMs, you know, that one might wonder today whether that was really a good contract that they should have entered into or should they have done it differently. So there's all different levels of sophistication among the clientele of this -- of the PBMs.

We still think that this regulation, this -- this law makes sense. It was -- as you know, you've probably heard all about the legalities of it. It was upheld by the First Circuit. We would very much like to see as much as possible this language to mirror the Maine language because we know we have a court case that says that's okay. So we -- the one thing that -- where it does differ and actually do approve of this difference is I think it's in -- on page 12 at the bottom and 13 at the top, A1. My recollection -- and, again, Robin will correct me if I'm wrong as she always does I hope -- is that the Maine section actually used the word fiduciary. It said that the PBMs are a fiduciary. This language does not actually use that word. It basically does every -- almost everything but.

SENATOR CUMMINGS: It defines that.

MS. BRILL: It -- it is using all words but fiduciary and we're -- we like -- we're fine with that. We don't think you need to put the word fiduciary.

SENATOR CUMMINGS: This is the section that the PBM was a (inaudible) fine --

MS. BRILL: I'm sure. I'm sure that they really didn't like A1 because that's the one that says that they have a duty of care with respect to their clients. That's what it does.

And, you know, there are the issues that Senator Condos was just talking about with respect to the rebates and with respect to what it is that they're doing with ultimate pricing versus pricing that they're showing their clients, things like that that while I do think that the industry has changed, I agree with that testimony -- or what I understand that testimony to be.

ATTENDEE FEMALE 1: (Inaudible).

MS. BRILL: Say that again.

ATTENDEE FEMALE 1: They aren't owned by pharmaceutical companies?

MS. BRILL: That is true, that is true.

At least as of right now that is true, although one of the other bidders for Caremark is CVS which is a huge retail pharmacy. And think about the vertical integration that that would lead to and what that might mean. I mean, there are all sorts of relationships out there that are going to be happening in the future that we can't really predict.

Right now no pharmaceutical company owns a PBM but that could change tomorrow.

ATTENDEE 2: Along the same lines, the vertical integration --

MS. BRILL: Yes.

ATTENDEE 2: -- I think about the solid waste industry and how (inaudible) it's become integrated. I mean, basically they -- they're picking it up at your door and they're also putting it in their landfill at the other end and everything in between, recycling.

ATTENDEE 4: (Inaudible).

ATTENDEE 2: Yeah. Well, those are the other things that -- I mean, that seems to me the way the world is going, is this vertical integration. It used to be it was going completely --

MS. BRILL: I'm only using that as an example of this is not a static market. I'm not saying that we would necessarily have an objection if CVS were to purchase Caremark. If ESI, Express Scripts, which is a competitor were to purchase Caremark, we would have some real serious issues.

The vertical -- I'm just -- I was really just trying to say that you can take a snapshot today of what the market looks like and I can tell you it will not look that way a year from now or two years from now or three years from now. It's a very dynamic market that's changing. That was the only point I was trying to make.

ATTENDEE 2: Okay. On this particular issue, A1 --

MS. BRILL: Yep.

ATTENDEE 2: -- the testimony that we had yesterday basically said what does it mean, what does care, scope, prudence and diligence mean from a legal standpoint? How do you define those words?
MS. BRILL: Oh, I think there's a lot of -- there's a lot of case of law out there that defines, care, scope, prudence and diligence.

ATTENDEE 4: They call it trust application which is a higher a higher burden.

MS. BRILL: A higher burden than a fiduciary, is that what they were saying?

ATTENDEE 4: No, a higher burden than present --

MS. BRILL: It is -- it is -- it is true, that is correct. It would be -- it's more.

ATTENDEE 4: And that's the desire.

MS. BRILL: The desire is that with respect to the unsophisticated consumers who have no -- consumers being companies. These are plans. But we're talking sometimes about small businesses. We're not necessarily talking about really large businesses -- that the PBM explains to the company, well, okay, here's what we're telling you your price will be, but you need to understand these are all the other ways in which we may be making money from your -- our transactions with you. We may sell your data, we may get a rebate. There are all sorts of other things that are happening.

You're not going to get a cut of that unless you ask us for a cut of that. And then they can go further and say, we'll give you a cut of that but what it's going to mean is your administrative fee will go up. So they then get the choice in terms of their pricing. That's what it would do. It would be sort of this open disclosure for what I view as a lot of their customers being somewhat unsophisticated in terms of how the market works.

The market is a very complicated market and, you know, I know something about it through the investigations. I am not an expert in this market but I know it -- I know it's complicated.

ATTENDEE 2: But they were saying that it is nothing but their customers.

MS. BRILL: I don't believe that to be the case. I don't understand that and I'd be --

I'd be interested to see the data on who their customers are and how many -- you know, what their capitalization is and what the number of employees are and things like that. I mean, I don't -- the data I've seen -- and I've seen customer lists of at least one, if not two of the PBMs, don't bear that out.

Now, the customer lists I've seen are somewhat older, you know, a couple of years old.

ATTENDEE 2: But if it was a small customer, it was through an aggregate.

MS. BRILL: They do that, they do that. I mean, the smaller customers use -- sometimes they use TPAs, a third party administrator. Sometimes they use an entity to negotiate on their behalf. That is true sometimes.

You know, I -- I can't sit here and say that all of them understand this market, though, and all of them are really aware of what's happening. I do think there's more awareness now as a result of the work we've done but I just don't -- don't know that they all understand it all.

SENATOR CUMMINGS: They were also quite blase about the fact that yes, they have leverage and they did use it against the local pharmacists.

MS. BRILL: And against the pharmaceutical manufacturers. I mean, I'll tell you --

SENATOR CUMMINGS: I don't think anyone cares if they use it against -- that's the giant pushing them back but it's the small pharmacist that they -- and they said, yeah, that's right. They want our business, they sell at our formulary price.

MS. BRILL: That's absolutely true.

They're squeezing both ends of the market and they take -- they take a cut and the argument -- I mean, the Federal Trade Commission thinks that PBMs walk on water. They think that without PBMs we'd be paying three or four times as much for pharmaceuticals.

ATTENDEE FEMALE 1: Well, I did ask them what would happen if we did away with PBMs and everybody had to pay the full market rate so people couldn't afford it so people stopped buying.

MS. BRILL: What was their answer?

ATTENDEE FEMALE 1: They thought I had three heads.

MS. BRILL: I think --

SENATOR CUMMINGS: They didn't answer it.
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1 MS. BRILL: Well, there aren't -- as you
2 know, there's a movement out there to try to
3 create nonprofit PBMs, basically saying it's a
4 good function that's served by squeezing both
5 ends of the market, both the manufacturers and
6 the retailers, meaning the pharmacists, that
7 squeeze some of that profit out so that
8 customers get a better price.
9 The problem that a lot of people have is,
10 well, how much is the PBM taking and how much
11 is really benefitting consumers and it's --
12 it's not a transparent market. It is not
13 transparent at all.
14 ATTENDEE FEMALE 1: And I think that
15 that's the issue right there --
16 MS. BRILL: That's right.
17 ATTENDEE FEMALE 1: -- is how do we know
18 how much the PBM is taking and where -- and
19 that's the fiduciary argument.
20 MS. BRILL: Well, that's right.
21 ATTENDEE FEMALE 1: Where does your loyal
22 lie, does it lie to your own business or does
23 it lie to your customers?
24 MS. BRILL: And the issue is not that they
25 can't make a profit. No one is saying that

PBMs can't make a profit. It's just disclosing
these different revenue sources especially when
they relate to the purchasing power of the
customer, the plan or the business and saying,
here's your option. You can take a cut of this
or you don't get -- and if -- and if you take a
cut, our other fees may go up because you're
going to get some more money back here or you
don't get a cut of this and we'll give you a
good price on the administrative fees. So --
ATTENDEE FEMALE 1: They say they do that
now?
MS. BRILL: I think they are doing more of
it. I do agree that it's -- it's gotten much
better since 2004 when we had our consent
judgment.
ATTENDEE FEMALE 1: And they were saying
that they thought our law required them to make
everyone do one thing and they had -- they're
going to send us some proposed language that
would make it clear.
MS. BRILL: Well, I'd be happy to look at
it.
ATTENDEE FEMALE 1: Something about the
customer contractually ask for the information

or -- yeah, we're waiting. As soon as we get
that, we'll make sure --
MS. BRILL: Yeah, I'd be happy to see
that. I apologize because I didn't hear all of
this. And so you're saying though maybe they
want to modify subsections two through six.
ATTENDEE FEMALE 1: Yeah. There's two
sections where we talked -- one, we talk about
administrative only policy and one we talk
about full disclosure and transparent policies.
MS. BRILL: I mean, requiring an
administrative fee only policy -- plan is fine.
It's not going to change. It's just going to
mean that they'll change the pricing of that.
You know, it's -- it's still not going to cause
a great effect in the marketplace, I don't
think. But that's fine to have that in here.
Anyway, I'd be happy to look at whatever it is
they propose.
Right now there's joint enforcement of
this Section on page 15 and a little bit of 16
between our office and BISHCA. This is how we
ended up with this enforcement question a
couple of years ago. And if that's what you
all want to do, that's okay by us.

It would probably be better to have one
agency enforce rather than both but -- let's
see. The next section --
SENATOR CUMMINGS: Julie, there was one
question --
MS. BRILL: Sure.
SENATOR CUMMINGS: -- on enforcement.
MS. BRILL: Sure.
SENATOR CUMMINGS: They were very
concerned because they thought this law with
the private right of action would give any
member of the public, not a private right of
action by somebody that was a member of the
plan but that if I belong to another plan, I --
that this was wide open, that anyone could sue
them and that they didn't have to keep the
information private.
MS. BRILL: Well, we don't -- I don't
believe that to be the case. Our consumer
fraud law requires that a plaintiff -- in a
private case a plaintiff be a consumer. So you
have to be part of the transaction with that
entity. So unless you're a member of the plan
or the plan itself who's contracting with the
PBM, I don't see how you'd have a cause of
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action but I may be misunderstanding the concern.

SENATOR CUMMINGS: Could not and it may just be the member of the plan.

MS. BRILL: Oh, so they -- they don't want the member to have an action, they just want the plan.

SENATOR CUMMINGS: Yeah, because then you've got, you know, preferential information and stuff that's out of there.

MS. BRILL: Yeah. It is true that -- you know, really it would be the plan -- now that I'm thinking about it, the plan would have the cause of action. And in Vermont our Consumer Fraud Act does allow businesses to sue other businesses. We're fairly -- not unique.

There's about 10, 15 states that allow that. And the business has to be acting as a consumer that is purchasing something from the defendant and not reselling it.

In this case obviously that is what a company who's contracting for the services of a PBM would be, so really it would be the plan that is the consumer.

SENATOR CUMMINGS: Maybe if we could make that clear in the statute, that it's not all the individual right but the plan that could sell, that would give them some -- because, you know they hate the word consumer fraud. We've been through that before, that (inaudible).

MS. BRILL: We talked a lot about the need to change that because it's just the statute as it was enacted, you know, in the 60's. You know, consumer protection act would be fine by us but that's probably for another day.

SENATOR CUMMINGS: We could do that now, notwithstanding anything you've ever been called before.

MS. BRILL: Moving on, Section seven I don't really relate to us.

I thought the next one that really related to us, Section eight is -- it just -- it just talks about when the PBM regulations would kick in for which contracts and it's fine.

Actually, I think it's good to have some kind of a traffic cop direction in terms of when it would kick in so that makes sense.

The next section that really seems to affect us is Section eleven which would require us along with the Department or in collaboration with the Department of Health to develop an evidence base education program.

My one suggestion for this section would be that if we really want to give the Department of Health helpful information, I think you should consider exempting the making -- allowing us to give to the Department of Health under the gift reporting the information that we gather, and that's so that we can communicate to them about what's actually happening in the marketplace in terms of marketing, who's getting marketed, what kind of specialties we may need to focus on, those kinds of things. So it would actually be an amendment to a different section but it would allow us to have a robust conversation with the Department of Health.

ATTENDEE FEMALE 1: Robin, (inaudible) legendary, certain legislators read but that sounds like a good one.

MS. BRILL: Yeah. So we would make that suggestion. All right.

Now, I think the next issue is Section twelve which I just did hear some testimony on that as well as here.

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As was mentioned, this law is enacted in a slightly different version in New Hampshire. There was a -- an injunctive -- injunction hearing that was held I think it was in January. The judge said he was going to rule from the bench. He then changed his mind at the end of close of evidence and he said it was going to be something on the order of 16 -- 60 to 90 days.

You know, we support this legislation, this Section. We think that this is a good idea. We don't think that -- you know, as -- as Steve was still here, I think Steve said that, you know, doctors don't want people to know what they're doing. I don't think that's the purpose.

ATTENDEE FEMALE 1: I think --

MS. BRILL: Well, whoever -- I'm not sure that that's really the purpose of this legislation.

I think the purpose of the legislation is that they don't want certain types of marketers for marketing for certain types of purposes to have their prescription information. There's tons of exemptions in here that would cover,
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1 for instance, the MS example that Steve had
given. There was another example about
research, you know, whether the information
would be -- could still be used for research.
All of those uses of the data are exempted.
The one area that is covered, if you look
at the bottom of page 21, is a commercial
purpose that is intended to be used or is used
to influence sales or the marketing of a
pharmaceutical product, influence or value the
(inaudible) prescribing behavior of an
individual health care physician, excuse me,
market prescription drugs to patients.
Obviously, we don't want any individual as --
as Steve said, and I do agree with him on this,
HIPAA does not allow individualized information
to go --

ATTENDEE FEMALE 1: So we can take that --

MS. BRILL: I don't think it's necessary.
I'm not -- I don't know that I agree with Steve
about why it's in there but I -- and I don't
think it's needed. I do agree with him that
the federal law covers that. But the -- so
it's a very limited type of commercial activity
that is being prescribed here. And the reason

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1 for it is, you know, as -- as we mentioned to
you when we were here a couple of weeks ago, we
did a report in 2005 on the pharmaceutical
industry including their -- the marketing to
doctors that they're engaged in.

Everyone is very upset about direct to
consumer advertising, you know, the ads that
you see for Viagra and whatnot on TV. That is
a huge market but it -- it is dwarfed by
multiple times the amount of money that is
spent on marketing to doctors. Marketing to a
doctors is a huge, huge activity. There are
some estimates it's $17 billion a year
nationwide. There's some estimates that it is
$70 billion a year. It is a huge, huge market.
And the differences in those estimates come
from what you do include.

For instance, do you include sampling; in
other words, the practice of giving to doctors
samples that they can give to their patients of
expensive branded drugs? Some people think
that's clearly marketing because you're
basically getting the consumer to use that drug
and then they're going to go off and have to
purchase it themselves. Other people say

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1 sampling is a charitable activity. So there's
a big debate out there about sampling which I
understand is a debate and is a legitimate
debate.

But there is no legitimate debate in my
view and in our office's view that the effort
that the industry is engaged in to market to
doctors to influence their prescribing
behavior -- pharmaceutical manufacturers are
not charitable organizations. They -- they do
a lot of good things. They do have charitable
foundations but primarily they are profit --
they are seeking a profit which is perfectly
appropriate, nothing is wrong with that. But
they are marketing to get people to purchase
their products. That's the reason for doing
this.

And to the extent that they're -- they are
engaged in marketing, that is detailing to
doctors, what they are trying to do is to get
them to purchase new and typically speaking
more expensive products; that is branded
products that are out there for a new
indication, you know, it's -- it's new.
They're trying to introduce it to doctors and

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1 they want the doctors to use that product as
opposed to other products that are on the
market that might be off patent, that might
have generics available and things like that.

So there's absolutely no question as to
what this activity is about; that is, it is
trying to increase prescribing for certain
types of products, typically speaking more
expensive products and typically speaking
branded as opposed to generic products. And --
and while Steve mentioned that there is no data
on this, I mean the -- the data -- you know, I
don't know that there really needs to be data.

There is -- there has been evidence
introduced in the New Hampshire case. There
are expert reports. There's a Dr. Jerry Ahorn
(phonetic) who we work with a lot, who's done a
lot of great stuff on evidence based programs
for Pennsylvania and other states. He
submitted an expert report saying that the
reason that this is happening is to try to
increase the use of expensive drugs and the
overall effect is to increase the cost of
prescription drugs in our country, in the State
of New Hampshire and elsewhere.
And, you know, we could bring you that expert report so you could have it for the record so you guys can see it. But the point is that I don't know if you need data to show the direct effect of the marketing. Clearly, the manufacturers think that what they're doing is effective because they're spending billions of dollars on it. Literally billions of dollars.

ATTENDEE FEMALE 1: Steve's other argument that the only reason this data exists is because it has commercial value and that if companies can't make money --

MS. BRILL: Right.

ATTENDEE FEMALE 1: -- from putting -- from developing it, from taking different sources, taking it, putting it all together which is time consuming, that they won't do it, that -- and that therefore medical research and other good endeavors without -- will be much more difficult and costly.

MS. BRILL: I think that -- that's a --

a -- a legitimate argument. I think there -- I think we can legitimately debate that issue.

I think that there are a lot of people that want this data. Government entities want it. Law enforcement wants it. I have looked at it. It's -- it is great data. There's no questions.

ATTENDEE FEMALE 1: Do they want to pay for it?

MS. BRILL: I -- it's very expensive data right now. I often get it from defendants; that is the pharmaceutical manufacturers.

I don't know -- that is an empirical question that Steve has posed, that is would this market dry up if the pharmaceutical manufacturers weren't purchasing it.

There are other uses for it that would be completely allowed under this statute. You know, you're talking about researchers, government entities. There are a whole bunch of entities that could still purchase it.

ATTENDEE FEMALE 1: They don't have the purchasing power that pharmaceutical companies --

MS. BRILL: Clearly, they don't. I mean, I'm not -- again, I think it is -- it is a legitimate area to debate.

Query whether Vermont in enacting this give us -- is to what is the current way in which their customer base is divided. I mean, how much of their revenue comes from these different sources.

The other issue, though, that you may hear from the medical society is -- and it is something similar to what I said about PBMS -- that may be their current revenue stream but query whether that would change.

I mean, if the rest of the country were to enact this law -- and that's a big if -- but if the rest of the country were to enact this law such that it might affect the ability of IMS or Veraspan to produce this data, are there other opportunities to be marketing this data for other purposes. And that's just the question I would leave you with because I don't know the answer because it's a -- it's -- it's a data issue.

ATTENDEE 2: Julie --

MS. BRILL: Yes.

ATTENDEE 2: Playing on the devil advocate's side here --

MS. BRILL: Sure.

