STATE OF VERMONT
(SENATE COMMITTEE ON FINANCE)

Re: SENATE BILL 115

Date: Wednesday, February 21, 2007

Type of Committee Meeting: Prescription Drugs: Mark Up

Committee Members:

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Julie Brill
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CD No: 2007 – 54, Track 1
the purchasing consortium on page six and has some more evidence based language at the bottom of page six. And then on page seven, I modified the section about the organ project, so that Ova would seek assistance but not require a contract.

And I also -- I changed the language in the Department of Health section because I wasn't sure if they could get the information sooner helpful. At what your testimony was, was that Ova could get the information for free if they wait longer. So I first made that Department of Health gave them sort of more discretionary language and let them do it separately since there wasn't a money issue involved.

And I also made the description general. Since from entities conducting independent research in the effectiveness of prescription drugs and then gave the organ product as an example.

In section three, one of the -- some of the testimony from the attorney general was that it would make sense for the attorney general to be able to share information from the gift disclosures with the Department of Health for the purpose of the evidence based education program, solely for

represent actual decisions you've made yet; it's just been different discussion points where I thought maybe a little addition additional language might be helpful. So, with that caveat, we'll jump right in.

So, the first page is just a statement of purpose now, which is quite lengthy. So I'm going to start with page two. Page two, section one, is the Pharmacy Best Practices and Cost Control program. This is the section where Ova (phonetic) establishes a preferred drug list. You'll remember a lot of the changes in here were shifting from the statewide PDL concept to the joint pharmaceutical purchasing consortium.

So the first change on that is on page five where Ova had testified that there are some instances where they believe the drug pricing is not as affordable under the FQHC program as under Medicaid, so I tried to add the caveat that the plan would encourage the use when the prescription drug pricing was more affordable under that FQHC since that really was our point, I think.

Otherwise, I did not --

The next change is on page seven. The rest of the language that from the first version describes

the development of that program, the information would still remain confidential with the Department of Health. So the bold language in section three would do that.

And then I renumbered the old section for it to be 3A so I wouldn't have to renumber the whole bill.

3A is in that same section for the gift disclosures, and this was the section which where now would required disclosure of the continuing medication program to the extent described in lines ten through 13 on page nine.

In section four, this is the section which would require disclosure to Ova by manufacturers of certain prices. You can see on page ten the changes there. The subdivision three on lines four and five, which would also require that the disclosure of the price that each wholesaler in the state pays to the manufacturer is from the Texas law that you heard discussed.

And then B, the bold there is language from the Maine revision in 2005, which provided for summaries of the methodology in determining the prices listed above. And this language about the office makes up standards from the National Rebate
Agreement entered into by the United States HHS and I think it’s the federal site (inaudible) methodology (inaudible) or adopted some standards by rules. That’s from the Maine law, 2005 change.

And then --

UNIDENTIFIED MALE ATTENDEE: Can we go back up to --

MS. LUNGE: Please.

UNIDENTIFIED MALE ATTENDEE: Section four.

MS. LUNGE: Yes.

UNIDENTIFIED MALE ATTENDEE: Number three.

MS. LUNGE: Yes.

UNIDENTIFIED MALE ATTENDEE: (inaudible). Who is reporting that, the wholesaler or --

MS. LUNGE: The manufacturer, not the wholesaler.

UNIDENTIFIED MALE ATTENDEE: (inaudible).

MS. LUNGE: Right. Then in D, that section of the bill has the changes are in bold. There is testimony that in the Maine one 2005 they amended that section to also provide that a designated employee of the manufacturer could report and certified the prices in lieu of the chief executive officer or president, in Maine, they say that CEO or the chief financial officer. So they have two different people.

So that language and the language on the top of page 11 that's in bold, that the designated employee shall be an employee that reports directly to the chief executive officer or president, and who has been delegated to make certification under the section; that's also from Maine. They worded it slightly differently, but the structure of the sentence got a little too wordy so I modified the structure, but the context is the same.

And then the rest of the section talks about when -- that the information would remain confidential with Ova and gives enforcement to the attorney general.

Healthy Vermonters, I didn’t make any changes in that. It sounds like Ova will be bringing suggestions to setting them up more on that issue.

In the PBM regulation section, pretty much, after looking over my notes, pretty much the only thing that I did in this section was make changes to either conform the terms to terms we use elsewhere in Vermont, and I only did that in one place, or conform the language to the most recent version of the Maine law, because I think a lot of the suggestions that you heard probably had more to do with should this stay in or out, and I didn’t receive specific language changes from anyone although Bishka (phonetic), I think, has some that they’ll be bringing into you later.

So I thought instead of attempting to do that finessing without the assistance of the PBMs and the other folks involved, I would just muddy the water. So, with that caveat --

UNIDENTIFIED MALE ATTENDEE: On one -- under the enforcement section (inaudible) --

MS. LUNGE: Yup.

UNIDENTIFIED MALE ATTENDEE: On the bottom of page 17 and the top of 18, I’m not sure -- I’ve got this confused with the section, if appears to remember if I remember correctly, (inaudible) authority that this was clarifying for them, she was okay with it, was -- if I understood her correctly, you said it really didn't matter; she thought they still had the authority. But then I thought we heard yesterday when you call (inaudible) that they wanted it clear that they could use the primary or first responder, so to speak --

MS. THABAULT: Right.
MS. THABAUT: At 2:00? Well, it's 20 after
so -- I was hoping they'd be here to work us
through some actual wording.

MS. LUNGE: And I do have their -- I do
have -- Herb did e-mail me their suggested changes
but he didn't distinguish where he made the
changes. So in order to tell that, I would need to
sit down and go through word for word to compare to
see where the changes are so --

MS. THABAUT: He just retyped them and did
not highlight his change or underline his changes
so we have to -- which is standard drafting
procedure (inaudible). So, yeah, yeah, 1:00 this
afternoon, we can just sit down in (inaudible) bill
and go through word for word. So we're hoping,
planning, on him to show up and go (inaudible).

MS. LUNGE: Do you want me to explain what I
did more or --

MS. THABAUT: Yeah.

MS. LUNGE: Okay. So the language from bold
on page 13 then, in our current definition of
health insurer that's referenced, we include third
party administrators but there's no mention of the
employer itself. And since the point of this
provision is to pass the information back to the

person who is sponsoring the health benefit plan
whether that's the insurance company or the
employer, it makes -- the Maine law had included
the employer in this exact language that you see,
except of course it's in Maine instead of Vermont.

So I -- that would more closely follow the Maine
language.

On page 14, I added chronic care because in
act 191 last year we did not use the term disease
management program, we used chronic care management
program so that would encompass both existing
disease management concepts as well as newer
chronic care concepts that you had started work on
last year.

And then I think I mentioned yesterday, in the
original version throughout it mentioned that
health plan; and the health plan is the contract,
not the entity. So there are a number of places
where I put insurer instead of plan. So any place
where you see insurer is highlighted, that's what I
did.

MS. THABAUT: Okay. And you say plan is
(inaudible).

MS. LUNGE: Since this is all new language --
I think just took it all out for me.

MS. THABAUT: Okay.

MS. LUNGE: And that's the only change I made
in this first section.

I did take a stab at the middle ground I
described yesterday in section seven where --

MS. THABAUT: I was just looking at the
enforcement and it says in addition to any remedy
provided to the commissioner under this title, so
that's the commission of Bishka, right?

MS. LUNGE: So the way the enforcement works
in this version is that it gives basically
concurrent jurisdiction to both Bishka and the AG,
meaning that Bishka has its regulatory authority
as the entity that does licensing and regulation of
insurers. And so they have their statute set forth
their enforcement powers, which are administrative
actions. And that kind of thing and the AG has
their authority under the consumer fraud act which
is more narrow, I think, than Bishka's general
regulatory authority and enforcement.

UNIDENTIFIED FEMALE ATTENDEE: (inaudible).

MS. LUNGE: So it does allow for the
commissioner and the AG to bring joint enforcement
actions in the current version.

UNIDENTIFIED FEMALE ATTENDEE: This is draft
from two?

MS. LUNGE: 2.1.

UNIDENTIFIED MALE ATTENDEE: 2.1.

MS. LUNGE: But if you see no bold, there are
no changes from the first draft.

MS. THABAUT: One of the notes I have, and I
believe it was in PBM's, was they hate the the
consumer fraud private right and action. I want to
make sure that it was the health insurer who had
the private right of action, not any member of the
public.

MS. LUNGE: That's -- I'm not an expert in the
consumer fraud act but that's my understanding,
that under the consumer fraud act, I can't just sue
because I'm a member of the public. I could only
sue if I'm a consumer in relation to, you know --
in relation to the seller and I'm personally
affected.

So I think in this case we're talking about,
to me, I think that's the insurer because the
insurer has the contract with the PBM.

MS. THABAUT: Okay. Could an individual
state employee sue the state employee's insurance
company's PBM?

UNIDENTIFIED MALE ATTENDEE: (inaudible).
MS. LUNGE: I don't think so because I can double check that while you're hearing other testimony this afternoon.

MS. THABAUT: Okay, yeah.

MS. LUNGE: But I think -- I don't think so but I will double check that. I think it has to be a contractual relationship and the --

MS. THABAUT: The one step removed from the (inaudible).

MS. LUNGE: Right. The individual doesn't have a contract with the PBM.

MS. THABAUT: Right, the insurance company does?

MS. LUNGE: Right.

MS. THABAUT: Okay. I think that will alleviate some of those...

MS. LUNGE: And it's also a little hard -- I don't think they -- maybe I don't understand the complexities of the relationship thoroughly, but I don't see how the consumer themselves will be harmed because the consumer, meaning the beneficiary of the health plan. So I have a set co-pay or whatever. I have -- my benefit is defined by my contract with the insurer and what the insurer is paying the PBM, you know, and what

price the PBM is negotiating for the insurer, I don't know that that would necessarily affect me, that employee.

MS. THABAUT: Okay. Unless I maintain I can't get my green pill because they have a rebate to get my purple pill.

MS. LUNGE: But that was a benefit's coverage issue and your contract would address how you can grieve that kind of decision but that still doesn't have anything, I think --

MS. THABAUT: Okay.

MS. LUNGE: -- vis-a-vis the PBM.

UNIDENTIFIED FEMALE ATTENDEE: In what paragraph is this, the individual's right of action?

MS. LUNGE: I think people are reacting to the language on page 18, line three where it says the remedies available to the attorney general in private parties to enforce the consumer fraud act. That doesn't give a broader right of action than what the consumer fraud act does, in my reading of the action. I think all that does is just say if you can do it under the consumer fraud act, you can do it under the consumer fraud act. It's not, in my mind, saying that additional people would have a right of action under that.

MS. THABAUT: We're going to see if we can get the attorney general (inaudible), see what that is, okay.

MS. LUNGE: Okay?

MS. THABAUT: (inaudible).

MS. LUNGE: Okay? Any other questions on what I -- on that section or what's in that -- do you want -- should I since -- I know this is going to be a section you're discussing. Would it be helpful if I went through in more detail?

UNIDENTIFIED MALE ATTENDEE: Yes.

MS. LUNGE: Okay. Then I'm going to start on page 13, beneficiary of the new draft, line 12, beneficiary is the individual enrolled in the health plan; so that would be the employee. Health insurer we defined under one of our existing health insurer definitions and, then just to be clear, I added this language for Maine and also this language makes it clear that the state of Vermont is included.

UNIDENTIFIED MALE ATTENDEE: The bold is from you?

MS. LUNGE: The bold is from me.

MS. THABAUT: And these are basically the (inaudible) group?

MS. LUNGE: Well, it would be health insurers, self insured employer -- employer, excuse me.

UNIDENTIFIED FEMALE ATTENDEE: Union?

MS. THABAUT: Yeah, union (inaudible), those would all be the self included (inaudible)?

MS. LUNGE: Right.

MS. THABAUT: Basically, we're picking up, or just --

MS. LUNGE: Or associations.

MS. THABAUT: Yeah.

MS. LUNGE: Yeah. It also includes Medicare from what (inaudible) in our other public programs, the state employees, third party administrators. The very -- I think it tried to capture the various entities who would be contracting with a PBM. It's broader than our normal common usage of the term insurer.

Health plan means the benefit plan, offered, administered or issued by health insured doing business in Vermont. Privacy benefit management is an arrangement for procuring prescription drugs at a negotiated rate for dispensation within this state to beneficiaries or the administration or management of prescription drug benefits under a
health plan or any of the following services with
regard to administration of benefits, including
mail service pharmacy, claims processing, retail
network management, payment of claims, clinical
formulary development and management rebate
contracting and administration, certain patient
compliance therapeutic intervention and generic
substitution programs, and disease or chronic care
management programs.
Pharmacy benefit manager meets an entity that
performs pharmacy benefit management. That term
would include the person or entity acting
(inaudible).

UNIDENTIFIED FEMALE ATTENDEE: (inaudible)
thing in grade school.
UNIDENTIFIED MALE ATTENDEE: (inaudible).
UNIDENTIFIED FEMALE ATTENDEE: (inaudible).
MS. LUNGE: This is the law, it's not good
writing.
UNIDENTIFIED FEMALE ATTENDEE: Yeah, okay.
MS. LUNGE: And so it includes also those in
contractual or employment relationships with PBM --
UNIDENTIFIED MALE ATTENDEE: We did raise the
standard, you know. That's not bold or --
MS. LUNGE: That -- the standard is in 9472A1,

which is on line six, page 15. This standard is
discharge the duties of care, skill, prudence and
diligence under the circumstances. I didn't change
that language.

UNIDENTIFIED MALE ATTENDEE: Oh, okay.
MS. LUNGE: The only difference for Maine is
that in the first sentence they say the PBM shall
have a fiduciary duty and then they go on to
describe what that means in subdivision one and I
don't think you actually -- you could add that
term.

UNIDENTIFIED MALE ATTENDEE: No.
MS. LUNGE: -- fiduciary duty, but it's not
necessary because you have the standard of the duty
in one.

UNIDENTIFIED MALE ATTENDEE: (inaudible).
MS. LUNGE: The duty is owed to the health
insurer contracting with the PBM.

UNIDENTIFIED MALE ATTENDEE: (inaudible).
MS. LUNGE: So the insurer or the employer.

So if you're PBM and I'm the insurance company and
I have a health benefit plan and you're going to
manage my pharmacy benefit, you owe a duty to me
because I'm hiring you to operate or administer the
benefit plan that I'm providing to the senator to

my right.

UNIDENTIFIED MALE ATTENDEE: (inaudible).
MS. LUNGE: Right, because the contract is
between you and me. And then I have a contract
with my beneficiaries.

UNIDENTIFIED MALE ATTENDEE: (inaudible).
MS. LUNGE: Right.
So under 94721 is the duty to operate with
care, skill, prudence and diligence, and basically
sets a reasonable person or reasonable PBM
standard.

UNIDENTIFIED MALE ATTENDEE: Can we go back to
number five?
MS. LUNGE: Sure.
UNIDENTIFIED MALE ATTENDEE: I just want to
make sure I understand this. I'm reading it over
and over and over again and I'm not sure I
understand it.

MS. LUNGE: Okay.
UNIDENTIFIED MALE ATTENDEE: It says pharmacy
benefit manager, which is identifying who the
pharmacy benefit manager is --
MS. THIABAUT: What it is.

UNIDENTIFIED MALE ATTENDEE: What it is, means
an entity that performs a pharmacy benefit

management. And then it says the term includes a
person -- the term, so we could say pharmacy
benefit manager includes a person or entity acting
for a pharmacy benefit manager. Is that right?

UNIDENTIFIED MALE ATTENDEE: Management for a
health plan.

UNIDENTIFIED MALE ATTENDEE: I'm just -- it
says --

MS. LUNGE: Yeah, I see what you're saying
because it's sort of circular.

UNIDENTIFIED MALE ATTENDEE: The reason it
says the pharmacy benefit manager is included, the
person acting for a pharmacy benefit manager, what
does that mean?

MS. LUNGE: Well, we could --

UNIDENTIFIED MALE ATTENDEE: It's the
designee.

UNIDENTIFIED FEMALE ATTENDEE: It would be the
person that works for the company.

MS. LUNGE: I could --

UNIDENTIFIED MALE ATTENDEE: May be it's
right. I'm just saying I don't understand -- on
the face of it, it doesn't sound right because
you're repeating it --

UNIDENTIFIED MALE ATTENDEE: It could change
MANDATORY --

MS. THAUBALT: So if I --

MS. LUNGE: -- in this provision.

MS. THAUBALT: So if I send out an RFP --

MS. LUNGE: This is after you have a contractual relationship. So this is after you've already sent out the RFP and made your arrangements.

MS. THAUBALT: (inaudible) there is something going on, there's been some press stories, you have a right to go back and say I would like this information.

MS. LUNGE: By request, regardless of what type of contract you decided upon initially.

MS. THAUBALT: Okay.

MS. LUNGE: Okay? So --

MS. THAUBALT: So, initially, this doesn't change anything. You can still go for an RFP, they submit their price for what you ask for, they are (inaudible) I've got all these other things. But if six months into the contract things are not working out the way you wanted, you really feel you didn't know a little bit more about rebates or --

MS. LUNGE: Then you could request that information.

benefit management, I think we're okay, and we get out of our -- defining ourselves.

UNIDENTIFIED MALE ATTENDEE: Thank you.

MS. LUNGE: -- through ourselves.

MS. THAUBALT: Yeah, that works.

MS. LUNGE: Okay, 9472. I think we discussed one. Two, this is the section that would require the PBM to provide all financial and utilization information requested by health insurer relating to the provision of benefits to beneficiaries through that health insurer's health plan. So I can ask for my information relating to my health plan that the PBM is administering. I can't ask for information about Senator Heir's (phonetic) health plan.

MS. THAUBALT: Okay. The individual or the health --

MS. LUNGE: The insurer.

MS. THAUBALT: The insurer, okay. So Senator Heir and I are both insures and we both have contracts with Senator McCormick for pharmacy benefit management. I can get my information, I can't get her company's information. And it says requested by the health the health insurer.

MS. LUNGE: Yeah. So this information is not
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| 1 disclosure would be under court filing or if the court ordered it for good cause. Think, although I --
| 2 Three, this provision is not by request, so Three, this provision is not by request, so
| 3 this is one of the mandatory provisions that a PBM would notify the health insurer in writing of any proposed or ongoing activity policy, et cetera, that would be a conflict of interest. Three, this provision is not by request, so
| 4 Four is also a mandatory requirement, and that Four is also a mandatory requirement, and that
| 5 sets up certain drugs substitution provisions. So, sets up certain drugs substitution provisions. So,
| 6 with regard to substitutions in which the substitute drug costs more than the prescribed drug and any benefit or payment directly or indirectly to the PBM as a result of the substitution. So this applies when the substitution would cost more than the prescribed MS. THABAUT: Okay. So if we're going to put in green pill instead of the purple pill and the green pill costs more --
| 7 MS. LUNGE: Yes.
| 8 MS. THABAUT: -- of the AWP or whatever level they're using, they have to disclose, we're doing this because we get a rebate for putting in the green pill or the purple pill or whatever color? UNIDENTIFIED MALE ATTENDEE: The more expensive.
| 9 MS. THABAUT: -- the more expensive pill, at which point -- all right, you know that. That doesn't mean you don't have a pass through, you can't do too much about it. MS. LUNGE: Well, in B, B also requires the pass through. So it would require transfer to the health insurer in the event for payment received in any form of PBM. As a result, it's substituting the higher price for the lower priced drug in A.
| 10 MS. THABAUT: Okay. So, if I've got a contract and it says will pass through 20 percent or 50 percent of our rebates, does this override the MS. LUNGE: I think it would override the contract to the extent that we're talking about this sub -- this particular type of substitution.
| 11 MS. THABAUT: Okay. MS. LUNGE: So if the contract provided for a 20 percent pass through if you use drug A, that would happen -- wouldn't override it in that type of a situation unless drug A was more expensive than drug B and there was a substitution. So that would be on a claim-by-claim kind of basis, I would come out with transparency -- if suddenly X becomes Y and they have a right of substitution in the contract and suddenly rather than 10 cents a pill you're paying $1 a pill to use, that's where the whole discussion of fiduciary has come into whose benefit are you working for? Are you working for the benefit of the customer, the health insurance company; are you working for the benefit of the pharmaceutical company or you working to line your own pockets, because as rumor has had it, X becomes Y, all the people in that health plan are paying more for their pharmaceuticals and the PBM is making more money. And so this says you can't cut those -- you can't charge us more money, you know, unless you -- if -- without telling us why you're doing that and sharing it with us. UNIDENTIFIED MALE ATTENDEE: Okay, but if you use -- and I just -- to your use your example, the original example, the contract requires 20 percent of the rebate to be passed through and the PBM could do that, could switch, substitute a different drug, give you your 20 percent and have a lower cost in the original drug. UNIDENTIFIED MALE ATTENDEE: Only if it was less than 25 percent higher than the other drug.
John Matthew back here, who is a doctor here in Plainfield, to talk about, you know, some things that are really simple and really cheap that do just as well as we really knew things. The best thing I ever heard for being congested was to hang over a tea kettle. It works well as most of those decongestants.

UNIDENTIFIED FEMALE ATTENDEE: But third degree burns really mess you up.

MS. THABAULT: You have to be careful but it really does work.

You know, and that’s it. These aren’t individual business plans. This is a general philosophy of how this should be exposed. You can’t cut side deals.

UNIDENTIFIED MALE ATTENDEE: All I’m saying is I think this precludes a PBM from saving an insurer some money because there’s going to be no reason for them to do this if what they’re doing is just passing on the entire amount to you. I mean, I’m talking about where you have a contract and you described as 20 percent of the rebates go back to the insurer --

MS. THABAULT: Right.

UNIDENTIFIED MALE ATTENDEE: Then now you’re doing the rebates unless they are assuming that the bulk of the folks that gets switched to the pink pill are going to stay on that more expensive pill, even though the green pill they were taking the year before may have been just as effective. And that’s been part of the concern about the escalation. The escalation goes up -- you know, it’s a lost leader. We give you money so we get you all hooked up on our pill, and then the next year we go up to another pill, but you all been elevated. (inaudible). The next year we elevate you ten more cents a pill on something else, and it’s a continuing building.

And this is meant to say you can’t substitute that without telling him passing through the market share or the thing. And we may want to say telling and sharing the rebate with folks. And we can do that. We don’t want to --

But the deal is the push is to make people take more expensive -- newer, which are generally more expensive pharmaceuticals, not -- and that’s why we’re trying to go to the effectiveness phase.

MS. LUNGE: Evidence phase.

MS. THABAULT: -- the evidence phase, because it -- there’s nothing. We probably should have saying, well, if you try to switch me from one brand to another brand, from a green pill to a pink pill, then I get 100 percent of that rebate, then there is -- you’ll never get that opportunity because he has no reason -- the PBM would have no reason to put you onto that other pill (inaudible).

MS. THABAULT: It always begs the question why would you want to go on the other pill anyway even though it’s new and expensive. I mean, that’s --

UNIDENTIFIED MALE ATTENDEE: Well, that’s because --

MS. THABAULT: I mean, that’s the dynamic that’s set up, is we’re always switching you to pills and there isn’t necessarily any evidence that this pill is better. Sometimes you can just take two of the old pill or they’re time released or -- they don’t necessarily cure the common cold any better than anything last year.

UNIDENTIFIED MALE ATTENDEE: To answer Senator (inaudible) question, what is the incentive to PBM to look for the ways to save money. PBMs are in business also. (inaudible), isn’t it?

UNIDENTIFIED MALE ATTENDEE: I think the PBM is in business, too.
MS. THABAULT: Right, but the PBM is being paid to do this management, okay? They're being paid to look after the interest of their customers. If they're cutting side deals or making more money, or almost more money, from somebody else and the customer doesn't know about it, you know, I go into a store and I want to buy a shirt and they're really pushing me and telling me how great this shirt looks on me, I need to know, you know, do I believe them? Probably. Unless -- it makes a difference if I find out they're getting you, know paid, 50 percent of that, a bonus to push this style of shirt because it's manufacturer that got stuck with a whole lot of orange shirts they can't get rid of, and that there's a side deal with the manufacturer. That's the issue.

You're getting paid for this contract and your cost. And what you're getting paid for is to get the best price for your customer. That's -- and you figure you're costing me a contract. You don't cut a side deal.

UNIDENTIFIED MALE ATTENDEE: What's (inaudible) he's going to (inaudible) or not and there is (inaudible).

UNIDENTIFIED MALE ATTENDEE: Yeah, I hate to ask this but it seems like we need to step back on this whole section. We're talking some very sophisticated buys. We're turning to eight pages, their contract is going to be probably 100 pages.

And I just don't know that the whole -- what we're trying to do is going to work. We keep digging the hole, and when you've got big company against big company and the outcome is to save money and for the other company to make some money, they're going to work it out. They've got Philadelphia lawyers that are going to write a contract that we haven't even seen yet and it's going to cover everything we're trying to cover. And so I -- I keep coming back. We're just making some lawyer someplace more money.

MS. THABAULT: Yeah, this industry has progressed or transformed itself.

UNIDENTIFIED MALE ATTENDEE: (inaudible).

MS. THABAULT: There used to be (inaudible) to drug company.

We may want to say if you're cutting a side deal and that's why you're pushing this pill, you have to tell us and then the Philadelphia lawyers work it out.

UNIDENTIFIED MALE ATTENDEE: Yeah, something that straightforward as opposed to trying to beat them at their own game.

MS. THABAULT: Yeah. Okay, I don't want to talk about medical mal anymore (inaudible).

UNIDENTIFIED MALE ATTENDEE: I can tell you what they said.

MS. THABAULT: Okay. So can we agree that we'll just take out you have to pass through the whole thing and just -- you've got to tell us. If you're going to substitute a more expensive drug, tell us because we're getting a really good deal, and then trust that your lawyer will say, yeah, but that's changing the contract, thank you very much, okay? (inaudible) or we don't contract with you next time.

We've got some puzzled looks. This thing is not coming out today.

UNIDENTIFIED MALE ATTENDEE: (inaudible).

MS. THABAULT: (inaudible) I understand that.

UNIDENTIFIED MALE ATTENDEE: (inaudible).

MS. THABAULT: What you do with the transparency, we're not going to -- I tell you if you are inclined to say, yeah, okay, that's fine.

UNIDENTIFIED FEMALE ATTENDEE: So we're going to stick with this (inaudible).

MS. THABAULT: Yeah.

UNIDENTIFIED FEMALE ATTENDEE: And take out subdivision 4A, just the A, keep the text, and then delete subdivision B in its entirety. And I'll make 4 just be one paragraph.

UNIDENTIFIED FEMALE ATTENDEE: Okay, that works.

MS. LUNGE: Subdivision five, this section addresses when pharmacy benefit managers derive any payment or benefit for drugs based on volume of sales for certain drugs or classes or brands of drugs, that that payment or benefit would be passed on to the health insurer unless the contract provides otherwise. So that leaves the negotiation option open.

Six, disclose to the health insurer all financial terms and arrangement for remuneration of any kind between the PBM and the manufacturer, including formulary management and drug switch programs, educational support, claims processing, pharmacy network fees and data sales fees.

Again, this information can be designated as confidential and must remain confidential with the health insurer, unless they have consent to the PBM.
or it's under a court filing or ordered for good
cause.

MS. THABAULT: I'm trying to preserve my
committee to (inaudible) from under me.

Is this the area where people wanted to add
unless provided -- unless provided for an contract
and not provided for in the contract, is this one
of the Bishka?

MS. LUNGE: Yes.

MS. THABAULT: Okay. Committee, what do you
think about that, because this would seem to
(inaudible) I just want 20 percent off, don't
bother me contract.

MS. LUNGE: Right, this would be the issue --
this would be the issue of the person who doesn't
want -- you heard some testimony that if I want all
the information, I can contract to get all the
information. If some of the insurers maybe don't
want the information, that's -- this section has to
do with, again, disclosing information and it
doesn't require the pass through, that the pass
through part is still left --
UNIDENTIFIED MALE ATTENDEE: Available.
MS. LUNGE: Right, available through the
contract but this is the section that required a
bunch of information being provided so that --
UNIDENTIFIED FEMALE ATTENDEE: This is number
six, right?

MS. LUNGE: Number six, yup.

So it's a broader set of information than what
was covered and what you just discussed in four.
Four was just the drug substitution information.
This is a broader kind of information provision.

UNIDENTIFIED FEMALE ATTENDEE: So what was the
question Robin; did we answer it?

MS. LUNGE: Do you want to allow this -- right
now, this provision would be a mandatory provision.
You could also add language that allows for
contracting around it similar to what --
UNIDENTIFIED MALE ATTENDEE: Unless between
the contractor between the pharmacy benefit manager
and health insurer provides otherwise.

MS. LUNGE: Exactly, the bottom of 16 and 17.
UNIDENTIFIED MALE ATTENDEE: Right. I think
we should put that in there. (inaudible) if I
remember correctly, (inaudible) requesting that we
put it in (inaudible).

UNIDENTIFIED FEMALE ATTENDEE: So adding that
language takes care of that?

MS. LUNGE: It basically allows for the

parties to contract around it if it's not what they
like.

MS. THABAULT: That one says (inaudible)
contract.

MS. LUNGE: No, six we're talking about that.
UNIDENTIFIED MALE ATTENDEE: We're adding that
language to six.

MS. THABAULT: Okay, yup.

MS. LUNGE: Okay? Compliance with the
requirement of this section is required in all
contracts for pharmacy benefit management entered
into in this state, by a health insurer in this
state. So that's meant to limit it just to
in-state activity.

9473 --
UNIDENTIFIED MALE ATTENDEE: What does the
health insurer end of state mean?

MS. LUNGE: It would be --
UNIDENTIFIED MALE ATTENDEE: Domiciles in the
state?

MS. LUNGE: Well, for an actual -- for a
health insurance company, Bishka has rules about
what health insurers they regulate as being in this
state. For employers, I think it would probably be
a domicile test. It's going to depend on --

9473A allows for a violation of the subchapter
to be enforced through the consumer fraud act, and
B provides for Bishka's determinations in actions
under the consumer fraud act to be given
presumption of the validity if it's a
interpretation or administration.

UNIDENTIFIED FEMALE ATTENDEE: Could you
repeat that? Allows Bishka to be...

MS. LUNGE: It allows Bishka the
interpretation and the administration of this sub
chapter any rules that they promulgate to be given
a presumption of validity in a consumer fraud
action. The AG and the commissioner shall consult
with each other prior to the commencement of any
investigation or enforcement action, the
commissioner may enforce a violation under 9412 of
title 18, which is Bishka's enforcement authority
provision, and also the commissioner and the AG may
UNIDENTIFIED FEMALE ATTENDEE: That was the compromised language from (inaudible). MS. LUNGE: I believe so. UNIDENTIFIED MALE ATTENDEE: Does this preserve the commissioner's number one standing in this relationship to this paragraph? MS. LUNGE: What it will do is give the entities the ability to act two different ways. So it allows Bishka to pursue their enforcement through their regulatory system, but it also allows the AG to have enforcement authority to consumer fraud act and does also provide for some consultation in working together on the issue. So it allows for two different tracks.

MS. THABAULT: We are assuming that they will work cooperatively together. UNIDENTIFIED MALE ATTENDEE: It just seems like -- it seems like captain of the team is switching places through the paragraph.

MS. LUNGE: Well, I think it depends on sort of which way you look at it because it's absolutely true that Bishka has the regulatory authority over this area. They have not, to my knowledge, brought lawsuits in this area. The attorney general's office has current investigations on PBMs, so this sort of preserves, I think, kind of the way things have been happening under existing law. So each of them have sort of their purviews in this area that they have within operating under and I think this language sort of tries to kind of keep the status quo on that while also recognizing that there may be a need for them to work together and pursue things --

UNIDENTIFIED MALE ATTENDEE: (inaudible) contracts where there are too afraid to (inaudible).

MS. LUNGE: Uh-huh.

UNIDENTIFIED MALE ATTENDEE: -- so they have to appoint a third one.

MS. LUNGE: Right.

UNIDENTIFIED MALE ATTENDEE: And I'm looking for (inaudible).

MS. LUNGE: Yup. Section seven, are we ready for section seven?

MS. THABAULT: I think so.

MS. LUNGE: Okay.

UNIDENTIFIED MALE ATTENDEE: I still question do we still need question six.

MS. LUNGE: That's not a question for me.

UNIDENTIFIED FEMALE ATTENDEE: (inaudible).

MS. THABAULT: I'm trying to get a hold of the attorney general. Her testimony was, yes, where many of the customers now are sophisticated, some are not. You still have small group, you know, employer groups, associations, doing contracting that may or may not be sophisticated. I'm hoping you get this to a point where you're saying this is the general principal. If you have an administrative only contract but if you have a (inaudible) information you need to tell us certain things, and that is why you're substituting, what's going on. They may be out of the woods, they may not.

If there's only three of them that hold the lion's share of the market, that's somewhat concerning. I know it's concerning (inaudible). I don't think it's as necessary as it was when they were owned by (inaudible).

UNIDENTIFIED MALE ATTENDEE: Oh, yeah.

UNIDENTIFIED MALE ATTENDEE: I think that's question, is how much has the world changed since this stuff started to happen, and are we really just behind the times now. And maybe its not (inaudible) I don't know the answer to that.

UNIDENTIFIED MALE ATTENDEE: Are you disclosing anything, then this won't be a problem. If they're not disclosing something, then you'll have a problem.

MS. THABAULT: And they get the complaint, so, you know, that's what I know. I don't know.

Is there anything in here that we don't feel should happen that a good (inaudible) kind of a business arrangement that we're putting something in here that we don't think you should do anyway, then we could come --

UNIDENTIFIED MALE ATTENDEE: It says right in the middle the attorney general and commissioner shall consult with each other prior to commencement of any investigation when the insurance department is doing the investigations all the time. All of a sudden they could be doing an investigation outside of this whole purview and then forget to call the attorney general, you know, of when they get this kind of a situation.

UNIDENTIFIED FEMALE ATTENDEE: There are only 40 PBMs in the entire country. There can't be that many investigations going on.

UNIDENTIFIED MALE ATTENDEE: It's a lot of
know what the rates are for the information for that, too. So that kind of tries to balance those
two competing testimonies that you were hearing
about whether or not this is necessary versus
making sure that somebody who is less sophisticated
has information for their options. And I would --
I'm sort of assuming that just on notice would be a
lot simpler than doing a full...

UNIDENTIFIED FEMALE ATTENDEE: Just an extra
piece of paper with (inaudible) kind of thing.

MS. LUNGE: Right, or it could be something
bold in at the top. You also have the right to
request this kind of a contract if you would like.

And then the rest of the additions here -- the
language in this section I changed to reflect the
term that we had used in the previous section so
that they were the same. So that's the -- a bunch
of the changes.

And then I also just, at the bottom, in terms
of health insurer, I used the same definition that
we had used previously instead of typing it all out
again. And on page 21, the reference, I think, was
incorrect. It was to a different subdivision than
the correct one. I think that's what I did in that
section.

say yes, no and maybe, okay.

MS. LUNGE: So section seven, 9421A provides
for the registration of pharmacy benefit managers
with the commissioner of Bishka.

Sub section B on page 19 --

UNIDENTIFIED FEMALE ATTENDEE: Oh, I guess
that's where I am, I'm sorry. Proceed.

MS. LUNGE: -- talks about the issue that was
discussed in terms of the RFP process. So what I,
basically, wanted to illustrate in this section was
that the current language provides that the PBM
would be required to offer the quotation for
administrative services only contract for each RFP.

The changes I made sort of reflect a second
option for you, which would be that the PBM would
notify an insurer that a quotation for an
administrative services only contract is available.
So if you're a big sophisticated insurer or
employer and you know all your different options,
you could just say, yeah, yeah, I knew what I was
talking about in my RFP, I don't want that. And if
you were a less sophisticated employer insurer and
you didn't really know your options when you did
your RFP, this would -- and you said, oh, well I
didn't know that was an option. Yes, I'd like to
evidence based program.

MS. THABAULT: Well, one the concerns was that
by putting argument in the statute --
MS. LUNGE: Oh, right. I can duplicate that
language.
UNIDENTIFIED FEMALE ATTENDEE: Such as?
MS. LUNGE: Yup. I'll mirror that language
from the earlier section. I just didn't think to
do that.
MS. THABAULT: I don't know why, you have so
little to think about.
MS. LUNGE: Mirror language (inaudible), okay.
Section 12 is the prescription drug data
confidentially section. A is a general finding and
purpose section. The definition start on page 24.
The first definition is for commercial purpose and
defines commercial purpose as advertising,
marketing, promotion or any activity that is
intended to be use or used to influence sales or
the market share of the pharmaceutical product
influence or evaluate the prescribing behavior of
an individual healthcare professional, market drugs
to patients or evaluate the effectiveness of
professional pharmaceutical detailing sales force.
Electronic transmission intermediary is an

entity that connects either through computer
systems or electronic devices, healthcare
professionals, prescribers, pharmacies, facilities,
PBM, insurers, et cetera, et cetera.
Healthcare facility has the same meaning as in
9402. Healthcare professional has the same meaning
as in 9402. Health insurer has the same meaning as
in 9410. These all reference are current
definitions.

Prescribers is a new definition on page 25.
An individual allowed by law to prescribe and
administer prescription drugs.
Regulated records means information or
documentation from the prescription written by a
prescriber doing business in Vermont or a
prescription dispensed in Vermont. So that's meant
to, again, to sort of address those (inaudible)
where we're just trying to regulate Vermont based
stuff.
C is the general prohibition, and it provides
that a health insurer, self insured employer,
electronic transmission, intermediary, pharmacy or
other similar entity shall not (inaudible) use or
sell regulated records, which include prescription
information containing patient identifiable and

prescriber identifiable data for any commercial
purpose.
So that's the limitation on the license
transfer or use or sale for a commercial purpose.
MS. THABAULT: Okay. And we've had this
discussion. There's been some discussion of doing
an opt in with the AMA. How much legal authority
do we have over the AMA?
MS. LUNGE: I guess I'm not sure if the AMA is
doing business in Vermont, which will probably be
the key question. But I believe they're a national
organization. I don't know if they have specific
chapters in states. But to the extent that they're
pretty much outside of the state of Vermont, we
have limited authority to tell them what to do.
UNIDENTIFIED FEMALE ATTENDEE: (inaudible)
information on our (inaudible).
MS. LUNGE: Well, if they're not in Vermont,
we can't tell them what to do regardless of whose
information they're selling. What we could do is
tell the self insurers, the self insured employers,
the pharmacies in Vermont you can't sell your
information for commercial use.
So you'll remember to this, the match involves
two parts. There's the match from AMA which has
the list of doctor with their prescriber number and
then there's the prescription information which
has doesn't have the doctor's name but has the
number, I guess. So you need both parts in order
to match them. We don't have control over this
part; we do have control over this part.
MS. THABAULT: Right. And the other argument
is the docs that don't want their detailer or don't
want any (inaudible) trying to get information as
to how extensive that fan is, putting himself on
the opt out for the AMA, what the result will be,
and does that accomplish what we want it to
accomplish.
UNIDENTIFIED MALE ATTENDEE: We don't have any
control over it, (inaudible).
MS. THABAULT: Well, they're already doing it.
And...
CERTIFICATE

THE STATE OF FLORIDA,
COUNTY OF PALM BEACH.

I, Jeana Ricciuti, Notary Public, Certified
Shorthand Reporter and Registered Professional
Reporter do hereby certify that I was authorized to
and did listen to CD 07-54/T1, the House
Committee on Health Care, Monday, August 27, 2007
proceedings and stenographically transcribed from
said CDs the foregoing proceedings and that the
transcript is a true and accurate record to the
best of my ability.
Dated this 28th day of August, 2007.

Jeana Ricciuti, RPR, FPR
STATE OF VERMONT
SENATE CHAMBER
STATE COMMITTEE ON FINANCE

RE: SENATE BILL 115.
DATE: WEDNESDAY, FEBRUARY 21, 2007
TYPE OF COMMITTEE MEETING: PRESCRIPTION DRUGS: MARK
UP. CD 55/ T1 & T2

COMMITTEE MEMBERS: ROBIN LUNGE, LEGISLATIVE COUNSEL
JULIE BRILL, ASSISTANT ATTORNEY GENERAL, ATTORNEY
GENERAL'S OFFICE
ED MILLER, LOBBYIST, VERMONT POLICE ASSOCIATION
STEVE TRUMBELL, LOBBYIST, IMS HEALTH
MADELEINE MONGAN, VERMONT MEDICAL SOCIETY
PAULETTE THABAUT, COMMISSIONER, DEPARTMENT OF
BANKING, INSURANCE, SECURITIES AND HEALTH CARE
ADMINISTRATION
HERB OLSON, COUNSEL, DEPARTMENT OF BANKING,
INSURANCE, SECURITIES AND HEALTH CARE
ADMINISTRATION
CHARLES STORROW, LOBBYIST, EXPRESS SCRIPTS
CD 07-TRACK ONE

SENATOR CUMMINGS: I think we're going to let Robin walk through and then we're going to take a short break, and then we'll come back and I know there's people that want to testify on this. We may just end up doing this and not anything else today, because I'd like to get through it.

Okay.

MS. LUNGE: So again there are two parts to this. There's the definition of commercial purpose which is one limitation on which data can be used, but then there's also an exception in D which has several examples which I think arguably are within that definition or what I should say is outside that definition of commercial purpose and one clear exception to the definition of commercial purpose. So I didn't do a whole lot in this section, although I made a few suggestions. I took the or as otherwise provided by law and moved it. So, even though that's struck, that's actually moved to the next page. This is on page 25, line 17. I struck or - I moved it in part because I think it was getting lost at the end of that paragraph, and I think some of the concerns were --

SENATOR CUMMINGS: Okay. We have concerns from the sheriff's association. I know I've gotten a letter, I know the rest of the committee did, about law enforcement and they're lawful, and we believe that's already covered under the law. And so they ought to be -- And we also have the new drug tracking in the department of OxyContin going out the door then they report to law enforcement. And I want to make sure that this is covered.

MS. LUNGE: Well, I think first of all that's not a commercial purpose. So it's not in the definition of commercial purpose. Also, it is specifically accepted on page 265. If you look, it says the use or disclosure of prescription information as authorized by Chapter 84 or 84A.

SENATOR CUMMINGS: So this should not change anything that is currently there?

MS. LUNGE: Right. I think it should be okay.

ATTENDEE 3: I understood the prescription monitoring that we passed last year would not be available to - for law enforcement, but in fact before we had ever pass that law enforcement can go to the pharmacies and get whatever information they want, that they have that right right now.

SENATOR CUMMINGS: As part of an investigation they can get, yes, with a subpoena.

ATTENDEE 3: But they just can't tap into the prescription --

SENATOR CUMMINGS: No. But this was if there seemed to be one patient who was getting an OxyContin prescription every other day from a different doctor every other day, that that would be - if the Health Department picked up that would be turned over. That's why we sent it to judiciary and didn't do it in here. That would be if it turned up that there was a physician that was just prescribing OxyContin up the kazoo they would probably get a call from the Health Department first. But it is a monitoring for abuse.

MS. LUNGE: We have on page 25ish.

SENATOR CUMMINGS: When it first came here I thought it was to make sure we weren't having, you know, interactions with senior citizens. But the minute it became clear that's why it got shifted into judiciary as part of the health care bill last year, because it is a law enforcement technique. But this is over beyond a specific investigation. I don't think they just go in and browse the pharmacy records.

ATTENDEE 3: That's good they know.

ATTENDEE 4: Not that they really care about my Geritol but --

MS. LUNGE: Okay. So the other sort of clarifications or exceptions in DR, dispensing of prescription medications to the patient.

Oh, I'm sorry. I don't think I finished with one on page 25. So the license, transfer, use or sale of the regulated records are allowed for pharmacy reimbursement, prescription drug formulary compliance, patient care management, utilization review, by the health care professional, the patient's insurer or an agent of either. So that would include disease management companies and the like. Or health care research.
Two, dispensing the medication to a patient, transmission on page 26, transmission of the information between the prescriber and the pharmacy or between pharmacies or in the event pharmacies ownership is changed or transferred.

Four, care, management, educational communications provided to a patient about the patient's health condition, adherence to a prescribed course of therapy or other information relating to the drug being dispensed, treatment options, and then I added recall or patient safety notices because it seems like some people were concerned that those items were somehow meeting the definition of commercial purpose, or clinical trials. The use or disclosure of prescription information is authorized as we just went through by other laws also.

Collection use, transfer or sale of patient or prescriber data for commercial purposes is an exception if the data does not identify a person and there is no reasonable basis to believe that the data provided could be used to identify the person. So --

SENATOR CUMMINGS: That doesn't just conflict with what we just did, that it can't be used for commercial purposes?

MS. LUNGE: This is an exception. So this says you can use it for commercial purposes, as long as you can't figure out who the provider is from the information that you get.

ATTENDEE 3: The provider. I was thinking it was the patient. The person.

MS. LUNGE: A person. So it could be the provider or the patient.

ATTENDEE 3: Okay.

SENATOR CUMMINGS: So the pharmacy (inaudible) could find out that Vermont per capita uses 28 percent less of the pain pill than the national average, and therefore could choose to target their advertising to Vermont.

ATTENDEE 3: But they won't know that Dr. Cummings isn't prescribing the pain pill?

SENATOR CUMMINGS: You got it. They won't know which doctor. But, given the small number of doctors, they can probably figure out as they said they figured out how many treat MS and therefore who you might want to target it to. But they won't know a specific doctor isn't, you know, represcribing or unprescribing or - yeah. They'll just know that the count of the state, plus the

numbers of some geographic. You know, you can tell north, south, east or west, whatever. But that should do it.

Okay.

MS. LUNGE: E is the enforcement provision which provides for AD enforcement through superior court, with the same investigation and remedies under the Consumer Fraud Act.

Section 13, I didn't make changes to this section. It's related to the section we just went through. It applies to the multi-payer database, and I'm - I didn't have a chance to thoroughly look through what Herb sent me earlier, but I'm assuming there's an amendment in there from him on that issue.

SENATOR CUMMINGS: Okay.

MS. LUNGE: But this basically would provide -- I modeled it on E1, which requires that records under physician patient privilege that are - or otherwise are confidential from the patient perspective would be filed with Bish (phonetic) in a manner that doesn't disclose the identity of the person. So I kind of kept - tried to keep that same model, but --

Section 14, Consumer Provisions. These next two sections address that situation we're talking about with the $4 generics if my copayment is $10. The first section, 14, is directed at the pharmacy. The second section is directed at the insurer so that the insurer would allow that $4 in lieu of the $10 as the copay. And I did remove the language about the PDPs under Medicare Part C and D, because there were concerns that we were preempted under part D.

SENATOR CUMMINGS: Okay. Unconscionable pricing. I'm going to try and take a break around 2:30.

MS. LUNGE: Okay.

SENATOR CUMMINGS: Okay?

MS. LUNGE: Okey-dokie.

So in this section, Section 16, maybe was ale do is sort of focus on the changes so we can get through this section; because I think there's been enough discussion, people know what it's about.

There is a suggestion that we, instead of call in - on page 29 the health condition a specified health condition that we label it a serious public health problem, which is how it's actually defined in A1. So I just changed those
two terms there.

There's also a suggestion to add another
factor that the Commissioner of Health would
consider when declaring that a health condition was
a serious public health problem. That's on page
30, and that's whether the consumers affected with
the health condition are unable to afford the drug
at the current price.

The AG's Office had suggested that
instead of having all that language from the
Consumer Fraud Act that we simply as we have in
other parts of the bill reference that the
enforcement for the AG would be through the
Consumer Fraud Act. And so then I've also - the
previous versions allowed AG enforcement in a way
very similar to the Consumer Fraud Act but also
allowed any affected person having standing to file
a civil suit to file through superior court. So I
removed the AG references in that section.

ATTENDEE 4: Did we have -- I don't
remember whether Robin was going to look at this
section from the interstate commerce clause, the
provision, but there was some discussion yesterday
about this and I don't understand. I guess I'm not
sure. Who does this apply to, this section? We

have one drug wholesaler in the whole state.

SENATOR CUMMINGS: It doesn't have to do
with the wholesaler. It has to do with the
manufacturer.

ATTENDEE 4: Okay.

MS. LUNGE: It requires that the
manufacturer or its licensee, this is on page 29,
shall not sell, supply for sale or impose minimum
resale requirements for a prescription drug
necessary to treat a serious public health problem
that results in the drug being sold in the State
for an unconscionable price. So it's targeted at
the manufacturer, but it's limited to sales in
Vermont. So it's meant to target it specifically
to drug sales in Vermont to Vermonters.

SENATOR CUMMINGS: The only time it would
probably affect the local wholesaler is if we had a
pandemic in this state and the wholesaler decided
to jack up the price of flu vaccine, at which point
I think we might want to stop it. In general, I
don't think the wholesalers are the ones that are
controlling the prices. That's the testimony we've
heard and we've heard in the past from the one
wholesaler.

ATTENDEE 4: I'm just trying to

understand. Who is it targeted at? Because the
manufacturer is not within the state. The
pharmacist, is this targeted at the pharmacist?

SENATOR CUMMINGS: No. It is targeted at
the manufacturer. And, the testimony that I've
heard on the commerce clause, the out is unless
there is a serious state interest or compelling
state interest. And that's what we're creating
here, is a compelling state interest. We can
regulate the price when we have a serious public
health problem in this state and people can't
afford the drugs at the price it's being sold
at. That's the compelling state interest. If it
will hold up? We don't know, but that's --

MS. LUNGE: And also we're not regulating
the manufacturer's behavior in sales to New
Hampshire, we're trying not to in language at
least, or New York. So that's the other
connection.

ATTENDEE 4: Well, let's just assume --
Yeah, Rite-Aid comes from New York State. CVS, I
don't know if they come from New York State or
Massachusetts, but they come from outside the
State. Brooks Drug is from Rhode Island or
whatever, or they used to be. And you have your

independent pharmacists who probably are buying
from in-state in most cases. So how does - how do
we -- I'm not sure how we get at the manufacturer
in this kind of a situation. I guess that's my
question. Is how does this work? Because the
pharmacist is selling the product and he's going
to, you know --

SENATOR CUMMINGS: I think what - if
somebody -- This is the same way you go after price
gouging in an oil embargo or an oil shortage or
fuel oil.

ATTENDEE 4: How do we do that? We
haven't done a very good job of it.

SENATOR CUMMINGS: You go after the
person that is unconscionably raising the prices.
If your local pharmacy - well, your local pharmacy
has got three guys down the block that - you know,
if you find the local pharmacy up in East Obishu
(phonetic) and they're the only pharmacy within 20
miles and you find them raising the price of, you
know, of a drug to keep you alive during a serious
health crisis then you could probably --

MS. LUNGE: You couldn't do that under
this provision, because this is the manufacturer or
it's licensor.
SENATOR CUMMINGS: Okay.
MS. LUNGE: So I don't believe, and I could be wrong, but I don't believe that pharmacies are licensees of manufacturers.
ATTENDEE 3: Can't Julie do that, go after the pharmacy in East Obishu?
ATTENDEE 4: Sure.
ATTENDEE 6: I'd be more than happy to answer this question. I think you're raising two questions.
ATTENDEE 4: I might be. I'm trying to understand it.
Do you want me to address it now, or do you want me to wait? I'm more than happy --
SENATOR CUMMINGS: Probably address now, and--
ATTENDEE 6: Sure. I'll try to do it real quickly.
You're making two points. One is a jurisdictional point, do we actually have jurisdiction over these guys; and then the other is a practical point which is how can we actually affect their pricing behavior given that there's so many middle men. I think that's the two questions you're raising.