ATTENDEE 2: -- a large -- a major portion
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1 of this data is coming from the AMA. The AMA
2 is a physician based organization --
3 MS. BRILL: Yes.
4 ATTENDEE 2: -- a national organization.
5 MS. BRILL: Yes.
6 ATTENDEE 2: Now, it appears from
7 Madeleine's comments that the Vermont medical
8 society which is the Vermont physicians, the
9 New Hampshire medical society and I guess the
10 rest of the New England are opposed to that
11 data mining so to speak from the AMA.
12 My response is why shouldn't they then say
13 to their organization, don't -- don't do this.
14 MS. BRILL: Say it to the AMA.
15 ATTENDEE 2: Say it to the AMA and have --
16 have -- if it's based on physicians, if the
17 physician worry is, its members, why not have
18 the members tell their board, we think you
19 should stop doing this if that's what the
20 ultimate goal is.
21 Instead, what's happening is you're coming
22 to us and saying you make them stop.
23 ATTENDEE FEMALE 2: Make me stop.
24 ATTENDEE 2: Yeah, make me stop doing
25 this. Essentially what I think -- what it

1 looks like to me -- and I'm saying this
2 somewhat facetiously but what it looks like to
3 me is they're trying to protect themselves from
4 themselves.
5 MS. BRILL: Right. I would say -- first
6 of all, I think that's a perfect -- a perfectly
7 appropriate question and I don't know to what
8 extent the Vermont medical society and the New
9 Hampshire medical society have tried to
10 influence the AMA or what voice they have in
11 the overall national organization.
12 I imagine this is a huge money driver for
13 the AMA and there probably is huge resistance
14 to stopping that but I -- I have not gotten
15 into the details of that issue yet.
16 But, you know, there are a lot of doctors
17 who are very concerned about the cost of
18 pharmaceuticals and they may be saying, look, I
19 don't let the detailers into my office but I
20 know that a lot of my colleagues do and my
21 concern isn't I'm not saying protect me from
22 myself. I'm saying protect the public from the
23 doctors who are allowing this to happen and may
24 be unwittingly, maybe they say gee, I'm not
25 going to be influenced by a marketer but they

1 are influenced by marketers.
2 ATTENDEE 2: But they also have the
3 opportunity to opt out.
4 MS. BRILL: Clearly, right. And -- and it
5 might be those who are -- who are concerned
6 about the overall cost of pharmaceuticals do
7 opt out but the question is what's happening to
8 the profession as a whole.
9 You know -- you know, it's a legitimate --
10 I'm not disagreeing that it's a legitimate
11 thing.
12 SENATOR CUMMINGS: Senator McCormack.
13 SENATOR McCormack: It seems to me it
14 makes sense to -- to keep information secret
15 from everybody except this or that select group
16 but here what we're talking about doing is the
17 opposite. The information is available and
18 there's certain select groups like the
19 pharmaceutical companies who say, you can't
20 have it. There's a lot of other people though
21 who can which seems to me that it's not very
22 secret at that.
23 And if Joy is saying, for example, that
24 the AG's office has this information and they
25 didn't buy it, it's given to them by other

1 people who (inaudible) so what we're saying is
2 everybody who wants this can have it except the
3 pharmaceuticals.
4 SENATOR CUMMINGS: No, they can't --
5 SENATOR McCormack: They're going to get
6 it from friends.
7 MS. BRILL: Pharmaceuticals -- but it will
8 say -- basically it will stop them from using
9 it for the purpose of detailing. I mean,
10 they -- pharmaceutical companies will get the
11 data because there are all sorts of other
12 purposes and uses for it that will be allowed
13 but they will not be able to give it to their
14 detailers, I would think, for the purpose of
15 the detailer going in and saying, you know,
16 gee, why aren't you -- why aren't you doing
17 better prescribing whatever, Lipitor, whatever
18 the drug is going to be.
19 ATTENDEE 2: It's like when you think you
20 get your own credit report.
21 SENATOR McCormack: Other people --
22 MS. BRILL: Well, you don't -- you don't
23 want someone marketing you to get your credit
24 report. You can get your own. The doctor can
25 get his own prescription history but you don't

10 (Pages 34 to 37)
ATTENDEE FEMALE 2: So is that sort of like insider trading in that you -- you should have that information, you're free to get that information, you're -- you're just not supposed to do certain things with it?

MS. BRILL: Right. You're not supposed to be you using it for certain -- certain limited purposes. That's right.

ATTENDEE FEMALE 2: So it's less of a restriction of access and more a restriction of action?

MS. BRILL: I think so. Let's look at the language.

SENATOR CUMMINGS: Julie, you've got about two minutes.

MS. BRILL: Oh, okay. I think that's the intent, Senator Ayer. Okay. Thank you.

SENATOR CUMMINGS: And we will have you back.

MS. BRILL: And I'd be more than happy to be back. Let me just go through this quickly. Section 14, I think this is designed to ensure that some -- an entity like Wal-Mart's low generic pricing would be available as opposed to someone being charged a co-pay. I think that's what 14 and 15 have to do.

SENATOR CUMMINGS: Yeah, it said the actual price is less than --

MS. BRILL: The actual -- the retail -- if the retail price is less than the co-pay, you get the retail price. That makes sense.

I -- I raised with Robin a question as to whether under Part D we're actually preempted so the mentioning of Part D in Section 15 may be a problem.

SENATOR CUMMINGS: The other one we had questioned was the advertising.

MS. BRILL: Okay. I -- I did have some thoughts about the unconscionable pricing section. That's the one -- that's section 16.

SENATOR CUMMINGS: Yeah.

MS. BRILL: And what I suggested to Robin -- let me just say this is designed going to the question that was mentioned earlier as to what the litigation risk might be. This Section, a very similar -- a Section very similar to this was enacted in D.C. It is currently being enjoined and on appeal. We don't know what the effects will be but I would like to see this changed to try to protect it from some potential litigation and I would recommend that on page 27 that you change the focus from specify health condition to serious public health problem. And you would do that on line one and line three.

And then in addition to that I would recommend adding a sub -- a new sub five at the bottom of 27 creating -- current sub five would be sub six and I would say that we should have the commissioner consider whether consumers afflicted with a disease are unable to pay for the drug at its then currently available price.

So what you're trying to do is you're really focused on the issue of, okay, we've got a serious condition, a serious public health problem, and consumers who have this condition cannot get the drug or are having trouble accessing the drug. So I would say that in that instance then we are really talking about state interest that may overcome any commerce clause problems or et cetera. So --

SENATOR MAYNARD: How -- how does this get off the hook.

MS. BRILL: It doesn't get us off the hook but it will -- it will -- it -- because it will demonstrate I think and I think that what -- that what -- what we'd then be talking about would be a strong state interest in preventing a serious public health problem as opposed to talking about a specified health condition which may or may not have a strong state interest.

ATTENDEE FEMALE 1: May be the common cold.

MS. BRILL: But if you talk about a serious public health problem --

ATTENDEE 1: HIV.

MS. BRILL: HIV is a great example because there have been problems with HIV drugs, not necessarily in Vermont, but the cost going way up.

So if you can show that -- that consumers who are afflicted with a disease or with a condition are having trouble getting the drug to treat it, then --

SENATOR MAYNARD: You're showing a state interest.

MS. BRILL: Exactly, exactly. And
that's -- once you show the compelling state
interest, it could overcome a commerce clause
challenge. Actually, it doesn't need to be
compelling. It needs to be a state interest, a
strong state interest. I'm not sure it needs
to be a problem. Okay.
I had mentioned to Robin quickly that on
section 4655 -- this is in the same D.C. law
section. It's page 28 -- that I would
recommend just making -- allowing the Attorney
General to have -- say this is a violation of
the Consumer Fraud Act and the Attorney General
has all the rights under the Consumer Fraud
And then 4656 is the civil action for
consumers and that is broader. This is any
affected party which may or may not be someone
who satisfies the definition of a consumer.
And if you want that to be broader, that's
fine. But rather than repeating the previous
three pages, what's already in the Consumer
Fraud Act, just say we've got the rights under
the Consumer Fraud Act. So it's easier.
Okay. Advertising, let's go there.
Section 17, I think -- did you want me to

address this WCAX issue or can we --
SENATOR CUMMINGS: No. I think this is
generally how -- how is the Attorney General
going to enforce against a pharmaceutical ad
that may be broadcast over WCAX. And it was
mentioned that we don't mention either TV or
or cable. I mean, WCAX most of its programming
comes over some cable company, that do they
have -- their antennas or satellites but you
know it originates in Long Island or California
or China. I mean, how, what's the risk to
our local guys and -- and how are you going to
do that?
MS. BRILL: Okay, there's --
SENATOR CUMMINGS: What's the --
MS. BRILL: There's a really easy answer
to this. First of all, under the Consumer
Fraud Act there's an exemption for any
advertising -- any medium that does the
advertising or any newspaper --
SENATOR CUMMINGS: That's in here?
MS. BRILL: It's not in here now but it
could easily be put in. And it's Section nine.
It's Title nine, Section 2452 and it's called a
Limitation. And what that does is it says that

if you're a media entity, television, radio,
newspaper and you don't know or have reason to
know that the ad is fraudulent, then you're not
liable under the Consumer Fraud Act.
ATTENDEE 2: But how about -- how about
the situation -- for instance, Mr. Martin was
talking specifically on page 33, line four
through nine where it says the regulated
advertising, the definition, and where it talks
about that is broadcast on television or radio
from a station that is physically located in
the state, from that point, that particular
one, the signal originates from WCAX within
Vermont. Okay. So it originates in South off
the top of Mount Edgesfield (phonetic) and out
the rest of the state but their signal comes
from New York or wherever by satellite. So
most of the advertising with very limited small
amounts, most of the advertising is national
advertising.
MS. BRILL: I understand. We -- we deal
with national advertising now. There's nothing
new here.
ATTENDEE 2: Okay.
MS. BRILL: When a -- when an

advertisement goes out that is directed at
consumers and it would satisfy the definition
of misbranding under the Food, Drug and
Cosmetic Act which means that it's basically
false, we will go after -- we will investigate
the pharmaceutical manufacturer. We do that
right now.
I thought his question was specifically,
well, what about us, the television station.
And what I'm telling you is that under the
Consumer Fraud Act we will not go after the --
the television station unless they know or have
reason to know that it's fraudulent.
ATTENDEE 2: Okay. What -- the other
point that he made and this is a question -- I
guess it's in that same section, the next piece
of it says broadcast over the Internet from a
location in the state. Although it is
broadcast under WCAX, he said they do have
pop-ups or they have ads, their ads, on some of
their web pages and -- but -- but the Web site
is actually in New Jersey. They don't have --
they don't have the Web site here. The Web
site is housed in New Jersey and he said
actually the controlling piece comes out of New
York into New Jersey before it goes on to the
Web.
   So my question is how -- where is the Web?
3  MS. BRILL: Yeah. We'll -- we'll -- we
4  believe we have jurisdiction over this. We
5  believe they are intentionally in that
6  circumstance advertising in the State of
7  Vermont.
8  There is a debate with respect to the
9  Internet over how much they need to be doing
10 that's directed at any particular state in
11 order for a state to take jurisdiction.
12  But with respect -- now, what we're
13 talking about -- let's remember -- is our
14 investigation and prosecution of the
15 manufacturer. That is, the one who creates the
16 advertisement. We're not talking about
17 prosecuting -- investigating and prosecuting a
18 television company or the newspaper.
19  And if you want to have a specific
20 exemption in here that's similar to what we
21 have in the Consumer Fraud Act, we are -- we'd
22 very happy with that because that is the
23 current -- that's how we operate.
24  We don't go out there after the
25

1  heard of cyberspace when they wrote this.
2  MS. BRILL: Well, if you look -- I mean,
3  look at 46D. I mean, subpart B has some real
4  quaint stuff in here. I mean --
5  SENATOR CUMMINGS: Yes. It's almost
6  getting as good as the thing that defines the
7  wealth you can keep when you're in bankruptcy
8  with your chickens and --
9  MS. BRILL: Right, right.
10  SENATOR McCORMACK: If you go back up to
11 the same page, page 35 under C, it says -- this
12 was also brought up by Mr. Martin -- it says no
13 publisher or radio broadcast licensee or agency
14 of media for dissemination. It says nothing
15 about TV.
16  MS. BRILL: I'm happy again to put all
17 that in there. You know, this is -- this is
18 old language. But what I find very quaint is
19 that it's not allowing direct to consumer
20 advertising for cancer, heart and vascular
21 diseases, high blood pressure along the bottom
22 of 35, now the top of 36, sexual impotence. I
23 mean, there are a lot of ads out there for
24 these diseases. So it's --
25  SENATOR CUMMINGS: Well, we could nail

advertising company unless they knew or had
reason to know. And I'm sorry he's not here
because I would have been happy to tell him.
1  SENATOR CUMMINGS: I think -- no, I
2  think -- I reassure -- my understanding was the
3  intent was we are going after the manufacturer.
4  MS. BRILL: Exactly. That's -- that's my
5  read of this. And we -- we do now -- under the
9  Consumer Fraud Act, if an ad would make a drug
10 misbranded, I don't use Title 18. I could use
11 Title 18. This is in the -- this is actually
12 under the Health Department's jurisdiction and
13 this actually -- this Section would make our
14 authority clearer to use Title 18 but I just
15 use the Consumer Fraud Act for this issue.
16 So -- but I do -- you know, again, I can help
17 Robin clean that up if she wants to, if you
18 want to address it again.
19  SENATOR CUMMINGS: I think we could
20 tighten it.
21  MS. BRILL: Sure.
22  SENATOR CUMMINGS: It sounds like it needs
23 to be brought into the 21st century.
24  MS. BRILL: Yes.
25  SENATOR CUMMINGS: I don't think they

them right away.
1  MS. BRILL: Just for doing Viagra.
2  SENATOR CUMMINGS: (Inaudible) That's an
3  insight out there every 30 seconds.
4  MS. BRILL: I actually did not know until
5  I read this Bill that this statute was on the
6  books.
7  ATTENDEE 2: So Vermont was way ahead of
9  themselves when you said in '50s and '60s. We
10 were way ahead of ourselves.
11  MS. BRILL: It is quaint; I will just say
12 that, it is quaint. Okay.
13  I -- and I suggested -- on Section 19 I
14 suggest -- suggested to Robin that she adds in
15 for the consumer protection piece Section 46,
16 55. That's the unconscionable pricing. And
17 then that would tie in with what we've done
18 earlier.
19  I wasn't sure -- so I'm really asking
20 you all a question -- as to why on the bottom
21 of page 37 and top of page 38 the subpart B1
22 and B2 are in there. I guess it's to deal with
23 Part D. It looks to me like it's -- it's
24 designed to deal with people who are marketing
25 to consumers and they appear to be selling Part
D policies and yet -- and then they start
selling other stuff. And I think that that --
we've had cases like that. We've worked with
BISHCA on those cases. I think they've been
dealing with them. I'm just not sure -- you
know, if you all want to add this as a consumer
protection violation, I guess that's okay, but
I just think we've been handling that under the
current laws.

SENATOR CUMMINGS: Do you know where did
that one come from, Robin?

MS. LUNGE: Maine.

ATTENDEE FEMALE 1: From Maine.

ATTENDEE 2: That's the Walter Grimlin
(phonetic).

MS. BRILL: There have been -- there were
problems -- a couple of years ago there were
problems on this when Part D was first launched
but I think we've cleaned that up and --

SENATOR CUMMINGS: Do you think you can do
it?

MS. BRILL: I think so.

SENATOR CUMMINGS: Maybe Maine isn't doing
it as well as we have.

MS. BRILL: I think -- well, maybe it was

enacted a year and a half ago and this was
really -- looked like it was going to be a
problem but now I think we've cleaned that up
so --

SENATOR CUMMINGS: We may be able to
jettison that and save half a tree.

MS. BRILL: Yeah.

SENATOR CUMMINGS: Okay.

MS. BRILL: I think -- I mean, I didn't
know if you wanted to talk about the littler
bills. Anyway, I wanted to make sure I got
through the committee bill for you.

SENATOR CUMMINGS: Okay. And we're only
ten minutes off. Sorry. You're the one that
had to be somewhere.

MS. BRILL: Well, I know you all wanted to
leave.

SENATOR CUMMINGS: Well, I think we want
19 to just get Robin -- I think I'd like --
20 because twice the people would like to have
21 this Bill go and things you want to have added
22 or subtracted you might want to let Robin know
23 so that we can come back next week. We've got
24 a little testimony to finish up but I want to
25 move it towards markup. And if there's any

point out that in that section, the
regulated -- the term regulated advertisement
which it has that language about the PBMs,
about prescription drugs is only used in this
subsection 12 which says the manufacturer can't
have that type of ad presented. So the rest of
the statute uses other terms, not that specific
term. So I don't think our friend from WCAX
quite under -- like connected that.

SENATOR McCORMACK: Well, I think based on
what Julie said --

MS. LUNGE: And we can clarify that, too.

I think that --

SENATOR McCORMACK: I think it's because
we didn't see the limitation.

SENATOR CUMMINGS: Right.

MS. BRILL: Right. Well, the thing is --
and that's in a totally different title.

SENATOR CUMMINGS: Yeah, I don't think he
read the Vermont's statute annotated. I think
he read our Bill.

MS. LUNGE: He wouldn't be expected to.

SENATOR CUMMINGS: After we finish, only
laws have to read it, and they can use green
books.
SENATOR McCORMACK: Your Honor, it's funny
because I remember when I -- in my previous
(inaudible) when I was across the hall as the
chair we were dealing with some campaign
finance issues and I remember a particular
lobbyist attorney -- slash attorney who came in
and said, look, I'm an attorney. My job is to
find a way around the law that's legal. Isn't
that what this is? (Inaudible).

ATTENDEE 1: If you turn the tape off,
I'll tell you what I really meant.

SENATOR CUMMINGS: We're dismissed. We're
out.

ATTENDEE 2: Is the tape off?
(Whereupon the CD 50 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 2007
- 50 /Track 1, the Senate Committee on Finance, Friday,
February 16, 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 28th day of August 2007.

Dona J. Wong, RPR, CSR
Esquire Job No. 889730B

ESQUIRE DEPOSITION SERVICES
STATE OF VERMONT
SENATE COMMITTEE ON FINANCE

5  Re: Senate Bill 115
6  Date: Tuesday, February 20, 2007
7  Senate Finance Committee
8  Committee Members:
9
10  Sen. Ann Cummings, Chair
    Sen. Claire Ayer, Vice-Chair
11  Sen. Bill Carris
    Sen. James Condos
12  Sen. Mark MacDonald, Clerk
    Sen. Hull Maynard, Jr.
13  Sen. Richard McCormack
    Robin Lunge, Legislative Counsel

15  CD No: 2007-51/Track 1
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call us up for a roll call if they're running late
or we're running late. But I'm going to try and
get us out of here at 4:30 -- at 4:15 so we can go
upstairs for 15 minutes and come back, so anytime
between now and probably 4:00.
MR. BILL SMITH: Yes, ma'am.
CHAIRPERSON CUMMINGS: Okay.
MR. BILL SMITH: (Inaudible.)
CHAIRPERSON CUMMINGS: Which would work.
Okay. Jill [sic] Corcoran?
MS. CORCORAN: Yes.
CHAIRPERSON CUMMINGS: Welcome.
MS. CORCORAN: Welcome, thank you.
CHAIRPERSON CUMMINGS: And you are from PhrMA?
MS. CORCORAN: I'm from PhrMA, yes. Thank
you.
CHAIRPERSON CUMMINGS: Maybe -- some of the
committee is new.
MS. CORCORAN: Okay.
CHAIRPERSON CUMMINGS: So you might just tell
us who PhrMA is.
MS. CORCORAN: Sure. I'd be happy to.
CHAIRPERSON CUMMINGS: They're not a PBM?
MS. CORCORAN: No, I'm not a PBM. Again, my
name is Julie Corcoran, and thank you very much for
the opportunity to come and speak before you all
today.
Yes, I work for Pharmaceutical Research and
Manufacturers of America. It is the trade
association that represent the innovator side of
the pharmaceutical industry, and we are a trade
association located in Washington, D.C. And I
am -- my title is deputy vice president for state
policy. So I work on issues involving Medicaid,
Medicare, and state issues. So I welcome the
opportunity to be here today to talk to you about a
couple of the issues in the legislation before you.
I actually appreciate -- it's kind of nice to
be before a legislative body in an atmosphere like
this too where you feel like you can have much more
kind of conversation about some of the issues here
too.
So you know, as I begin, I just -- there are
about four issues in this legislation that I know
you have before you that I'd like to kind of talk
about today. Those deal with the price disclosure,
the unconscionable pricing aspect of the bill, the
prescriber data issue as well as the section
dealing with advertising.
In the first section, like I said, dealing
with the requirement to have certification on certain pricing in this legislation, I'd love to direct your attention to Maine, which I'm sure you're all aware had a similar provision passed in 2003.