With respect to jurisdiction, there's no problem. Most of these manufacturers have lots of presence here in the State. Even though their offices are - their headquarters aren't located here, they have sales reps and detailers running around the State. If we didn't have legal jurisdiction over them, we would deal with that on a case-by-case basis. But that's not something I'm worried about. Okay.
Your practical point -- So that's the jurisdictional legal issue. The practical point is how if Vermont says okay, your price is unconscionable, you have to lower your price, and that's directed at the manufacturer, how can you make sure that that price gets through to the consumers. The manufacturer would have to lower its price to any third parties it's selling to or middle men that it's selling to, or it would have to provide the product directly to Vermonters. And many manufacturers through their PAPs, their prescription assistance programs, which they advertise, and -- They're great programs. I have no problem with them, but they talk about them all the time. They would have to provide the product through something like a PAP, prescription assistance program, directly to consumers if they can't do it through the middle men, their normal channels.
SENATOR CUMMINGS: So if insulin suddenly went through the ceiling they would have to find a way if we decided that diabetes was a major health problem and the State was going broke trying to provide chronic care treatment to them and -- because -- Yeah. But, like any law, it's assuming forewarned is forearmed?
ATTENDEE 6: Your example of a flu vaccine is actually a very good one, because we actually took a look at that issue very closely a couple of years ago. You may remember when that was a problem.
SENATOR CUMMINGS: So it's not beyond May. Okay.
How are we?
MS. LUNGE: I can we're up to page 32.
SENATOR CUMMINGS: Okay. We may make it through this.
MS. LUNGE: There are two versions of the advertising stuff in here. So, version one, I tried to tweak a little bit the existing version that was in the Title 18 provisions by including cable or the cable company if it's physically located in the State. But I think really what -- Oh. And also on 35 by striking this language that was causing people concern and adding the language from the Consumer Fraud Act that applies to owners or publishers of newspapers, magazines, etc. et cetera. I think it--
ATTENDEE 4: What happened to the carbuncles and all that?
MS. LUNGE: The what?
ATTENDEE 4: The carbuncles and the list of diseases.
ATTENDEE 4: I like that.
ATTENDEE 3: You have carbuncles?
ATTENDEE 4: I'm not sure what one is.
They were out of date when I was young.
MS. LUNGE: So I think a lot of the existing law was what was troubling at least some of the people who were testifying, and part of the reason why I did version two is because revising the existing law would be quite a mammoth undertaking because in addition to what you see here there's a bunch of it still in the statute.
that I didn't touch.

So version two is on, let me find it,
page 38. So we're going to skip page 37 for the
moment. We're on 38. First of all, there is
testimony that you didn't really - everything was
going fine with the Medicare part D marketing at
this point. So maybe you wanted to take out B. So
just - so I just struck that trigger that
recollected. And then I added the relevant parts
of the advertising in this consumer fraud section
which would be more narrow than putting in the
advertising section of existing law, because that
section is also enforced by the Department of
Health. So this would limit the enforcement to the
AG's Office. It would leave the Department of
Health out of it, which they probably would be
perfectly happy about. I don't know, because we
didn't hear from them.

So what I tried to do then was
restructure it in this section so that we had the
violation - it would be a violation of the Consumer
Fraud Act for a manufacturer to present or cause,
and this is the same language from that previous
section, or cause to be presented in the State a
regulated advertisement unless the advertisement

meets the requirements under the misbranded drugs
devices under the federal law and regulation, which
is probably a little bit clearer way to say that
part as well. And imported the definitions for
that, which defines a manufacturer and also defines
the regulated advertisement which is the
presentation to the general public of a commercial
message regarding a prescription drug or product
that is broadcast on television, cable or radio
from a station or cable company physically located
in the State again to address that nexus issue.

SENATOR CUMMINGS: Okay.

MS. LUNGE: Et cetera.

So I tried to restructure it. I didn't
change a lot of the language otherwise.

ATTENDEE 7: So how does this deal with
the idea that WCAX had one advertisement for which
they were paid directly? Are we still only focused
-- I think I missed a big picture piece here.

MS. LUNGE: It's -- if you notice, in B1
on page 38 it's a violation for the manufacturer.

It's not a violation for CAX.

ATTENDEE 7: Okay.

ATTENDEE 4: Does that change the
neighborhood, or does that - was CAX

misunderstanding?

MS. LUNGE: CAX misunderstood, because of
the existing law which has broader language about
regulating advertisements. So that was kind of the
problem with trying to fit it into our existing
laws without completely rewriting our whole
existing laws, is there were some outdated
provisions that are really broad. So --

SENATOR CUMMINGS: Okay.

MS. LUNGE: And then the last - and again
I wasn't sure what you were going to do with S87 or
S84. So I just stuck them in because it's easier
to delete than to insert. And then last couple of
- the last couple of sections on page 44 are
technical, moving things around and repealing
outdated reports.

ATTENDEE 8: And as the sponsor, whatever
Section 21 is, I'm not ready to go forward with
that right now unless the committee would like to.

ATTENDEE 4: Which one is that?

ATTENDEE 8: That's the eight-day
payment.

ATTENDEE 4: Yeah. I was the
cosponsor. So let's make that a unanimous.

ATTENDEE 8: Jettison that one.

All right. The other one just requires
that you give notice that you can buy the
pharmacy? Is that all --

SENATOR CUMMINGS: That's the 90-day
thing?

ATTENDEE 8: Yes.

MS. LUNGE: That is the --

ATTENDEE 8: You shall give conspicuous
notice that you can do it.

MS. LUNGE: Yes.

SENATOR CUMMINGS: Okay. Be back at
four, and we've got testimony. I know Bishka's got
things they want to put in.

Yeah. And Julie's here, and Kimbell's
here and the sheriffs are here, and anybody else
that's here let us know.

ATTENDEE 8: The whole gang.

SENATOR CUMMINGS: Well, okay.

CD 07 - TRACK TWO

MR. MILLER: I promise I'll be the
shortest.

SENATOR CUMMINGS: Okay. I didn't think
we had any major problem.

MR. MILLER: I don't think that's a
major problem.
I'm Ed Miller. I represent the Vermont Police Association. We do have sheriffs, but the bulk of the police association are municipal officers. We also represent state police, as I said sheriffs, game wardens, liquor investigators, et cetera. It's sort of an umbrella organization of law enforcement, and there are approximately 800 members that I've represented for a good number of years now.

I would like to call your attention briefly to pages - I sent you a memo yesterday and the memo is still on track, but the pages have changed by one or two. So I'll kind of work through this just going over the bill that's been presented to you today.

And start on the bottom of page 23, and this is a good sentence here, and I know this is what the bill is trying to do. "It's the intent of the general assembly to ensure privacy of Vermonters and health care professionals by prohibiting the commercial use of prescription information." I'm on the very last two lines.

SENATOR CUMMINGS: Okay.

MR. MILLER: The very last sentence of line 23. That's fine, you know. I mean, that tells us what the intent is. The bill begins to get into a little bit of trouble for law enforcement here on the top of page 24. And as Robin said that does include a definition of commercial purpose.

However, I would point out that commercial purpose shall include any activity that is intended to be used or is used to evaluate the prescribing behavior of an individual health care professional. And that is done periodically by law enforcement.

That portion, the evaluation of prescribing behavior of an individual health care professional, is what concerns us. We saw that in a house bill, and we sort of put an asterisk next to that language because it seemed to, even though you're still talking about a commercial purpose, it seemed like the commercial purpose would include things that frankly law enforcement is interested in at least having access to.

SENATOR CUMMINGS: Okay. Now, right now under current law you have the ability to do this? Right?

MR. MILLER: Yes. And there are some parameters.

SENATOR CUMMINGS: All right. And we thought that by saying unless - what we need to put in here, unless allowed by - otherwise by law.

MR. MILLER: Well, let's skip down to Number 5 and Number 6, because there are references in those exceptions to a couple of law enforcement chapters. I'm on page 26 now, subparagraph five. And these are exceptions to the general rule that says this section shall not apply to.

And Section 5 does address law enforcement, but it does not address in our opinion all of the law enforcement activities that are out there right now in terms of investigating prescription drug activities.

Specifically, Chapter 84 of Title 18 is basically talking about general provisions of drug law. It talks about possession of a variety of drugs, cocaine, et cetera. It's sort of a laundry list of - it's a laundry list of drug crimes and descriptions of various types of drugs that are illegal.

Chapter 84A is a little bit more on track. That does deal specifically with law enforcement, but Chapter 84A is a - is the Vermont prescription monitoring system. And that does allow under certain circumstances law enforcement officers to get prescription drug information.

However, there are a couple of parameters that would serve to restrict law enforcement in general, and I don't think that the reference to 84A is -- 84A basically would allow law enforcement officers that are designated by the Department of Public Safety and who are subject to the completion of a course at a procedure prescribed by the Health Department, 84A --

SENATOR CUMMINGS: That's the new registry.

MR. MILLER: That's the new registry.

And my point is that that monitoring system basically applies to officers who are designated by the Department of Public Safety, and they're subject to the rules of the Health Department. So that is not at all all of the law enforcement activities which are going on as far as prescriptive drugs.

SENATOR CUMMINGS: And I think as otherwise provided by law we hope let's that up.

And maybe we may just say "or law enforcement" and make that specific. But I don't want to make this a back door to let law enforcement have more authority than they presently do.
MR. MILLER: I'm not asking for
that. But I am asking for things not to be
constrained beyond what they are now.
SENATOR CUMMINGS: And that is not our
intent.
MR. MILLER: Okay. And I sent you
language that I would at least like you to think
about, and I don't think that this expands existing
law enforcement. We've got just a little thing
right here. It's a one-pager. Okay? And --
Go ahead.
SENATOR CUMMINGS: That seems very broad
to me. It doesn't say according to existing law.
It just says in their official capacity they can
buy this? I mean, this is --
MR. MILLER: No. They can collect it
and transmit it if they're engaged in their
official duties.
SENATOR CUMMINGS: But they're not
forbidden to collectively transmit it now in their
official duties because they're not selling it,
unless they're collecting it in their official
duties and then selling it to PHARMA (phonetic).
MR. MILLER: Well, they're not
collecting - you wouldn't think this they're using
it for commercial purposes at all.
SENATOR CUMMINGS: No. Then it shouldn't
be touched by this at all.
MR. MILLER: They shouldn't be, I agree
with you. But my point is that the definition of
commercial purpose is broad enough so that I think
it pulls in activities which are not at all
commercial purposes for law enforcement.
Go back to commercial purpose on page
24, and you can read it - and you read that. It
says commercial purpose shall include any activity
that is intended to be used or is used to evaluate
the prescribing behavior of an individual health
care professional. And, even though law
enforcement is not intending to use that for a
commercial purpose, I would submit that that
language is broad enough so that it falls within
that definition. That's the problem.
And I think the problem is pretty easily
solved by basically having an exemption for the
collection and transmission of prescription
information by a Vermont or federal law enforcement
officer engaged in his or her official duties.
So I'm not trying to expand what they're
doing right now. I'm trying to make sure that this

definition of commercial purpose doesn't
accidentally snag legitimate law enforcement
efforts.
SENATOR CUMMINGS: I'm thinking about the
commercial purpose. There's nothing in here that
talks about sale, commercial sale? Right? Or the
purpose of?
MR. MILLER: Well, this definition
doesn't even talk about sale, commercial purpose.
It's any activity that is intended to be used or is
used to evaluate the prescribing behavior of an
individual health care professional, and that's
pretty broad.
SENATOR CUMMINGS: It is.
Can we tighten that up?
MS. LUNGE: You could just put in - you
could just leave out evaluate, because that's what
law enforcement --
MR. MILLER: I would propose you adding
a seven.
SENATOR CUMMINGS: If we add a seven,
that's going to send this bill to judiciary.
MR. MILLER: Well --
SENATOR CUMMINGS: I'm not doing that.
MR. MILLER: If you don't add seven it
might send me to judiciary. So what's your, you
know, it's --
I think this is a legitimate issue. If
you -- If you and your committee want to try to
think about it, I'm not wedded to this language.
If it's not quite right, fine. But I do think
there's an issue here that revolves around the
definition of commercial purpose.
SENATOR CUMMINGS: Okay.
Julie?
MS. BRILL: I saw it.
SENATOR CUMMINGS: What do you think?
MS. BRILL: We are supporting it.
That's fine.
SENATOR CUMMINGS: It's fine? Can you
tell that to Senator Sears?
MS. BRILL: Sure.
ATTENDEE 5: Only when he asks.
SENATOR CUMMINGS: I'm trying to avoid
trips to judiciary. I just want to make sure that
doesn't expand it more, to allow them to get
more information without a subpoena than they
currently could get.
MS. BRILL: Right.
SENATOR CUMMINGS: And I don't want to
expand.

MS. BRILL: We don't want to expand

either. We actually want this information as

well. You know, we're on the same side of the

street as the sheriff.

MR. MILLER: Most of the time.

MS. BRILL: And today. Today we are,

yes. That's right.

But I don't think that this expands

anyone's right to get the data. It's just that

they already have the ability to get the data in a

law enforcement activity.

MR. MILLER: That's what's intended.

MS. BRILL: Okay.

SENATOR CUMMINGS: If that's what's

intended, we'll see what we can do to draft it out

so that it makes it clear that under other existing

law.

ATTENDEE 5: I'll move the language if

that's what you want.

SENATOR CUMMINGS: No. I think we all

know.

MR. MILLER: You should have been here

last year when I was looking for a motion.

SENATOR CUMMINGS: I think I'd be more

comfortable if we tightened it a little bit, yeah,

just to make sure that it's --

MS. LUNGE: Tighten this language? Okay.

SENATOR CUMMINGS: Yeah. Just to make

sure that it's --

MS. LUNGE: I can work on that.

ATTENDEE 5: Why don't you guys work on

that while we move on to the next one?

SENATOR CUMMINGS: All right. We're

going on. Okay.

MR. MILLER: Point made. Thank you.

SENATOR CUMMINGS: Okay.

UNIDENTIFIED SPEAKER: Madam Chair, I'd

like to just bring up something. On page 36, you

had many discussions in here about what are

carbuncles. And at the break I Googled it, and

here's the definition.

ATTENDEE 5: I think I'm done.

UNIDENTIFIED SPEAKER: A carbuncle is an

acute inflammatory nodule of the skin caused by

bacterial invasion into the hair follicles or

sebaceous gland ducts. It is actual a boil, but

one that has more than one focus of infection; in

other words, involves several follicles or ducts.

Carbuncles occur more often in men because of their

more extensive body health care growth.

SENATOR CUMMINGS: Thank you for that.

Now we know --

UNIDENTIFIED SPEAKER: I know that was a

real serious question on this committee.

MS. BRILL: I think carbuncles start at

the same place as rheumatism.

SENATOR CUMMINGS: I'm trying to get

through this, because I know BISHCA's got

some major rewrites. I'm trying to get through

this.

Julie. Well, maybe we'll do Steve. You

want to testify now?

MR. KIMBELL: Whenever you're ready.

SENATOR CUMMINGS: Okay. And then we'll

do the Medical Society and then BISHCA. And we've

got someone on the phone, and maybe you can tell us

who that is.

MR. KIMBELL: Madam Chair, this is Steve

Kimbell, here for IMS Health. And you asked a

question the last time I was here about what

percentage of my client's business is involved in

selling prescriber data to people who want to use

that data for some other purpose. And I'm

authorized to give a general answer to say it's a

very small percentage, less than 20. They were a

little -- They have competition in this business,

and it's somewhat proprietary. But this is not -
it's very far from their sole purpose. It's on the

other end of the scale. That is, they sell a lot

of health related information. They're not wedded

to PHARMA for example for their life blood. This

is a product line. They have thousands of product

lines, and there are four of them that are involved

in this prescriber identified data.

So that will give you an idea.

ATTENDEE 5: But that's 80 percent of

their --

MR. KIMBELL: No. I said that the

prescriber identified piece of our business is less

than 20 percent. So that means it's between zero

and 20, and I didn't want to get any more specific

than that.

SENATOR CUMMINGS: That's more than

adequate.

MR. KIMBELL: But I think that gives you

an idea.

And you had a letter that I distributed

from Harvey Ashman who's the vice president and

General Counsel of IMS Health, and the other
question that I've had from the Chair and others is
what is the strength and the enforceability and the
penalties for violation of the opt out program that
the AMA has in place; if my client or a
pharmaceutical company violates one of those
provisions, a contract provision or a physician
desires to opt out, what's that penalty. And those
are matters of contract, and Mr. Ashman can take
five minutes and tell you because he's familiar
with them.

SENATOR CUMMINGS: Okay.
Hello, Mr. Ashman. Can you hear us?
MR. ASHMAN: Yes, I can. Can you hear
me all right?

SENATOR CUMMINGS: Very well, thank you.
This is Senator Ann Cummings, and you are speaking
to the Senate Finance Committee in Vermont. The
room is full of interested parties, and your
lobbyist Steve Kimbell is here with us. And you're
going to I guess give us some testimony about the
AMA opt out, the physicians and what's involved in
that and what kind of contracts and, you know,
penalties there are. And anything you can tell us
would be helpful.

MR. ASHMAN: Thank you, Senator. I
appreciate - to all the committee members, I
appreciate the opportunity to speak with you and
happy to share with you any information about the
opt out program and how it works.

Let me start by just talking basic
mechanics of how the program works from the
standpoint that a physician contacts the AMA and
expresses an interest to opt out, and the AMA has
contracts with companies like IMS where it
communicates the physician's preference on a weekly
and monthly basis, provides us a list of those
physicians who have elected to opt out. And then
IMS in turn and the other companies licensed by the
AMA, our competitors, in turn provide all of the
physicians who have opted out to the manufacturers,
and they are under contract with IMS and our
competitors to abide by that opt out restriction.

And so as the program was being
developed and then rolled out and communicated we
worked very closely with our customers as they
invested millions of dollars to modify the systems,
to change business processes, to build out
compliance programs or enhance existing compliance
programs so that they were in a position on July
1st, 2006, when the program went into effect to be
able to comply with it.

And, as the AMA and we communicated the
requirements of the program, we also described a
course available if the manufacturer failed to
comply with the program. And those consequences
were that the AMA could terminate its agreement
with the manufacturer or require us to terminate
its agreement with the manufacturer for AMA
demographic information. And, because all the
prescribing information that we access to
manufacturers is linked to the AMA demographic
information, the manufacturers could lose access to
all the prescribing information nationwide.

UNKNOWN SPEAKER: Is there a complaint
process? I'm sorry.

SENATOR CUMMINGS: Go ahead
UNKNOWN SPEAKER: Is there a complaint
process for individual physicians, Harvey?

MR. ASHMAN: There is on the AMA
website. There is information about how physicians
can inform the AMA about any problems they
encounter. For example, pharmaceutical sales reps
come into the office and has access to this
information, or just in general if they become
aware of something they can report those problems
to the AMA and the AMA will turn around and provide
that information to the manufacturers and a list of
the manufacturers that match those problems can
address it.

It also puts the AMA in a position of
accumulating these complaints so that if there is a
pattern of - or a practice by a company of
consistently not abiding by the terms of the
program then appropriate action could be taken.

SENATOR CUMMINGS: Any questions?

UNIDENTIFIED SPEAKER: What percent of
the physicians opt out?

MR. ASHMAN: That's changing weekly.
Maximum numbers I saw, I believe the opt outs were
approaching 6,000. But I'm not sure of the precise
number.

UNIDENTIFIED SPEAKER: That's 6,000, and
what's the universe?

MR. ASHMAN: The universe is about
800,000 MDs and DOs.

SENATOR CUMMINGS: But this is programs
staying in for what? Six months?

MR. ASHMAN: Six, seven months, that's
correct.

The AMA is continuing to roll out a very
A-684

MR. ASHMAN: Organizations like tele-information companies, continuing medical education companies, pharmacies, pharmaceutical manufacturers. Any number of organizations that, either for purposes of managing issues around controlled substances or for other purposes like bridging information sources together will have access to the information.

UNIDENTIFIED SPEAKER: How does it link up with Vermont’s registrat - doctor license numbers, or state by state license numbers and Vermont in particular?

MR. ASHMAN: There are different organizations. Ours is one of them. The AMA I believe also does it, makes state licensing information available. So, the pharmaceutical manufacturer for example who for purposes of compliance with the Prescription Drug Marketing Act wishes to leave samples with the doctor, they're obligated to confirm the doctor is properly licensed. We would make that information available to manufacturers for PDMA. So then we have the ability to link those things, and that's a helpful thing for people to do.

UNIDENTIFIED SPEAKER: You link them, or someone else links them?

MR. ASHMAN: We can do it, and there are a number of other organizations out there that can do it.

UNIDENTIFIED SPEAKER: But, for the purposes of opting out of your list, are you going to rely on someone to make those matches, or you're going to do it yourself?

MR. ASHMAN: I'm not suggesting those linkages are done for the purposes of opting out. That's all just managed through use of the ME number which is - the AMA's files are very comprehensive in terms of active doctors and inactive doctors. So we simply use that information. And, if there's any question about a doctor out there, whether or not that doctor or any doctor has opted out, we have the ability to compare the two records from different sources and say here's the same doctor, he needs to abide by that restriction.

UNIDENTIFIED SPEAKER: Thank you.

SENATOR CUMMINGS: But they do not call for telemarketers?

MR. ASHMAN: The restriction, (Inaudible). The opt out program would apply to telemarketers as well as the pharmaceutical companies.

SENATOR CUMMINGS: Any other questions from the committee?

Okay. Thank you very much. That helps fill in our background.

MR. ASHMAN: Thank you for the time. I appreciate it.

SENATOR CUMMINGS: Thank you for the time.

Okay.

MR. KIMBELL: That's all I have, Madam Chair, just with those clarifications. We hope you'll delete the section of the bill, because it seems like the physicians have a way to avoid it that's got some teeth in it, and thank you.

SENATOR CUMMINGS: Okay. Thank you.

Now we'll hear from the Medical Society.

UNIDENTIFIED SPEAKER: Did we hear what the penalty was? Did I zone out?

UNIDENTIFIED SPEAKER: The penalty is the loss of all the data.

SENATOR CUMMINGS: All the data. If you violate you don't get anything, which for pharmaceutical companies could be very expensive.
MS. MONGAN: Good afternoon. I'm
Madeleine Mongan from the Vermont Medical Society.
I'm just here again to ask you to support this
section of the bill. We think it's important. We
think that the opt out, we still don't feel like we
know enough about it. And we're kind of grateful
for this process for the information that we have
been able to learn about some of the uses of the
data that are going on and looking at ways to
address that.
But on the opt out, listening to
everyone from PHARMA yesterday, I'm still not
here. Where does the law go? Does it just prevent
the information from going to the detailers? Can
it still go to the marketing department? Can it go
to the drug - the consumer advertising department?
Can it go to many other places within the
pharmaceutical manufacturing companies?
We would be much more comfortable with
an opt in which would be an opt in, not to the AMA
part of the equation, but an opt in to the part
that happens here in Vermont where the information
is sold, licensed and transferred from the pharmacy
or wherever to IMS. So the physicians could opt
into that, the physicians could see their data.

Because this is pretty much of a black box. So
even when the data goes to IMS and to the
pharmaceuticals the physicians never see the data
about themselves. That is all sort of blind and
black. They don't get to see that.

SENATOR CUMMINGS: You said you had to do
an opt in. You can't through the AMA. They're a
separate organization.

MS. MONGAN: I don't know if you can do
the AMA. It seems to me it's a little more
challenging to do the AMA. It seems like you could
do the side of the equation that is here in Vermont
in the same way that you did the banking and the
insurance opt ins a few years ago.

SENATOR CUMMINGS: Right. But --

MS. MONGAN: Which I think has work d
fine and not disrupted any of the commercial
purposes or uses for those industries.

SENATOR CUMMINGS: Yes, but it's painful
to do it, and I'm thinking there's a lot more
pharmacies than that are banks. And -- Well, so
far. And if every local pharmacy, you know, had to
do this then they would be --

MS. MONGAN: What I hear from, which I
believe you also might want to hear from is that

companies come in with the Freedom of Information
Act requests and, you know, the prices go up. And
she's seen - and she knows a lot more than about it
than I do.

UNIDENTIFIED SPEAKER: Did you just say
that patients and doctors get letters saying how
come your doctor - why the doctor didn't prescribe
X, Y and Z?

MS. MONGAN: We have heard this, and
it's anecdotal. We have heard that they get
letters, not about - mostly what I've heard about
diabetic supplies and diabetic drugs.

UNIDENTIFIED SPEAKER: We need to be
careful about anecdotal information I think,
unless we have a way of verifying it.

SENATOR CUMMINGS: Yes.

MS. MONGAN: Well, it's a hard thing to
verify. Maybe AARP is a --

UNIDENTIFIED SPEAKER: If a patient
gives it to the doctor and says look, this is what
I received, that's something we can verify. I
mean, it's really --

SENATOR CUMMINGS: We need a letter
UNIDENTIFIED SPEAKER: We need to see it
before we can say that it exists.
UNIDENTIFIED SPEAKER: It's evidence.

SENATOR CUMMINGS: All right. I mean, some things like they address it by age, by records, and AARP sends everybody whenever they 55 or 60 gets, you know, congratulations.

MS. MONGAN: So it may be --

UNIDENTIFIED SPEAKER: They give them 30 days ahead of time.

SENATOR CUMMINGS: Yes. So anyway, you know.

MS. MONGAN: That may be legal. I don't know.

SENATOR CUMMINGS: I'm sure that is legal. You know, those are public records. You can get anyone's birthday. And -- But --

MS. MONGAN: But it this case I think on the patients it doesn't hurt to leave them in. At worst it's duplicative.

SENATOR CUMMINGS: Well, it's already illegal to do that. But it sounds like, unless everybody at a certain age is getting (inaudible) a new insulin supplier in town, that somehow they're able to target folks who are diabetic.

MS. MONGAN: Yes.

And the other thing is on the patient issue is, again, we don't know what information goes from the pharmacy and how cleaned up that is and if there's patient information going along.

But IMS has a business associate agreement under HIPAA with -- We don't know that. So I think it's protective. I know in New Hampshire they thought it was important. And I'd encourage you to leave that protection for patients in there.

SENATOR CUMMINGS: Okay. Any questions for the Medical Society?

UNIDENTIFIED SPEAKER: Yes.

You're representing the Vermont doctors?

MS. MONGAN: That's right, yes

UNIDENTIFIED SPEAKER: And yet the American Medical Association is just 180 degrees, and the opt out rate is less than a percent. I'm just --

MS. MONGAN: Yeah. Well, I think that might have something to do with the fact of how busy physicians are. You know, and Steve Kimbell the other day said they're sophisticated. And they are sophisticated about science and about medicine and about treating patients, but they're not really business people and they don't necessarily pay attention to our newsletters that urge them to opt out of the program. So --

MS. BRILL: I can vouch for that.

MS. MONGAN: Yes, and so can we by the things that we send out.

So they are sophisticated, but they're not in business. They didn't know about this. I mean, we heard that our doctors heard about this from the doctors in New Hampshire at a meeting of the New England doctors. And they were -- You know, to a doctor that has heard about it they don't think it should be going on, because they think it undermines evidence based prescribing, you know, which is our focus, is on the evidence based prescribing that you're putting in there, transferring from over to the Department of Health. So we think that that's important.

Now, the Medical Society in the AMA.

Some members of the Medical Society, I think about five percent of the docs in Vermont, one of the smallest rates in the country, are members of the American Medical Association which is the national organization for doctors. We're a state membership organization for doctors. We're completely separate. We take different positions, like on things like physician assisted suicide, than the AMA takes. So our governance is just our governance here in Vermont.

Now, we have a delegate on our board that represents Vermont docs with the American Medical Association and we participate with the New England delegation to the American Medical Association, and that's one place where there's resolutions are brought to try to work on this issue of the opt in the opt out.

UNIDENTIFIED SPEAKER: How much overlapping membership is there? Are a hundred percent of the Vermont Medical Society members of AMA?

MS. MONGAN: No, no. Very small number of Vermont docs are members of the American Medical Association. About two-thirds, a little more, of practicing docs in Vermont are members of the Vermont Medical Society, but less than five percent of docs in Vermont are members of the American Medical Association.

The docs have a lot of - they have their specialty societies. They have, you know, their state society and then they have their national society. In Vermont I think they first prioritize
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specialties societies and then us, and then the
AMA.

SENATOR CUMMINGS: But the AMA has their
numbers?

MS. MONGAN: The AMA --

SENATOR CUMMINGS: That can sell their
information as their numbers, even though they're
not members?

MS. MONGAN: Right.

SENATOR CUMMINGS: Okay.

Okay. Any other questions?

Thank you.

MS. MONGAN: Thank you.

SENATOR CUMMINGS: Herb and Paulette, and
whomever.

Okay. Now, Herb, I know you sent this,
but no one's had time to go counsel and go through
--

MS. LUNGE: Actually, we have a new one
for you.

SENATOR CUMMINGS: Good. A new one will
help. But this will show - this will show the
existing bill and the pages that go into it?

MS. LUNGE: Exactly.

SENATOR CUMMINGS: All right.

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MS. THABAULT: Okay. Should I go?

SENATOR CUMMINGS: Okay. Drafted by
legislative counsel, but at your
request? Right? This says --

MS. LUNGE: The bold just looks like the
changes that you saw in 2.1.

SENATOR CUMMINGS: Oh. Okay.

UNIDENTIFIED SPEAKER: The highlighted
is what --

UNIDENTIFIED SPEAKER: Robin has sent us
a draft. So we used that.

SENATOR CUMMINGS Okay. The highlighted
is yours?

UNIDENTIFIED SPEAKER: Right.

MS. THABAULT: So these -- This is
Paulette Thabault from BISHCA.

MR. OLSON: And Herb Olson, general
counsel for BISHCA.

MS. THABAULT: And so that the changes
that we are proposing here from the testimony
yesterday, and I just wanted to reiterate to the
committee that our concern really is cost
containment and the issue of being clear about the
regulatory authority of the very - over the health
insurers and the PBMs. So Herb's actually going to

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walk through some of these changes and the
recommendations, and hopefully answer any
questions.

MR. OLSON: If I can just draw your
attention to the bottom of page 1, there's some
highlighted material there.

SENATOR CUMMINGS: That's your page 1.

It's not lining up with page 1 --


SENATOR CUMMINGS: Okay. So that's
where we need to start.

MR. OLSON: Right. And you would find
the definition in the draft that you just looked at
on page 13, and there's really only one point that
we are trying to make here. In a - the section on
fiduciary duty, we wanted to make clear that the
companies that we traditionally regulate which are
commercial health insurance companies, health
maintenance organizations, Blue Cross/Blue Shield,
that they have the primary obligation to comply
with the statutes in Title Eight and to act in
conformance with the policy of the private
contract.

So in order to accomplish that goal we
are proposing an amendment of how you present the
definition of health insurer by separating out the
different components. I don't think that it is
actually difference in substance than what Robin
has suggested in her draft, but we wanted to
separate out in subdivision 2A the traditional
companies, the commercial companies, the health
maintenance organizations and Blue Cross/Blue
Shield. That's really the only purpose of that.

We also had a question about regulatory
authority and vis-a-vis the respective roles of
Attorney General's Office and the department. We
are continuing to talk with Julie. We're just
running out of time in terms of some of these
issues. And we're not going to ask that you change
what's in Robin's draft in terms of what the
respective roles of our office are, but we would
ask that you give us a little more time to talk,
understanding that you need to act.

SENATOR CUMMINGS: I think this has got
another whole concept.

MR. OLSON: We understand. But we still
have some concerns about that. I think we're
getting a little bit closer in terms of our issues
and defining those. We're comfortable with having
you pass the bill out on that issue as it is in

14 (Pages 50 to 53)
Robin's draft, but we would like to have the opportunity to come back if we're able to offer a more appropriate resolution.

SENATOR CUMMINGS: It's got to go to the health committee, and if it can't be resolved in there, this forum, I know there's some folks here would like more time to work on it. They may end up with more amendments too. So --

MR. OLSON: I appreciate that.

UNIDENTIFIED SPEAKER: Madam Chair?

SENATOR CUMMINGS: Yes.

UNIDENTIFIED SPEAKER: Herb, I'm not sure I understand how the way you've written two changes what's written in on page 13.

MR. OLSON: I think the best way to explain it is by all we're doing is separating out the various components that you have in your draft on page 13. Right now on page 13 of your draft you have health insurers defined by subdivision 9429, and that lists both the traditional companies that we regulate as well as other entities. Those other entities are - we've identified in subdivisions B, C and D.

And I apologize for being a little cumbersome. We wanted to zero in on those entities identified --

UNIDENTIFIED SPEAKER: How does that reflect in the box though? The box just says - next to it says BISHCA's proposed changes to the definition are intended to distinguish between health insurance companies in subdivision A concerning which BISHCA should remain exclusive regulator and others who offer health benefit plans concerning which BISHCA and the AG's Office will have joint enforcement. I don't see anything that says that.

MR. OLSON: Right. We'll get to that in a minute, but actually what I am saying is we're willing to let that issue of roles pass by and we can revisit that, because we're still continuing to talk with the Attorney General's Office.

SENATOR CUMMINGS: Right. There's still an open discussion.

MR. OLSON: The next change that we're proposing, and the next really substantive issue, is on page three of this document that I just handed out, lines nine through 15. And there are two things that we're proposing here.

UNIDENTIFIED SPEAKER: Page 15?

MR. OLSON: Right. Page 15 of the draft that Robin went through.

And what we're proposing is two matters. First, what each of these requirements as Commissioner Talbot testified yesterday, we think it's helpful to have the parties be able to vary the terms of the contract if they so choose.

SENATOR CUMMINGS: I think the concern is to make sure that both sides of the contract know that they have the right to vary. This is essentially the fiduciary responsibility. So, if my PBM comes in and gives me something that says, you know, we have a contractual, since I'm sure most health insurers aren't going to be carrying around a law book, I'm not sure that folks will know that they have gone to a less than legal standard.

MR. OLSON: On the contrary. I think the insurers or at least the ones that we're familiar with, there are three principal insurers in Vermont: NVP, Blue Cross/Blue Shield of Vermont, and CIGNA.

MS. THABAULT: Are they the only ones that have contracted PBMs in Vermont?

MR. OLSON: Well, again, when we're looking at the health insurers that we regulate --

SENATOR CUMMINGS: Yes. But I think, you know, what we're trying to get a handle on is are there other groups that are contracting with PBMs that are not health insurers, you know, or a self-insured group that may be a small union or, you know, in a business association? And they may arguably be not as sophisticated in this realm as a professional insurance agency.

MR. OLSON: You know, I think that since the last time we revisited this provision I think things have come a fair way. And I think that certainly the health insurers have the sophistication to contract the way they want to contract. I think that in the plans that the companies or the organizations that are large enough, including self insurers are very big, you're not going to find the Chamber of Commerce self insuring itself.

SENATOR CUMMINGS: The City of Montpelier self insured itself.

UNIDENTIFIED SPEAKER: Through us.

SENATOR CUMMINGS: No. The City of Montpelier has self insured itself. They may have changed, but they were a holdout on the league and I don't know if they're still doing it, but they
were.
UNIDENTIFIED SPEAKER: Did they use somebody like Blue Cross?
SENATOR CUMMINGS: This is before PBMs.
UNIDENTIFIED SPEAKER: Okay.
SENATOR CUMMINGS: No. They -- Yeah. I think they had Blue Cross as an administrator.
UNIDENTIFIED SPEAKER: So that's where the sophistication comes in.
SENATOR CUMMINGS: Okay. We're going to hear from the Attorney General. So --
MS. THAUBALT: And I would just add that I think that in these situations you're talking about a contract, and no matter what the contract is for there's usually some legal advice involved before anyone enters into. I mean, these are not individual consumers that are contracting with PBMs. They're groups. And there's always going to be some - so you would assume that there's some level of sophistication in terms of understanding that when you contract with someone there's always a negotiation.
MR. OLSON: And I guess the only other point and the only reason why we're raising this is that's generally speaking a price that's associated with any requirements such as this. And if -- And you're right. If the parties are sophisticated enough to be able to bargain over these terms, they could also bargain over the price associated with the required terms.
SENATOR CUMMINGS: If they know, both sides, if they know that they could buy someone who would work with care, skill, prudence and diligence on their behalf for $3 more as compared to somebody who just has to fulfill the things of the contract which says I'll get you - I'll save you 20 percent, but I am making 20 million dollars off of this.
MR. OLSON: Or maybe something in between. Maybe some provision in the contract that talks about fair dealing but doesn't impose that particular standard. You know, the parties might be able to reach some other agreement. Again, if they're sophisticated enough to be able to bargain like that, they might be able to reach some other agreement that might be more appropriate and that they can assign a price to and they're happy with.
SENATOR CUMMINGS: Unfortunately, the law covers everybody, not just those that are sophisticated. So I think that we're still working on it.

MR. OLSON: Those are the issues that we wanted to raise.

The next sentence there goes to why we propose to amend the definition of health insurer, and what we wanted to make clear in that sentence in the case of a health benefit plan offered by a health insurer as defined by subdivision 94712A.
Those are again the health maintenance organizations, Blue Cross/Blue Shield, and a commercial company. But those entities shall remain responsible for the administration of the benefit plan in accordance with the policy and in compliance with our statutes. We wanted to make sure that the health insurers' feet are held to the fire. They are the ones primarily responsible, and we wanted to make sure that this isn't diluted by focusing on the PBM.

SENATOR CUMMINGS: Okay.
MR. OLSON: Bottom of page two, again you'll see that theme throughout, that we think that the parties should be able to vary the terms of contract if they so desire.

SENATOR CUMMINGS: Okay.
MR. OLSON: Over on page 4, there is an issue about information. And there was some protections built into this particular subdivision about the PBM being able to designate certain information as confidential and trade secret, and then there's an exception that was in the draft that Robin walked through with you. We are asking that you include a further exception that would recognize that when the commissioner seeks to regulate the health insurance company that information that might have been designated as trade secret would still be available to the regulator for our purposes.
MS. BRILL: That's fine.

SENATOR CUMMINGS: Go get them.
MR. OLSON: And you see the language in subdivision three and four again about the ability of parties to vary the terms of the contract; and again over on page 5 with respect to the disclosure of revenue.

Over on page 6, that's an information issue again, and if it's designated as confidential that's fine and it should be, but if the commissioner needs to have that information available to her in connection with a financial exam for example that that should be disclosed for her information.
Okay. Now, at the bottom of page 6 is the item that we're willing to pass over while we continue to talk.

SENATOR CUMMINGS: Okay.

Mr. OLSON: It is an important issue for us. It's really critical.

SENATOR CUMMINGS: Isn't the language that's in there? Because I know we worked out --

Mr. OLSON: I agree.

SENATOR CUMMINGS: It held up the bill for three days, there were so many e-mails. And I thought we had reached an agreement. But that was two years ago. So --

Mr. OLSON: It was two years ago, and we think we can improve on that language. But we need a little more time.

SENATOR CUMMINGS: Okay. I have reservations about having one commissioner need to have permission from another commissioner to perform their duties or what they see as their duty.

UNIDENTIFIED SPEAKER: Right.

Mr. OLSON: We appreciate that. We just want to make sure that the health insurers are regulated as effectively and as efficiently as possible.

SENATOR CUMMINGS: I think that yes. They're preserving your privacy of inspection in regulating insurance companies, but I wouldn't have any problem with, you know, reiterating in the law and that, you know, administrative remedies would generally go before criminal remedies. But I think there's also a point at which the Attorney General's Office has to do what they feel their duty requires.

Mr. OLSON: And we welcome that as well. We refer a number of matters to the Attorney General's Office, and we wouldn't be able to do a lot of what we do without their help in the courts. Most of what we do is in the administrative sphere of things.

Ms. BRILL: And well I'm told.

Mr. OLSON: Thank you.

Can I move to page 8? Page 8 is - tracks 7, which is actually the medical language that you have in the Robin's draft. And the only comment that we have in that little text box there is we're not sure that this section is absolutely necessary. We do, because of the provision for registration of PBMs that was authorized last year,
STATE OF VERMONT
(SENATE COMMITTEE ON FINANCE)

Re: SENATE BILL 115
Date: Wednesday, February 21, 2007
Type of Committee Meeting: Prescription Drugs: Mark Up
Committee Members:
Robin Lunge
Julie Brill
Ed Miller
Steve Kimbell
Harvey Ashman
Madeleine Mongan
Paulette Thabault
Herb Olson
Charles Storrow
CD No: 2007 - 56, Track 1
MR. OLSON: -- broad array of transfers of data and we were concerned that it could be that to include the transfer of data from payers to Bishka (phonetic) in connection with our data collection responsibilities under 9410 of Title 18. For that reason, we are proposing on page 13, in the highlighted material here, an exclusion that would say that the section would not apply, that the healthcare data collection of regulatory activity of the department, including but not limited to the authorized by 9410H.

And again, I heard Robin and Ed, their dialogue about whether those types of activities were included within the definition. We were concerned in reading it that could be included and that's why we're looking for this particular example.

MS. THABAUT: It's almost, as I can see, once we start doing exclusions, you know, every time somebody needs data, having us to go back to the law to do exclusions. I'd like to see if we couldn't tighten up commercial purposes. What we've talked about is we talked about the sale of data and that somehow there is a monetary benefit here, not (inaudible), legally authorize --

MR. OLSON: Legally directed, required --

MS. THABAUT: And we thought that, as otherwise prescribed by law, but I think we may need the type of the definition (inaudible) about it. That's not the intent.

MR. OLSON: Okay.

MS. THABAUT: Unless you guys are marketing the insurance is something to the doctors related to your (inaudible). Remind us we can't send them or (inaudible) brochures either.

MR. OLSON: What we're doing in the 1410 is actually obligating as a matter of regulatory obligation the payers to transfer data to a Bishka entity when it's up and running so that we're able to help the healthcare system, figure out how to do chronic care little bit better, how to handle prescribing issues in a more effective manner in this sort of aggregated way.

But to get to the next section, sec. 13, and that's on page 14, we were concerned about this section because subdivision two would say that the records information was protected by section 4621 and this title shall be filed in a manner that does not disclose of the identity of the patient and prescriber. Again, we have a concern about how we would be able to implement the (inaudible) database program with this limitation. We have no intention of disclosing in a public manner that kind of identifiable information.

On the other hand, if we're not able to -- if we have a limitation about insurers filing that information, it's going to be very difficult to us for us to do the type of analysis that we're going to need that would be helpful.

MS. THABAUT: I don't think -- Robin?

UNIDENTIFIED FEMALE ATTENDEE: Can I ask one question? Do you need something saying that the prescriber information would remain confidential (inaudible) on the records?

MR. OLSON: I think those provisions are already in 9410H.

MS. THABAUT: Let's check that out. I don't --

MR. OLSON: In any case --

MS. THABAUT: -- anything that you're asking here is something we don't want to do. I think we need to find out a way that the law enforcement can still enforce the law and let the (inaudible) system and health departments, prescription drug registry programs can continue to work. At the same time saying, but if you get a little short of funds, you can't sell it.

MR. OLSON: Understood.

UNIDENTIFIED FEMALE ATTENDEE: Don't we file most of those kinds of claims under Social Security numbers? I mean, do we need names?

UNIDENTIFIED FEMALE ATTENDEE: (inaudible). Social Security numbers, don't they still use them?

UNIDENTIFIED FEMALE ATTENDEE: They specifically have not -- have moved away from that.

UNIDENTIFIED FEMALE ATTENDEE: Hospitals don't use those for identification?

UNIDENTIFIED FEMALE ATTENDEE: Hospitals may use them, you know, intermittently, but they really have moved away. Your insurance card no longer has your Social Security number as your ID. It has some CIA number or some sort of UU number. Okay.

MR. OLSON: The next issue that we would like to offer to you, on page 15 of this draft, let me just hand you that.

MS. THABAUT: Fourteen and 15?

MR. OLSON: It's sec 19. If you remember in your original draft that Robin went over yesterday,
there was some standards around marketing. But we
found that they were in a wrong section of the
statute. We have a bulletin that talks about
marketing of health insurance and actually Medicare
probably (inaudible) plans as well. We think
that -- we're quite sure that we can regulate that
conduct but it has to be codified in the right
place, and the right place is in our insurance
producer and agent licensing section.
So if you are interested in and comfortable
with those standards, we're offering this section,
19, to you as a substitute for the sec 19 that you
had in yesterday's draft.
I know Robin's draft that she went over today
took out that section but we're trying to respond
to what we said yesterday and offering you
standards in another section of our statute.
UNIDENTIFIED FEMALE ATTENDEE: Section 19?
UNIDENTIFIED MALE ATTENDEE: Just yesterday's
half (inaudible).
MR. OLSON: Yeah, we didn't see this draft.
UNIDENTIFIED MALE ATTENDEE: Did you have a
chance to look at today's draft?
MR. OLSON: Yes, and I do have some comments
about today's sec 19 but we're offering this as a
substitute for yesterday.
UNIDENTIFIED MALE ATTENDEE: Both of them?
MR. OLSON: Yes, that's true.
UNIDENTIFIED MALE ATTENDEE: (inaudible).
MR. OLSON: Now, if you're not interested
incorporating those standards in the bill, that's
fine too. We just thought that if you do want to
incorporate them, this would be the place to do it.
MS. THABAULT: This would be the place to do
it? And these are things you feel that would be
helpful in regulating the Medicare part, the market
practices or marketing?
UNIDENTIFIED FEMALE ATTENDEE: Yes, absolutely.
MS. THABAULT: So, all right.
MR. OLSON: Maybe I can go on.
MS. THABAULT: I don't think I can read this.
MR. OLSON: (inaudible).
MS. THABAULT: You struck it in this one
because testimony was that since part B come in
that they had gotten a handle on it and Bishka is
saying these would be helpful to us in regulating
that (inaudible) whether it needs to be in another
section of the statute.
MR. OLSON: I mean, we do think we do have a
handle on it --
MS. THABAULT: Medicare part D.
MR. OLSON: We do think we have a handle on
the marketing. We're just suggesting that those
would be helpful additions.
MS. THABAULT: And why don't you go over them
MR. OLSON: I'm sorry?
MS. THABAULT: Can you just walk us through
them --
MR. OLSON: Oh, sure.
MS. THABAULT: -- because we haven't seen
those before.
MR. OLSON: Right. This whole section 19 is
codified in the insurance producer agent licensing
section of title 8. And it there's a long list of
standards of conduct, and we're proposing to amend
one of those standards of conduct, sub 8, and
generally, that is that the licensee can be
disciplined if he or she is committed any unfair
trade practice or fraud as defined in this title.
And then what we did was add into that, it
should be an unfair practice under this section for
a licensee to sell, solicit, negotiate the person's
health insurance by one of two means: Advertising
and making use of any other marketing that fails to
disclose that one of the purposes of marketing is
solicitation of insurance. I think that is
intended to make sure that when folks, especially
some of the seniors who are being solicited, they
know exactly what the purpose is of this
solicitation --
MS. THABAULT: (inaudible) Medicare, and if
I'm going to try to sell you health insurance at
the same time, I have to let you know, and by the
way, I'm also going to try to sell you health
insurance, a long term care insurance or life
insurance or something else.
MR. OLSON: B would get that back, too.
MS. THABAULT: Yeah.
MR. OLSON: B would say that if you have an
appointment with someone to talk about Medicare
products, you can't use that opportunity to talk
about a life insurance product unless you set up
the appointment for that purpose, so that it's --
MS. THABAULT: You can't use Medicare to get
your foot in the door?
MR. OLSON: I guess you can, but you have to
be clear about what you're doing.
MS. THABAULT: Unless you tell me, I'm really
not here to give you paid vacation, I'm really here
to sell you a condominium.

UNIDENTIFIED MALE ATTENDEE: (inaudible).

UNIDENTIFIED FEMALE ATTENDEE: Madam Chairman,
I'm confused. My notes said that you didn't like
this three or four days ago because it added a
third layer (inaudible) which I rushed right out
and I did. But why are we putting this back in?

MR. OLSON: The way that it was originally
drafted in the draft yesterday put these standards
into the consumer file statute, if I remember. So
what we're doing is taking that material and
instead of having it consumer file statute, we're
putting it into title 8.

UNIDENTIFIED FEMALE ATTENDEE: Okay. So the
highlighted stuff after the three asterisk is all
related and going to the same place?

MR. OLSON: Is all what?

UNIDENTIFIED FEMALE ATTENDEE: The highlighted
stuff before and after the asterisk is just stuff
that you're moving from one section in our proposed
bill to another section of Bhiska (inaudible)?

MS. THABAUT: Well, no. (inaudible).

MR. OLSON: Yeah --

UNIDENTIFIED FEMALE ATTENDEE: It was consumer
product but we're moving it over to insurance --

MS. THABAUT: Insurance, right.

UNIDENTIFIED FEMALE ATTENDEE: Okay, got it.

MS. THABAUT: Okay.

MR. OLSON: Can I just comment though on a
couple of pieces that we hadn't seen maybe back in
this material? The current section, 19, on page 38
of your draft brings back in, I think, into the
consumer fraud statute violations of the PBM
statute without some of the material that talks
about the relationship between the (inaudible)
office and Bhiska. You see on page 38, lines 3 and
4 it says that a violation of subdivisions, et

UNIDENTIFIED FEMALE ATTENDEE: I didn't
understand. Would you say that again, please, sir?

MR. OLSON: Section 20 in this draft here
doesn't modify existing law with respect to what
the requirements of the health insurer are. All it
does is to say, at the bottom of page 41 and the
top of page 42, you have to give some addition
notice. And what we were saying yesterday was we
have a bulletin, we've issued it to the insurers,
we're not aware of consumer complaints that have
been filed with us around this issue, so we're not
aware of any need for this section of the bill. If
there are complaints, we encourage people to get in
touch with us, we'd do a good job resolving it.

UNIDENTIFIED FEMALE ATTENDEE: So you're
saying the consumers don't need this? This is
about consumers, not about --

UNIDENTIFIED FEMALE ATTENDEE: No, this is
about insurance.
MS. THABAULT: The insured.
UNIDENTIFIED FEMALE ATTENDEE: Those right consumers, right?
MR. OLSON: But it would obligate the insurer to notify the insured specifically. And I guess my sense is that we're not aware that the insurance companies aren't complying with this, so we're not sure why you need to have an additional notice, especially if it's -- it will just add --
We think the law is being complied with now and if people think it isn't being complied with, we'd like to know so we can investigate.
UNIDENTIFIED FEMALE ATTENDEE: All right.
MR. OLSON: Over on page 43, you have S84.
MS. THABAULT: That's out.
UNIDENTIFIED MALE ATTENDEE: That's out.
MR. OLSON: Okay.
MS. THABAULT: They were attached for purposes of discussion. Okay.
MR. OLSON: Thank you very much.
MS. THABAULT: Thank you.
MS. BRILL: Good afternoon, again. I know it's very late in the day so I'm --
MS. THABAULT: We have instructions to go to midnight.

MS. BRILL: Oh, my goodness. Lucky you.
UNIDENTIFIED MALE ATTENDEE: Just you. I'm leaving in 15 minutes.
MS. THABAULT: Okay, well, that answers my question about do you want to finish this up.
UNIDENTIFIED MALE ATTENDEE: Let's finish this up because I'll be out of here in about 20 minutes.
MS. BRILL: What I can do is respond to the things I heard this afternoon, focus on that, and then if you have other questions, I'm more than happy to answer anything that is within my power to answer.
I registered out with the prescription privacy section and what we just heard from the gentleman Harvey Ashman, general counsel for IMS.
UNIDENTIFIED FEMALE ATTENDEE: Can you give us the page number?
MS. BRILL: Sure. I was going to speak more on policy but that's fine.
UNIDENTIFIED FEMALE ATTENDEE: That's fine.
MS. BRILL: No, no, no. It's section 12, I believe. And the page --
UNIDENTIFIED MALE ATTENDEE: 23.
MS. BRILL: Thank you. Exactly, prescription data privacy. I think what we're being told by IMS
and others who do not like the section is well, gee, all that needs to be done is educate doctors about the AMA opt out and then they'll be all set. None of this information will go forward and there won't be any breach of privacy or any concern about over reaching in terms of marketing, that kind of thing. I think that's a red herring.
Obviously, the AMA does have an opt out. I think that that's great that they have it, but you heard the percentage of doctors who are currently opted out which is less than 1 percent. If that opt out starts to get popular and doctors move more and more to opt out, you can bet your bottom dollar that data brokers, like IMS and Verispan (phonetic), will move to other identifiers for this information. They'll get the state licensing number, maybe they'll be able to get the DEA numbers, I don't know, but certainly state licensing numbers are available. We use state licensing numbers for our gift reports. They're available online. They're easy to get.
So, I was very happy that Senator McDonald asked that question to show that there is a distinction between the AMA numbers and other identifiers that are out there. These are very sophisticated data brokers. It won't take them long to figure out a way to get this information through some other mechanism than the AMA numbers.
So, it's nice that the AMA has it. I applaud that. I think the medical society, if they so choose, should certainly let their members know about it, but it's not going to solve the problem.
UNIDENTIFIED MALE ATTENDEE: (inaudible) also that the AMA requires that they started in the -- (inaudible).
MS. BRILL: Who would lose what fire wall?
UNIDENTIFIED MALE ATTENDEE: Between the rep and the pharmaceutical company.
MS. BRILL: Maybe I -- what fire wall is that?
UNIDENTIFIED FEMALE ATTENDEE: The fire wall with the AMA agreement is that you cannot transmit this information to your rep, and we were also told with the marketing. But if they get the information from somewhere else then that's gone.
MS. BRILL: That's right. The point I'm trying to make from a policy perspective is currently, the current business model that these marketers use, and actually, we only heard from IMS. I don't know if we've heard from Verispan; they may use a totally different identifier. But
the current business model is to use one identifier to link up the data, the prescription data. There
are other business models that will easily be developed in the event that the AMA information
either becomes less valuable because of lot of opt outs or for other reasons. Maybe the fire wall
that you're even talking about might be something they're even now thinking about moving way from
moving from.