FEMALE ATTENDEE 1: Can you refer us to the page in the bill that we're working from?

MS. CORCORAN: Okay.

FEMALE ATTENDEE 1: That would be useful.

Thank you.

MS. CORCORAN: Let me grab my bill.

FEMALE ATTENDEE 1: Sure. I can find it eventually, but you may have it marked.

MS. CORCORAN: I have -- on the copy I have it's page 8. I'm not sure if it would be the same.

FEMALE ATTENDEE 1: Thank you.

MS. CORCORAN: On page 8?

FEMALE ATTENDEE 1: Yes. That's the right --

MS. CORCORAN: Actual price disclosures. And if you look down on that page -- and I guess it would be Section C -- when a manufacturer of prescription drugs dispense and the state reports the average manufacturer price or best price, the president or chief executive officer of the manufacturer shall certify to the office on a form provided by the director of the office of Vermont.

Maine had introduced similar legislation in 2003. And through the next two years, kind of working with the industry and a lot of lawyers for the company, it basically came to the conclusion that it was very difficult to implement it as written like this in terms of having -- you know, do understand this industry is a global industry, so a lot of CEOs are located outside the United States and, in many instances, have individuals who are designated in the United States that do a lot of the compliance work. By that, I mean the reporting of AMP to CMS and your federal agencies.

As a result of kind of continuous dialogue with this state, in 2005 they changed the law to reflect that -- show that it is much easier for Maine to get the information that they had -- we're looking for based on this law.

And I have that before -- in front of me, and I'd be happy to kind of walk you through it or at some time kind of provide you with that language as Maine has changed it.

CHAIRPERSON CUMMINGS: Soon you can either provide it to Robin who is going to draft it --

MS. CORCORAN: Okay.

CHAIRPERSON CUMMINGS: I assume she's seen it.

MS. CORCORAN: Sure.

MS. LUNGE: I'll be happy to. I'll get a copy (inaudible.)

MS. CORCORAN: Great.

CHAIRPERSON CUMMINGS: And what's the difference here?

MS. CORCORAN: The difference is it allows the CEO to basically designate the individual who is already basically responsible here in the United States for reporting that information to CMS to be the person that would report that information to Vermont. So in essence, a person who reports to the federal government who reports to Maine would also report to Vermont.

FEMALE ATTENDEE 2: I thought maybe we had done that once before but (inaudible).

FEMALE ATTENDEE 1: I think I remember the conversation before.

CHAIRPERSON CUMMINGS: I remember the conversation.

FEMALE ATTENDEE 1: Yeah. I remember the conversation. I remember the question I asked then, and I still don't know the answer to it.

As I understood it, our intent, in putting this language in, is to make sure we hold the head of the companies' feet to the fire. And if she designates Bill Carris to be the one who says, "That's 15 cents a pill," does Bill Carris go to the slammer for lying to us or is it she who told him that?

MS. CORCORAN: Well, I think at the end --

FEMALE ATTENDEE 1: I'm exaggerating.

MS. CORCORAN: Okay.

FEMALE ATTENDEE 1: That wasn't a very good plan, but --

ATTENDEE 1: It got their attention.

MS. CORCORAN: I understand your --

FEMALE ATTENDEE 1: But the purpose is to make sure that it's not somebody -- that they can't designate somebody else to take the heat, that the leadership of the company is saying this -- this -- we know this is true, that they stand by the price.

MS. CORCORAN: Sure. I mean what I -- I guess what I would say to that, at the end of the day, the CEOs of the industries are the ones who are ultimately held accountable for certifications in the state or at the federal government. I think, in terms of just the ease of getting this information, this is why you have a designee there.
because they're the ones who internally in the corporation have access to it. It's part of the composition of their job.

You know, I don't know enough about state law, federal law in terms of who you would sue and how you would sue. But I do understand there's a certain amount of corporate accountability for the CEO if they're making a certification to a state or to the federal government that this pricing is X, Y, and Z.

CHAIRPERSON CUMMINGS: And there is a person presently that is designated to do the certifying with the federal government and --

MS. CORCORAN: Yes, Yes, ma'am. Yes, ma'am.

CHAIRPERSON CUMMINGS: Okay.

MS. CORCORAN: Yes. AMP as a result -- two, three years ago, the change in the Medicaid statute required the reporting of this type of information, as well as information relative to Medicaid and best price. So there are individuals in the companies already situated to handle this.

CHAIRPERSON CUMMINGS: Okay. That wasn't too difficult.

MS. CORCORAN: The next issue I'd like to talk about deals with the unconscionable pricing

section, and this is an area where there's a couple of things I'd just like to bring your attention to. As designed, this section would reach out to transactions that largely, if not 100 percent, occur outside the state of Vermont. As a practical matter, the pharmaceutical industry and most of the manufacturers, they, at the end of the day, will sell from manufacturer to wholesalers; and there are three large wholesalers out there in the United States. Those transactions largely occur outside the state of Vermont.

A good example: You might have a manufacturing entity in California that sells to --

I'm sorry.

CHAIRPERSON CUMMINGS: It's page 26 I was telling you (inaudible.)

MS. CORCORAN: Page 26, yes.

As I was saying, in many instances, you'll have a manufacturer, for example, in California who has a product. They'll sell that product to a wholesaler that could be based in Illinois. That Illinois wholesaler might sell that product to another wholesaler in Rhode Island or another large pharmacy who, in turn, sells that product to Vermont. What this bill, as designed, would do is it would reach out to that initial transaction from California to Illinois.

A similar bill that was passed last year in D.C. had a provision just like this. And recently, which was the source of litigation in D.C., the court found that provision, as well as some other provisions that I could get into that are affected by this, on its face unconstitutional for the very reasons that while states clearly have the authority to engage in laws that impact transactions within the state that the commerce clause gives Congress the authority to engage in and set the laws and the parameters for transactions that occur among a whole bunch of states, whether it's California to Illinois and such.

D.C. passed a similar provision. When it was litigated, the court basically held that case on its face unconstitutional for that reason.

There are a couple of other reasons dealing with the fact that this law, like the D.C. law, would impact the patent laws which are largely guided by Congress. And the court in D.C. held that, again, the D.C. law, which is very -- this law is very similar to, would be preempted under the supremacy clause because, at least at this time, Congress has kind of designated itself the entity by which it regulates and sets the laws for patents. It's not just with the pharmaceutical industry but with other entities out there.

The other area of concern with how this bill is written too is, if you read it -- and I think it's on the third or fourth page -- should a citizen, should the attorney general or another entity bring suit under the provisions of this?

One of the remedies for the court would be to enjoin the sale of that product, or a couple products, depending on which ones were determined to be of public concern in Vermont. That would or could basically have the net effect of precluding patients in this state from receiving drugs.

And that's another real big concern of ours too because it would -- from an access point of view, a court could enjoin the sale of a product.

So if you had a department that decided that, you know, hypertension was of a public health and concern here in the state of Vermont, they could enjoin the sale of that product, if they found that that product was unconscionable. So again, that's a concern of ours.
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The other area in this bill that I'd like to talk about deals with the prescriber data provision, which, if I have it correctly on my mind, actually, I don't think I have that flagged, and I apologize for that.

CHAIRPERSON CUMMINGS: I think it's the next one.

MS. CORCORAN: I think that -- which I had the advertising, I think it might be right after or before.

(Inaudible.)

CHAIRPERSON CUMMINGS: Wasn't this just after that?

MS. CORCORAN: I think it's before. I'm sorry. I have everything --

FEMALE ATTENDEE 2: It's on the confidentiality?

CHAIRPERSON CUMMINGS: It's on the, yeah, the database.

FEMALE ATTENDEE 2: 21.

MS. CORCORAN: 21. thank you. Yes, it's confidentiality of prescriptions.

There's a couple areas of concern I'd like to talk to you about this, and I know you've heard testimony before on this issue. This provision would have the effect of limiting the ability of the pharmaceutical industry and the FDA of using aggregate data to expedite educational information about certain products.

For example, you have a lot of products out there that when the FDA makes a determination working with the industry whether that product can be marketed. Depending on kind of the data, depending on kind of the risk-benefit analysis that occurs between the industry and the FDA, many times the FDA will require what is called a risk map to be implemented by the pharmaceutical company working with the FDA.

Inherent in that discussion on risk maps is a built-in assumption by the FDA that the pharmaceutical industry has access to information that enables it to target certain physicians, depending on what product it is.

One of the products that I can talk to you about is a product that was -- I think it was in 2006 when the FDA approved a product for people with epilepsy. That approval was contingent on the fact that they had a risk map in place that insured that physicians were receiving targeted information, as well as going online to be educated.

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on this matter. The ability of the industry to have this to target those physicians was essential in the FDA's discussion and approval of this drug for patients with epilepsy.

The other thing that I'd like to talk to you about when it comes to this issue is that while we recognize that physicians quite often have concerns with how sales and marketing forces within companies use this information in their dialogues with doctors, we have been working very closely with the AMA.

And earlier this summer, after spending probably about a year or two outreaching to physicians on this very issue came up with the AMA PDRP, which is a program -- and I have some fact sheets here that I can send around -- which is a program that allows physicians the choice of whether the industry, pharmaceutical manufacturer X, Y, or Z receives access to their prescribing data.

Now, this is an opt-in program where -- I mean opt-out program whereby a physician goes into a computer that is set up at an offsite data base and would prohibit pharmaceutical manufacturers' sales and marketing forces from having access to this information.

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It does not preclude the use of that data from being used by the industry, in conjunction with the FDA for targeted information, whether it's a risk map, Dear Health Care Providers, whether there's a recall on a product. That -- the information is still available for that.

And the AMA, when they were going around talking to different physicians groups on this very issue, one of the things that came out very clear in their discussions is that the doctors were very comfortable having this opportunity to opt out of having the industry have that data used by their sales and marketing forces. But they understood the need for it to be used on the kind of patient safety side of products, when it comes to receiving the targeted Dear Health Care Provider letter, whether it's dealing with a drug like Tysabri for MS.

They recognize that it was an appropriate balance, and that's how the AMA came up with that. And we at PhrMA support the AMA opt-out and encourages doctors and states to be educated on this as an option for them.

CHAIRPERSON CUMMINGS: I don't think anyone is
trying to stop that use. The concern -- and we understand that the AMA sells their list to the pharmaceuticals. So this is a major income source for them.

The concern is that -- when that information is used to push certain pharmaceuticals. Our concern is to keep down the price of pharmaceuticals to make sure that the most effective, not necessarily the newest and most expensive pharmaceutical, is prescribed. And so we're trying to work through education. We understand that lobbyists, the detailers -- I should say for disclosure, my sister was one once -- you know, provide a valuable service.

But the complaints are coming with, "How come you haven't, you know, prescribed the new-and-improved orange pill this month and you're still prescribing the old blue pill or the old orange pill that isn't new and improved," and that kind of pressure. And that's the issue that we have.

MS. CORCORAN: Yes. And that is why we believe, and I believe the AMA believes, that the opt-out addresses that very concern, that concern with the detailers coming in and saying, "I have this data in this form. You know, explain to me," or questioning how they are prescribing and what they are prescribing.

The AMA opt-out would preclude those sales and marketing forces individuals from having that data, from having that discussion. We recognize that.

We also recognize, too, that while it would preclude the sales and marketing force from having that data, which is why we like the AMA opt-out, that data is still very valuable in the instance where it's important for that physician to receive information in an expedited manner about a drug or a product where it has come to the attention of the FDA that there's a counterindication or a concern. So it's a balance.

CHAIRPERSON CUMMINGS: It's when that also leads to that physician receiving a mass of information on the new-and-improved orange pill which has no FDA issue which he just isn't prescribing.

MS. CORCORAN: And the thing I would also say on that with physicians, physicians are free to tell a pharmaceutical sales rep, a detailer, that they don't want to see them.

CHAIRPERSON CUMMINGS: I think that they provide information. I think there's information and there's too much information.

MS. CORCORAN: Information.

CHAIRPERSON CUMMINGS: And when you get too much information about the new pill, that it is in the pharmaceutical's best interest, the company's best interest is to market it. That's where the rub comes in. I don't think that it's that no one wants to say, "Don't come see me because you do bring me information about the newest."

It's -- so in that -- you know, it would -- it would probably be irresponsible not to get that information.

MS. CORCORAN: And you know, I would hope that those are situations where a physician feels comfortable enough to engage in the dialogue with the sales and marketing reps that are coming to see them in a particular practice by having a dialogue saying, you know, "Thanks, but I would appreciate it if you were more targeted in the kind of information." And there's not -- what we often hear about is just a lot of noise that they receive.

And you know, I would just kind of more encourage that dialogue from happening because many times, when efforts are out there to kind of regulate and preclude information, at the end of the day, sometimes that ends up with more information, the less targeted you are with your doctors and understanding where the practices are and the type of information that might be useful with them. And in the instance with a drug that has a very kind of high risk-benefit and the industry doesn't have the information to target it, they might feel compelled to just provide that information to every doctor in this state versus the ten that they are aware of that are prescribing that product. So...

FEMALE ATTENDEE 1: I think we're on the same page in a lot --

MS. CORCORAN: Yeah.

FEMALE ATTENDEE 1: -- a lot of ways. So why not -- and doctors should have the right and take -- should have the right to say: I don't.

So I'm the doctor and you're the detailer and I say, "Well, you know, I'd like you not to use the information that you get about me and my prescribing habits."

How are you going to do that?

MS. CORCORAN: Well, one of the solutions --
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1. FEMALE ATTENDEE 1: (Inaudible.)
2. MS. CORCORAN: Yeah, sure. I mean one of the
3. solutions I would say to the physician -- and I
4. guess I'm not really talking as a detailer right
5. now: I would encourage you to do the AMA opt-out
6. because that would preclude me, detailer, from
7. having that information in front of you.
8. FEMALE ATTENDEE 1: So why don't we have a
9. default position; and if you want -- and if doctors
10. want the detailers to have that kind of
11. information --
12. CHAIRPERSON CUMMINGS: Opt-in.
13. FEMALE ATTENDEE 1: -- the detailers can give
14. them a slip and say: I want to know how you
15. prescribe my drug, Doctor, and just sign here.
16. MS. CORCORAN: Again, the opt-out.
17. FEMALE ATTENDEE 1: All the other uses --
18. MS. CORCORAN: Right.
19. FEMALE ATTENDEE 1: -- for the information are
20. wonderful.
21. MS. CORCORAN: Sure. And I think the other --
22. you know, as I said before, I mean doctors have the
23. ability to say to an individual: As long as you're
24. coming in here and, you know, throwing in my face
25. how I'm prescribing, I don't want to see you. If

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1. you want to come in and talk to me about X, Y, and
2. Z, great, set an appointment.
3. FEMALE ATTENDEE 1: Okay. But (inaudible.)
4. MS. CORCORAN: So I think we're --
5. CHAIRPERSON CUMMINGS: No. I think everyone
6. wants to see this information available for
7. research, for recall, for all of those good things;
8. and the AMA option would allow the detailer not to
9. have it.
10. MS. CORCORAN: Yes.
11. CHAIRPERSON CUMMINGS: It still allows the
12. marketing department to have it to send out to
13. those doctors. And I think, if we could find a way
14. so that the doctor that doesn't do what you want
15. isn't subject to a barrage of mail or phone calls
16. not from their particular detailer but from an
17. entity in Milwaukee or Kansas City or wherever,
18. that might be helpful.
19. MS. CORCORAN: You know, two things: The PDR
20. PDMA it does preclude the sales and marketing
21. forces and detailers. Those are kind of terms that
22. are used interchangeably. So your sales and
23. marketing forces --
24. CHAIRPERSON CUMMINGS: Be it detailers, the
25. individual person, it's the doctors' office.

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1. MS. CORCORAN: It is. And I guess when I'm
2. talking about your sales and marketing forces, I'm
3. talking about those individuals too. I'm using
4. that interchangeably.
5. CHAIRPERSON CUMMINGS: Nobody in marketing
6. gets the information.
7. MS. CORCORAN: They do no get that data. The
8. data goes to the different parts. This is my
9. understanding on how the industry works with the
10. AMA opt-out, and this has been explained to us by
11. the AMA --
12. CHAIRPERSON CUMMINGS: The opt-out?
13. MS. CORCORAN: Right. And this -- if I'm
14. understanding, this is what the concern is. The
15. way the AMA structured the opt-out -- and they have
16. contracts with the companies -- is that the
17. companies -- and there's a contractual relationship
18. with the AMA and the companies on this. So the AMA
19. can hold, you know, the manufacturers' feet to the
20. fire on this to make sure that their sales and
21. marketing forces are not getting the information to
22. do that which you're hearing the concerns about.
23. Now, I mean, this is my understanding from
24. talking to the AMA, and we have worked quite a lot
25. with the individuals there. And I would encourage

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1. you, and we would be happy to have -- you know, get
2. more information from the AMA about the kind of
3. logistics of that and the contracts. But that is
4. my understanding of how it works so that that sales
5. and marketing division would not have that
6. information.
7. And the final topic deals with the advertising
8. section. And this is an area, too, again, where
9. the industry -- you know, it works very closely
10. again with the FDA on the dissemination of
11. information, whether it's done in electronic form,
12. whether it's done in written form, or whether it's
13. done on the broadcast.
14. The FDA, again, has the authority and the
15. responsibility to review all information before a
16. drug is marketed, whether it's the labeling
17. information that's sent out on it, again,
18. electronic and print.
19. And under that, the guise in which the
20. industry works with the FDA, all that information,
21. that written information, must be accurate and
22. comply with the FDA's approval labeling.
23. FEMALE ATTENDEE 1: Where are we in this?
24. MS. CORCORAN: That is in the section after --
25. CHAIRPERSON CUMMINGS: Page 35.
FEMALE ATTENDEE 1: 35, thank you. This is --
we're advertising now?
MS. CORCORAN: Yes.
ATTENDEE 1: Can we go back to the PDRP first
for a second?
CHAIRPERSON CUMMINGS: Yes. Do have a
question?
ATTENDEE 1: Yeah. Looking at the -- this
document which was just handed out on one page --
the pages aren't numbered, but back on the second
page, it says: An enforceable plan that puts the
decision in the right hands.
How -- what is the enforcement? I don't -- I
don't see anything here that says it's enforced.
What happens if someone breaks the rule?
MS. CORCORAN: My understanding on how this
works -- and this is how the AMA has explained to
us -- is that the AMA has contracts with individual
manufacturing companies. And in that contract is
the enforcement by which the AMA says to the
manufacturers: We have this PDRP. These
doctors -- and they keep a running list of all the
doctors -- have opted out. They do not want this
information used.
Manufacturers are obligated within and I

believe it's 90 days -- it could be 60 days -- to
make sure that that information is honored for that
doctor. The contract is -- the enforcement is
through the contract between the manufacturer and
the AMA. I'm not privy because I'm -- to what that
contract looks like. But from my discussions with
the AMA, that's where the enforcement is. It's a
contractual agreement between the manufacturer and
the AMA.
ATTENDEE 1: If we're going to know whether to
trust this or not, we need to know what the
enforcement is. I mean to me there's no
enforcement, and I don't know what the enforcement
is. So I would like to see what the enforcement
is. This is not going to -- if this is what we're
going to rely on.
CHAIRPERSON CUMMINGS: The more I think about
this too, I'm starting -- that this may be a
section that's going to need more work by the
health care committee because it really deals with
that balance of what is good health policy in terms
of the risk of having this available and not
available out there. So we will probably not give
the final word on that. I think -- the more I'm
listening to this, that's what the cost --

that's -- the issue is if we're just banning it or
not banning it. But in banning it, are you going
to end up having information not be available for
research, not be available for recall, not --
and --
FEMALE ATTENDEE 1: Our legislation does not
say that.
CHAIRPERSON CUMMINGS: No. But --
FEMALE ATTENDEE 1: It says --
CHAIRPERSON CUMMINGS: The testimony has been
that, if there is not money involved for these
companies to compile it, they will not compile it.
And I would say that the AMA has a conflict of
interest here, that this is a major source of
revenue and --
ATTENDEE 2: Put the state's attorney over the
AMA to enforce the law quite frankly.
CHAIRPERSON CUMMINGS: If they -- you know,
you're putting them -- they're putting themselves
in a difficult position that if you encourage
physicians to do this that encourages their losing
money. I mean if enough physicians do that --
well, no, because you'll still get the information.
You just can't give it to your marketing
department.