So my point is that great that there's an opt out; it's not going to solve the problem. These are very sophisticated marketers making lots of money on this data, although, as Steve pointed out, less than 20 percent of their overall gross revenue, it's still quite a bit of money.

So our position is the AMA opt out: Helpful, glad it's there; not going to solve the problem, and that's why I called it a red herring and we'd still like to see this section enacted in order to stop the kind of detailing that is leading to more expensive prescriptions, in our opinion.

Again, going back to something I said the other day, these institutions are not (inaudible) they are not charitable organizations. The pharmaceutical manufacturers know how to market.

And when they spend billions and billions of dollars to get this data and send their reps out to talk to doctors, they're doing it because they're selling their more expensive drugs. That was my only point with respect to the AMA number.

I can move on. Do you guys want to move on here?

PBM's. You know, Senator Cummings, I think you really hit the nail on the head and I think, to a certain extent, we spent a lot of time with PBMs, and I'm not sure to what extent Bishka has or hasn't had an opportunity to have the same pleasure that we've had in dealing with this industry.

They -- a large swath of their customer base has nothing to do with insurers. These are self insured businesses, from IBM, all the way down to someplace like the City of Moppillar (phonetic).

Sometimes they work through a third party marketer -- a third party administrator, excuse me, a TPA who helps them deal with the PBA and sometimes they don't.

MS. THABAULT: And there's a charge for every each one of those --

MS. BRILL: Absolutely, absolutely,

mark settlement try to set up some standards for how PBMs ought to be dealing with their clients. Many of the clients can handle these negotiations but many of them can't. And so that's the reason why these settlement provisions have been put in place.

So it's just -- again, and it may be that Bishka, you know, because they're thinking about things from the insurance perspective, they think every PBM is dealing through an insurer and they're just simply not. We've looked at their customer base and it's quite far from that.

So, that goes to some of the provisions that Herb was suggesting, Herb and Commissioner Tybo (phonetic) were suggesting. We don't really mind having something in there that says unless the parties contract otherwise, but it ought to say unless the parties, through equal bargaining power contract otherwise, so that you have some sort of quality there.

MS. THABAULT: How do you regulate that?

MS. BRILL: Police that?

MS. THABAULT: Yeah. What is equal bargaining practice?

MS. BRILL: That's a good question. I'm just
saying that I think there are going to be situations where you could have a PBM say this is really good for you, client; you should do, and the client just doesn't have the sophistication or the ability to understand, yeah, you know, maybe it is, and maybe it isn't.

UNIDENTIFIED FEMALE ATTENDEE: Thirty percent says it's really good --

MS. BRILL: Whatever.

UNIDENTIFIED FEMALE ATTENDEE: Until you find out they made twice as much as you say you do.

MS. BRILL: We've looked at a lot of contracts. As I said when I first testified here there's a lot of change going on in the industry; there's no question about it. But the contracts are all over the place with respect to the clients. And some of them get great deals and some of them get lousy deals.

So if you think that that may be too difficult to police, then I think that that would be a question as to whether or not you do want to allow for that out in the event that the parties negotiate otherwise.

Herb is right though. Every one of those provisions may have a price for certain plans. So,

that's why I kind of like the idea of putting in there the ability to have some negotiating room, but I'd like to see arm's length negotiation. I mean, that is something we can certainly police and we have policed, and some concept of a equal bargaining power but maybe I can work on that language.

MS. THABault: Yeah (inaudible).

MS. BRILL: Okay. This business about the enforcement joint jurisdiction of the attorney general in Bishka, we worked hard a couple of years ago with Herb and with Bishka to come up with the language that is in Robin's draft, which has a lot of provisions in where we defer to Bishka on how they interpret the law, and we're very willing to do that.

Where we cannot go is to seek their consent before we investigate; we can never do that. We are independent law enforcement officers and we just can't seek the consent of another agency under its separately elected entity to conduct an investigation.

So having said that, I certainly appreciate -- Herb sent me this language earlier today and I appreciate that he did that. I told him I had a real problem with it. I told Robin.

We're very committed to working with them on seeing if we can come up with something else, but I just want -- I don't want you to think I'm going to go off and talk to Herb and we're going to work out something that we will have on the table that we're going to consent, we're going to seek their consent before we investigate because we just -- we can't do that.

MS. THABault: The chair would have a problem with that.

MS. BRILL: Great, okay. Well, that's certainly helpful to know.

MS. THABault: So (inaudible).

MS. BRILL: We're very helpful -- we're very interested in working with them to make them comfortable, although we happen to like the language we came up with two years ago; we felt that was satisfactory. So, we're working on that we did.

UNIDENTIFIED MALE ATTENDEE: (inaudible).

MS. BRILL: We look a long time. Is Herb still here? It took a week, right? It took a while to come up with the language. Those of you who were here may remember.

I had mentioned last time that I wasn't sure the Medicare, the bait and switch issue, which is in -- it was part of --

MS. THABault: Herb's.

MS. BRILL: Herb's proposal was to bring it into their statute, and I don't have a problem bringing it into their statute. I just mentioned last time, I think just think it's being handled now. I just don't know that it needs a section of law. If you decide to do it, that's fine. I think both of our agencies have been handling those issues.

MS. THABault: But it go into Herb's, not into the consumer fraud?

MS. BRILL: It's fine to put it -- because actually to the extent that there is not pre-emption under part D, the federal government seems to recognize the licensing authority that a state may have. And so I agree with Herb that it is better to be in their balliwick rather than ours.

What are some others issues that were raised? The very last issue that was raised was whether or not there would be a cross reference to our -- in the consumer fraud acts to the PBM enforcement.
Actually, I think that is very important that if
actually stay within the consumer fraud act if
we're going to be cross referencing these other
sections that give us new authority, that it list
this one as well, so it's clear that we will ben
enforcing it under the consumer fraud act.
I think -- did I touch on everything that you
guys wanted to -- those are the new things I heard.

MS. THABAUWT: Interstate commerce?
MS. BRILL: Oh, yeah. Did you want to talk
about that? The interstate commerce, and this was
the issue with respect to whether or not we can
regulate the manufacturers (inaudible).

UNIDENTIFIED MALE ATTENDEE: (inaudible).
MS. BRILL: Did you want me to talk about that
again?
UNIDENTIFIED MALE ATTENDEE: Yeah, just a
little bit.

MS. BRILL: Okay.

UNIDENTIFIED FEMALE ATTENDEE: Yes.
MS. BRILL: Well, as I said, there's really
two issues, one is do we have jurisdiction, and
I've think I answered that, right? And then the
question with respect to interstate commerce, I
think is, you know -- the test for the courts,
typically speaking, is does the state law overly
burden interstate commerce. And one of the things
that the court will look at, one of the elements is
is there a state interest in the regulation that's
sufficient to outweigh any burden that may exist on
interstate commerce. In other words, we're not
prohibited outright from having anything to do with
interstate commerce because on some level that
would mean we could never do anything because
everything is interstate commerce -- or almost
everything is interstate commerce now.

But what the courts will look to is whether
there is a sufficient state interest in the
regulation that outweighs that burden. And in this
case, I think the suggestions I made to the bill,
which are currently in Robin's draft, will very
much help with respect to that argument by showing
that there is, you know, a stronger state interest
here.

I think before, arguably, there would have
been a problem and, in fact, that was one of the
bases on which, if I remembering right, that the DC
trial court struck down the DC law that was
basically talked about health condition as opposed
to a serious health problem between now; we've
now modified. So it was really designed to deal
with that interstate commerce issue.

UNIDENTIFIED FEMALE ATTENDEE: We're trying to
get a handle on this for a long time.

UNIDENTIFIED FEMALE ATTENDEE: Interstate
commerce jurisprudence is opaque, at best.

MS. THABAUWT: All right. It fits very well
in (inaudible).

UNIDENTIFIED FEMALE ATTENDEE: I do think -- I
do think -- the bottom line is I think that the
draft that you have now will do better under a
challenge under the interstate commerce clause than
it would have before.

MS. THABAUWT: Questions for Julie? Thank
you.

MS. BRILL: Thank you.

MS. THABAUWT: Okay. Julie, I'm going to try
to get this firm up but I'd like to vote it out
first thing tomorrow. If we can get Robin and
(inaudible) to do a final draft. So anybody else
in the room that wants to talk? Okay.

We've been waiting a long time. I'm sure
tomorrow morning Robin will have a chance to go
through the final duties to do.

UNIDENTIFIED FEMALE ATTENDEE: I've actually
done most of them except for the some of the most
recent thing. I'm not sure what you want to do.

So, if we can take five minutes to clarify that and
we'll be (inaudible).

MS. THABAUWT: We'll be ready and we'll
take it up at maybe 1:30, maybe we'll start a
little early tomorrow, like 1:15.

UNIDENTIFIED MALE ATTENDEE: If you want me --
I won't be here after 1:00.

MS. THABAUWT: After 1:00?

UNIDENTIFIED MALE ATTENDEE: I'm on my way to
Boston.

MS. THABAUWT: That's right. (inaudible). If
the committee wants to meet at 12:30 tomorrow to do
this, we could do that.

UNIDENTIFIED MALE ATTENDEE: It works for me.

MS. THABAUWT: Bring your lunch and we can
meet and then adjourn until 1:30 when we've got
witnesses.

Okay. So we'll meet tomorrow at 12:30.

Hopefully, we'll work this out.

UNIDENTIFIED FEMALE ATTENDEE: And
(inaudible), and call him.

MS. THABAUWT: Yeah, well find those. Okay.

Okay, let's go.
MR. STORROW: Thank you, Madam Chairman. My name is Charles Storrow, please call me Chuck. I'm with the firm of Kimmer, Sherman, Alas (phonetic), and we represent Express Scripts, which is one of the major PBMs, who obviously has an interest in this bill.

I just handed out some billing with some propose amendments to the PBM sections of the bill that the committee is considering, section 6, 7 and 8.

And I would like to state at the outset that Express Scripts' preference is that those sections be deleted from the bill in their entirety. We are offering these amendments, sort of essentially as a fall back that if the bill does move forward with these PBM provisions in it, we would like to see the bill amended in these fashions. But our first preference is that those sections be deleted from their entirety.

And at the risk of beating a dead horse, I guess, I would just say -- state as a general philosophical or policy matter that I think it's been clearly demonstrated that the marketplace in which the PBMs are operating is an evolving marketplace where the actors are dealing with each other in their own interest. No doubt the PBMs are in it business to make money, but the health insurers are also in business to make money. And as a result of that, we're having a shifting or (inaudible) process that is going on where people are dealing with each other for their own interest in terms of contract terms and there's a lot of creativity that's going out there, and give and take that's going on back and forth between these entities to try and accomplish their objectives and to essentially impose contract terms on that relationship, you could have an unintended consequence of actually increasing drug prescription benefit cost and, you know, limiting the creativity that people, dealing with each other in the marketplace, can achieve on their own.

And I don't know, and I cannot say to you with any definitive nature, you know, exactly the nature of these client base but I would suggest that it's clear that there's a lot of -- our company's customers are very sophisticated and can more than adequately handle themselves. And that to the extent there are smaller, unsophisticated customers out there that need protection, you may be accomplishing what you think is protection in a way that's going to hurt and drive up cost in terms of the other more sophisticated actors in the marketplace.

So that's essentially the philosophical approach that we're following in this matter and we would urge the committee to adopt.

You know, I could take the time to go through the proposed amendments line by line. They, more or less, track the notion that the terms in the bill would apply unless otherwise provided by contract and, in that regard, is very similar to what Commissioner Todd (inaudible) and Mr. Olson are suggesting that the committee do.

You know, with respect to -- on the first page this issue of the duty, the fiduciary duty, implied in every contract is an obligation of good faith and fair dealing, and we're certainly willing to live with that. But to provide that somebody is unnerved and, you know, it doesn't say fiduciary duty, it's using the phraseology that's involved in a fiduciary duty is taking a whole body of law that relates to trust law, that relates to a completely different context in which people are interacting with each other. When you are handing over a portion of your paycheck to the state employees of retirement board to invest, then you're talking about a situation where a fiduciary duty is appropriate because they have to then manage that in a way -- and to make it grow and so forth. But when you're talking about purchasing services, it's a different -- it's just -- it's taking an area of the law that doesn't apply to transactions involving purchase and sale services and posing a whole host of obligations and rights and responsibilities that could have unintended consequences because of the mismatch there between --

MS. THABAUT: I've been told, as a realtor, I have fiduciary responsibilities to my clients in marketing, but I'm contracting them to advertise their house to arrange, you know, to bring people through. So it's --

MR. STORROW: I don't know if it's a fiduciary duty --

MS. THABAUT: (inaudible).

MR. STORROW: -- Madam Chair. You certainly -- you're under an obligation in that context to disclose information that the other party should need to know or an obligation not to misrepresent, affirmatively misrepresent. But I'm
exceptions to that raised price.

MR. STORROW: To the issue of drug substitutions and, you know, Madam Chair, I'll confess, I don't know all the ins and outs of the workings of these proposed amendments. But I think if you look at them, they're pretty self evident but that in situations where the drugs substitutions is initiated for patient safety reasons, the currently prescribed drug is no longer available in the market or the substitution is required for coverage reasons in which the prescribed drug is not covered under the covered person's formulary or health benefits plans. If those are on the face of a legitimate exceptions to the rule that's otherwise established in that section or --

MS. THABAUT: I think the intent of that section is that if the substitution is made for the purpose of increasing market chair (inaudible) and the purpose of receiving a rebate, is that that be made the presence of the rebate be made known. But they sound reasonable.

Julie, going backwards, I apologize, it took me a minute to catch up with you. The sub two that Chuck is proposing relates to a (inaudible) going

fact that that would create a whole -- potential
for a whole another avenue of litigation and cost on their end and duplicative regulatory authority.

MS. THABAUT: Okay. You had a couple in here, unless I missed something, that you skipped.

(inaudible) information.

MR. STORROW: Yes, I didn't know if you wanted to take the time to go through this bit by bit.

Going over onto the second page up at the top, yes this is where information is provided to the health plan (inaudible) confidential unless there's a court filing and then our client would simply liken (inaudible) that -- if the information is provided to the court, that it be kept under seal and that they be given an opportunity before it's unsealed to intervene or at least to have a shot at asking the court that it remained sealed.

MS. THABAUT: I need to know more about what that means. (inaudible) yes or no from Julie on the sealing or unsealing.

MS. BRILL: I'm sorry, which provision is it here?

MR. STORROW: On the second page.

MS. THABAUT: -- (inaudible) underlining there. We can go on. The next one is some to be filed by the plan in the event they felt that the PBM had (static) law and it doesn't relate to our litigation or our (inaudible) ability to get data and information because that's what (static) investigated from (inaudible). Chuck, am I reading that right?

MR. STORROW: Yes, I think you are.

MS. THABAUT: This is a private suit in which case I don't have an objection to provision that's would require that even when after filing court, the information would be kept confidential unless the court would agree it can be unsealed, if you will. But again, I just want to make sure I'm understanding that this is limited to a private plan suit and not (inaudible) our suit because we communicate with other law enforcement agencies, other state attorney general with the US Department of Justice all the time and (inaudible) they would not be subject to that kind of provision.

So, again, if I'm reading it correctly, which I think I am, it relates to the suit by a plan against the PBM.

MR. STORROW: I understand what you're saying. It's a very fine (inaudible) there because the language that isn't -- that we're not proposing to
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1. amend is talking about, basically, in a court
2. filing under the consumer file provisions of
3. Chapter 63, Title 9, that is the consumer fraud
4. statute in which you would operate under -- in
5. addition to a private -- an insurer bringing its
6. own claim under that.
7. UNIDENTIFIED FEMALE ATTENDEE: But it's
talking about the plan, may not disclose it.
8. MR. STORROW: That's right.
9. UNIDENTIFIED FEMALE ATTENDEE: By (inaudible)
doesn't affect us. So, again, I would want to look
10. at this a little more carefully. Assuming I am
11. reading it correctly, (inaudible) I think it's
12. okay.
13. UNIDENTIFIED FEMALE ATTENDEE: Okay.
14. MR. STORROW: Skipping down to subsection B,
15. again, here's the language that basically is
16. carried forward in five, six -- five and six, which
17. essentially gives the parties the ability to
18. contract around the requirement that are set forth
19. in that.
20. MS. THABAULT: This also says that you have to
21. give notice.
22. MR. STORROW: Right. And again, I think that
23. that would give the parties the information they

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1. need in order to make the intelligent choices
2. because you're basically saying, look (inaudible)
3. you give them the notice of quote for an
4. alternative way of going about doing it.
5. MS. THABAULT: Okay.
6. UNIDENTIFIED FEMALE ATTENDEE: I'd like to get
7. back to another section before we finish.
8. MS. THABAULT: Okay, go ahead.
9. UNIDENTIFIED FEMALE ATTENDEE: Going back to
10. 4A.
11. MR. STORROW: Yes.
12. UNIDENTIFIED FEMALE ATTENDEE: The exceptions
13. to disclosure to the (inaudible) plan, I don't
14. understand why that would be necessary -- I mean, I
15. don't understand why you want that, why your --
16. Express Scripts wants that.
17. MR. STORROW: I think the idea, Senator, there
18. is that each time a disclosure is required is going
19. to drive up cost, and that if there is certain
20. situations as enumerated in the exceptions where
21. the substitution is done for a legitimate purpose,
22. then why make them -- make a disclosure that has a
23. potential of increase in cost in those scenarios?
24. UNIDENTIFIED FEMALE ATTENDEE: How is that
25. different from -- because I'm doing it for your own

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1. good, not having to tell you -- I mean, it seems
2. really patronizing. If I want to know or if my
3. insurance company knows, why did you take
4. (inaudible) aspirin and put her on this other
5. expensive drug. That the PBM gets to say because
6. it's for your own good; don't ask me anymore
7. questions?
8. MR. STORROW: I could say why you would say
9. that but then it brings us back to the initial
10. point, which is that a requirement that you tell us
11. in any and all circumstances why there was a
12. substitution could easily be a term of contract
13. negotiation.
14. UNIDENTIFIED FEMALE ATTENDEE: Okay. I think
15. what it said is when you substitute it, the price
16. goes up, you have to disclose if there is any
17. rebates involved in that decision. So unless you
18. were getting a rebate here, you wouldn't have to
19. disclose under the present law if drug isn't any
20. longer available.
21. UNIDENTIFIED FEMALE ATTENDEE: How many times
22. do you have to tell the insurance company that
23. after it's off the market? It's doesn't make any
24. sense to me.
25. UNIDENTIFIED FEMALE ATTENDEE: Unless there is

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1. also a rebate, and that's what this is getting at,
2. is that if you're going to put a higher priced drug
3. on my formulary and say this is what would cover
4. it, then the insurance company has a right to know
5. that you're doing that in part or full because
6. you're getting paid to do that, and that was the
7. purpose. We don't want you to have to describe --
8. you know, if there is no rebate, if the drug isn't
9. available so you have to get one, if the drug is
10. causing side effects and people are dying, you
11. don't have to get one. Now, if you have a choice
12. of eight drugs and you recommend the one you are
13. going to get a rebate for, I think you need to tell
14. them there is money at play here. In (inaudible)
15. the risk is you give them all the money, and now it
16. says you don't have to give anything but you do
17. have to tell them that there's money changing
18. hands.
19. UNIDENTIFIED FEMALE ATTENDEE: But that's the
20. reason.
21. MR. STORROW: I understand what you're saying,
22. Senator Cummings, but I think if -- my reading of
23. that A, it says with regard to substitutions in
24. which the substitute drug costs more than the
25. prescribed drug. So that if that's the event, then
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<td><strong>UNIDENTIFIED FEMALE ATTENDEE:</strong> It says have you to disclose the price of both drugs. Well, if the drug is going away for patient's safety, they know that the one that's making them sick and you're most certainly going to tell them the price of the one you're recommending where you might get more disclosure if the drug is no longer available and there's three possible substitutes. You probably have to tell them the cost of the three substitutes. But we can write this up where it's getting is where the decision as to which one to recommend has some money changing hands somehow. <strong>MR. STORROW:</strong> Okay, I understood. I think. <strong>UNIDENTIFIED FEMALE ATTENDEE:</strong> Or a golf trip or (inaudible). <strong>MR. STORROW:</strong> I understand where you're going with that. I'm not sure if the language is limited to just that situation. <strong>UNIDENTIFIED FEMALE ATTENDEE:</strong> Okay, we'll see.</td>
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<td>**that's why you're doing it. You've got to tell the health insurer, the customer, which is the health insurance (inaudible) so they know what you're doing. If they want to say fine, as long as you give us a share, that's okay. If they say no, we want to go back to the old one, then you fight it out with the attorneys -- is that the phrase? Fight it out. <strong>MR. STORROW:</strong> Again, as I read this, it would require the disclosure simpling the event if the substitute drug caused more than the prescribed drug. <strong>MS. THABAULT:</strong> If it costs more than the prescribed drug, you have to disclose the price anyway (inaudible) and you have to disclose any remuneration, right? When you substitute, you've got to disclose the new price; they know that. The only thing else you're going to have to disclose is if you're getting a rebate or you're sending all the kids in the company to college or med school or, you know, if that's an intrical part of the -- if that's part of the decision making process, is you're getting paid to make that decision. <strong>MR. STORROW:</strong> Okay. Duly noted. <strong>UNIDENTIFIED FEMALE ATTENDEE:</strong> Good answer.</td>
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<td><strong>if we can tighten that up. But that's the intent. If there is no money changing hands -- <strong>UNIDENTIFIED FEMALE ATTENDEE:</strong> I think he and I are talking about different things. This raised new issues that these proposed amendments, as far as I'm concerned -- I've always taken aspirin and I go to Frank, the pharmacist and he says, oh, you can't have aspirin anymore but I don't know why. Am I sick? Have I been taking something that causes cancer? What's up with that? Why shouldn't I know that? I'm a customer. <strong>MS. THABAULT:</strong> (inaudible) under the contract (inaudible). Yeah, under the contract, your insurance company would know that they're changing drugs and there is a substitution or what terms and what conditions, substitutuions can be made and, you know, that's in the contracts. But what this says if you just decide to change the contract and the reason you're doing it is because you've got a rebate to increase market share here, formal expensive drug. You can -- if you get a rebate for a less expensive drug, that's fine. But again, there's substitutions all the time, and that's how (inaudible) contracts is my understanding. But this says over and above that</strong></td>
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<td><strong>MR. STORROW:</strong> Okay, where are we? I think we talked about that, unless the contract provides otherwise, you give them a quote of the alternative. And the likewise, five, actually, that was one where it already provided -- the committee bill already provided that unless the contract -- <strong>MS. THABAULT:</strong> This looks it's addressing some of the concerns about -- unless the contract provides otherwise. You probably with more -- <strong>UNIDENTIFIED FEMALE ATTENDEE:</strong> (inaudible). <strong>MR. STORROW:</strong> I'm sorry. <strong>MS. THABAULT:</strong> If this looks okay, just (inaudible) in fact tightening up that unless the contract -- trying to get some flexibility here but get some level playing field. All right. <strong>MR. STORROW:</strong> Okay, going over onto the next page, sub section six, which is the provision that would require the PBM to disclose to the health plan all financial terms and arrangements between the PBM and the drug manufacturer, what the proposed amendment would do would limit that disclosure to the provision, to the information as pertinent to the provision of the benefits to the beneficiaries through that health plan and all</td>
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financial and utilization information relating to services to that health plan. So it's focusing it on, okay, this is how it affects your plan. And then it has, unless the contract provides otherwise and the client would be notified that they have that option. It's a long sentence there, no doubt, but...

MS. THABAUT: Okay.

MR. STORROW: And again, here -- this is similar to what we've already discussed, the next set of amendments there. The obligation under the bill is that when that disclosure is made to the health plan, it has to be kept confidential, and then there is an exception for when it's filed with the court and then we sort of want an exception to the exception that that information be provided, that be kept under seal, and that we get notice before it gets unsealed.

MS. THABAUT: Okay.

MR. STORROW: And --

MS. THABAUT: It sounds reasonable.

MR. STORROW: As I said earlier, where we are (inaudible) of the tie in with the consumer fraud statute and we're proposing that that provision be deleted in its entirety. And that is -- well, excuse me.

MS. THABAUT: You've got one more.

MR. STORROW: Yes, we do. Oh, okay.

MS. THABAUT: This is the audit provision?

MR. STORROW: Right. And again, it's that (inaudible) blank language where that obligation of providing access and so forth would govern unless the contract between the PBM and the health plan would provide otherwise --

MS. THABAUT: Have you hit all the same places that Herb hit unless the contract provide, if we just say and the client has been notified beforehand that they have the option for simplicity?

MR. STORROW: We may well be. I haven't compared what Herb has done --

MS. THABAUT: -- and the wording I found, we're looking for a way to get a little -- level playing field that the client has been notified prior to contracting that they have that option and that may -- so you know you've got the option there, you know you should probably ask your attorney which is a better option. And we're working under the assumption that they all do have attorneys or they're probably beyond protection.

UNIDENTIFIED MALE ATTENDEE: (inaudible).

MR. STORROW: And then, Madam Chair, the only thing I would add -- and this isn't red lined -- but on the very last page of our proposal under section 19, consumer protection prescription drugs and I know that this -- sub section A says a violation of subdivisions (inaudible) and 9472 of Title 18 shall be considered a violation under this section. If the committee were to delete the tie in to the consumer fraud statute, then that referenced in 9472 would need to come out because that's the title and that's --

MS. THABAUT: Okay.

MR. STORROW: I thank you for your consideration.

MS. THABAUT: Thank you. Committee, any questions? All right. Rhonda?