MS. CORCORAN: Yeah. I mean the information
is still available for the patient safety aspect of
stuff, but it would not be available for the sales
and marketing. I don't know how that impacts.
CHAIRPERSON CUMMINGS: Would you buy it from
the AMA, the first part of that data, if it didn't
have an economic benefit to the pharmaceutical
companies? If it was just for patient safety,
would you invest that money?
MS. CORCORAN: I can't speak for the
pharmaceutical industry and how they would or would
not behave. I guess I would argue that patient
safety still provides a great benefit to the
industry. I mean, again, this is an industry
that's committed to coming up with new medicines
for individuals for life saving. So that patient
safety aspect is still clearly important.
I mean the MS drug Tysabri is a great example
of a drug that absent that information that drug --
would likely not be marketed. So I can only
speak for what I know of the uses and --
CHAIRPERSON CUMMINGS: If it's not -- because
that's -- that's the crux. The testimony has been
that if we don't allow this to be used commercially
then it will not exist in its present usable form
because the reason it is collected and collated is for commercial use. And so I don't think anyone here wants to do away with the information for medical research or safety. And it would be helpful to know, from both the AMA and the pharmaceutical companies, what kind of money are we talking about. Why would you keep paying for this list if you can't increase your sales because...

MS. CORCORAN: This data -- I mean I can't speak for the AMA and IMS. I mean that is --

CHAIRPERSON CUMMINGS: (Inaudible.)

MS. CORCORAN: I mean that's just, at the end of the day, like with anything, there's -- you know, there's a balance that -- that exists out there. Currently the structure is such that the FDA functions in this structure; we function in this structure. That the entities that gather the information, the AMA, IMS that have the mechanisms in place to put it in a form in the aggregate because it is -- it protects patients so that the industry can use it, whether or not for the commercial side, which is sales and marketing, or for the side that deals with the FDA. And again, I don't -- each company functions very differently.

I just -- I would argue that that data is --

is such a function now in how the FDA interacts with companies that there is almost this assumption built in when new products come out. And you are seeing many more products enter the market where they have either risk maps or a much stronger kind of what I would call operating agreements before something can get marketed that there would still be a great value to the industry to ensure the viability of this information and from the FDA.

They're not the only entities out there too that use the data too. Law enforcement, law enforcements within this state and other states, use this data too to help, whether it's with issues with abuse of painkillers or other areas too.

So I mean there are a lot of entities out there. The DEA uses it. I mean when you look at not just the federal but the state law enforcement, they also use this data.

FEMALE ATTENDEE 1: Do they go through that database or do they go directly to the pharmacies?

MS. CORCORAN: My understanding is that most of the data is received through IMS, that they tend to be -- there's three entities out there: IMS, Walters Core, and one other that tend to be the big database entities.

FEMALE ATTENDEE 1: And they all maintain selling the data. So I would question the intuition that the only way to pay for the gathering of this data is to allow this kind of access for this kind of purpose. I mean I think I want to make sure that that's a true statement. I find it hard to believe.

(Inaudible.)

MS. CORCORAN: Just in closing on the advertising, what I would just say on this, again, you know, the industry works very closely with the FDA. They have great relationships. When it comes to print, when it comes to electronic information, it's all run through the FDA for accuracy to make sure its consistent with the labeling requirements.

On the broadcast side, while it is not legally required for the industry to provide the FDA with their advertisements that are broadcast, most of the companies do, as a practical matter, work with the FDA very closely and show them all this before it's broadcast.

The FDA, at the same time, also does have the ability, if they see something, whether it's in electronic, whether it's in written or on the air, that they believe falls outside of their labeling requirements, they send enforcement letters and, you know, warning letters to the industry saying that: We believe that, you know, this document falls outside the scope.

So again -- and there's also some concerns too with this provision, at least in terms of a lot of information that ends up in this state, much like with the manufacturing side, is stuff that is originated outside the state of Vermont. I would imagine, much like some of your neighboring states, a lot of your television, your advertisements that are received through the networks are probably coming out of even a Boston and New York too. So there would be concerns about --

FEMALE ATTENDEE 3: Montreal.

MS. CORCORAN: Montreal. There would be concerns about the reach into those states and those markets on that.

FEMALE ATTENDEE 3: We understand that this will only -- this will only allow our attorney general to enforce the FDA rules. We're not setting up separate standards. We're not setting up separate -- you know, this will be -- if the FDA says something is not up to par and a letter is sent, it will allow our attorney general to enforce
it, if it is continued to be sent into the state of Vermont. We're not setting up a different standard than the FDA. So if you have no problems with the FDA, you're not going to have any problems with the state of Vermont.

MS. CORCORAN: The standards are with the FDA. As I read this, though, I'm reading this to suggest that some information that ends up in this state is per se falsely misleading. So it's not so much --

FEMALE ATTENDEE 3: That is not my understanding of the intent of this legislation.

MS. CORCORAN: Okay.

FEMALE ATTENDEE 3: It was merely to allow for local enforcement for an FDA finding, once that letter is sent, saying: This is false or misleading.

MS. CORCORAN: Okay.

FEMALE ATTENDEE 3: That (inaudible). But I can check it again.

MS. LUNGE: The confusion might be this. The part that's not underlined on page 35, that's current law.

CHAIRPERSON CUMMINGS: And we have -- we have --

MS. LUNGE: And that's the section you're referring to. That's current law, and the amendments (inaudible) are just technical.

CHAIRPERSON CUMMINGS: And we have already decided that current law is slightly archaic. It may need some updating in language.

MS. CORCORAN: You know, I understand what your intent is, and I will take a closer look.

CHAIRPERSON CUMMINGS: (Inaudible.)

CHAIRPERSON CUMMINGS: We read this to potentially kind of impact information coming in that would be, you know, saying it would be kind of per se false and misleading outside the scope of the FDA. But as I understand what your intent is, that's different. And that would be a concern for your attorney general working with the FDA, how that would be accomplished.

CHAIRPERSON CUMMINGS: Yeah. But this is -- that was pure the intent.

MS. CORCORAN: Okay.

CHAIRPERSON CUMMINGS: Not to set up any kind of a state standard or state standard regulation. It's merely to give local enforcement to the national ruling or national. Okay.

Senator MacDonald?

SENATOR MACDONALD: The witness was concerned with the prohibition against transferring use of records would prohibit the safety books. I'm on page 23 of the legislation.

ATTENDEE 1: (Inaudible.)

SENATOR MACDONALD: In the middle of the page, there's --

FEMALE ATTENDEE 1: What line are you on?

SENATOR MACDONALD: Page 23, there's a prohibition against the dissemination of those --

FEMALE ATTENDEE 1: And the use of this language, if there are epidemiological issues, if there are side effect issues, that kind of thing.

MS. CORCORAN: Well, I think, if I understand your --

CHAIRPERSON CUMMINGS: (Inaudible.)

MS. CORCORAN: Yeah, I mean I understand your -- you're more concerned with what I would say is more the inappropriate use that physicians feel is being used by sales and marketing forces in terms of, you know, how a doctor is prescribing, and that's your concern that you are seeking to address.

FEMALE ATTENDEE 1: Yes.

MS. CORCORAN: At the same time preserving the ability for this information to be used for safety and the FDA.

CHAIRPERSON CUMMINGS: Safety, monitoring, research.
MS. CORCORAN: Research.

CHAIREPERSON CUMMINGS: It's --

MS. CORCORAN: Approval, it's just that. And

we're happy to work with you on -- on addressing

that.

CHAIREPERSON CUMMINGS: It's fine to encourage

a doctor to prescribe something. It is not fine if

he chooses not to take your advice to call him and

start -- send him so much stuff he will start

prescribing just to make you go away.

Okay. Any further other questions?

(INAUDIBLE.)

CHAIREPERSON CUMMINGS: Okay. Thank you.

FEMALE ATTENDEE 1: Madame Chair, are we going
to have the AG people talk with us again? It's
not -- the reason I ask --

CHAIREPERSON CUMMINGS: We can if you would
like.

FEMALE ATTENDEE 1: Julie Brill said that she
could use consumer fraud to deal with what I thought it
was the advertising.

FEMALE ATTENDEE 5: Yes.

FEMALE ATTENDEE 1: But now I'm wondering if
it's the -- okay. So what about the preposterous
price? What do you call that?

ATTENDEE 1: The unconscionable price.

FEMALE ATTENDEE 1: The unconscionable price,
what about that?

MS. LUNGE: Yes. She suggested that for the
AG section of that that we change it so that it
reference the consumer fraud act.

CHAIREPERSON CUMMINGS: Which was broader.

MS. LUNGE: And then for that (inaudible) part.

One was the AG part and (inaudible).

FEMALE ATTENDEE 1: So that's two of the four
issues right there that the AG could use existing
statutes and we just need to lay it out?

CHAIREPERSON CUMMINGS: Not --

FEMALE ATTENDEE 1: I guess I'm missing a
point.

CHAIREPERSON CUMMINGS: Unless, you know, we
don't have a general price gouging, we have to go
under price gouging --

FEMALE ATTENDEE 1: Oh, yeah.

MS. LUNGE: Do you mean can she use existing
law to do it? No.

FEMALE ATTENDEE 1: Yes.

CHAIREPERSON CUMMINGS: We have to say it's
illegal or we have the right to regulate it before
she can enforce it. If she has to enforce it, then

she can use consumer fraud statutes. It's like

when all the flu vaccine went up when there was a
shortage.

FEMALE ATTENDEE 1: Yeah, yeah. That was the
question I asked somebody else (inaudible) about
this.

(INAUDIBLE.)

FEMALE ATTENDEE 1: And we heard about a
couple of these things, but they're out of our
hands because they're outside of the state. Does
that mean no one will be able to do anything about
it?

CHAIREPERSON CUMMINGS: No. That's -- the
argument would -- anything coming over the border.

FEMALE ATTENDEE 1: Hi. This is the Senate
Finance Committee. Tracy Allmon? I'm going to put
you on speakerphone.

CHAIREPERSON CUMMINGS: Hello, Tracy?

MS. ALLMON: Hi.

CHAIREPERSON CUMMINGS: Hi. Can you hear us?

MS. ALLMON: I can. Can you hear me?

CHAIREPERSON CUMMINGS: Yes, very well.

MS. ALLMON: Great.

CHAIREPERSON CUMMINGS: I'll turn up the
volume.
can do questions at the end, whatever you all --

CHAIRPERSON CUMMINGS: Okay. If I have an
urgent question here, I will rudely break in
because I can’t make eye contact or wave at you.
Okay.

MS. ALLMON: Okay. Caremark clients
(inaudible) budget for a minute include a broad
range of private and public health sponsors,
including Blue Cross Blue Shield plans, other
managed care organizations, private employers,
state, Federal, local government, third-party
administrators of health plans, insurance
companies, and a labor union based trust.

Caremark contracts with over 2,000 clients
nationwide, and our contracts -- our clients
contract with us in order to provide a
discretionary pharmacy benefit to their
beneficiaries, whether it’s employers or normal use
of their health plan.

Importantly, we do not contract with small,
unsophisticated clients. We don’t contract with
individuals. We service smaller employers through
an aggregator, such as a health plan or third-party
administrator and those small employers who choose
to do business with a particular health plan or

third-party administrator recognizing that that
party utilizes the services of a PBM pursuant to a
contract that smaller employer would not be a party
to. In other words, we don’t have contracts with
the small employers, but we may provide benefits to
their beneficiaries.

Caremark is one of the nation’s largest
independent providers of health improvement
services touching lives of millions of health plan
participants. We process over 550 million
prescriptions per year, and we provide other
services to our clients, which we can talk about
later.

We offer health plan customers a wide range of
health improvement products and services designed
to lower the cost and improve the quality of
pharmaceutical care delivered to plan participants.
Excuse me. By providing options that clients can
choose from to improve health and decrease costs,
we enable employers to continue to offer a
high-quality, cost-effective, outpatient drug
benefit to (inaudible) patients and patients needs
and a health care system over the course of one
contract or several.

We are pleased to be here today to,

unfortunately, oppose the (inaudible) of the bill
because we believe that that section takes several
different aspects of PBM services that can be used
along or in combination to create a cost-effective
drug benefit and turns them into a statutory,
one-size-fits-all approach.

We don’t believe that a one-size-fits-all
contract is in the best interest of those paying
for pharmacy benefit services in Vermont, regardless
of the fact that the payor or the PBM used. We
also don’t believe it’s in the best interest of the
patients and the beneficiaries in Vermont either.

I’d like to discuss a few aspects of the PBM
business that are touched upon in the bill and
would be affected by the proposal.

First, I’d like to talk a little bit about the
RFP process, and I know that there has been
testimony prior to this that we -- from other PBMs.
So some of this may be repetitive; and for that, I
apologize.

When an employer health plan is ready to put a
plan out to bid, they issue a request for proposal
that includes everything they’re interested in
learning from the responding PBM. Some of the
things that may included are a request for

information under the management, drug compliance
and adherence programs, generic incentive programs,
formulary management, copay structure, coverage for
over-the-counter drugs (inaudible), the size and
convenience of the PBMs pharmacy network either in
a particular region or nationwide, and the
availability of mail pharmacy services.

If the employer or health plan has a preferred

 type of program they’re looking for, whether a
pass-through benefit or guaranteed discount
benefit, that’s included in the RFP. The other

employers or health plan asks for a response in the
form of both types of benefits, both the

pass-through discount and the guaranteed; and
 others identify the type, just one type.

There are some health plans that negotiate
manufacturers’ rebates themselves and only contract
with PBMs (inaudible) mail service, and formulary
management. That also would be indicated in the

RFP, if that’s the type of service they’re
requesting.

CHAIRPERSON CUMMINGS: And we allow for that
in this bill.

MS. ALLMON: Yes. And I think that’s
important because if that’s something that that
employer or health plan is -- feels that they are
able to deal on their own then certainly that's --
that's something that they should be able to do.
Contracting for the pass-through and the
guaranteed discount programs is very specific, and
I'd like to discuss those two models and how the
contracts look.
The prescription drug marketplace has evolved
extensively over the last several years, and the
PBM industry has responded to those market changes.
Many clients now request or require an RFP
response to include a bid for a program of
pass-through rebates, which would also be known as
a transparent benefit. A client who chooses a
pass-through benefit signs a contract with the PBM
that requires that the client receive a high
percentage, or even 100 percent, of the rebate
negotiated and received from pharmaceutical
manufacturers by the PBM for the members of that
client's benefit.
These contracts would include a provision
permitting the client of the PBM to ensure at any
given time that they're receiving the correct
amount of rebate dollars from the PBM. In other
words, the provisions outlined in the proposed bill

exist in many of the PBM contracts today. The
difference is the provisions exist at the request
of the client and with the agreement of both
parties.
Neither party, the client nor the PBM, is
forced into a deal that does not meet the needs for
the particular coverage periods. The benefit is
designed by the client, and PBM responders price
what the client identifies as necessary in their
benefit. And that's also included in the response
to CRMP. The client, and not the PBM, decides what
the contract is going to look like.
CHAIRPERSON CUMMINGS: Okay. And I guess
that's been my question is: If you're already
doing this and all this says is you can offer
administration only, you know, just give me
20 percent of AWP or whatever it is, or you go into
this full transparency thing, if you're already
doing this, why is everybody so upset?
MS. ALLMON: Well, we believe that it starts
with the client and --
CHAIRPERSON CUMMINGS: That's fine.
MS. ALLMON: And frequently in states where we
have clients that we contract with directly, the
clients will testify with us in support of letting
them drive the contract.
CHAIRPERSON CUMMINGS: I don't see anything in
this bill that precludes that.
MS. ALLMON: But if you're going to make us
give options that they may not be particularly
interested in, then in some ways what it's doing is
it's interfering in the private contract by saying:
These are the responses that you have to give.
These are the things that you have to lay out.
It's our belief that these are predecessor
contracts, and these are negotiating terms. I
mean, if we were to submit two -- two different RFP
responses, one for pass-through and one for
guaranteed discount, because that's what the client
wanted, then they have all of our prices laid down
and we are happy to do that or we would like to
respond to only one and not to both, unless they
made it a requirement that if you want to bid on
one model you bid on the other. That gives them a
level of understanding of our business, it gives us
a level of understanding of what they want, and
that then becomes part of the negotiation.
If what they're looking for is a particular
type of business model or benefit model, then they
should have the right to ask for only that and we

should have the right to only respond to that; and
then that becomes a negotiation. So the client
(inaudible) the negotiation, not the state.
CHAIRPERSON CUMMINGS: Okay. I'm not sure
we're trying to preclude that. But continue and we
will work that out with our drafters and the
attorney general and whoever else we're working
with here. Okay.
MS. ALLMON: So -- and if I can just talk then
a little bit about the guaranteed discount
proposal, which is that the client is insulated
from any price risk and from the variations in drug
prices and the utilization that may occur
throughout the contract period, whether they are
anticipated or unanticipated.
So in responding to a request to our
guaranteed discount proposal, the PBM evaluates the
state of the drug market, including which
brand-name drugs are expected to be available
generically during the contract period, the
utilization by plan members and major therapeutic
causes, and the prevalence of common diseases in a
client's member population.
In addition, the PBM must estimate the value
of future negotiated manufacturer rebates. Those
contracts may not be determined at the time that the -- that the response is due to the RFP. The response submitted by the PBM to the RFP gives the client the comfort of knowing with certainty the monthly cost of the client's drug benefit. If the rebates actually received by the PBM from manufacturers are less than expected because of inaccurate predictions on market share movement for another -- the PBM affords that loss and the client's costs do not change from that which is included in the contract. 

Some employers and purchasers of health care want this certainty of cost every month projected the uncertainty that is inherent in trying to predict utilization and market share movement. An employer health plan that issues RFP for both types of bids, pass-through and a guaranteed discount, will review the responses and settle on the type of contract and pick the PBM which they believe best suits their needs. 

Clients often one or more consultants to review the RFP responses and insure they're getting the best possible deal for (inadmissible) PBM. 

(Inadmissible) identified, the contract terms are discussed, agreed upon, and accepted and the client

and the PBM enter into a contract that, again, meets both their needs but is believed there is an indication of their unilateral intentions to provide a particular level benefit for agreed-upon costs. I'm going to talk a little bit about transparency and what happens in that type of an agreement. 

CHAIRPERSON CUMMINGS: Okay. Let me see if there's any questions. 

MS. ALLMON: Okay. 

CHAIRPERSON CUMMINGS: Senator Ayer? 

SENATOR AYER: Tracy, this is Claire Ayer from Addison County. You're going to go into the transparency of the agreement, and maybe that'll address my question. You talk about clients understanding or knowing the cost of their benefits. And I think what we're trying to get to, as we're trying to get a handle on health care costs in general, is the cost of medicine; and that's not what's transparent. So maybe you'll address that in your comments after this.

MS. ALLMON: And that would be the cost of --

SENATOR AYER: The drugs. 

MS. ALLMON: -- rather than to whom. Would

that be AMP? Is that what you're talking about or are you talking about the cost of the PBM phase or? 

CHAIRPERSON CUMMINGS: Well, I think part of the problem is that, unlike other wholesale prices, which you can say is cost, you know, material costs plus labor plus overhead equals the cost, and it doesn't seem to -- you know, I've been in retail sales and manufacturing. And my cost, unless my raw material went up, didn't fluctuate monthly. I didn't change the price of my base product every month. And other than petroleum products, you know -- and even that's supply and demand -- it's hard for the average person to figure out because I haven't found anyone that could testify to help us figure out what the average wholesale price is based on or why it fluctuates. 

So that in that case it's very hard for the customers to look back and say: Oh, yeah, it's clear I'm getting 30 percent off the list price because the list price is not the same. 

And you know, it's just a difficult place, you know. It's like walking on Jello. And you know, you have people in vulnerable positions. They need the pharmaceuticals frequently to stay alive. It's a necessity of life. And there's a lot of concern about pharmaceutical companies being more interested in profit and encouraging the use --

(Inadmissible.) 

CHAIRPERSON CUMMINGS: Well, no, this is pharmaceuticals -- you know, in encouraging the use of newer, more expensive drugs. And the -- you know, then the issue of, you know, to who -- where does -- who does the PBM work for. And I think that's the goal of transparency to know, you know, are you making more money from the pharmaceutical company than from the customer? Where does your loyalty lie? What -- how does the customer know this when it's very murky out there.

MS. ALLMON: Okay. That -- that changes what I was going to talk about on transparency and how manufacturers determine AMP and what AWP is and how that relates. So let me just talk for a minute, if you don't mind, about the audit provisions that are included in the contracts and some of -- some of what the FDC has said on -- about transparency of PBM prices and one that's not necessarily good and then I can talk a little bit about other wholesale price and other manufacturers price. And I don't know if it will answer all your questions, but it might help to point the committee in the correct
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1 direction for future discussions.

CHAIRPERSON CUMMINGS: Okay. That would be helpful.

MS. ALLMON: Nearly anyone who (inaudible) is available in PBM client contracts today, and over the past two years, the Federal Trade Commission has reviewed various state bills that attempt to limit the ability of employer health plans and PBMs to contract for various levels of services and to mandate a transparency.

In one letter to the California legislature, the FDC stated that vigorous competition in the marketplace for PBMs in contrast to the restriction imposed by a particular (inaudible) is more likely to arrive as an optimal level of transparency than regulation of the contract term.

This is because from the time that you would publish what a PBM is receiving as -- excuse me -- a negotiated rebate from a manufacturer, then that manufacturer of the drug within that therapeutic class will have access to that information. So what you've done is create an artificial reading feeling.

CHAIRPERSON CUMMINGS: Okay. We would keep all -- this would all remain confidential. This would not be a public publishing or public announcement. This would be a confidential communication between the PBM and the customer because we do understand that issue.

MS. ALLMON: Right. And that would be the type of contract term that we believe should be included in a contract by agreement between the two parties. So it's not that the transparency of what they're reading is a secret.

I mean in a -- in the guaranteed pass-through contract, those would already be included, and there would be monthly or quarterly or annual audits of the client by the client and an agreed-upon audit firm of the PBM records to make sure that whatever the percentage of rebates that were passed through were, indeed, being passed through. So that is an option for a contract term.

We just -- we just don't believe that it should be a mandated contract term to the extent that no matter what the contract states, no matter what the interest of the clients or the PBMs are in that particular discussion, that that is a mandated requirement.

CHAIRPERSON CUMMINGS: It's mandated in that kind of contract. You can have a full disclosure and you can have a no-disclosure, set-fee contract.

But if you're going to disclose, you need to disclose enough that it's useful.

Can I assume that in the -- the disclosed or the pass-through that that starts -- that that puts more risk on the client, is that true, because you may or may not get the rebates?

MS. ALLMON: No. Actually, the pass-through rebate we would give them every rebate that we negotiate. So they might not know exactly what they are for each particular drug at the time that they sign the contract, but they would know exactly what they were getting out of what we negotiated.

And we would give them a range of what we would anticipate negotiating for say a brand-name formulary drug in a particular class, in the NSAID class or something.

CHAIRPERSON CUMMINGS: How would you go -- what is -- what is a rebate negotiated on?

MS. ALLMON: Whenever a PBM negotiates with a manufacturer, it is based on utilization within the PBM, the entire PBM client base. So in the instance of Caremark, we would be negotiating with a manufacturer based on the fact that we represent however many million lives and that we would pick a

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particular drug, let's say a particular drug that would be the preferred drug, and then we would attempt to get at or 5 percent above national market share for that drug in exchange for "X" percent rebate.

CHAIRPERSON CUMMINGS: Okay. And does that --

MS. ALLMON: And then there would be an additional rebate if we give us, the PBM, within the lives that were covered by Caremark, we would get national market share plus 10 percent, then we would get an additional rebate. And all of those in a pass-through would come back to that pass-through client.

CHAIRPERSON CUMMINGS: Okay. But is this on an annual basis? So it's now increased it. Can I assume, just based on some of the testimony we've heard, that these market shares are for new drugs?

You are not out increasing the market share of amoxicillin I would assume or -- that these would be newer drugs and that, in order to increase their market share, you're taking market away from another similar drug?

MS. ALLMON: Only whenever -- only whenever the two similar drugs you're discussing are new versus new. In a class -- if you look at the
antipsychotic market, for instance, the
non-atypical antipsychotic market where there are
several drugs that are -- none of them available
generically, then we would be negotiating with all
of those brand companies to get the best discount
for the one or two drugs in that class that we
would believe would serve the needs of most of the
patients for the beneficiaries.

Now, if it's a class where the drugs are
really not similar to each other, it's harder to do
that. But we would not be switching people from
Haldol, which is a very old antipsychotic
medication, to a newer Risperdal type medication
just because we managed to negotiate a rebate on
Risperdal. Haldol is much less expensive, and it's
in the client's best interest to use that, if it's
appropriate for the patient and the prescriber has
prescribed it. We would never switch from a very
cheap, older agent, if that's what's prescribed, to
a newer, more expensive agent.

CHAIRPERSON CUMMINGS: Well, that's been what
some of the concern has been. And antipsychotics
are probably kind of a class by themselves because
they don't have generics and we know they are very
sensitive. We hear more about cholesterol

medications, blood pressure, antacid where there
may be some minor variations.

But if you get a rebate, how long is that
rebate good for? You have increased the market
share 5 percent. Is it forever or is it next year
the rebate goes away and your customer pays more?

MS. ALLMON: The rebate is -- the rebate is as
long as you keep -- it's a separate contract
negotiation with the manufacturer.

CHAIRPERSON CUMMINGS: Right.

MS. ALLMON: If we (inaudible) the client. So
a manufacturer contract may run from January 1st of
2007 for the next two years, but we might not pick
up that client until toward the end of the
contract. What we would do is indicate to them
that, via our formulary recommendations of the
rebate contract that we have, the preferred drug in
this class is, for instance, Pravachol because even
though it's now available generically the rebate
that we have from Pravachol's manufacturer is very
good and it still makes it less expensive for our
client to use the brand name that we have the
rebate on.

Now, beginning January 1st of 2000 --

CHAIRPERSON CUMMINGS: Next year when that

contract ends --

MS. ALLMON: Right.

CHAIRPERSON CUMMINGS: -- what happens to your
customer?

MS. ALLMON: We would send out a formulary
notice to our clients and let them know that our
rebate with the Pravachol manufacturer has expired.

At this time the least expensive drug in this
class, and the one that we picked from the
formulary, is a generic. And whether it's generic
Pravachol or generic Mevacor, we would let them
know that, that was our new recommended agent in
that class.

Now that...

(End of CD 7-51, Track 1.)

CERTIFICATE

STATE OF FLORIDA )
COUNTY OF INDIAN RIVER )

I, Kristen A. Houk, Registered Professional
Reporter and Florida Professional Reporter, do hereby
certify that I was authorized to and did listen to CD
07-51/Track 1, the Vermont Senate Committee on Finance
meeting of Tuesday, February 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 28th day of August, 2007.

Kristen A. Houk, RPR, FPR
STATE OF VERMONT

SENATE COMMITTEE ON FINANCE

RE: Senate Bill 115
Date: February 20, 2007

Committee Members:
Sen. Ann Cummings, Chair
Sen. Claire Ayer, Vice-Chair
Sen. Bill Carris
Sen. James Condos
Sen. Mark MacDonald, Clerk
Sen. Hill Maynard, Jr.
Sen. Richard McCormack
CD no: 2007 - 52
Track 1 # 889709
orange pill. We are the people saying, take
ibuprofen, 600 milligrams, before you try anything
else, and we would suggest that you try it if your
doctor approves it, for a couple of months to see
how it works for you. That's what we are doing.

MADAME CHAIRPERSON: Okay.

MS. ALLMON: And then if the generic isn't
working, we have, you know, the list of, well, then,
we would suggest next that you go to this level, and
it, again, would be something that has been on our
formulary showed to the client passed through our
committee as being the next step in this line of
therapy for rheumatoid arthritis, or whatever the
disease is.

MADAME CHAIRPERSON: Yes, but if somewhere
in that chain there now is a new green pill, aren't
you inclined, in order to get that rebate, to push
the new green pill?

MS. ALLMON: No, because, I mean, if we
decide we went to negotiate for that type of a
market share rebate contract for the green pill, we
still have the responsibility to our clients to go
to four or five agents first, and that's what we
promise them. We promise them, especially in the
contracts that are the most common for us are the
guaranteed discount contracts, where they know what
they will pay. So that's what our clients prefer.
So, if they prefer that, then we let them know that
if this is the way that our hierarchy works for you,
which is that the first year of therapy be
ibuprofen, 600 milligrams, or the second tier be
something like Relafen, that has been available for
awhile, which is safe and effective, it will be
available generically or is just becoming available
generically, and then, you know, the final level is
the Celebrex level.

So, we don't go to a manufacturer and say,
you have a great new product and so we want to
guarantee you that we will give you market share
plus five percent.

MADAME CHAIRPERSON: No.

MS. ALLMON: That's really on for those
classes where there is no general available. And
you negotiate with every manufacturer at the same
time. So, you five manufacturers with five
different products, where you are trying to negotiate
that type of contract. Or, you negotiate a flat
contract where you say, this is the percentage
rebate we want, and this is this number of lines,
and so that's a different type of contract. So,
there are a couple different kinds.

MADAME CHAIRPERSON: Okay. Committee, any questions at this point?

No.

Okay.

MS. ALLMON: I am sorry, I --

MADAME CHAIRPERSON: No questions at this point.

MS. ALLMON: It's very confusing, and it differs from PBM to PBM, and also from manufacturer to manufacturer how you negotiate those contracts and how long they last.

MADAME CHAIRPERSON: Okay.

MS. ALLMON: Should we talk about -- I don't know what your timeframe is, and I am happy to kind of skip through some of this that you may have already heard from others. Should we talk about AWP and AMP and how pricing --

MADAME CHAIRPERSON: Would that be helpful, committee?

MR. ATTENDEE: Sure.

MS. ATTENDEE: I don't want to hear about AWPs. I would like to hear about the price.

MADAME CHAIRPERSON: Well, that's it.

Let's see, whatever you would like. Can you finished up with testimony on the bill?

MS. ALLMON: Let me --

MADAME CHAIRPERSON: I am running a little constricted this afternoon because we unanticipatedly have to go back on the floor, so not til 4:15, but I have got several other witnesses to get to. So, can you finish up in ten minutes? That would probably be helpful.

MS. ALLMON: Okay.

MADAME CHAIRPERSON: Okay?

MS. ALLMON: Why don't we talk a little bit about coverage wholesale price and coverage manufacturer price, how they started out, because this is more about the requested information on how to direct the price and what it means to the average person.

I think one of the reasons that drug pricing is so confusing is because there are so many levels and there is no clearly printed price. So, while nobody knows the price of a box of Cheerios, nobody gets terribly bent out of shape about it, because the difference between, you know, the local market and the chain market two miles down the road at eighty cents, isn't necessarily life or death.

However, whenever you start talking about pharmaceuticals and a lot of people paying cash for them, it's a lot different, and it's different on a variety of levels, not only emotional, but from our -- from the human sense in terms of common sense just tells you that it's just odd that you can see that many differentiations.

So, if we start with average wholesale price, which is AWP, average wholesale price, as you may have seen in the news a few months ago, is probably going away, because it has turned into something that is not really a good indicator of what is going on within that market. AWP has been determined over the years by a couple of different publishers of AWP. The information that they use to set AWP is given to them by manufacturers and is actually the average manufacturer price as calculated by the manufacturer for purposes of Medicaid. And so when they give that AMP to certain data banks to determine the AWP, First Data Bank then marks it up at some level to create AWP.

Now the recent discovery and possible settlement of a lawsuit involving First Data Bank actually indicates that they basically picked some arbitrary twenty or twenty-five percent and added that on to the average manufacturer price.

But, AWP, which is frequently used as a benchmark as a - as one of the parts of pharmacy reimbursement, for retail pharmacy reimbursement, it would be AWP minus eighteen percent, so three dollars, for example.

AWP is a (inaudible), and unfortunately, that's a number that the entire system has been built around. It would be highly unusual for a retail pharmacy to have a contract that says a brand name that drug reimbursement that did not send it up AWP, because that's the number that's published.

Recently, the Center for Medicare and Medicaid Services, in response to the Deficit Reduction Act of 2005, has issued proposed rules for the calculation of AMP, which is the average manufacturer price. Now average manufacturer price came about after over ninety as a way for manufacturers to report Medicaid rebates at the best price to the government.

The problem with average manufacturer price has always been that manufacturers don't know specifically what rebates they are and are not to include within the calculation of that price.

So, it's been fairly difficult to have that number mean anything, because some manufacturers
will include, say, rebates to PBMs, and others will not. Some will include other rebates they give to wholesalers sub flooring AMP, and others will not.

To complicate the problem, CMS, who is supposed to be responsible for the AMP, frequently give guidance that is not only not binding, but can also conflict with previous prices that they've given.

So, up until the recent proposed rule, manufacturers, the (inaudible) manufacturers would calculate AMP fifteen different ways. So, you have a price up there upon which AWP is built which doesn't really mean anything.

So, now we have the new AMP proposal, and the purpose of the AMP proposal is to identify what a manufacturer receives from a wholesaler that is selling to the retail something.

So, AMP will be, supposedly, an indicator of what a manufacturer gets for a particular drug.

So if his cost of goods and his built in mark up is, say a hundred dollars per unit, but what he actually gets from wholesaler, say in Texas, who is going to sell to chain pharmacies or independent pharmacies, is actually ninety dollars, then that will be the AMP. And then --

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<td>MADAME CHAIRPERSON: Could you repeat discounts as are outlined by the proposed rule.</td>
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<td>MS. ALLMON: -- they are also --</td>
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<td>MADAME CHAIRPERSON: -- that please?</td>
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<td>MS. ALLMON: -- include or exclude</td>
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<td>Now, common renew of that rule today, so it is not certain yet how many different rebates will be included in the AMP by the time they finalize the rule, but currently what they are recommending, CMS recommends that any rebates that are given to pharmacies should be included. That would such continue to lower the AMP. You would take the hundred minus the ten dollars that a wholesaler gives a discount of maybe another five dollars to a pharmacy, so now you are highest rebate is a fifteen percent rebate.</td>
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<td>Also, specialty pharmacies local PBM rebates would all be included in that AMP, which would such lower the AMP. Now, you may have heard from retail pharmacies, and there has recently been a lot of congressional outcry that by including all of these different rebates that are not necessarily available to a retail pharmacy that is artificially lowering AMP, which is then going to be used as a reimbursement metrics similar to how AWP is used</td>
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now. And we, as the something, are very concerned about that, because we do think that is true. We think that lowering the AMPs too much and making it not a realistic number for retail pharmacy prices means that reimbursement will be driven so low that there will be no reason to use generics, because the reimbursement will be too low, and then retail pharmacies just will not be able to function at that level.

So, it's a long -- it's a long task to get to the final AMP number, but right now as it's proposed it will be a better indicator of what the manufacturer cost is, but as proposed currently, that AMP is actually, we think, too low. And you will hear the same from retail pharmacies and numerous others, I suspect.

MADAME CHAIRPERSON: Okay.

MS. ALLMON: Did that help?

MADAME CHAIRPERSON: It helps. I don't know if it makes anyone feel better.

MS. ALLMON: Again, we went from AWP as a fictitious number that several publishers make up, to AMP, where there is a very good opportunity to make this number mean something and to have it be reasonable, but we don't know yet whether CMR is going to get there.

MADAME CHAIRPERSON: Okay.

MS. ALLMON: Thank you.

MS. ATTENDEE: That was one of my impressions, and that is, who is proposing this to whom?

MS. ALLMON: The DRA has required CMS to take them out with the AMP proposal, so it was released in the Federal Register two months ago, and then everybody who was interested in commenting had the opportunity to comment today at 5:00 o'clock for CMS to review and listen to the logic of various parties who may or may not think that CMS is on the right track.

MS. ATTENDEE: Thank you.