UNIDENTIFIED FEMALE ATTENDEE: I think that I still (inaudible) other part I'd love to hear what somebody else things.

UNIDENTIFIED MALE ATTENDEE: (inaudible) this is about you have to disclosure whether you get rebates unless the contract says you don't have to. That's (static). If the contract says it's okay for the benefit to keep the rebates unless they agree to that but they don't know what they are.

UNIDENTIFIED FEMALE ATTENDEE: (inaudible)

John Kennedy on behalf of MedCo. Our company did work with Express Scripts on that language, so I just wanted you to know that it was an industry presentation that I think Chuck had read his work on it.

UNIDENTIFIED FEMALE ATTENDEE: Okay. There's a couple of issues. One, and it's in response to the changing industry, our bill says you can have this full disclosure and this is what it is, or you can -- and we recognize the need, that you can just have a new administrative only and we contract for (inaudible) 10 to 20 percent savings over AWP or whatever is in the contract.

We've had testimony that many, if not most, customers now, health plans, go out with an RFP and says this is what we want to you bid on and there's a contract derived. The concern is, and it was my concern, that if I'm not one of the Philadelphia lawyer guys and I'm using my cousin, Charlie, who happens to be a lawyer in --

UNIDENTIFIED FEMALE ATTENDEE: (inaudible)

lawyer.

UNIDENTIFIED FEMALE ATTENDEE: (inaudible)
he's never dealt with corporate law, he does mostly, you know, wills and the rest of it, I might not know. And so what I see this saying is prior to signing the contract, you're told, you know, you bring in a bid with an RFP and you just want the 20 percent off what I'm paying now and you're told, okay, but we can -- you know, you also -- and there's a cost involved -- you have the option of getting this and this and this, and these are the costs differentials, and then there's a decision. I think where the rebates come in is when you are, in fact, changing your coverage, we're going to now buy pink instead of green pills, and the guiding reason for that, or the prime reason for that is because we're now getting money to make you -- to make that change. Now, we're getting that, and I think there's a good reason to do that. But I'm wondering if Robin, you know, if that works -- if the attorney general said she does not mind there being that unless provided by -- because she thought it was a good thing to have flexibility, there was some kind of need on her part to provide a level playing field. This would hurt --

UNIDENTIFIED MALE ATTENDEE: (inaudible) would

be where we talking about the parties being able to vary in terms of the contract. I think I was kind of accepting the notion that there might be some parties that need a little bit of help from the regulator and if you wanted to conclude in some of the language that we talked about the notice of the alternative, that the Bishka would have an obligation to frame -- you know, to prescribe the terms of the type of notice so that for the little guy would know what's at stake and we'd be glad to make that happen.

MS. THABAUT: Okay.

UNIDENTIFIED MALE ATTENDEE: Put a notice on it if your (inaudible). Probably --

MS. THABAUT: You probably ought to look elsewhere.

UNIDENTIFIED MALE ATTENDEE: (inaudible),

UNIDENTIFIED MALE ATTENDEE: (inaudible) with that type of provision, you'd be allowed to (inaudible) the (inaudible) to do what they want --

MS. THABAUT: I have things in my contract that say, and we strongly encourage you to seek legal and financial consultation. It's a lot tighter on realtors than we are on PBMs.

Okay, I don't define financial or legal

advice.

So, Robin, you got -- you said you've done most of the changes. So what --

MS. LUNGE: What do I have questions on?

MS. THABAUT: What have you done?

MS. LUNGE: What I did -- I did a bunch of technical little things, type of (inaudible) things that we found along the way.

MS. THABAUT: Okay.

MS. LUNGE: Let me just -- I -- let me just run right through this. This is probably better.

I just need to look for bold.

MS. THABAUT: It looks like we did get to section six. I think that's --

MS. THABAUT: And that's page 13.

(MS. LUNGE: No, I think I didn't do anything with the (inaudible) section six. So I think that you want to know what Herb's definition of health insurer, I haven't done that yet but I think you want to do that, right?)

MS. THABAUT: Yeah, it sounds like just clarify, wasn't it?

MS. LUNGE: And --

UNIDENTIFIED MALE ATTENDEE: Three categories.

MS. LUNGE: The three categories, yup. In 9472 we get into the variance options and terms that -- in terms of the duty, Herb had suggested adding is that that would be the duty unless the contract provided otherwise. On that point, industry folks have suggested a different -- different language on the duty.

MS. THABAUT: And that's been suggested many times. I think I'm not ready to change that at this point.

MS. LUNGE: Not change that section at all or not change the duty itself?

MS. THABAUT: Not change the (inaudible).

UNIDENTIFIED MALE ATTENDEE: The level of duty.

MS. LUNGE: Okay, okay.

MS. THABAUT: I think unless provided by contract provided that the things according to rules to be promulgated by, Commissioner, Bishka or whatever (inaudible) -- I'm sure (inaudible) language for that somewhere.

MS. LUNGE: Right. I think there are two issues. There's the issue of the notice, which is I think what Herb was speaking to that and I can -- what I probably do, I think, if you want the
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notice -- very two questions. Do you want the
notice to apply to each of these issues or just
some of the items?
MS. THABAULT: I think it sounds like -- the
phrase I don't recall I was provided that they --
UNIDENTIFIED FEMALE ATTENDEE: Where are you
reading from, Sharon.
MS. THABAULT: I'm not exactly sure.
MS. LUNGE: On I'm section 9472. What was
family (inaudible). (inaudible).
MS. THABAULT: Page 15, I think and page
three. And we're suggesting unless contract to
prove pharmacy the PBM --
MS. LUNGE: Which is a separate issue from the
notice.
MS. THABAULT: Where is the notice?
MS. LUNGE: The notice language is not in this
section at this point.
UNIDENTIFIED MALE ATTENDEE: No wonder.
MS. THABAULT: Okay.
MS. LUNGE: The notice issue came up in the
discussion and in the industry language on the
second page -- oh, wait.
UNIDENTIFIED FEMALE ATTENDEE: Let's see.
MS. LUNGE: I think it was in the audit

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section that the industry suggested the notice but
then you were discussing the notice more generally
as applying to some of these provisions, too.
MS. THABAULT: What notice?
MS. LUNGE: The notice about what options were
available --
MS. THABAULT: Oh, okay.
MS. LUNGE: -- for the little guy --
UNIDENTIFIED FEMALE ATTENDEE: Unless they
signed their options away.
MS. THABAULT: The safe thing we would do was
to say unless -- here it is. And the client has
been -- unless the contract provides otherwise and
the client has been notified prior to contract
being (inaudible) but they have this option. So
what Herb has --
MS. LUNGE: Okay.
MS. THABAULT: -- that, then you could do that
in someplace, you will find a place to put Bishka
will find --

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CERTIFICATE
THE STATE OF FLORIDA,
COUNTY OF PALM BEACH.
I, Jeana Ricciuti, Notary Public, Certified
Shorthand Reporter and Registered Professional
Reporter do hereby certify that I was authorized to
and did listen to CD 07 - 54/T1, the House
Committee on Health Care, Monday, August 27, 2007,
proceedings and stenographically transcribed from
said CDs the foregoing proceedings and that the
transcript is a true and accurate record to the
best of my ability.
Dated this 28th day of August, 2007.

Jeana Ricciuti, RPR, FPR
STATE OF VERMONT

SENATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: Wednesday, February 21, 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 57, Track

Esquire Job #889698
PROCEEDINGS

CD No: CD 2007 57, Track 1

SENATOR CUMMINGS: And because we're working with three copies.

FEMALE ATTENDEE: The notice is the thing that Herb added at the end of --

SENATOR CUMMINGS: They all the way through page 5.

FEMALE ATTENDEE: Yeah.

SENATOR CUMMINGS: And then you get to page 6.

FEMALE ATTENDEE: "Unless the contract."

SENATOR CUMMINGS: "Or when ordered by health insurance," and that just allowed the Commissioner to get information, so I think that one's okay.

MS. LUNGE: Yes, yep.

SENATOR CUMMINGS: And --

MS. LUNGE: And I have one other question before you move on.

SENATOR CUMMINGS: Okay.

MS. LUNGE: Just let me check one thing.

I'm assuming you're also okay with the additional language under the duty that Herb added.

"In addition to that contract, in the case of a health benefit plan offered by a health insurer as defined," blah, blah, blah, "the health insurer shall remain responsible for administering..."

SENATOR CUMMINGS: Yes, yeah.

MS. LUNGE: Okay.

SENATOR CUMMINGS: Yes.

MS. LUNGE: I thought so, but I just wanted to check so I know what I'm doing.

SENATOR CUMMINGS: All right. I thought we -- I actually thought we'd agreed to that yesterday.

MS. LUNGE: Okay.

SENATOR CUMMINGS: All right.

MS. LUNGE: Okay, so I think on Herb's copy anyway, we are --

SENATOR CUMMINGS: We're up to page 13?

MS. LUNGE: On to page 8, which is the Section 7.

ATTENDEE: Herb's 8, yeah.

SENATOR CUMMINGS: Wait, Herb's 8, yes.

MS. LUNGE: Herb's 8.

SENATOR CUMMINGS: Herb's 8.

FEMALE ATTENDEE: Herb's 8?

MS. LUNGE: You had talked about removing B.

Do you -- you're still there, right?

SENATOR CUMMINGS: Yep.

MS. LUNGE: Okay.

FEMALE ATTENDEE: And deleting the letter A?

MS. LUNGE: Yes.

SENATOR CUMMINGS: And just saying you only have to --

ATTENDEE: And B.

FEMALE ATTENDEE: And all of B?

SENATOR CUMMINGS: Yeah. She's just going to get renumbered.

FEMALE ATTENDEE: On our original draft?

MS. LUNGE: Yes.

SENATOR CUMMINGS: So this says that if you're making a substitution for a higher-priced drug, you have to disclose any benefits, that the PBM has to disclose any benefits they're getting in relationship to that, and you'd only have to deal with other things if there is a benefit attached to it.

Otherwise, you just tell them it's the new, high-priced drug, per our substitution contract.

FEMALE ATTENDEE: I just wonder if we don't add those things that Chuck would like us to add,
1 does it mean that they don't have to answer those
2 questions?
3 If Blue Cross/Blue Shield says, Hey, what
4 happened to the aspirin? Why can't we have
5 aspirin? They don't have to -- they don't have to
6 tell Blue Cross/Blue Shield?
7 SENATOR CUMMINGS: Under this, they wouldn't
8 have to tell them. Right now --
9 FEMALE ATTENDEE: Do they ever -- do they
tell them now?
10 SENATOR CUMMINGS: No. Well, they have --
11 FEMALE ATTENDEE: How can that be?
12 MS. LUNGE: Well, the "why" is different than
13 what's required.
14 SENATOR CUMMINGS: Yes.
15 MS. LUNGE: What's required is the cost of
16 both drugs.
17 ATTENDEE: Yeah.
18 MS. LUNGE: And any benefit or payments going
19 to the PBM from the substitution. That's what's
20 required.
21 So Blue Cross can ask about, Why did you
22 switch this and not that?
23 And I don't know if they'll answer, but this
24 doesn't change whether or not they would answer.

SENATOR CUMMINGS: Right.
MS. LUNGE: That would be the same as it is
now.
ATTENDEE: But it happens now. The doctor
will say --
FEMALE ATTENDEE: Yeah.
ATTENDEE: -- that it's not a preferred drug.
SENATOR CUMMINGS: I mean, preferred drugs
change all the time.
What this is getting at is the primary reason
it's changing is because we're getting a rebate.
ATTENDEE: Yeah.
SENATOR CUMMINGS: And we're getting paid X
for every pill we sell or whatever but...
ATTENDEE: But I don't think that that will
ever trickle down to the client.
FEMALE ATTENDEE: No. The issue is that the
client needs to know that you're going on this
fancier, more expensive drug because it costs us
less. Now, that's the issue.
SENATOR CUMMINGS: It might be a reason when
you go to renew your contract to do it differently
or to negotiate that substitution section
differently.
ATTENDEE: Yeah.

MS. LUNGE: All right.
MR. STORROW: I'm just wondering, Madam
Chair, if that Senate --
SENATOR CUMMINGS: I just need you to say
your name for the record.
ATTENDEE: I'm sorry. Yes, of course.
MR. STORROW: Chuck Storrow from Express
Groups.
SENATOR CUMMINGS: Okay.
MR. STORROW: Under 4-A, if we had something
like this, and I'm going to do this off the top of
my head so it may not be perfect, but with regard
to substitutions in which the substitute drug
costs more than the prescribed drug and the PBM
receives a benefit or payment directly or
indirectly as a result of the substitution, then
disclose --
SENATOR CUMMINGS: Those facts must be
disclosed. All right.
MS. LUNGE: Okay.
ATTENDEE: Payment or any other --
SENATOR CUMMINGS: Payment or benefit,
directly or indirectly. Your kid gets a
scholarship to med school.
MR. STORROW: Right. If that's the reason,
then the disclosure would be made, but if that
isn't --
SENATOR CUMMINGS: You got to sell a lot of
pills.
ATTENDEE: When you divide that by the number
of pills you sell, that's (inaudible).
MS. LUNGE: Okay, so I think I know what I'm
doing with that.
SENATOR CUMMINGS: Yep.
MS. LUNGE: It sounds like the under seal
court language is fine.
SENATOR CUMMINGS: Yeah.
MS. LUNGE: As applied to the private plan.
FEMALE ATTENDEE: Does that -- what does that
mean?
SENATOR CUMMINGS: That's the Attorney
General (inaudible) sends up a red flag.
MS. LUNGE: What that means is that if I, the
health insurance plan, want to file under the
Consumer Fraud Act against my PBM, when I file,
the court would be required to keep that
information confidential.
Normally, anything you file in court is a
public record.
FEMALE ATTENDEE: Oh.
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1 MS. LUNGE: So it would be kept under seal until such time as the court determined there was no proprietary information or whatever so...
2 SENATOR CUMMINGS: This is the concern that's been ongoing.
3 FEMALE ATTENDEE: Uh-huh. Yeah, I just wanted to make sure that --
4 SENATOR CUMMINGS: If they know what the state of Vermont's getting and they're only half the market share, but then you've got other customers that are saying, Why are they getting 20 and we're only getting 15?
5 FEMALE ATTENDEE: Well, things are so rarely as simple as they sound. I thought it had to be something else.
6 MS. LUNGE: I'll probably change this language a little bit so that it's clearer.
7 FEMALE ATTENDEE: Okay.
8 MS. LUNGE: In terms of the sentence structure, but I won't change the -- I'll try not to change the intent or the meaning in my finessing of that.
9 Okay. I think -- I think in 6, the intent, and this is in version, Chuck's version --
10 SENATOR CUMMINGS: Chuck's yeah.

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1 MS. LUNGE: His 6, subdivision 6.
2 SENATOR CUMMINGS: Uh-huh.
3 MS. LUNGE: I think the intent there was to make sure that we were talking about disclosing to the health insurer their own information, not other people's information.
4 SENATOR CUMMINGS: Uh-huh.
5 MS. LUNGE: I can tighten that up.
6 SENATOR CUMMINGS: Okay, yeah. That works.
7 MS. LUNGE: Because I think that's what we were meaning.
8 SENATOR CUMMINGS: I'm not prepared (inaudible) consumer fraud.
9 Audit, section 7.
10 MS. LUNGE: So is there anything else that I missed? I'm tired, so I may have missed something --
11 SENATOR CUMMINGS: I haven't seen anything.
12 MS. LUNGE: -- in my three versions.
13 SENATOR CUMMINGS: We're all tired. I'm trusting Herb is (inaudible) monitoring his.
14 FEMALE ATTENDEE: What did we decide about the Consumer Fraud Statute?
15 Is that all tied up with the discussion that Herb's going to do?

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1 SENATOR CUMMINGS: They have always hated consumer fraud.
2 FEMALE ATTENDEE: Okay.
3 SENATOR CUMMINGS: We have always kept consumer fraud. That's just what --
4 FEMALE ATTENDEE: Just checking.
5 SENATOR CUMMINGS: That's what the law is brought, this suit is brought under. That's the Attorney General's. Herb has a whole bunch of regulatory tools in his tool box.
6 Yeah. No, that's just -- they just don't like that they may be associated with fraud.
7 MS. LUNGE: And in terms of that cross -- were you talking about the cross-reference?
8 FEMALE ATTENDEE: Yeah. So we're leaving it off?
9 MS. LUNGE: Okay. In terms of the cross-reference, if I change that to the subchapter that all of that language is in, does that work better for you? Because the 9472 is just that one required practices, which doesn't have all your other language, but if I refer to the subchapter --
10 ATTENDEE: I don't mind the cross-reference at all as long as it also incorporates --

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1 MS. LUNGE: The other consultation.
2 ATTENDEE: -- consultation and the presumptions.
3 MS. LUNGE: So I can take a shot at that and then e-mail it to you later.
4 SENATOR CUMMINGS: All right.
5 MS. LUNGE: Okay, so Section 7.
6 So that my two questions here are in the middle ground version of doing the notice, and I wasn't entirely clear that you wanted -- which way you wanted to go on that, the notice about that there's an admin only contract, quote, available, as opposed to offering it. I'm guessing --
7 SENATOR CUMMINGS: I think it's just letting it know that it's available.
8 MS. LUNGE: Okay. That's where I thought you would go.
9 SENATOR CUMMINGS: Yes.
10 MS. LUNGE: But I just wanted to make sure.
11 SENATOR CUMMINGS: I think we're recognizing it.
12 MS. LUNGE: And then also -- let's see. In Chuck's language, there was -- he had added in the "unless the contract," et cetera to the audit
SENATOR CUMMINGS: My gut says to just leave it alone, and I'd rather go for more transparency.

1. I think at this point. Okay, it's a (inaudible).
2. MS. LUNGE: So just a couple more things.
3. SENATOR CUMMINGS: Okay.
4. MS. LUNGE: In the prescription drug data
5. confidentiality that we talked about earlier this
6. and afternoon, I can add the --
7. FEMALE ATTENDEE: Where are we now, Robin?
8. MS. LUNGE: We're in Herb's draft, page 11 or
9. the big draft, page 23.
10. FEMALE ATTENDEE: Yep.
11. MS. LUNGE: So the easiest thing to do is to
12. add those two exceptions that people talked about, the
13. law enforcement and the BISHCA multi-payor
14. database collection.
15. FEMALE ATTENDEE: Okay.
16. SENATOR CUMMINGS: That's easier than saying
17. commercial use has something to do with the
18. exchange of cash.
19. MS. LUNGE: Well, because it describes
20. commercial purpose, not commercial use.
21. SENATOR CUMMINGS: Okay.
22. MS. LUNGE: So commercial purpose could
23. include advertising which, you know, has a

in accordance with rules adopted by the
Commissioner by the health insurer to financial
and contractual information necessary to conduct a
complete and independent audit."
And then 2 only applies if there is an
administrative services contract, so if you had a
different kind of contract, those don't apply.
And 3 says, "Any other verifications relating
to the pricing arrangements and activities
required by the Commissioner."
So BISHCA by rule could say well, if you have
this other kind of contract, if there's an audit
request, you should disclose this type of
information. And the question is should that
audit capability be allowed as an optional
contract term?
SENATOR CUMMINGS: I mean your audit is part
of transparency, but on the other hand, I can see
where there would be a cost involved and --
MS. LUNGE: This is not hard language to add,
so if you want to think about that one overnight.
SENATOR CUMMINGS: Yeah.
MS. LUNGE: I can have that one in my pocket.
SENATOR CUMMINGS: Okay.
MS. LUNGE: All right, and then I think --

financial component. It's just having to think
that all through at this point is --
SENATOR CUMMINGS: Yeah, okay.
MS. LUNGE: -- is going to kill me.
SENATOR CUMMINGS: All right. Then that's
fine.
ATTENDEE: Kill us too.
SENATOR CUMMINGS: Okay. We'll let Health
Care sweat that one.
Right now, we'll just make the police happy.
MS. LUNGE: Okay.
SENATOR CUMMINGS: Okay.
MS. LUNGE: And her.
SENATOR CUMMINGS: And her. All right.
We're on a roll.
MS. LUNGE: I did check 9410, which is the
multi-payor database, and it requires the patient,
physician/patient privilege information to be kept
private, but it's not clear to me that prescriber
data is in that confidentiality provision, so that
might be something that you'd want to clarify if
you wanted that to remain confidential at BISHCA
and not subject to public records.
SENATOR CUMMINGS: You get it. We just don't
want the public to have it.
ATTENDEE: Well, right, and the concern we had about that subdivision 2, it talked about filing with BISHICA.
MS. LUNGE: Right, and I agree that that's not right, subdivision 2.
SENATOR CUMMINGS: Okay.
ATTENDEE: Oh.
MS. LUNGE: I'm not suggesting subdivision 2. I'm suggesting that I take another stab at a confidentiality provision that says after you get the data, you keep it confidential from -- so it won't be a public record.
ATTENDEE: Oh.
SENATOR CUMMINGS: Public records.
ATTENDEE: I see.
MS. LUNGE: And I think I can do that by just clarifying not this section, but another.
SENATOR CUMMINGS: Then, yeah. Steve's taking notes. If it's a public record, they'll be writing in tomorrow.
ATTENDEE: Well, it won’t exist if you ban its commercial use.
SENATOR CUMMINGS: Okay.
ATTENDEE: So you won’t have -- nobody will have -- the cops won't have to worry. It won’t be there.
SENATOR CUMMINGS: It'll be somewhere. All right.
MS. LUNGE: And then so that -- other than that, and then I was going to put in Herb's language in Title 8 so that it was in there, and then you can decide tomorrow if you want it or not.
SENATOR CUMMINGS: Herb's -- all right.
About the --
MS. LUNGE: About the Medicare Part D marketing.
SENATOR CUMMINGS: That stuff, yeah. It sounds like that's a tool. It may or may not be necessary now, but things change. Okay.
MS. LUNGE: And then the other things I've already done are I added -- in that second reference to the Oregon project, I added that language.
SENATOR CUMMINGS: Yeah. "Such as"?
MS. LUNGE: Yep, exactly.
SENATOR CUMMINGS: Okay.
MS. LUNGE: And I think the rest were like making sure the "a's" were there, "the's" and little typos that people found for me on the way.
SENATOR CUMMINGS: Okay. Committee?
ATTENDEE: Did we delete Chapter 84-A? Was that something we were supposed to?
MS. LUNGE: No. We need to keep that because that's the --
FEMALE ATTENDEE: Okay.
MS. LUNGE: That's the Department of Health's program.
SENATOR CUMMINGS: Okay, but we've removed Section 84 and eighty -- those two things that were attach to the back.
MS. LUNGE: Okay. So I'll remove both of those.
SENATOR CUMMINGS: Yeah.
MS. LUNGE: And which way do you want to go on the advertising? That was the last thing.
Do you want to go with it as part of consumer fraud, like the second model that's a little cleaner without the old language or --
SENATOR CUMMINGS: I like the second model.
MS. LUNGE: Okay.
SENATOR CUMMINGS: Okay?
MS. LUNGE: I think that's all I have.
SENATOR CUMMINGS: Okay. Okay. You think you can get this done by 12:30 tomorrow?
MS. LUNGE: Yes.
SENATOR CUMMINGS: When I think I'll have a whole Committee?
MS. LUNGE: Yeah, that's all coming out.
SENATOR CUMMINGS: Okay, and we will convene here. We will vote at 12:00, and we will --
FEMALE ATTENDEE: That's our only -- we'll go through it. We'll have a half hour to go through it and vote?
SENATOR CUMMINGS: Yep.
FEMALE ATTENDEE: Okay.
SENATOR CUMMINGS: And then you can bring lunch to Committee. They'll tell David Sheets, (phonetic), or you can eat before or after, depending on your schedule but we'll --
FEMALE ATTENDEE: Are we finished with the Committee early tomorrow?
SENATOR CUMMINGS: No, because we've got people scheduled for the rest of the day. No, you're not finished.
FEMALE ATTENDEE: Oh, okay.
SENATOR CUMMINGS: Actually, sometimes -- (CD 2007-57 ended there, mid-sentence.)
CERTIFICATE

STATE OF FLORIDA
COUNTY OF BROWARD

I, Katherine Milam, Notary Public, Registered Professional Reporter do hereby certify that I was authorized to and did listen to CD 2007-57 Track 1, the Senate Committee on Finance, Wednesday, February 21, 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 #889698
STATE OF VERMONT

SENATE CHAMBER

STATE COMMITTEE ON FINANCE

RE: SENATE BILL 115

DATE: THURSDAY, FEBRUARY 22, 2007

TYPE OF COMMITTEE MEETING: PRESCRIPTION DRUGS: VOTE

COMMITTEE MEMBERS: ROBIN LUNGE, LEGISLATIVE COUNSEL
JULIE BRILL, ASSISTANT ATTORNEY GENERAL, ATTORNEY
GENERAL'S OFFICE
PROCEEDINGS

1  CD 07-58
2  MS. LUNGE: Actually, I just realized
3  this second I haven't changed the statement of
4  purpose to reflect taking out some things. So I'm
5  going to have to revise the statement of purpose,
6  but that's not a big deal.
7  SENATOR CUMMINGS: Okay.
8  MS. LUNGE: That's not something that's
9  usually marked up anyway.
10  SENATOR CUMMINGS: And that doesn't go
11  into the law? Right?
12  MS. LUNGE: No, no. That's just a
13  descriptive statement, and we usually revise that
14  after we know what's in the final bill anyway. So
15  I will do that.
16  ATTENDEE 5: Do we know where we're
17  going?
18  SENATOR CUMMINGS: We're about to finish.
19  UNIDENTIFIED SPEAKER: We'll pass the
20  bill first.
21  ATTENDEE 5: Then we'll figure out where
22  we're going?
23  SENATOR CUMMINGS: Okay.
24  MS. LUNGE: Okay. So I am going to bring

us -- Well, how would you prefer it? What I was
going to do is go through and highlight what was
changed from the version you got.

SENATOR CUMMINGS: Yes. You can do that.

MS. LUNGE: Okay. So all of the
beginning stuff is the same. So that brings us to
page 13 with our favorite section. So on page --
So on page 13 the first change is in the
definition of health insurer. This is the language
which Herb Olson from the Banking Insurance
Security and Health Care Administration had offered
which broke out the different people under the
health insurer definition into subparts, in part
because in language later on he references the
particular folks in 2A, the health insurance
company, nonprofit hospital and medical services
corporation and health maintenance organization.