MADAME CHAIRPERSON: Okay. Thank you.

MS. ALLMON: Certainly.

MADAME CHAIRPERSON: That's been helpful.

MR. CARRIS: And if I may, Madame Chair?

MADAME CHAIRPERSON: Yes.

MR. CARRIS: We would provide some brief comments in writing directly on the bill language itself, and we'll provide that to the committee.

MADAME CHAIRPERSON: Okay. Thank you.

MS. ALLMON: I'm sorry -- was that --
MADAME CHAIRPERSON: That was Bill, and he said he will provide us some written comments with suggestions for changes in the bill.
MS. ALLMON: Excellent.
MADAME CHAIRPERSON: Okay. Well, thank you for joining us this afternoon.
MS. ALLMON: Thank you so much.
MADAME CHAIRPERSON: Okay.
MS. ALLMON: Bye-bye.
(Telephone call concluded.)
MADAME CHAIRPERSON: Okay. Committee, I have got Kathy here. Josh is here. Paulette is here.
How long is Paulette --
MR. CARRIS: No, Paulette is not here.
MADAME CHAIRPERSON: Paulette, she is not here yet. She is set for 3:30. How long do you think, Josh, I know you said you were --
MS. ATTENDEE: He was here.
MADAME CHAIRPERSON: He's not here.
MR. CARRIS: He was here.
MADAME CHAIRPERSON: He was here. I know he told me his testimony was not too long.
How long do you think yours might be?

MS. ATTENDEE: Mine will be ten or less.
MADAME CHAIRPERSON: Ten or less. Okay. Committee, I am going to give you a fifteen minute break. We'll be back. I think we can all use a little break.
(A recess was taken.)
MADAME CHAIRPERSON: Okay. We are back in session, and Kathy Callaghan. And take the time you need, okay? Paulette is coming over at 2:30? Okay. So, yeah, we're fine. It's not even roll call, and if we aren't done by 4:15 on this topic, they said they will call us upstairs for a roll call.
MS. CALLAGHAN: Thank you.
For the record, I am Kathy Callaghan, and I am representing the State Employees Health Plan, which is the subject of this bill. And my testimony will be a little bit different than it usually is. Usually, I am here giving you information. This time I am here to say that we first became aware of the bill last week, and have not had a chance to really adequately review it in terms of the implications that there might be for the plan and for the contract involved with the PBMs.
What we would like to be able to do is consult with our PBMs as to the possible implications, so I'm going to give the information, because I think that's important.
MADAME CHAIRPERSON: I would assume there would be no implications on present contracts. They would be grandfathered and --
MS. CALLAGHAN: Right.
MADAME CHAIRPERSON: Yeah.
MS. CALLAGHAN: Right. I was referring more to the specific provision that has to do with pooling.
MADAME CHAIRPERSON: Okay.
MS. CALLAGHAN: The provision --
MADAME CHAIRPERSON: That's the one I thought would interest you.
MS. CALLAGHAN: Yeah.
MADAME CHAIRPERSON: Yeah. You can all have your own PDLS, but I know we have been trying for years to find a way to have all the state groups bargain together, since the name of the game seems to be market share.
MS. CALLAGHAN: Yes.
MADAME CHAIRPERSON: And it was state employees weren't really sure they wanted the Medicaid PDL, or -- so, this says you can have your own, we just bargain together. So, I -- yes?
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<td>Medicaid to use a certain PDL to get the lowest possible pricing quote, I think some of their costs are paid by the federal government, which is not the case in our plan, et cetera. Because of -- and, also because of the way the market works, that what's cost effective for Medicaid, if you put it together, becomes non-cost-effective for a commercial plan. And the reason that I would like to be able to give you more detail on that is because I think it is very important, and I apologize that I didn't have an opportunity to get more detail on it before. MADAME CHAIRPERSON: That's fine. Again, this is another one of those issues that's being dealt with down the hall in Health and Welfare. So, you will have plenty of time, you know, once this bill leaves here -- MS. CALLAGHAN: Okay. MADAME CHAIRPERSON: -- to go and work on it down there, because they are traditionally done. MS. CALLAGHAN: They are going to talk about the financing aspect, and how -- MADAME CHAIRPERSON: Well, they do the health, you know, the implications on health, and they have always done PDLs.</td>
<td>MADAME CHAIRPERSON: Okay. MS. CALLAGHAN: -- regarding the language. And I am looking now on page two, and I am looking at line eleven. MADAME CHAIRPERSON: I think it's been crossed out. MS. CALLAGHAN: Yes. That's section that goes from eleven to twenty-one has been crossed out, and I was wondering why that was. MADAME CHAIRPERSON: Because it's been being replaced somewhere else. Robin? MS. LUNGE: What is in section -- this section used to mandate Human Services under certain circumstances to join into the Statewide PDL with Medicaid which is not something which has happened. MS. ATTENDEE: Human Resources? MS. LUNGE: Yes -- sorry. So the chain is, basically, take out the mandated combined PDL and move to this process of joint purchasing consortium. So, if you don't want to do a joint PDL, I think this language helps you. MS. CALLAGHAN: Okay. I wasn't reading it that way. MS. ATTENDEE: It takes out something that hasn't happened? MADAME CHAIRPERSON: Yes. This language here, Robin, doesn't mention the PDL. MS. LUNGE: It's a subdivision of one -- MADAME CHAIRPERSON: It talks about one. MS. LUNGE: -- that a preferred list covers prescription drugs, so it says OVHA will do a cost control program. That's on page 600-A. And the program shall include a preferred method that would cover prescription drugs. B is a subdivision of one, so it referring, when it says the commissioner of Human Resources shall use this preferred drug list, that is referenced to the OVHA preferred drug in a one? MADAME CHAIRPERSON: Okay. I get you. Okay. And it also takes out authorizing the actuary something, line seventeen and eighteen. MS. LUNGE: If you think you need this language, I think then we should move it to the Human Resources section of the statute, because where it is now is, it's talking about the OVHA preferred drug list, and Human Resources using the OVHA preferred drug list. MADAME CHAIRPERSON: Okay. MS. LUNGE: So, I don't think you are</td>
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1 actually using this language now.
2 MADAME CHAIRPERSON: Okay.
3 MS. LUNGE: But if somehow this other
4 language is necessary to what you are doing, you can
5 look at your other statutory requirements around
6 that, and deal with it there.
7 MADAME CHAIRPERSON: Sure.
8 MS. CALLAGHAN: Okay. I had another
9 question on page five, line fourteen. It says for
10 entities in Vermont the director shall directly or
11 by contract implements a program through a joint
12 purchasing. The joint pharmaceuticals purchasing
13 shall be offered on a voluntary basis with mandatory
14 participation by state and publicly funded
15 administered or subsidized purchases to the extent
16 practicable and consistent with the purposes of this
17 chapter.
18 For us, what would that mean; to the extent
19 practicable? If it didn't work --
20 MS. ATTENDEE: If it didn't work, you don't
21 have to do it.
22 MS. CALLAGHAN: Okay.
23 MS. ATTENDEE: I think that means that if
24 you find that it's going to cost you more --
25 MS. CALLAGHAN: Right.

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1 MS. ATTENDEE: You are not going to get a
2 better deal by having bigger market share that
3 interest --
4 MS. CALLAGHAN: Okay. That's what I
5 thought.
6 Okay. That was really it.
7 MADAME CHAIRPERSON: Okay.
8 MS. CALLAGHAN: I did want to mention that
9 they are purchasing prop right now is somebody from
10 CareMark was talking earlier about how many
11 millions, with express it's fifty million lines.
12 So, that's the pool that we're in, and that's the
13 purchasing agreement, which was I think is pretty
14 good.
15 MS. ATTENDEE: We are running market shares
16 every -- and I think that's why I think this was a
17 particular interest of Senator Letty, if I remember
18 it.
19 MADAME CHAIRPERSON: I think so, to.
20 MS. ATTENDEE: That -- because if market
21 share is everything, the bigger the number of votes,
22 the better it would be. But if conflicting
23 regulations and rules -- and I've seen a lot of them
24 come from the federal level -- I think that's not
25 such a no-brainer, that if it doesn't work, then we

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1 don't. Okay?
2 MS. CALLAGHAN: Good. Thank you.
3 MS. ATTENDEE: But any input you could give
4 us on that would be very helpful.
5 MS. CALLAGHAN: I will. I will get it over
6 to you right away.
7 MADAME CHAIRPERSON: Okay.
8 Thank you.
9 There is a chair right there. This is
10 committee musical chairs.
11 MR. SLEN: Hello. Thank you for having us
12 today. My name is Joshua Slen. I am the Director
13 of the Office of Vermont Health Care, and I have Ann
14 Rugg, who is our Deputy Director, and has been in
15 charge of the pharmacy program for a number of
16 years, and ever since we initiated the PDL and a
17 pharmacy benefit manager. So, she's been around the
18 pharmacy for some time. So, I would like to echo --
19 MS. LUNGE: Should we send her our
20 condolences?
21 MR. SLEN: I would like to echo the
22 commissioner of personnel's comments, and I
23 apologize that due to the blizzard over the weekend,
24 we have not produced written documentation for the
25 committee for today, but we will do so, if not in

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1 time for this committee to act, we will copy it the
2 committee on any correspondence with Health and
3 Welfare.
4 So generally, we are neutral on many
5 provisions that don't impact us, and supportive of a
6 number of other provisions. There are a couple of
7 areas, actually three areas in particular, that I
8 would like to mention, and we can go into some
9 detail on a number of other areas that the
10 committee's request.
11 The first one that I would like to mention
12 is that the FQHC section that you have. We did a
13 study in 2006 --
14 MR. CARRIS: Which is where?
15 MR. SLEN: Section 1998, page seven.
16 MADAME CHAIRPERSON: Okay.
17 MR. SLEN: The section appears to create a
18 plan that increases the usage of FQHC for the
19 purchase of drugs in order to access the fee portion
20 pricing.
21 MADAME CHAIRPERSON: Right.
22 MR. SLEN: Medicaid did a study in 2006
23 where we found that, in fact, the cost of drugs
24 where there were -- that were not subject to
25 Medicaid rebate were in fact more expensive for us
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<td>1. to something than for us to purchase through the Medicaid program.</td>
<td>1. you are already doing?</td>
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<td>2. So, from a public payor perspective we actually had a better deal outside of the 340-B setting, at least in a number of instances. And so we would like to continue to have that situation.</td>
<td>2. MR. SLEN: We believe so, yes.</td>
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<td>3. MADAME CHAIRPERSON: I think we can write a state clause, right?</td>
<td>3. MADAME CHAIRPERSON: Thank you for being ahead of us.</td>
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<td>4. Okay.</td>
<td>5. Okay.</td>
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<td>5. MR. SLEN: In section 1998 G.</td>
<td>6. MR. SLEN: The last one that I am going to address the record today is section 203 B on page nine.</td>
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<td>6. MADAME CHAIRPERSON: Which is page six?</td>
<td>7. MADAME CHAIRPERSON: All right. 203 is another -- okay. Pharmacy discount.</td>
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<td>7. MR. SLEN: Yes. This is the section with the drug effectiveness project. And while we are supportive of utilizing evidence based practices, which we use now with our Drug Realization Review Board, contracting having statutory language to contract directly with the specific organization may in the future be restrictive if there is another organization that could do that, and there will be some administrative costs.</td>
<td>8. MR. SLEN: Basically, this is the expansion of the Healthy Vermonters Program, and our quick read of this section indicates to us that there is potentially some significant administrative complexity to rolling this out the way it's designed, and that the group of folks that may be -- that may be assisted by such an expansion may be very small. And so, we would like the opportunity the bring some of that evidence to the Senate so that they would have a little more information from our perspective on the group of people so at the end, how many people are there that would be assisted in this, and what the administrative complexity in doing it as it's written.</td>
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<td>9. I would also like to point out that once their one page promulgate their best practices they are available to us, and so by creating a formal relationship where we pay for their expertise on an ongoing basis, what we get is to be involved earlier</td>
<td>9. MADAME CHAIRPERSON: Okay.</td>
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<td>1. in the process with them, in fact that our DUR board had utilized their final recommendations to help us make policy in the State of Vermont.</td>
<td>1. MR. SLEN: So, we haven't had time to flush that out really, but we would like to bring some of that before the Senate.</td>
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<td>2. And so this is an issue where on two fronts, one is if there was better entity in the future, how would we access them with the statue written as it is. And, two, it appears that the bill would require a statute to purchase their services, when in fact we used ethnic based practices today.</td>
<td>4. MADAME CHAIRPERSON: Okay.</td>
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<td>3. MADAME CHAIRPERSON: So, You have access to their information perhaps a little later in the process?</td>
<td>5. MR. SLEN: Were there any other provisions that you want us to talk about?</td>
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<td>4. MR. SLEN: That's correct.</td>
<td>6. MADAME CHAIRPERSON: I would like -- excuse me. I would like to talk about that provision on page twenty-one about the confidentiality of the information.</td>
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<td>5. MS. ATTENDEE: Even though it's readily available online when they finalize their findings.</td>
<td>11. MADAME CHAIRPERSON: Page twenty-one?</td>
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<td>6. MADAME CHAIRPERSON: So, your advice is to put, such as, before their name so that if somebody else turns up bigger and better or smaller and better, we can go there? And you don't think it's necessary to spend money to do this, or additional money?</td>
<td>12. MADAME CHAIRPERSON: Yes. I was saying to Josh earlier, I would like to say we should absolutely support this provision. Actually, I think I said if you could cut it out and get it passed this afternoon, that would be nice.</td>
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<td>7. MR. SLEN: That's correct.</td>
<td>17. MR. CARRIS: I don't think the sentiment is the same in this room.</td>
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<td>8. MADAME CHAIRPERSON: All right. That will work. So, we are telling you to do something that</td>
<td>19. MADAME CHAIRPERSON: Not perhaps from some of the people that are in the room, but I can speak to that. We were with some regularity approached, not solely by manufacturers, but by organizations representing manufacturers seeking this information and to the extent that it is in the form of a public record that is without beneficiary information. It</td>
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8 (Pages 26 to 29)
has been made available, but our feeling is that making that information available ultimately results in the manufacturers having the opportunity to market products contrary to the Pharmacy Benefit Management Program as it has developed over the last five years.

To the extent that this was discussed in the Drug Realization Review Board meeting last Tuesday and the board voted unanimously for us to prepare a letter for their behalf to this committee, and to anyone else who was -- actually, I understand that there was an earlier plan to roll out this provision under a separate bill. So, I am saying that the pharmacists and the physicians on the Drug Realization Review Board want us to speak on their behalf and fully in support of that.

MS. ATTENDEE: This committee doesn't do health care. What is the Drug Realization? I am still figuring out what OVAH is.

MS. ATTENDEE: The Drug Realization Review Board started out as a Medicaid entity and Medicaid required entity into part of a Medicaid program. We are dealing on a routine basis, utilization in the Medicaid program. As the Pharmacy Best Practices and Cost Containment Program was developed, the Drug Realization Review Board also took on the role of being our program Pharmacy and Therapeutic Committee, and they provide advice to us as the result of proposals we make for, say, a drug's inclusion on the preferred drug list, criteria for access to drugs that are non-preferred, appropriate clinical practices, clinical advisories to be sent to the prescriber community. And, in fact, in terms of what we are talking about here, when products have been removed from the market or there are clinical concerns, we have used the Drug Utilization Review Board to advise us on how to proceed. Most commonly, we actually have used our own claims information to approach, say, physicians, notified beneficiaries, notified pharmacies when product concerns have been raised. So, rather than relying on the manufacturers or PhRMA to notify patients and physicians and pharmacies. We are using our claims information to direct the community.

MS. ATTENDEE: Okay. And when you are doing this you are using your claims information?

MS. ATTENDEE: Right.

MS. ATTENDEE: Which is what doctors prescribe, okay.

MS. ATTENDEE: Right.

MS. ATTENDEE: To the extent that it would tell --

MS. ATTENDEE: And to the extent that we have it available, then it is accessible as a public record.

MS. ATTENDEE: Okay.

MS. ATTENDEE: In fact, the language that we wrote we will be sharing with Robin would include language that would also protect it as public information section of the statute for that very reason.

MADAME CHAIRPERSON: Now, how much money could we get for the end fund if we sold it?

MS. ATTENDEE: If you are referring to the --

MADAME CHAIRPERSON: No, I was actually going to say, I could comment on we would have something in the area of five hundred manufacturers. Your little provision in here would provide a reasonable fund to support your education fund without having us sell the claims information.

MS. ATTENDEE: Okay. Is that the registration?

MS. ATTENDEE: Yes.

MADAME CHAIRPERSON: Okay. Any questions?

Thank you.

MR. SLEN: Thank you.

MADAME CHAIRPERSON: Paulette Thabault, is Paulette Thabault here?

MS. THABAUT: Good afternoon. Paulette Thabault, Commissioner from Banking, Insurance, Securities and Health Care Administration.

MADAME CHAIRPERSON: Paulette, before you start, we are back on the floor at 4:15.

MS. THABAUT: I have I am done long before then.

I am going to talk to you a little bit about what we think about this bill, and try to focus on the pieces that are concerning BISHCA.
MADAME CHAIRPERSON: Okay.
MS. THABAULT: Because we know that you are hearing from other agencies and individuals. And I wanted to start by just sort of reminding you that BISCHCA's current concern right now is the implementation that it has on health plans, and that includes our multi payor data base. So, that's very important. Those are very important activities that we were involved with right now. I think it's really important, and whatever we are doing really has a major focus of cost and payment.

So, as we look through this bill, the central question really that we looked at for each of the provisions is what the impact of that provision would be on health care costs, whether directly to the consumer, or to the consumers through premiums because of the increase of the costs of administration, administrative costs that might be associated with implementing these provisions.

We know that all consumers are concerned about health care costs as you are, and so that was really the lens from which we looked at this, and the comments that I am going to make will be focused on that. Again, I am going to address the BISCHCA-related provisions.

So, starting with page eleven, if I can get my notes here, starting on page eleven, the bill is concerned with regulating the PBMs. And our concern here is whether these provisions are actually going to help reduce prescription costs, or if they will either have chilling effects on the PBMs of doing business in Vermont, or if they are going to cause increased administrative costs that are going to then be passed on to consumers.

We think that PBMs can be good for consumers, and if we regulate them to the extent that they look at Vermont and say it's not worth doing business there, it's too much trouble, we will lose the benefits that they might offer.

The first section I want to talk about is on page 1213 of the bill subdivision one, where it calls for the PBMs to act as a fiduciary.

MR. ATTENDEE: It doesn't use that word.
MS. THABAULT: No, but the language that it uses discharging its duties with the care, skill, prudence, and diligence under the circumstances, those are terms that are associated with a fiduciary role. And while we don't impose that, we want to make sure and would like to have the legislation clarify that it's the health insurance company that is primarily responsible for administering the Health Insurance Benefit Plan and that those are administrated pursuant to the policies that are issued and in compliance with Title 8018. So, we would like to see a little clarification on that.

Again, if the PBM understands that provision to be a higher fiduciary role then, and then they become ultimately responsible for the plan, that could create some administrative costs, and it might deter them from wanting to do business here.