SENATOR CUMMINGS: And that's to ensure
that he has regulatory status with those groups
now?

MS. LUNGE: Yes, because they regulate
those groups in a different way than the other
corporation in BPM do, some of whom aren't regulated at
by BISHCA.

So the bottom of page 14 we also

modified the pharmacy benefit manager definition so
we weren't circling around on ourselves, using our
defined term in our definition. So I just reworked
it so that the term includes a person or entity in
a contractual or employment relationship with an
entity performing pharmacy benefit management for a
health plan.

In 9472 there are a number of changes.
One of the decisions that you discussed last
evening was allowing the pharmacy benefit managers
and the health insurers to contract differently
than the provisions in the statute. And I think
that you were - the sense that I had is that you
were going to allow that to vary for all five or
six of those items. So what I did was in A say
unless the contract provides otherwise, so that it
would apply to all the subparts and I wouldn't have
to put it in each subpart.

SENATOR CUMMINGS: Okay.

MS. LUNGE: So then also in one which was
the duty of care, skilled, prudence and diligence
there is language offered by BISHCA that in the
case of a health benefit plan offered by a health
insurer, and again this is under that 2A which is
the health insurer, Blue Cross/Blue Shield and

HMOs, the health insurer shall remain responsible
for administering the health benefit plan in
accordance with the health insurance policy or
subscriber contract or plan and in compliance with
all applicable provisions of Title Eight.

In subdivision two, this is one of the
transparency provisions where information is
provided to health insurers. There are a couple of
different changes. So I reworked the end so it
would be a little bit easier to read than one
really long sentence. So what this section says is
certain information will be passed on to the health
plan if it's requested and that the health plan
would - could -- I'm sorry. The PBM could
designate that information that's passed on to the
health insurer as confidential. If that
information was designated as confidential by the
PBM, the health insurer may not disclose the
information without consent of the PBM except the
health plan - health insurer, excuse me, could
disclose the information in a court filing under
the Consumer Fraud Act provided that the
information would be filed under seal and that
prior to being unsealed the Court would give notice
and an opportunity to be heard to the PBM on why
the information should remain confidential.

B, when authorized by, and I should - instead of saying that chapter I should probably say Chapter 63 of Title Nine, when ordered by a court for good cause shown or, and this is language proposed by BISHCA, when ordered by the commissioner as to the health insurer defined in subdivision, again this is the 2A people, pursuant to the provisions of Title Eight.

SENATOR CUMMINGS: And this allows BISHCA to do the regulating that they need to do?

MS. LUNGE: Right, under Title Eight.

In four, I reworked four a little bit.

This is the drug substitution. So, with regard to dispensing substitute prescriptions to a beneficiary in which the substitute drug costs more than the prescribed drug and the PBM gets a benefit or payment, in that circumstance the PBM would disclose to the health insurer the cost of both drugs and the benefit or payment directly or indirectly accruing to the PBM as a result of the substitution.

So we narrowed that some so that they only have to disclose it when the substitute drug was more costly and the PBM received a benefit. So both of those conditions would have to happen before disclosure. And again, since you can contract around this, it's not really a mandatory provision if the contract says otherwise.

In five I just deleted the unless the contract says otherwise, since I moved that to A so it applies uniformly.

In six we discussed trying to clarify that what we were talking about here was financial terms or arrangements that related to the benefits provided to the beneficiaries or services to the health insureds, health plans. So we were just making that a little clearer that what we mean is the disclosure about the financial terms and agreement between the PBM and the manufacturer have to in some way be related to what the PBM is doing for the health plan.

SENATOR CUMMINGS: Okay.

MS. LUNGE: Again, the language at the bottom of page 17 going on to page 18 is the same language that we just went through on page 16 about the court filing and the sealing of records.

And then I added a new provision, because you discussed having notice provided. So the PBM shall provide notice to the health insurer that the terms contained in this section may be included in the contract between the PBM and the health insurer. So that the PBM would send a notice to the health insurer saying, just so you know, here are six options that we - could be included in your contract. So that people --

SENATOR CUMMINGS: And this is what is taking the place of --

MS. LUNGE: Requiring it in every document.

SENATOR CUMMINGS: Right. And Herb yesterday was - it was excluded in the contract provided the insurer had received prior - notice prior to signing that this option was available?

MS. LUNGE: Right.

SENATOR CUMMINGS: Okay.

MS. LUNGE: Right, because that was in just one subsection. And I think that might have been in the next section, and if that was in the next section it's still there.

SENATOR CUMMINGS: Okay.

MS. LUNGE: But I thought what I heard you discussing last night is you were fine with people contracting around the requirements if --

SENATOR CUMMINGS: Right, as long as they knew --

MS. LUNGE: What were this doing.

SENATOR CUMMINGS: -- what they were getting - what the options were.

MS. LUNGE: Right, what the options were.

SENATOR CUMMINGS: And that is --

MS. LUNGE: And this would make sure that people knew that these six items were options.

SENATOR CUMMINGS: Oh. Okay.

MS. LUNGE: And then C requires compliance with the requirements of this section for pharmacy benefit managers entering into contracts. And mostly what I did was just rework this, because it used to say these six things had to be in every contract. Of course, if you're contracting around it then they wouldn't be in the contract. So I just figured - mostly making the sentence work with the new concept.

SENATOR CUMMINGS: Okay.

MS. LUNGE: And the enforcement provision I didn't make any changes to, because that's the section that Herb and Julie are going to work on some more.

In the registration provision on page 19, I just highlighted the shall notify. You had
this language yesterday, but I just wanted - you had - after I handed it out you did make the decision to change this to notification instead of providing the quote with every single RSP. So that was just a note.

SENATOR CUMMINGS: I didn't see that.


SENATOR CUMMINGS: Okay. There it is.

MS. LUNGE: And then in C I restructured it a little bit because I added a two on page 21, and one of the things you discussed yesterday was for this audit to also allow that to be contracted around. So in two the PBM and the health insurer may waive the audit provided for in subdivision one of this section in a contract if the health insurer has been notified prior to entering into the contract that the ability to audit is available.

UNIDENTIFIED SPEAKER: You've got misspelled on --

MS. LUNGE: Where?

UNIDENTIFIED SPEAKER: Two.

MS. LUNGE: Oh. Thank you.

UNIDENTIFIED SPEAKER: I'm the last person that's supposed to pick that up.

MS. LUNGE: I think actually that was -

somehow the proofers unspelled that word. Maybe our typists are typing too fast; I don't know. But I can fix that, yeah. I don't think that's what we mean. And so that's it for this section in terms of changes.

The next change is in the evidence based education program on page 24. I had forgotten to change the specific reference to the Oregon project yesterday, so I changed that in this version.

There's also a bunch of little typos that I'm not telling you about, but I'm assuming that's fine. You don't need to know that I changed the section numbers so that they're in the right order and things like that.

The next set of changes are in the prescription drug data confidentiality section. This is the section which would prohibit the use of certain data for commercial purposes. We added a couple of exceptions on page 27. In five, BISHCA had asked us to exempt them also so that it was clear that their multi-payer database project could collect the data. And so I added the collection, because they're actually collecting data in that case; user disclosure under Chapter 84, Chapter 84A, or Section 9410 of this title, which is the multi-payer database. And then I also added six, which is the language about the Vermont or federal law enforcement officers engaged in his or her official duties as otherwise provided by law. SENATOR CUMMINGS: Did Ed Miller like this language?

UNIDENTIFIED SPEAKER: (Inaudible).

Yes, that's fine. Thank you very much. SENATOR CUMMINGS: You're welcome.

MS. LUNGE: And I forgot to bold this, but on page 28 in section 14 one of the discussions we had is that the information collected by BISHCA could be subjected to public records if there wasn't a clear confidentiality provision. So in their current confidentiality provision for the multi-payer database which is on page 28 line five they have current protection for physician patient privileged records or information, and also I added records or information protected by Section 4631 which is the prescription data confidentiality.

The next set of changes, I made a technical change that I also neglected to bold in unconscionable pricing section, page 33. The remedy section used to just say remedies, but when we changed the structure of that so that the Consumer Fraud Act was just referenced this really just applies to the civil action provision immediately prior. So I just changed the heading to remedies for civil action and clarified in the first sentence that the action was brought by an affected party under Section 4656 and removed any remedies that aren't available to someone other than the State. So that was something I had missed the first time through.

In the advertising I took out all the advertising provisions in Title 18. And so you can see on the page following page 34, section 19, is the consumer fraud provision that I added the advertising provisions in. So I left that version in. And also there was a discussion about that reference to the PBM yesterday in terms of referencing the section, but also getting in the whole sharing of responsibility language. So I did that by adding a new B on page 35 that says as provided for in Section 9473, which is the enforcement provision that has all that language about consultation, et cetera, the violation of Section 9472 is a consumer fraud violation. So that gets at Herb's concern I think.

Page 36, insurance marketing, section
SENATOR CUMMINGS: Yes.

MS. LUNGE: Well, I think Julie can probably speak more specifically to if they've seen that type of consumer fraud violation in the past and that kind of thing than I can.

SENATOR CUMMINGS: Julie?

MS. BRILL: Julie Brill from the Vermont Attorney General's Office. We have authority to represent protect (Inaudible) --

SENATOR CUMMINGS: Julie?

MS. BRILL: Julie Brill from the Vermont Attorney General's Office. We have authority to protect both individual consumers, you know --

SENATOR CUMMINGS: Right.

MS. BRILL: The entities --

SENATOR CUMMINGS: The people you would expect?

MS. BRILL: Right.

We also have authority to protect businesses when they're acting as consumers. And we have prosecuted PBMs and investigated them and litigated against PBMs and their activities with respect to beneficiaries, that is, the ultimate consumer that you're thinking that, and also with respect to their activities vis-a-vis the employers and the plan. We have the responsibility to protect those entities under our Consumer Fraud Act.

And the reason why I think it makes sense to talk about the PBM regulation in the consumer fraud context is it's a well-developed vehicle that we have for dealing with activities where we've got a business that's dealing with other businesses as consumers all of whom are acting as consumers. They're purchasing services from that PBM. So that's why it comes well within this Consumer Fraud Act.

UNIDENTIFIED SPEAKER: So you've answered my question by saying we've used consumer fraud in other situations?

MS. BRILL: No.

UNIDENTIFIED SPEAKER: Which didn't specify in the contract, in a contract that you could. You used it because the statute authority grants it?

MS. BRILL: Yes.

UNIDENTIFIED SPEAKER: But now we're including it?
MS. BRILL: Yes.
UNIDENTIFIED SPEAKER: Making this document just so much more wordy that --
MS. BRILL: Well, I actually tried to -
it actually was a little bit wordier, and we tried
to cut down by simply referencing the Consumer
Fraud Act in a number of places rather than
repeating all the rights and remedies and other
issues that are within the Consumer Fraud Act.
Anyway, we have used the Consumer Fraud
Act in the context of PBMs and also in the context
of where the (Inaudible) as a consumer.
SENATOR CUMMINGS: Okay. Other questions
from the committee? If not --
UNIDENTIFIED SPEAKER: Ma'am Chair? Oh,
from the committee.
SENATOR CUMMINGS: I'm ready --
UNIDENTIFIED SPEAKER: Madam Chair, I
move that we introduce this as a committee bill
with the few changes, page 16 and 18 and 21 that we
discussed.
SENATOR CUMMINGS: Okay. And those were
the numbers and --
UNIDENTIFIED SPEAKER: Yes.
SENATOR CUMMINGS: And the motion from

Senator MacDonald is that we present as a committee
bill draft two? What is the official --
UNIDENTIFIED SPEAKER: 2.2.
SENATOR CUMMINGS: 2.2.
UNIDENTIFIED SPEAKER: 222.
SENATOR CUMMINGS: 222 07, Robin.
Further discussion? If not, then if the
clerk would call the roll.
COMMITTEE MEMBER MacDonald: Ms. Claire
Ayer?
COMMITTEE MEMBER AYER: Yes.
COMMITTEE MEMBER MacDonald: Carris?
COMMITTEE MEMBER CARRIS: Yes.
COMMITTEE MEMBER MacDonald: Condos?
COMMITTEE MEMBER CONDOS: Yes.
COMMITTEE MEMBER MacDonald: MacDonald
votes yes.
Maynard?
COMMITTEE MEMBER MAYNARD: No.
COMMITTEE MEMBER MacDonald:
(Inaudible)?
UNIDENTIFIED SPEAKER: Yes.
COMMITTEE MEMBER MacDonald: Cummings?
SENATOR CUMMINGS: Yes.
COMMITTEE MEMBER MacDonald: Six/one,
STATE OF VERMONT
SENATE CHAMBER
STATE COMMITTEE ON FINANCE

RE: SENATE BILL 115.
DATE: WEDNESDAY, FEBRUARY 21, 2007
TYPE OF COMMITTEE MEETING: PRESCRIPTION DRUGS: MARK UP.

COMMITTEE MEMBERS: ROBIN LUNGE, LEGISLATIVE COUNSEL
JULIE BRILL, ASSISTANT ATTORNEY GENERAL, ATTORNEY GENERAL'S OFFICE
ED MILLER, LOBBYIST, VERMONT POLICE ASSOCIATION
STEVE TRUMBELL, LOBBYIST, IMS HEALTH
MADELEINE MONGAN, VERMONT MEDICAL SOCIETY
PAULETTE THABAULT, COMMISSIONER, DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION
HERB OLSON, COUNSEL, DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION
CHARLES STORROW, LOBBYIST, EXPRESS SCRIPTS
PROCEEDINGS

CD 07-TRACK ONE

SENATOR CUMMINGS: I think we're going to let Robin walk through and then we're going to take a short break, and then we'll come back and I know there's people that want to testify on this. We may just end up doing this and not anything else today, because I'd like to get through it.

Okay.

MS. LUNGE: So again there are two parts to this. There's the definition of commercial purpose which is one limitation on which data can be used, but then there's also an exception in D which has several examples which I think arguably are within that definition or what I should say is outside that definition of commercial purpose and one clear exception to the definition of commercial purpose. So I didn't do a whole lot in this section, although I made a few suggestions. I took the or as otherwise provided by law and moved it. So, even though that's struck, that's actually moved to the next page. This is on page 25, line 17. I struck or I moved it, in part because I think it was getting lost at the end of that paragraph, and I think some of the concerns were --

SENATOR CUMMINGS: Okay. We have concerns from the sheriff's association. I know I've gotten a letter, I know the rest of the committee did, about law enforcement and they're lawful, and we believe that's already covered under the law. And so they ought to be -- And we also have the new drug tracking in the department of Oxycontin going out the door then they report to law enforcement. And I want to make sure that this is covered.

MS. LUNGE: Well, I think first of all that's not a commercial purpose. So it's not in the definition of commercial purpose. Also, it is specifically accepted on page 265. If you look, it says the use or disclosure of prescription information as authorized by Chapter 84 or 84A. 84A is the section of Title 18 which deals with the Department of Health's project on monitoring prescription use. So that's clearly not covered. And the or is otherwise provided by law I think covers other law enforcement purposes, in addition to the fact that it's not a commercial purpose.

SENATOR CUMMINGS: So this should not change anything that is currently there?

MS. LUNGE: Right. I think it should be okay.

ATTENDEE 3: I understood the prescription monitoring that we passed last year would not be available to - for law enforcement, but in fact before we had ever pass that law enforcement can go to the pharmacies and get whatever information they want, that they have that right right now.

SENATOR CUMMINGS: As part of an investigation they can get, yes, with a subpoena.

ATTENDEE 3: But they just can't tap into the prescription --

SENATOR CUMMINGS: No. But this was if there seemed to be one patient who was getting an Oxycontin prescription every other day from a different doctor every other day, that that would be - if the Health Department picked up that would be turned over. That's why we sent it to judiciary and didn't do it in here. That would be if it turned up that there was a physician that was just prescribing Oxycontin up the kazoo they would probably get a call from the Health Department first. But it is a monitoring for abuse.

MS. LUNGE: We have on page 25ish.

SENATOR CUMMINGS: When it first came here I thought it was to make sure we weren't having, you know, interactions with senior citizens. But the minute it became clear that's why it got shifted into judiciary as part of the health care bill last year, because it is a law enforcement technique. But this is over beyond a specific investigation. I don't think they just go in and browse the pharmacy records.

ATTENDEE 3: That's good they know.

ATTENDEE 4: Not that they really care about my Geritol but --

MS. LUNGE: Okay. So the other sort of clarifications or exceptions in DR, dispensing of prescription medications to the patient.

Oh, I'm sorry. I don't think I finished with one on page 25. So the license, transfer, use or sale of the regulated records are allowed for pharmacy reimbursement, prescription drug formulary compliance, patient care management, utilization review, by the health care professional, the patient's insurer or an agent of either. So that would include disease management companies and the like. Or health care research.
Two, dispensing the medication to a patient, transmission on page 26, transmission of the information between the prescriber and the pharmacy or between pharmacies or in the event pharmacies ownershsip is changed or transferred.

Four, care, management, educational communications provided to a patient about the patient's health condition, adherence to a prescribed course of therapy or other information relating to the drug being dispensed, treatment options, and then I added recall or patient safety notices because it seems like some people were concerned that those items were somehow meeting the definition of commercial purpose, or clinical trials. The use or disclosure of prescription information is authorized as we just went through - by other laws also.

Collection use, transfer or sale of patient or prescriber data for commercial purposes is an exception if the data does not identify a person and there is no reasonable basis to believe that the data provided could be used to identify the person. So --

SENATOR CUMMINGS: That doesn't just conflict with what we jist did, that it can't be used for commercial purposes?

MS. LUNGE: This is an exception. So this says you can use it for commercial purposes, as long as you can't figure out who the provider is from the information that you get.

ATTENDEE 3: The provider. I was thinking it was the patient. The person.

MS. LUNGE: A person. So it could be the provider or the patient.

ATTENDEE 3: Okay.

SENATOR CUMMINGS: So the pharmacy (inaudible) could find out that Vermont per capita uses 28 percent less of the pain pill than the national average, and therefore could choose to target their advertising to Vermont.

ATTENDEE 3: But they won't know that Dr. Cummings isn't prescribing the pain pill?

SENATOR CUMMINGS: You got it. They won't know which doctor. But, given the small number of doctors, they can probably figure out as they said they figured out how many treat MS and therefore who you might want to target it to. But they won't know a specific doctor isn't, you know, represcribing or unprescribing or - yeah. They'll just know that the count of the state, plus the numbers of some geographic. You know, you can tell north, south, east or west, whatever. But that should do it.

Okay.

MS. LUNGE: E is the enforcement provision which provides for AD enforcement through superior court, with the same investigation and remedies under the Consumer Fraud Act.

Section 13, I didn't make changes to this section. It's related to the section we just went through. It applies to the multi-payor database, and I'm - I didn't have a chance to thoroughly look through what Herb sent me earlier, but I'm assuming there's an amendment in there from him on that issue.

SENATOR CUMMINGS: Okay.

MS. LUNGE: But this basically would provide -- I modeled it on E1, which requires that records under physician patient privilege that are - or otherwise are confidential from the patient perspective would be filed with Bish (phonetic) in a manner that doesn't disclose the identity of the person. So I kind of kept - tried to keep that same model, but --

Section 14, Consumer Provisions. These next two sections address that situation we're talking about with the $4 generics if my copayment is $10. The first section, 14, is directed at the pharmacy. The second section is directed at the insurer so that the insurer would allow that $4 in lieu of the $10 as the copy. And I did remove the language about the PDPS under Medicare Part C and D, because there were concerns that we were preempted under part D.

SENATOR CUMMINGS: Okay. Unconscionable pricing. I'm going to try and take a break around 2:30.

MS. LUNGE: Okay.

SENATOR CUMMINGS: Okay?

MS. LUNGE: Okey-dokie.

So in this section, Section 16, maybe was ale do is sort of focus on the changes so we can get through this section; because I think there's been enough discussion, people know what it's about. There is a suggestion that we, instead of call in - on page 29 the health condition a specified health condition that we label it a serious public health problem, which is how it's actually defined in A1. So I just changed those
two terms there.

There's also a suggestion to add another factor that the Commissioner of Health would consider when declaring that a health condition was a serious public health problem. That's on page 30, and that's whether the consumers affected with the health condition are unable to afford the drug at the current price.

The AG's Office had suggested that instead of having all that language from the Consumer Fraud Act that we simply as we have in other parts of the bill reference that the enforcement for the AG would be through the Consumer Fraud Act. And so then I've also - the previous versions allowed AG enforcement in a way very similar to the Consumer Fraud Act but also allowed any person having standing to file a civil suit to file through superior court. So I removed the AG references in that section.

ATTENDEE 4: Did we have -- I don't remember whether Robin was going to look at this section from the interstate commerce clause, the provision, but there was some discussion yesterday about this and I don't understand. I guess I'm not sure. Who does this apply to, this section? We

have one drug wholesaler in the whole state.

SENATOR CUMMINGS: It doesn't have to do with the wholesaler. It has to do with the manufacturer.

ATTENDEE 4: Okay.

MS. LUNGE: It requires that the manufacturer or its licensee, this is on page 29, shall not sell, supply for sale or impose minimum resale requirements for a prescription drug necessary to treat a serious public health problem that results in the drug being sold in the State for an unconscionable price. So it's targeted at the manufacturer, but it's limited to sales in Vermont. So it's meant to target it specifically to drug sales in Vermont to Vermonters.

SENATOR CUMMINGS: The only time it would probably affect the local wholesaler is if we had a pandemic in this state and the wholesaler decided to jack up the price of flu vaccine, at which point I think we might want to stop it. In general, I don't think the wholesalers are the ones that are controlling the prices. That's the testimony we've heard and we've heard in the past from the one wholesaler.

ATTENDEE 4: I'm just trying to understand. Who is it targeted at? Because the manufacturer is not within the state. The pharmacist, is this targeted at the pharmacist?

SENATOR CUMMINGS: No. It is targeted at the manufacturer. And, the testimony that I've heard on the commerce clause, the out is unless there is a serious state interest or compelling state interest. And that's what we're creating here, is a compelling state interest. We can regulate the price when we have a serious public health problem in this state and people can't afford the drugs at the price it's being sold at. That's the compelling state interest. If it will hold up? We don't know, but that's --

MS. LUNGE: And also we're not regulating the manufacturer's behavior in sales to New Hampshire, we're trying not to in language at least, or New York. So that's the other connection.

ATTENDEE 4: Well, let's just assume -- Yeah, Rite-Aid comes from New York State. CVS, I don't know if they come from New York State or Massachusetts, but they come from outside the State. Brooks Drug is from Rhode Island or whatever, or they used to be. And you have your independent pharmacists who probably are buying from in-state in most cases. So how does - how do we -- I'm not sure how we get at the manufacturer in this kind of a situation. I guess that's my question. Is how does this work? Because the pharmacist is selling the product and he's going to, you know --

SENATOR CUMMINGS: I think what - if somebody -- This is the same way you go after price gouging in an oil embargo or an oil shortage or fuel oil.

ATTENDEE 4: How do we do that? We haven't done a very good job of it.

SENATOR CUMMINGS: You go after the person that is unconsciously raising the prices.

If your local pharmacy - well, your local pharmacy has got three guys down the block that - you know, if you find the local pharmacy up in East Obishu (phonetic) and they're the only pharmacy within 20 miles and you find them raising the price of, you know, a drug to keep you alive during a serious health crisis then you could probably --

MS. LUNGE: You couldn't do that under this provision, because this is the manufacturer or it's licensee.
SENATOR CUMMINGS: Okay.

MS. LUNGE: So I don't believe, and I could be wrong, but I don't believe that pharmacies are licensees of manufacturers.

ATTENDEE 3: Can't Julie do that, go after the pharmacy in East Obishu?

ATTENDEE 4: Sure.

ATTENDEE 6: I'd be more than happy to answer this question. I think you're raising two questions.

ATTENDEE 4: I might be. I'm trying to understand it.

Do you want me to address it now, or do you want me to wait? I'm more than happy --

SENATOR CUMMINGS: Probably address now, and --

ATTENDEE 6: Sure. I'll try to do it real quickly.

You're making two points. One is a jurisdictional point, do we actually have jurisdiction over these guys; and then the other is a practical point which is how can we actually affect their pricing behavior given that there's so many middle men. I think that's the two questions you're raising.

With respect to jurisdiction, there's no problem. Most of these manufacturers have lots of presence here in the State. Even though their offices are -- their headquarters aren't located here, they have sales reps and detailers running around the State. If we didn't have legal jurisdiction over them, we would deal with that on a case-by-case basis. But that's not something I'm worried about. Okay.

Your practical point -- So that's the jurisdictional legal issue. The practical point is how if Vermont says okay, your price is unconscionable, you have to lower your price, and that's directed at the manufacturer, how can you make sure that that price gets through to the consumers. The manufacturer would have to lower its price to any third parties it's selling to or middle men that it's selling to, or it would have to provide the product directly to Vermonters. And many manufacturers through their PAAs, their prescription assistance programs, which they advertise, and -- They're great programs. I have no problem with them, but they talk about them all the time. They would have to provide the product through something like a PAP, prescription assistance program, directly to consumers if they can't do it through the middle men, their normal channels.

SENATOR CUMMINGS: So if insulin suddenly went through the ceiling they would have to find a way if we decided that diabetes was a major health problem and the State was going broke trying to provide chronic care treatment to them and -- because -- Yeah. But, like any law, it's assuming forewarned is forearmed?

ATTENDEE 6: Your example of a flu vaccine is actually a very good one, because we actually took a look at that issue very closely a couple of years ago. You may remember when that was a problem.

SENATOR CUMMINGS: So it's not beyond May. Okay.

How are we?

MS. LUNGE: I can we're up to page 32.

SENATOR CUMMINGS: Okay. We may make it through this.

MS. LUNGE: There are two versions of the advertising stuff in here. So, version one, I tried to tweak a little bit the existing version that was in the Title 18 provisions by including cable or the cable company if it's physically located in the State. But I think really what --

Oh. And also on 35 by striking this language that was causing people concern and adding the language from the Consumer Fraud Act that applies to owners or publishers of newspapers, magazines, et cetera. I think it --

ATTENDEE 4: What happened to the carbuncles and all that?

MS. LUNGE: The what?

ATTENDEE 4: The carbuncles and the list of diseases.


ATTENDEE 4: I like that.

ATTENDEE 3: You have carbuncles?