MADAME CHAIRPERSON: Okay. I just wanted to --
MS. ATTENDEE: How does that work, Madame Chair? We can't control a lot of things because they are interstate commerce, and PBMs deal with this one and that one out of state. We can't control that, but they cannot do business here because our instate regulations will cramp their style.

MS. ATTENDEE: They can choose to.
MADAME CHAIRPERSON: They can choose not to bother with Vermont. Vermont is kind of small. We don't have a whole lot of lives here, and they can say, wait, it's not worth it to comply with those regulations and not --
MS. THABAULT: Well, we were just told that we couldn't ask certain things of them because most of what they do is considered interstate commerce, and we don't have any say about that. That is a federal issue.

Am I confusing things completely?
MS. ATTENDEE: I think you on the other topic.
MS. THABAULT: Am I?
MS. ATTENDEE: Yes.
MS. THABAULT: Okay.
MS. ATTENDEE: Yes. That's regulation of pricing and advertising.
MS. THABAULT: So, the answer would be yes then.
All right. But I thought there were several issues of this nature. We will continue.
Sorry about that.
MS. ATTENDEE: There are several issues.
I'm not sure this is one of them. This is another issue.
MS. THABAULT: With respect to this issue, we would be happy to provide you with some language
that would make that clarification better.

MS. ATTENDEE: Okay.

MS. THABLAUT: On pages thirteen and fourteen, there are several subdivisions here that we think are -- specifically subdivisions two, four, and five, and six. I'm sorry, not five -- two, four and six.

These are all division -- the language in these provisions are all areas that we don't oppose in substance, but we think that these are contractual matters, and that the health insurance plan should be able to vary the terms of the contract. And we ask you to keep in mind that when there is a contractual obligation such as these, they come with a price. And we think that it is very likely that these will increase administrative costs, and ultimately show up in the premiums.

So, again, cost containment being our concern and health care costs in the form of premiums that are seen by the consumers is what we are worried about, and we think each of those provisions have a potential impact to do that.

In the, specifically in subdivision four which contains substitute provisions, we think they are is some section already in existence to Rule Ten which protects consumers from inappropriate prescription substitutions. And, in fact, consumers can save money if the appropriate therapeutic equivalent substitution is made for the lower price. And this, again, will be able to have that for so they are contractual.

Subdivision five on page fourteen actually has the language that we like better, because it does set forth the substance that you are trying to get at, but it allows -- it does make a provision unless the contract between the pharmacy benefit manager and the health plan provides otherwise.

That language would help if it were included in those other subdivisions so that it does allow for the contractual negotiations to occur.

I'm going to go back just for a minute to page thirteen of the subdivision three. This section requires the health plan to notify a -- for the PBM to notify the health plan in writing of any proposed or ongoing activities, policy or practice of the pharmacy benefit manager that presents directly or indirectly in conflict of interest with the requirements of this section.

We don't really oppose that, but we don't really know what it means. We think it's vague, and

that if the PBM is not clear as to what is expected of them, then it could be something that is going to defer PBMs from doing business in Vermont, especially if they don't have some clear expectation about what is required.

MADAME CHAIRPERSON: I was writing the note for the last one. Were you on this one?

MS. THABLAUT: I'm on page thirteen.

MADAME CHAIRPERSON: Thirteen.

MS. THABLAUT: Subdivision three.

MADAME CHAIRPERSON: Okay. I am going backwards.

All right. That's where it comes from.

Okay. Yes.

MS. THABLAUT: Then I am on to page fifteen under enforcement.

These are some joint enforcement provisions by BISHCA and the Attorney General's office with BISHCA as the primary regulator. We are fine with this provision, provided that the language is clear that BISHCA is the primary regulator, so that at the time -- so that time and enforcement resources are not wasted and we don't come up with interagency conflicts.

So, again, that -- BISHCA should be the exclusive regulator of health insurance companies.

That's our job. That's what we do. And we think it needs to be clear here in this language.

MR. ATTENDEE: Do you have language?

MS. THABLAUT: We could certainly provide you with the language for that, as well.

MR. ATTENDEE: Would you refer to this new?

MADAME CHAIRPERSON: I think we had this discussion before. If I remember, this was going out of here. They were doing telegrams over how we worded this. So, there must be an agreed -- there was agreed upon language I think at one point as to how that played out.

MS. THABLAUT: Sure.

MADAME CHAIRPERSON: So, somewhere, we have it.

MS. THABLAUT: Perhaps we could move on.

MADAME CHAIRPERSON: Somewhere in those e-mails we have it.

MR. ATTENDEE: Natural resources attended to the file, they should be handled administratively by BHD and Natural Resources. Then at a certain point, they'll decide, okay, this is --

MADAME CHAIRPERSON: Yes.

MR. ATTENDEE: -- this is non-compliance
and we're handing them over to you. They are doing civil rights.

MADAME CHAIRPERSON: Yes, same deal. But there is a little fuzzy gray area in between that becomes problematic.

MS. THAUBALT: So, I guess we could provide you with the language for that, the one that BISHCA has.

On pages sixteen through nineteen, there are requirements around legislation of the firms of benefit management, and we were supportive of the legislation requirements, but wanted to remind you that we are already preparing to register the PBMs pursuant to the multi pair data collection project, and the PBMs are subject to that already.

MADAME CHAIRPERSON: I think we have that testimony to that effect.

MS. THAUBALT: On pages twenty-one to twenty-five concerning the confidentiality of specific information, we were supportive of the confidentiality of this section. I think that this has been beneficial and protective to consumers and providers.

But, we would like the exclusion that's on page twenty-three, it identifies the entities that are not subject to the section, we would like it specified there also that the multi pair data base project is also subject, so there is not any concern about PBMs providing that information under that project. And we can provide some additional language for that as well.

MADAME CHAIRPERSON: Be enough.

MS. THAUBALT: On page twenty-five, we have some concerns about subdivision two on that confidentiality issue that if BISHCA is not able to use that data, it's the piece about the identity of the patient and the prescriber, that is prohibited from being transferred to us, it may interfere with our ability to do the kinds of evaluation and research that we intend to do through that multi payor project. And not that we would ever disclose that information to the public, but if you are evaluating a program or - involving prescriptions and providers, it may be necessary to know who the individuals are and what providers we are talking about when trying to evaluate whether there can be --

MADAME CHAIRPERSON: Okay. So, you may have one person getting pharmaceuticals from two different doctors, or --

MS. THAUBALT: That would be an example.

MADAME CHAIRPERSON: Okay. Or --

MS. ATTENDEE: I'm sure it's vital we would need this kind of information at some point for patient records.

MS. THAUBALT: To the extent that they are not selling it, it wouldn't be covered, because, again, it's commercial purpose.

MADAME CHAIRPERSON: Okay. So, this would not, as written preclude BISHCA from getting it unless BISHCA was buying it, right?

MS. ATTENDEE: Or selling it.

MADAME CHAIRPERSON: Or selling it.

MS. ATTENDEE: Are you saving for a new vacation, Commissioner. You have to sell the -- you have to sell it?

MADAME CHAIRPERSON: We have are put the --

MS. THAUBALT: I guess I'm really concerned about --

MADAME CHAIRPERSON: -- we are already looking at it for property tax relief, so --

MS. THAUBALT: I guess I am just looking at why it references selling it in that section.

MR. ATTENDEE: It's showing in section -- it's not in print. It's already in business.

MS. THAUBALT: It's in section twelve.

That's where it talks about commercial data. This particular section I think is the multi-care data base in item ten, E.

MS. ATTENDEE: So, you feel that the language here is only prohibitive --

MS. THAUBALT: Yeah, that's exactly what -- maybe we can talk about that.

MADAME CHAIRPERSON: I think the intention of this committee is to prevent the commercial sale, not for use for program evaluation or patient safety or medical. So, if it's not clear --

MS. ATTENDEE: We can clarify that.

MADAME CHAIRPERSON: Yeah, we will fix it.

MS. THAUBALT: On page twenty-five under section sixteen, there is a section about prescription drug co-payments. Under this section we are not aware what there was a problem with this, that the health insurers are not providing the information or that it is being implemented this way, so we are questioning the value of another mandate if there is not a problem. So --

MS. ATTENDEE: Where are you?

MADAME CHAIRPERSON: Twenty-five, line fifteen.
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1. MS. THABALT: Twenty-five.
2. MS. ATTENDEE: Okay. I thought we heard
3. statements to that.
4. MADAME CHAIRPERSON: From consumers. They
5. might have been secondhand consumers.
6. MS. THABALT: I mean, we get consumers
7. complaints all the time, and we are not aware of any
8. problems in this area.
9. MADAME CHAIRPERSON: Okay.
10. MS. THABALT: So, we're not sure what the
11. value is here of that, and it's another mandate.
12. MADAME CHAIRPERSON: I mean, unless it's a
13. really high co-pay --
14. MS. ATTENDEE: Or unless you have an
15. extremely cheap drug --
16. MADAME CHAIRPERSON: Yeah.
17. MS. ATTENDEE: I mean --
18. MADAME CHAIRPERSON: It can happen.
19. MS. THABALT: You can have a generic drug
20. that's very inexpensive, like three dollars.
21. MADAME CHAIRPERSON: I think the concern
22. was WalMart with their four dollar generic, that if
23. you have got a ten dollar co-pay, you shouldn't have
24. to pay ten dollars for a a four dollar generic.
25. This may just be warning to the insurance companies;

1. if you were thinking of doing it, don't. But we can
2. check.
3. Who does the co-pay go to?
4. MS. THABALT: The co-pay goes to the --
5. MS. ATTENDEE: To the pharmacist, right?
6. MADAME CHAIRPERSON: Yeah.
7. MS. ATTENDEE: Or to the insurance
8. companies?
9. MS. ATTENDEE: No, I think it goes to the
10. pharmacist.
11. MADAME CHAIRPERSON: It goes to the
12. pharmacist to help offset that cost that the PBM is
13. negotiating.
14. Okay. So, maybe Wal-Mart needs that to do
15. the four dollar generic.
16. But, Anthony, do your people have anything
17. to say about that? Are you interested in hearing?
18. MR. ATTENDEE: (Inaudible).
19. MADAME CHAIRPERSON: Either here or --
20. MR. ATTENDEE: Down the hall.
21. MADAME CHAIRPERSON: Or down the hall.
22. MR. ATTENDEE: -- down the line.
23. MADAME CHAIRPERSON: Yeah.
24. Okay.
25. MS. THABALT: So, Herb was just reminding

1. me that this section is directed to the health
2. insurers, not to the WalMarts. So if that is the
3. purpose of that provision is, we are not pursuing
4. it.
5. MADAME CHAIRPERSON: Okay. If the co-pay
6. is required be the insurer but it is collected by
7. the pharmacy, isn't it?
8. MS. THABALT: Right.
9. MADAME CHAIRPERSON: But who pockets it?
10. MR. ATTENDEE: The pharmacy.
11. MADAME CHAIRPERSON: The pharmacy.
12. MS. THABALT: But the provision is
13. directed towards the health insurers.
14. MR. ATTENDEE: But, generally speaking, the
15. co-pay is a lot less than the drug. So --
16. MADAME CHAIRPERSON: Okay. The draft says
17. it's both.
18. MS. THABALT: Section fourteen applies to
19. the pharmacy.
20. MS. ATTENDEE: Which line?
21. MS. THABALT: Twenty-five, line four.
22. MADAME CHAIRPERSON: Okay. This is just a
23. reference.
24. MS. ATTENDEE: Okay. Well it's not a like
25. I said.

1. (Inaudible)
2. MS. ATTENDEE: And don't pharmacies have to
3. sort of a Blue Cross Blue Shield tells them how they
4. get people to pay for this and pay people for that.
5. They take their queues from the insurance people.
6. MADAME CHAIRPERSON: Oh, yes.
7. MS. ATTENDEE: They are the ones that pay
8. them.
9. MADAME CHAIRPERSON: Yes.
10. Okay.
11. MS. THABALT: Now, moving over to pages
12. thirty-seven and thirty-eight, this is subjecting
13. the health insurance marketing activities to the
14. Consumer Fraud Law. These provisions, and think
15. that it would increase confusion. BISHCA already
16. regulates these practices. There is additionally a
17. CMS regulation on the Medicare Part B, and this
18. would just be adding a third layer of regulation.
19. So, we don't think that would be helpful.
20. We have issued a bulletin that addresses
21. the marketing for Medicare Part B and Medicare
22. Advantage plans. I actually have a copy of that
23. bulletin today. It goes through the -- it's very
24. explicit about the kinds of activities.
25. It's supposed to go one way -- sorry.
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1 So, we don't really think that this is
2 going to be helpful, and in fact can be just more
3 confusing. We could, if it would be helpful, we
4 could offer some specific language that would
5 incorporate the specific standards into Title Eight
6 so that there would be some concern that those
7 standards were not being adhered to but rather that
8 we were concerned about.
9 MADAME CHAIRPERSON: Okay.
10 MS. THABAULT: On S-84, this is for the
11 prompt payment of prescription claims.
12 That is all I have.
13 MADAME CHAIRPERSON: Okay. That's the next
14 bill.
15 MS. THABAULT: Sorry.
16 MADAME CHAIRPERSON: Okay.
17 MS. THABAULT: Just, we are unsure about
18 the change to the eight day, and our concern is the
19 administrative costs associated with that. It's
20 going to cost more to make an eight day --
21 MADAME CHAIRPERSON: We have heard that.
22 MS. THABAULT: So, those are going to be
23 tacked on to the insured in the premium form, so
24 just to be aware.
25 And then fifty-eight-seven, again, these are

consumer rights about what the current law
requirements are already, and we issued a bulletin
about this from already, the prescription drug
purchasing piece and --
MADAME CHAIRPERSON: We have that already.
MS. THABAULT: Here it is.
MADAME CHAIRPERSON: When did or is that
going out?
MS. THABAULT: It went out in May of 2005.
MADAME CHAIRPERSON: Okay.
MS. THABAULT: So, our understanding is
this is current law. It's already been implemented,
and we are enforcing it.
MADAME CHAIRPERSON: I guess we were told
that there was a little foot dragging when customers
called up about -- part of the issue is that
customers don't know and pharmacists don't know that
they can get it at their local pharmacy --
MS. ATTENDEE: Yes, at the same price.
MADAME CHAIRPERSON: -- and the insurance
company is not overly forthcoming in informing them
of that. But --
MS. THABAULT: Again, we are not aware of
problems. We haven't gotten consumer complaints
about it. We have issued a written bulletin to help

them through, telling them what they need to
include. We review and approve all of their forms
for when they are filling their benefits, and we look
for that language. So --
MADAME CHAIRPERSON: Okay. I think I can
say that those two bills are probably not going to
be attached to this one. Overwhelming desire for
the community to keep it.
Okay.
MS. THABAULT: So, I think that completes
my testimony, unless you have any questions.
MADAME CHAIRPERSON: Questions?
No?
Okay. Thank you.
Robin, can I get -- are you next on the
agenda?
MS. LUNGE: I think so.
MADAME CHAIRPERSON: Okay -- yes.
MS. LUNGE: I have from -- well, let me
tell you what I can do. We have two options. I
think based on sort of the comments that we've had
today, we can try and quickly go through and talk a
little bit about different things we want to do with
the bill and what I should include and what I
shouldn't include, or I did try to do some new

language based on your testimony last week, which I
could hand out. I am not sure that I can get
through it, so it might be better for us to have a
more general discussion --
MADAME CHAIRPERSON: Yes.
MS. LUNGE: -- and then tomorrow, instead
of giving you a version now that's just going to
change and be new tomorrow, I can just give you a
new version tomorrow.
MADAME CHAIRPERSON: That would probably be
MS. LUNGE: -- but it's up to you.
MADAME CHAIRPERSON: If we can get it done.
I think the first note I have is on page
five. It may be before that committee.
MS. ATTENDEE: Can I ask a really general
question? And it goes to what I didn't -- I was
inarticulate about it, and Ms. Thabault, maybe I
will remain inarticulate, but there are a couple of
sections. One was about advertising, and the other
was fraudulent -- what was that, outrageous pricing,
whatever it was?
MS. THABAULT: Unconscionable pricing.
MS. ATTENDEE: Unconscionable pricing. And
it was determined that those involved interstate
commerce and we can't do anything. And the note I
sent to Senator McCormack was, surrender Dorothy,
after we heard half of these.

But how is it that just about every about
PBM isn't interstate commerce? They may do almost
all of their -- they get their drugs and do their --

MADAME CHAIRPERSON: No. We don't have --
we have one PBM, I think they do, one retail
pharmacy for all of things in the State of Vermont.

MS. ATTENDEE: Yes.

MR. ATTENDEE: One wholesale.

MADAME CHAIRPERSON: Didn't I hear
something like that?

MS. ATTENDEE: So, why isn't everything
interstate commerce and why don't we surrender,
Dorothy?

MS. THABAUT: I don't think I should
answer that question.

MS. ATTENDEE: Okay. Well, no, I won't --
I guess I want you to say --

MS. ATTENDEE: I don't think they are
selling -- they are not selling -- if you recall --

MS. ATTENDEE: It's not their drugs.

MS. ATTENDEE: You just heard some
testimony also from the NLAI counsel about for the

opposite argument about why it would be -- we would
be able to regulate --

MS. ATTENDEE: Would you remind me?

MS. ATTENDEE: -- as instate counsel.

MS. ATTENDEE: Maybe we could --

MADAME CHAIRPERSON: Did he send us his

MS. ATTENDEE: John Flynn.

MADAME CHAIRPERSON: Maybe we could get the
summary of his testimony in writing.

MS. ATTENDEE: Let me find my notes on that
page.

MS. ATTENDEE: So, what --

MR. ATTENDEE: Is this is unconscionable
basis?

MADAME CHAIRPERSON: Yes.

MR. ATTENDEE: The question I have with

regards to that section is that if we have one drug

wholesaler in the State of Vermont, what are we are

accomplishing by doing this? That's -- that's -- I

mean, we can't control anybody else.

MADAME CHAIRPERSON: But we can.

MS. ATTENDEE: So, that's my question.

MADAME CHAIRPERSON: Well, I'll let Robin

--- as we have gone through this, there is always,

--- there's a thing in the commerce clause, a clause in
the clause that says unless there is an overriding state
interest, and that's what this revolves
around; do we have an overriding state interest
in some -- and it sounds like fairly rare points, we
regulate drugs. And we did run into this, I
remember the testimony, when there was a shortage of
flu vaccine, and ito and behold, the prices started
to go up, and states did intervene.

MS. LUNGE: The reason I don't want to
weigh in sort of on the commerce clause stuff today
is because I have to refresh my memory on the
litigation that has happened in that area, and I
haven't looked at that recently enough to be able to
really be able to fluently discuss that issue with
you, because it is a constitutional doctrine.

So, that means that the parameters of what
is and is not interstate commerce is defined by the
courts through case law, and it's not a simple
answer. So, you are going to always -- I think when
you are looking at commerce and whether something is
in or out of state, there will be some very clear-
cut examples, if there is a case on point.

If there is not a case on point, you are
always saying, well, is it more like this or is it

more like that? And there will be some discussion,
and, you know, reasonable legal minds will differ on
that question.

MS. ATTENDEE: So, are you saying that it's
not whether or not it's in Vermont, it's really what
the law says?

MS. LUNGE: It's what -- well, it's a
combination -- it's a combination of how closely
does this particular type of commerce or question or
bill language mirror other cases, combined with how
much connection is there in Vermont. Now,
obviously, we have prescription drugs in Vermont, so
it's in commerce in Vermont. The question is
whether the regulation is too much of a burden or
hindrance on out of state, how we defined it as just
Vermont State well enough in the statute, or are we,
you know, through our words, also touching New
Hampshire and New York.

MS. ATTENDEE: That might be all the
information I need, actually. You gave me a little
homework. I was confused as to where that question
began and ended.

MS. LUNGE: Well, it's not the kind of
question where there is going to be probably an
instant answer. What I can say is that the
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1 definition for most favored purchase price was
2 litigated in Wisconsin, an that was determined not
3 to violate the commerce clause by the 4th Circuit.
4 So, I know that little piece of the bill has been
5 upheld in one circuit. We are not in the 4th
6 Circuit, so the 2nd Circuit may have a different
7 opinion. But, we know one court has said that
8 Wisconsin requiring everyone to get the most favored
9 price doesn't violate interstate commerce.
10 MS. ATTENDEE: And then that's only in
11 _______________________________________________________________________________________
12 MS. LUNGE: Wisconsin didn't even have that
13 limited language. They said everybody in the State
14 of Wisconsin shall get the most favored purchase
15 price, which, in theory, should mean everybody's
16 price is the same in Wisconsin, which I am guessing
17 is probably not being enforced, but I don't know
18 that for a fact.
19 MS. ATTENDEE: I would doubt that or it
20 would be on Oprah or somebody.
21 MADAME CHAIRPERSON: Okay.
22 MS. LUNGE: So, does that --
23 MADAME CHAIRPERSON: Thank you.
24 MS. LUNGE: So, I am just going to go
25 through and touch on things. Is that okay?

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1 MADAME CHAIRPERSON: Okay. Yes. And,
2 Counsel, use that red flag.
3 MS. LUNGE: Okay. So page four, it sounds
4 like what you would like to do is make a language, I
5 guess page four, we have the SGC issue that someone
6 testified on. I can add some languages and try to
7 specify that it will only do it if it makes sense.
8 MS. ATTENDEE: This is the flag you have on
9 five?
10 MS. LUNGE: And you had a flag on five?
11 MS. ATTENDEE: No, that was the same flag.
12 MS. LUNGE: Okay.
13 MS. ATTENDEE: I just wrote it in a
14 different place.
15 MS. LUNGE: Okay. And I think we are
16 waiting for more information from Ms. Callaghan at
17 this point, or is there something you wanted to
18 do in response to her testimony on this?
19 MS. ATTENDEE: The next note I have is on
20 page six.
21 MS. LUNGE: Yes.
22 MS. ATTENDEE: Which just on before Oregon,
23 a such as.
24 MS. LUNGE: Yes, so --
25 MS. ATTENDEE: We may not want to apply

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1 them.
2 MS. LUNGE: The contract?
3 MS. ATTENDEE: The contract.
4 MS. LUNGE: We can make that more
5 general --
6 MS. ATTENDEE: Yes.
7 MS. LUNGE: -- language about using it.
8 Let's see. On page seven, the notes that I
9 have was, Jill Berlaki (phonetic) testified to this
10 in the later part of the bill, but she said add
11 Department of Health department to trade secrets.
12 This reporting section, which would be in this
13 section three --
14 MS. ATTENDEE: Where is that?
15 MS. LUNGE: It's not in here because it
16 would be an addition.
17 MS. ATTENDEE: Okay.
18 MS. LUNGE: So, it's my note of where I
19 would add it.
20 MS. ATTENDEE: Because since they got all
21 the information, that is really the Department of
22 Health would be --
23 MS. LUNGE: This is for the evidence base
24 education program. So for the limited purpose of
25 that program, allowing the two agencies to keep the

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1 information confidential between the two agencies
2 and allow the agencies to share that with the DOH.
3 So, if you want to do that, that will show
4 up in section three.
5 In section four on the price disclosure,
6 there was a suggestion to add some language for a
7 Texas bill that added another price, which was the
8 price that each wholesaler pays to the manufacturer.
9 MS. ATTENDEE: The final price that each --
10 the --
11 (Inaudible)
12 MS. LUNGE: I don't have it right here in
13 front of me, but I will copy it out of --
14 MADAME CHAIRPERSON: Okay.
15 MS. ATTENDEE: That's what you told me,
16 yeah.
18 MADAME CHAIRPERSON: Okay.
19 MS. ATTENDEE: I mean, it's just a matter
20 of finding out what's the best price to pay things.
21 MS. LUNGE: The best -- you mean the best
22 practice defined under federal law?
23 MS. ATTENDEE: Well, Texas.
24 MS. ATTENDEE: We were talking about --
25 MS. LUNGE: Texas says a third. They

16 (Pages 58 to 61)
require these two, plus one.

MS. ATTENDEE: Okay.

MS. LUNGE: Actually, I think I have it here. Here we go. Texas says that they require an average manufacturer price and the price that each wholesaler in Texas pays the manufacturer to purchase the drug. So, those are the two things required by Texas. So, the suggestion was to add that as a third thing in ours. Also, today, there have been suggestions on some revised language in Maine, which would, in subsection C, which is on page eight, it would allow the Chief Executive Officer or Officer to designate an employee in a position that reports. The other thing that the Maine language, the newer Maine language says that's not in this bill, would also require a report of the methodology, so that in terms of reporting, the average manufacturer price is the best price, the manufacturer also reports sort of what their method was of coming up with that price. So, I don't know if that is something you are also interested in.

MS. ATTENDEE: It probably wouldn't hurt to put it in writing.

MS. LUNGE: I'm sorry?

MS. ATTENDEE: It probably wouldn't hurt to get the methodology in writing, at least to start out. It seems at this point, to be able to figure out how things get priced.

MADAME CHAIRPERSON: Okay.

MS. LUNGE: And it sounds like in terms of the Healthy Vermonters section that OVHA is going to provide me with information from Health and Welfare.

MS. ATTENDEE: Yes, Healthy Vermont is the Health and Welfare.

MS. LUNGE: Okay. Section six, we have had lots of different suggestions on this section. So,

I am not entirely sure which way you want to go. I haven't yet received language from the manufacturers.

MADAME CHAIRPERSON: Okay.

MS. LUNGE: So, I didn't --

MS. ATTENDEE: I have a feeling the first question is, is it in or out? And after that it's, what is it?

MR. ATTENDEE: I neglected to write who made the suggestion. If someone suggested that we track names.

MADAME CHAIRPERSON: Yes.

MR. ATTENDEE: As opposed to having them that was in the Maine language that we didn't have in ours, so I did add that. But other than the actual terms, the definitions for those terms are the same.

MADAME CHAIRPERSON: Okay.

MS. LUNGE: But that doesn't -- the Maine language, I don't think is resting some of other issues we have heard, such as that some of the provisions should be optional instead of mandatory, and it should be that you should be able to contract around them.

MS. ATTENDEE: I guess the thing I am having difficulty visualizing is when I read this in and whenever we've done this, it's been looked at as, they come in and make an offer to us. What the testimony from the PBMs has been that we send out a request and they respond to the request. And I guess that's different dynamic, and I am trying to look through how the fiduciary works in here, along with the contractual, and that seems to be the issue that's going on. Is this a contract that gets enforced under contract law, or are we raising it up to a different level?

MS. ATTENDEE: I think that would be the first time we did this type of thing. I thought
that we deliberately did raise that.
2 MS. ATTENDEE: We did. And this bill
3 deliberately raises it to a higher level.
4 MS. ATTENDEE: So, they know who they are
5 working for?
6 MS. ATTENDEE: That's right, and that's
7 there. But how do you deal with that? You know, it
8 says you have to offer -- you have to have both
9 kinds of plans available. But if you are going to
10 respond, you have to respond with all of this, even
11 if I don't want it?
12 MS. LUNGE: Well, there are two different
13 parts.
14 MS. ATTENDEE: Okay.
15 MS. LUNGE: And the second section talks
16 about what you have to respond to the RFP with, and
17 you could -- and that's in section seven -- and you
18 could change that to say that in that response, the
19 PBM responds to the IFP, that they will notify that
20 they have other services available so that the
21 person requesting it knows that there are other
22 options. So, that if you are talking about the big
23 insurer that does this all the time and is very
24 savvy, they are not getting unnecessary information.
25 But if you are talking about someone who doesn't

1 know what they are doing, and they don't know that
2 there are other options, they at least get a notice
3 that, well, we also have this other type of contract
4 that you could request us to give you a bid on, as
5 well. So --
6 MS. ATTENDEE: I would assume they would
7 prefer the administration only.
8 MS. LUNGE: I don't know. I don't know.
9 MS. ATTENDEE: Okay.
10 MS. LUNGE: I think that if you wanted to
11 try and do a middle ground on that issue of offering
12 the administrative services, you could offer a
13 notice that it exists, without the PBM having to
14 actually develop a whole bid on that for ever single
15 customer and send it.
16 MS. ATTENDEE: Okay. And I think it would
17 be more that you want them to know that there is an
18 alternative to get more information, and that may be
19 what you want to write into the contract. You know,
20 you think thirty percent savings sounds really good,
21 but, you know, does anyone bother to tell you, and
22 by the way, if you ask us we could disclose that --
23 da, da, da. And that may be the way I would think
24 about going.
25 I am looking at the committee.

1 MR. ATTENDEE: I have some basic
2 questions.
3 MADAME CHAIRPERSON: Okay.
4 MR. ATTENDEE: What are we trying to
5 accomplish with this bill?
6 Just a basic question.
7 MADAME CHAIRPERSON: We are trying to get a
8 handle and control the cost of pharmaceuticals,
9 which is a major cost in the rising health care.
10 MR. ATTENDEE: And I guess, from my
11 standpoint, I understand that there needs to be some
12 regulation, but I just don't want to over regulate
13 to the point were we are creating such a morass of
14 documentation, that we are actually driving the
15 price up. And that could be --
16 MS. ATTENDEE: Yes, we are trying to find
17 out a way to ensure that customers and the Attorney
18 General's -- she said not all of them are --
19 MR. ATTENDEE: And I'm not saying that it
20 is obscure. What I'm saying is --
21 MADAME CHAIRPERSON: Right. And that's how
22 you --
23 MR. ATTENDEE: You keep throwing things
24 out.
25 MADAME CHAIRPERSON: And that's how you --

1 it's that fine line. I don't think we want to
2 increase the cost, but we want to make sure that
3 customers know that they are allowed to get
4 information if they want it.
5 MR. ATTENDEE: Right. But it does cost
6 money to get information.
7 MADAME CHAIRPERSON: It does.
8 MR. ATTENDEE: My point is along with what
9 I think the commissioner was speaking about to a
10 certain point. We can go to a certain point, and
11 then at some point --
12 MADAME CHAIRPERSON: Right.
13 MR. ATTENDEE: -- we start tipping the
14 scale the other way, and the price starts climbing,
15 rather than decreasing.
16 MADAME CHAIRPERSON: I think the testimony
17 I've heard is, they do offer the, we'll tell you
18 what our rebates are contracts, and if people send
19 out and say we want, you know, you can come in and
20 tell us what it would look like if you trade rebates
21 with us, they will tell them that. And they can do
22 the same thing with administrative only.
23 I think the concern might be, if you come
24 for administrative only, a foot note that says, be
25 aware that, if you wish, you can be figured into

18 (Pages 66 to 69)
this contract. Right now --
(End of tape.)

CERTIFICATE

STATE OF FLORIDA
COUNTY OF BROWARD

I, Susan D. Fox, Notary Public, Florida Professional Reporter, do hereby certify that I was authorized to and did listen to CD 07-52, Track 1, the Senate Committee on Finance, February 20, 2007, proceedings and stenographically transcribed from said CD the forgoing proceedings and that the transcript is a true and accurate record to the best of my ability. Dated this 27th day of August 2007.

Susan D. Fox, FPR
Esquire Job #: 889709

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STATE OF VERMONT

SENATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: Tuesday, February 20, 2007

Senate Finance Committee

Committee Members:

Sen. Ann Cummings, Chair
Sen. Claire Ayer, Vice-Chair
Sen. Bill Carris
Sen. James Condos
Sen. Mark MacDonald, Clerk
Sen. Hull Maynard, Jr.
Sen. Richard McCormack
Robin Lunge, Legislative Counsel

CD No: 2007-53/Track 1
**PROCEEDINGS**

CHAIRPERSON CUMMINGS: -- consumer and how much do we need protect it?

ATTENDEE 1: I don't like to -- Senator (inaudible) to speak alone.

CHAIRPERSON CUMMINGS: Okay.

ATTENDEE 1: Because I've been feeling the very same thing this afternoon.

CHAIRPERSON CUMMINGS: Okay.

FEMALE ATTENDEE 1: I did notice, Madame Chair, that the PBM's always talk about their customers being sophisticated. I don't think there are any exceptions to that, you know, that they -- that they imply that these are people who know what they're doing. But I have to wonder if there have never been any human resources people, or whatever department that is, who have ever screwed up because they didn't have the right information. I mean I think of lots of companies as such. It doesn't mean they're perfect and they know everything.

ATTENDEE 2: But I think most probably work through a third party. So it's -- it's a third-party administrator for them. And you know, my company doesn't -- doesn't work out the PBM with the -- I mean doesn't work out the contract with the PBM; we work it out with our health insurer who then contracts with the PBM. So I think most companies in Vermont probably work under that -- under that model. I think there's probably very few that actually are actually dealing directly with the PBM.

ATTENDEE 3: Yeah. We do the same thing through Cigna.

ATTENDEE 2: Right.

ATTENDEE 3: I mean if those guys can't figure it out, nobody can.

CHAIRPERSON CUMMINGS: That's -- that's one of the questions is has the market -- we started this --

ATTENDEE 3: It mean it does bring into question Section 6.

CHAIRPERSON CUMMINGS: -- when it was owned by Merck and the market has changed. So that one is still...

ATTENDEE 2: I mean there might still be a need for Section 6 --

CHAIRPERSON CUMMINGS: Yeah.

ATTENDEE 2: And I'm not -- I'm not discounting what's here. I'm just saying that I guess, you know, I hear some comments being thrown out: Well, maybe we ought to do this or maybe we ought to do that.

CHAIRPERSON CUMMINGS: This could be suggested that we add all the clauses, the clause on page 14, No. 5: Unless the contract between the pharmacy and the health plan to provide otherwise.

That's your escape clause. So anyway...

MS. LUNGE: Well, I'll put that -- why don't I put that -- that suggestion in in bold, and that way you can see it there, and then you -- that gives you an option of taking it out, you know, further refining or whatever. And I'll try and incorporate as much as I can. I'm probably going to miss some things in this section. But if I get language from other people, I'll just put -- try and put everything in so that you see all the options and then you can have all the options.

(inaudible.)

MS. LUNGE: Yes.

CHAIRPERSON CUMMINGS: Yeah. They're going to call us for roll call I'm sure. So we're going to have to -- well, we --

FEMALE ATTENDEE 1: It would be nice (inaudible.)

CHAIRPERSON CUMMINGS: I will head upstairs and you tell us all to the vote.

FEMALE ATTENDEE 2: Just do what I do, Paul. ATTENDEE 4: Is this on the farm bill?

CHAIRPERSON CUMMINGS: Yes. And it's -- there's going to be an amendment to add Barnes. And they told me we could stay here and they will call us for roll call. We will send our emissary to find out what the debate is.

ATTENDEE 4: Well, for one thing (inaudible) farm bill is 400,000 of it is coming from Lyheap (phonetic).

CHAIRPERSON CUMMINGS: Yes.

ATTENDEE 4: And yesterday we had -- it was on the news that Lyheap and -- Lyheap itself has money, but the crisis management is about a week and a half away from being --

CHAIRPERSON CUMMINGS: So I'm hearing we would like to go to the floor for this debate.

And maybe Robin, let's go quickly through.
That one is up in the air.
MS. LUNGE: What I can do is just try and incorporate as much of what I heard --
CHAIRPERSON CUMMINGS: Okay.
MS. LUNGE: -- to the extent that I can figure that out.
CHAIRPERSON CUMMINGS: And I think a couple --
MS. LUNGE: Including conflicts and --
CHAIRPERSON CUMMINGS: Yeah. You need to talk to Jamie Woodruff. She has a four-color thing she
prints (inaudible) what you said, what we hate, what they love.
MS. LUNGE: I'll see what I can do --
CHAIRPERSON CUMMINGS: Okay.
MS. LUNGE: -- in terms of incorporating language to sort of -- I think most of what you
heard in Section 12 was: We like it. We don't like it.
CHAIRPERSON CUMMINGS: Yes.
MS. LUNGE: And then there were some more specifics.
CHAIRPERSON CUMMINGS: The PBMs are ours. I think we can send, with some minor tweaking, that
confidentially down to health care because that's -- we'll just -- we'll see if we can tighten it up and then send it without prejudice because that -- you start getting into medical research, and that's not regulating health insurance, so -- which is our area. So I think we'll work with the PBMs, probably advertising.
ATTENDEE 4: Well, the advertising piece I'm just curious because I thought I heard the commissioner -- not the commissioner -- the AG's office, Julie Brill, state they already have the authority. So I'm just questioning whether --
CHAIRPERSON CUMMINGS: They can -- they have -- they can enforce under consumer fraud if -- but this is a federal rule. So I'm not clear about that. Maybe we need to have Julie --
MS. LUNGE: What I heard her say was that they believe they have a theory that would allow them to enforce under the consumer fraud act but I liked the clarity of having something specific.
The two suggestions I had on this: One is that right now it's in our current law in Title 18, and I think a lot of the concern is about actually more the current law than the new stuff, although not exclusively. But for instance --
FEMALE ATTENDEE 3: It's a little archaic.
MS. LUNGE: Exactly. And quite frankly, tackling that is a much bigger project than the limited extent that you were discussing it here. So the other option is to take it out of Title 18 and just clarify it in a consumer fraud like position, if you wanted to sort of clarify for the AG that they have the authority that they think they have.
(inaudible.)
MS. LUNGE: And get rid of all the references to --
CHAIRPERSON CUMMINGS: Okay.
ATTENDEE 4: That might -- that might work.
CHAIRPERSON CUMMINGS: That might work.
ATTENDEE 5: I don't know if the rest of the committee would be interested in this, but I could benefit from a memo on the current state of the law on the current interpretation of the interstate commerce clause (inaudible). And I don't know what --
MS. LUNGE: You're not going to get it by tomorrow, unless somebody else has already done it.
ATTENDEE 5: Also, I'm not sure if you want to be the one to do that.
MS. LUNGE: Right.
ATTENDEE 5: Whoever it is (inaudible).
CERTIFICATE

STATE OF FLORIDA  
COUNTY OF INDIAN RIVER  

I, Kristen A. Houk, Registered Professional 
Reporter and Florida Professional Reporter, do hereby 
certify that I was authorized to and did listen to CD 
07-51/Track 1, the Vermont Senate Committee on Finance 
meeting of Tuesday, February 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 28th day of August, 2007. 

Kristen A. Houk, RPR, FPR