ATTENDEE 4: I'm not sure what one is.

They were out of date when I was young.

MS. LUNGE: So I think a lot of the existing law was what was troubling at least some of the people who were testifying, and part of the reason why I did version two is because revising the existing law would be quite a mammoth undertaking because in addition to what you see here there's a bunch of it still in the statute.
that I didn't touch. So version two is on, let me find it, page 38. So we're going to skip page 37 for the moment. We're on 38. First of all, there is testimony that you didn't really - everything was going fine with the Medicare part D marketing at this point. So maybe you wanted to take out B. So just - so I just struck that trigger that recollection. And then I added the relevant parts of the advertising in this consumer fraud section which then would be more narrow than putting in the advertising section of existing law, because that section is also enforced by the Department of Health. So this would limit the enforcement to the AG's Office. It would leave the Department of Health out of it, which they probably would be perfectly happy about. I don't know, because we didn't hear from them.

So what I tried to do then was restructure it in this section so that we had the violation - it would be a violation of the Consumer Fraud Act for a manufacturer to present or cause, and this is the same language from that previous section, or cause to be presented in the State a regulated advertisement unless the advertisement meets the requirements under the misbranded drugs devices under the federal law and regulation, which is probably a little bit clearer way to say that part as well. And imported the definitions for that, which defines a manufacturer and also defines the regulated advertisement which is the presentation to the general public of a commercial message regarding a prescription drug or product that is broadcast on television, cable or radio from a station or cable company physically located in the State again to address that nexus issue. 

SENATOR CUMMINGS: Okay. MS. LUNGE: Etcetera.

So I tried to restructure it. I didn't change a lot of the language otherwise.

ATTENDEE 7: So how does this deal with the idea that WCAX had one advertisement for which they were paid directly? Are we still only focused -- I think I missed a big picture piece here.

MS. LUNGE: It's -- If you notice, in B1 on page 38 it's a violation for the manufacturer. It's not a violation for CAX.

ATTENDEE 7: Okay.

ATTENDEE 4: Does that change the neighborhood, or does that - was CAX misunderstanding?

MS. LUNGE: CAX misunderstood, because of the existing law which has broader language about regulating advertisements. So that was kind of the problem with trying to fit it into our existing laws without completely rewriting our whole existing laws, there were some outdated provisions that are really broad. So --

SENATOR CUMMINGS: Okay.

MS. LUNGE: And then the last - and again I wasn't sure what you were going to do with S87 or S84. So I just stuck them in because it's easier to delete than to insert. And then last couple of the last couple of sections on page 44 are technical, moving things around and repealing outdated reports.

ATTENDEE 8: And as the sponsor, whatever Section 21 is, I'm not ready to go forward with that right now unless the committee would like to.

ATTENDEE 4: Which one is that?

ATTENDEE 8: That's the eight-day payment.

ATTENDEE 4: Yeah. I was the co-sponsor. So let's make that a unanimous.

ATTENDEE 8: Jettison that one.

All right. The other one just requires that you give notice that you can buy the pharmacy? Is that all --

SENATOR CUMMINGS: That's the 90-day thing?

ATTENDEE 8: Yes.

MS. LUNGE: That is the --

ATTENDEE 8: You shall give conspicuous notice that you can do it.

MS. LUNGE: Yes.

SENATOR CUMMINGS: Okay. Be back at four, and we've got testimony. I know Bishka's got things they want to put in.

Yeah. And Julie's here, and Kimbell's here and the sheriffs are here, and anybody else that's here let us know.

ATTENDEE 8: The whole gang.

SENATOR CUMMINGS: Well, okay.

CD 07 - TRACK TWO

MR. MILLER: I promise I'll be the shortest.

SENATOR CUMMINGS: Okay. I didn't think we had any major problem.

MR. MILLER: I don't think that's a major problem.
I'm Ed Miller. I represent the Vermont Police Association. We do have sheriffs, but the bulk of the police association are municipal officers. We also represent state police, as I said sheriffs, game wardens, liquor investigators, and et cetera. It's sort of an umbrella organization of law enforcement, and there are approximately 800 members that I've represented for a good number of years now.

I would like to call your attention briefly to pages - I sent you a memo yesterday and the memo is still on track, but the pages have changed by one or two. So I'll kind of work through this just going over the bill that's been presented to you today.

And start on the bottom of page 23, and this is a good sentence here, and I know this is what the bill is trying to do. "It's the intent of the general assembly to ensure privacy of Vermonters and health care professionals by prohibiting the commercial use of prescription information." I'm on the very last two lines.

SENATOR CUMMINGS: Okay.

MR. MILLER: The very last sentence of line 23. That's fine, you know. I mean, that tells us what the intent is. The bill begins to get into a little bit of trouble for law enforcement here on the top of page 24. And as Robin said that does include a definition of commercial purpose. However, I would point out that commercial purpose shall include any activity that is intended to be used or is used to evaluate the prescribing behavior of an individual health care professional. And that is done periodically by law enforcement.

That portion, the evaluation of prescribing behavior of an individual health care professional, is what concerns us. We saw that in a house bill, and we sort of put an asterisk next to that language because it seemed to, even though you're still talking about a commercial purpose, it seemed like the commercial purpose would include things that frankly law enforcement is interested in at least having access to.

SENATOR CUMMINGS: Okay. Now, right now under current law you have the ability to do this? Right?

MR. MILLER: Yes. And there are some parameters.

SENATOR CUMMINGS: All right. And we thought that by saying unless - what we need to put in here, unless allowed by - otherwise by law.

MR. MILLER: Well, let's skip down to Number 5 and Number 6, because there are references in those exceptions to a couple of law enforcement chapters. I'm on page 26 now, subparagraph five. And these are exceptions to the general rule that says this section shall not apply to. And Section 5 does address law enforcement, but it does not address in our opinion all of the law enforcement activities that are out there right now in terms of investigating prescription drug activities.

Specifically, Chapter 84 of Title 18 is basically talking about general provisions of drug law. It talks about possession of a variety of drugs, cocaine, et cetera. It's sort of a laundry list of - it's a laundry list of drug crimes and descriptions of various types of drugs that are illegal.

Chapter 84A is a little bit more on track. That does deal specifically with law enforcement, but Chapter 84A is - is the Vermont prescription monitoring system. And that does allow under certain circumstances law enforcement officers to get prescription drug information.

However, there are a couple of parameters that would serve to restrict law enforcement in general, and I don't think that the reference to 84A is -- 84A basically would allow law enforcement officers that are designated by the Department of Public Safety and who are subject to the completion of a course at a procedure prescribed by the Health Department, 84A --

SENATOR CUMMINGS: That's the new registry.

MR. MILLER: That's the new registry.

And my point is that that monitoring system basically applies to officers who are designated by the Department of Public Safety, and they're subject to the rules of the Health Department. So that is not at all all of the law enforcement activities which are going on as far as prescriptive drugs.

SENATOR CUMMINGS: And I think as otherwise provided by law we hope let's that up. And maybe we may just say "or law enforcement" and make that specific. But I don't want to make this a back door to let law enforcement have more authority than they presently do.
MR. MILLER: And I'm not asking for that. But I am asking for things not to be constrained beyond what they are now.

SENATOR CUMMINGS: And that is not our intent.

MR. MILLER: Okay. And I sent you language that I would at least like you to think about, and I don't think that this expands existing law enforcement. We've got just a little thing right here. It's a one-pager. Okay? And --

Go ahead.

SENATOR CUMMINGS: That seems very broad to me. It doesn't say according to existing law. It just says in their official capacity they can buy this? I mean, this is --

MR. MILLER: No. They can collect it and transmit it if they're engaged in their official duties.

SENATOR CUMMINGS: But they're not forbidden to collectively transmit it now in their official duties because they're not selling it, unless they're collecting it in their official duties and then selling it to PHARMA (phonetic).

MR. MILLER: Well, they're not collecting - you wouldn't think this they're using it for commercial purposes at all.

SENATOR CUMMINGS: No. Then it shouldn't be touched by this at all.

MR. MILLER: They shouldn't be, I agree with you. But my point is that the definition of commercial purpose is broad enough so that I think it pulls in activities which are not at all commercial purposes for law enforcement.

Go back to commercial purpose on page 24, and you can read it - and you read that. It says commercial purpose shall include any activity that is intended to be used or is used to evaluate the prescribing behavior of an individual health care professional. And, even though law enforcement is not intending to use that for a commercial purpose, I would submit that that language is broad enough so that it falls within that definition. That's the problem.

And I think the problem is pretty easily solved by basically having an exemption for the collection and transmission of prescription information by a Vermont or federal law enforcement officer engaged in his or her official duties.

So I'm not trying to expand what they're doing right now. I'm trying to make sure that this definition of commercial purpose doesn't accidentally snag legitimate law enforcement efforts.

SENATOR CUMMINGS: I'm thinking about the commercial purpose. There's nothing in here that talks about sale, commercial sale? Right? Or the purpose of?

MR. MILLER: Well, this definition doesn't even talk about sale, commercial purpose. It's any activity that is intended to be used or is used to evaluate the prescribing behavior of an individual health care professional, and that's pretty broad.

SENATOR CUMMINGS: It is.

Can we tighten that up?

MS. LUNGE: You could just put in - you could just leave out evaluate, because that's what law enforcement --

MR. MILLER: I would propose you adding a seven.

SENATOR CUMMINGS: If we add a seven, that's going to send this bill to judiciary.

MR. MILLER: Well --

SENATOR CUMMINGS: I'm not doing that.

MR. MILLER: If you don't add seven it might send me to judiciary. So what's your, you know, it's --

I think this is a legitimate issue. If you -- if you and your committee want to try to think about it, I'm not wedded to this language.

If it's not quite right, fine. But I do think there's an issue here that revolves around the definition of commercial purpose.

SENATOR CUMMINGS: Okay.

Julie?

MS. BRILL: I saw it.

SENATOR CUMMINGS: What do you think?

MS. BRILL: We are supporting it.

That's fine.

SENATOR CUMMINGS: It's fine? Can you tell that to Senator Sears?

MS. BRILL: Sure.

ATTENDEE S: Only when he asks.

SENATOR CUMMINGS: I'm trying to avoid trips to judiciary. I just want to make sure that this doesn't expand it more, to allow them to get more information without a subpoena than they currently could get.

MS. BRILL: Right.

SENATOR CUMMINGS: And I don't want to
expand.

MS. BRILL: We don't want to expand either. We actually want this information as well. You know, we're on the same side of the street as the sheriff.

MR. MILLER: Most of the time.

MS. BRILL: And today. Today we are, yes. That's right.

But I don't think that this expands anyone's right to get the data. It's just that they already have the ability to get the data in a law enforcement activity.

MR. MILLER: That's what's intended.

MS. BRILL: Okay.

SENATOR CUMMINGS: If that's what's intended, we'll see what we can do to draft it out so that it makes it clear that under other existing law.

ATTENDEE 5: I'll move the language if that's what you want.

SENATOR CUMMINGS: No. I think we all know.

MR. MILLER: You should have been here last year when I was looking for a motion.

SENATOR CUMMINGS: I think I'd be more comfortable if we tightened it a little bit, yeah, just to make sure that it's --

MS. LUNGE: Tighten this language? Okay.

SENATOR CUMMINGS: Yeah. Just to make sure that it's --

MS. LUNGE: I can work on that.

ATTENDEE 5: Why don't you guys work on that while we move on to the next one?

SENATOR CUMMINGS: All right. We're going on. Okay.

MR. MILLER: Point made. Thank you.

SENATOR CUMMINGS: Okay.

UNIDENTIFIED SPEAKER: Madam Chair, I'd like to just bring up something. On page 36, you had many discussions in here about what are carbuncles. And at the break I Googled it, and here's the definition.

ATTENDEE 5: I think I'm done.

UNIDENTIFIED SPEAKER: A carbuncle is an acute inflammatory nodule of the skin caused by bacterial invasion into the hair follicles or sebaceous gland ducts. It is actual a boil, but one that has more than one focus of infection; in other words, involves several follicles or ducts. Carbuncles occur more often in men because of their more extensive body health care growth.

SENATOR CUMMINGS: Thank you for that.

Now we know --

UNIDENTIFIED SPEAKER: I know that was a real serious question on this committee.

MS. BRILL: I think carbuncles start at the same place as rheumatism.

SENATOR CUMMINGS: I'm trying to get through this, because I know BISHCA's got some major rewrites. I'm trying to get through this.

Julie. Well, maybe we'll do Steve. You want to testify now?

MR. KIMBELL: Whenever you're ready.

SENATOR CUMMINGS: Okay. And then we'll do the Medical Society and then BISHCA. And we've got someone on the phone, and maybe you can tell us who that is.

MR. KIMBELL: Madam Chair, this is Steve Kimbell, here for IMS Health. And you asked a question the last time I was here about what percentage of my client's business is involved in selling prescriber data to people who want to use that data for some other purpose. And I'm authorized to give a general answer to say it's a very small percentage, less than 20. They were a little -- They have competition in this business, and it's somewhat proprietary. But this is not -- it's very far from their sole purpose. It's on the other end of the scale. That is, they sell a lot of health related information. They're not wedded to PHARMA for example for their life blood. This is a product line. They have thousands of product lines, and there are four of them that are involved in this prescriber identified data.

So that will give you an idea.

ATTENDEE 5: But that's 80 percent of their --

MR. KIMBELL: No. I said that the prescriber identified piece of our business is less than 20 percent. So that means it's between zero and 20, and I didn't want to get any more specific than that.

SENATOR CUMMINGS: That's more than adequate.

MR. KIMBELL: But I think that gives you an idea.

And you had a letter that I distributed from Harvey Ashman who's the vice president and General Counsel of IMS Health, and the other
question that I've had from the Chair and others is
what is the strength and the enforceability and the
penalties for violation of the opt out program that
the AMA has in place; if my client or a
pharmaceutical company violates one of those
provisions, a contract provision or a physician
desires to opt out, what's the penalty. And those
are matters of contract, and Mr. Ashman can take
five minutes and tell you because he's familiar
with them.

SENATOR CUMMINGS: Okay.
Hello, Mr. Ashman. Can you hear us?
MR. ASHMAN: Yes, I can. Can you hear
me all right?

SENATOR CUMMINGS: Very well, thank you.
This is Senator Ann Cummings, and you are speaking
to the Senate Finance Committee in Vermont. The
room is full of interested parties, and your
lobbyist Steve Kimbell is here with us. And you're
going to I guess give us some testimony about the
AMA opt out, the physicians and what's involved in
that and what kind of contracts and, you know,
penalties there are. And anything you can tell us
would be helpful.

MR. ASHMAN: Thank you, Senator. I
appreciate - to all the committee members, I
appreciate the opportunity to speak with you and
happy to share with you any information about the
opt out program and how it works.
Let me start by just talking basic
mechanics of how the program works from the
standpoint that a physician contacts the AMA and
expresses an interest to opt out, and the AMA has
contracts with companies like IMS where it
communicates the physician's preference on a weekly
and monthly basis, provides us a list of those
physicians who have elected to opt out. And then
IMS in turn and the other companies licensed by the
AMA, our competitors, in turn provide all of the
physicians who have opted out to the manufacturers,
and they are under contract with IMS and our
competitors to abide by that opt out restriction.
And so as the program was being
developed and then rolled out and communicated we
worked very closely with our customers as they
invested millions of dollars to modify the systems,
to change business processes, to build out
compliance programs or enhance existing compliance
programs so that they were in a position on July
1st, 2006, when the program went into effect to be
able to comply with it.

And, as the AMA and we communicated the
requirements of the program, we also described a
course available if the manufacturer failed to
comply with the program. And those consequences
were that the AMA could terminate its agreement
with the manufacturer or require us to terminate
its agreement with the manufacturer for AMA
demographic information. And, because all the
prescribing information that we access to
manufacturers is linked to the AMA demographic
information, the manufacturers could lose access to
all the prescribing information nationwide.

UNKNOWN SPEAKER: Is there a complaint
process? I'm sorry.

SENATOR CUMMINGS: Go ahead
UNKNOWN SPEAKER: Is there a complaint
process for individual physicians, Harvey?
MR. ASHMAN: There is on the AMA
website. There is information about how physicians
can inform the AMA about any problems they
encounter. For example, pharmaceutical sales reps
come into the office and has access to this
information, or just in general if they become
aware of something they can report those problems
to the AMA and the AMA will turn around and provide
that information to the manufacturers and a list of
the manufacturers that match those problems can
address it.

It also puts the AMA in a position of
accumulating these complaints so that if there is a
pattern of - or a practice by a company of
consistently not abiding by the terms of the
program then appropriate action could be taken.

SENATOR CUMMINGS: Any questions?
UNKNOWN SPEAKER: What percent of
the physicians opt out?

MR. ASHMAN: That's changing weekly.
Maximum numbers I saw, I believe the opt outs were
approaching 6,000. But I'm not sure of the precise
number.

UNKNOWN SPEAKER: That's 6,000, and
what's the universe?

MR. ASHMAN: The universe is about
800,000 MDs and DOs.

SENATOR CUMMINGS: But this is programs
staying in for what? Six months?

MR. ASHMAN: Six, seven months, that's
correct.

The AMA is continuing to roll out a very
broad communications program. I understand they sent out male to 100,000 physicians recently. They've put advertisements and articles about the program in several of their journals and other communications material.

SENATOR CUMMINGS: Okay. Any other questions from the committee?

UNIDENTIFIED SPEAKER: How does - how does the AMA keep track of the doctors with --

MR. ASHMAN: They do. The AMA has a medical education number, which is a number used in connection with continuing medical education. And so that's what their models are keyed off of.

UNIDENTIFIED SPEAKER: And how does that match up with the DEA number?

MR. ASHMAN: Organizations that wish to link the two together so then you can bridge information from different sources will go ahead and do that. I don't recall if the AMA actually has that information, but it is available from different sources.

UNIDENTIFIED SPEAKER: How do you mean, organizations?

MR. ASHMAN: Organizations like tele-information companies, continuing medical education companies, pharmacies, pharmaceutical manufacturers. Any number of organizations that either for purposes of managing issues around controlled substances or for other purposes like bridging information sources together will have access to the information.

UNIDENTIFIED SPEAKER: How does it link up with Vermont's registrar - doctor license numbers, or state by state license numbers and Vermont in particular?

MR. ASHMAN: There are different organizations. Ours is one of them. The AMA I believe also does it, makes state licensing information available. So, the pharmaceutical manufacturer for example who for purposes of compliance with the Prescription Drug Marketing Act wishes to leave samples with the doctor, they're obligated to confirm the doctor is properly licensed. We would make that information available to manufacturers for PDMA. So then we have the ability to link those things, and that's a helpful thing for people to do.

UNIDENTIFIED SPEAKER: You link them, or someone else links them?

MR. ASHMAN: We can do it, and there are a number of other organizations out there that can do it.

UNIDENTIFIED SPEAKER: But, for the purposes of opting out of your list, are you going to rely on someone to make those matches, or you're going to do it yourself?

MR. ASHMAN: I'm not suggesting those linkages are done for the purposes of opting out. That's all just managed through use of the ME number which is - the AMA's files are very comprehensive in terms of active doctors and inactive doctors. So we simply use that information. And, if there's any question about a doctor out there, whether or not that doctor or any doctor has opted out, we have the ability to compare the two records from different sources and say here's the same doctor, he needs to abide by that restriction.

UNIDENTIFIED SPEAKER: Thank you.

SENATOR CUMMINGS: But they do not call for telemarketers?

MR. ASHMAN: The restriction, (Inaudible). The opt out program would apply to telemarketers as well as the pharmaceutical companies.

SENATOR CUMMINGS: Any other questions from the committee?

Okay. Thank you very much. That helps fill in our background.

MR. ASHMAN: Thank you for the time. I appreciate it.

SENATOR CUMMINGS: Thank you for the time.

Okay.

MR. KIMBELL: That's all I have, Madam Chair, just with those clarifications. We hope you'll delete the section of the bill, because it seems like the physicians have a way to avoid it that's got some teeth in it, and thank you.

SENATOR CUMMINGS: Okay. Thank you. Now we'll hear from the Medical Society.

UNIDENTIFIED SPEAKER: Did we hear what the penalty was? Did I zone out?

UNIDENTIFIED SPEAKER: The penalty is the loss of all the data.

SENATOR CUMMINGS: All the data. If you violate you don't get anything, which for pharmaceutical companies could be very expensive.
MS. MONGAN: Good afternoon. I'm Madeleine Mongan from the Vermont Medical Society. I'm just here again to ask you to support this section of the bill. We think it's important. We think that the opt out, we still don't feel like we know enough about it. And we're kind of grateful for this process for the information that we have been able to learn about some of the uses of the data that are going on and looking at ways to address that.

But on the opt out, listening to everyone from PHARMA yesterday, I'm still not here. Where does the law go? Does it just prevent the information from going to the detailers? Can it still go to the marketing department? Can it go to the drug - the consumer advertising department? Can it go to many other places within the pharmaceutical manufacturing companies?

We would be much more comfortable with an opt in which would be an opt in, not to the AMA part of the equation, but an opt in to the part that happens here in Vermont where the information is sold, licensed and transferred from the pharmacy or wherever to IMS. So the physicians could opt into that, the physicians could see their data.

Because this is pretty much of a black box. So even when the data goes to IMS and to the pharmaceuticals the physicians never see the data about themselves. That is all sort of blind and black. They don't get to see that.

SENATOR CUMMINGS: You said you had to do an opt in. You can't through the AMA. They're a separate organization.

MS. MONGAN: I don't know if you can do the AMA. It seems to me it's a little more challenging to do the AMA. It seems like you could do the side of the equation that is here in Vermont in the same way that you did the banking and the insurance opt ins a few years ago.

SENATOR CUMMINGS: Right. But --

MS. MONGAN: Which I think has work done fine and not disrupted any of the commercial purposes or uses for those industries.

SENATOR CUMMINGS: Yes, but it's painful to do it, and I'm thinking there's a lot more pharmacies than that are banks. And -- Well, so far. And if every local pharmacy, you know, had to do this then they would be --

MS. MONGAN: What I hear from, which I believe you also might want to hear from is that it's not every local pharmacy that's doing this.

It's the chain pharmacies that are selling this for large amounts of money, and that the pharmacists aren't benefiting from this and the small pharmacies aren't benefiting from it. So that's what I hear from him.

SENATOR CUMMINGS: Okay.

MS. MONGAN: Again, it's hard to get information about this.

SENATOR CUMMINGS: Yes.

MS. MONGAN: This issue.

And, as far as Steve raised the point about the patients, again, we don't know how the information travels to the patients. But what we hear is that patients get letters. Diabetic patients get letters talking about new kinds of insulin or new supplies. Now, where that comes from, I mean, I can't link it back to the AMA and to IMS any more than I could sit here and tell you the cost of the drug pricing is going to -- I can't prove that. But they have sort of access to the proof and to the information. We don't have that information. But you heard Ann Rugg yesterday talk about how she believes that when they tried it only to get a handle on the prices of the drugs then the companies come in with the Freedom of Information Act requests and, you know, the prices go up. And she's seen - and she knows a lot more than about it than I do.

UNIDENTIFIED SPEAKER: Did you just say that patients and doctors get letters saying how come your doctor - why the doctor didn't prescribe X, Y and Z?

MS. MONGAN: We have heard this, and it's anecdotal. We have heard that they get letters, not about mostly what I've heard about it diabetic supplies and diabetic drugs.

UNIDENTIFIED SPEAKER: We need to be real careful about anecdotal information I think, unless we have a way of verifying it.

SENATOR CUMMINGS: Yes.

MS. MONGAN: Well, it's a hard thing to verify. Maybe AARP is a --

UNIDENTIFIED SPEAKER: If a patient gives it to the doctor and says look, this is what I received, that's something we can verify. It mean, it's really --

SENATOR CUMMINGS: We need a letter

UNIDENTIFIED SPEAKER: We need to see it before we can say that it exists.
UNIDENTIFIED SPEAKER: It's evidence.

SENATOR CUMMINGS: All right. I mean, some things like they address it by age, by
records, and AARP sends everybody whenever they 55
or 60 gets, you know, congratulations.

MS. MONGAN: So it may be --

UNIDENTIFIED SPEAKER: They give them 30
days ahead of time.

SENATOR CUMMINGS: Yes. So anyway, you

MS. MONGAN: That may be legal. I don't
know.

SENATOR CUMMINGS: I'm sure that is
legal. You know, those are public records. You
can get anyone's birthday. And -- But --

MS. MONGAN: But it this case I think on
the patients it doesn't hurt to leave them in. At
worst it's duplicative.

SENATOR CUMMINGS: Well, it's already
illegal to do that. But it sounds like, unless
everybody at a certain age is getting (inaudible) a
new insulin supplier in town, that somehow they're
able to target folks who are diabetic.

MS. MONGAN: Yes.

And the other thing is on the patient

issue is, again, we don't know what information
goes from the pharmacy and how cleaned up that is
and if there's patient information going along.
But IMS has a business associate agreement under
HIPAA with -- We don't know that. So I think it's
protective. I know in New Hampshire they thought
it was important. And I'd encourage you to leave
that protection for patients in there.

SENATOR CUMMINGS: Okay. Any questions
for the Medical Society?

UNIDENTIFIED SPEAKER: Yes.

You're representing the Vermont
doctors?

MS. MONGAN: That's right, yes

UNIDENTIFIED SPEAKER: And yet the
American Medical Association is just 180 degrees,
and the opt out rate is less than a percent. I'm
just --

MS. MONGAN: Yeah. Well, I think that
might have something to do with the fact of how
busy physicians are. You know, and Steve Kimbell
the other day said they're sophisticated. And they
are sophisticated about science and about medicine
and about treating patients, but they're not really
business people and they don't necessarily pay

attention to our newsletters that urge them to opt
out of the program. So --

MS. BRILL: I can vouch for that.

MS. MONGAN: Yes, and so can we by the
things that we send out.

So they are sophisticated, but they're
not in business. They didn't know about this. I
mean, we heard that our doctors heard about this
from the doctors in New Hampshire at a meeting of
the New England doctors. And they were -- You
know, to a doctor that has heard about it they
don't think it should be going on, because they
think it undermines evidence based prescribing, you
know, which is our focus, is on the evidence based
prescribing that you're putting in there,
transferring from over to the Department of
Health. So we think that that's important.

Now, the Medical Society in the AMA.

Some members of the Medical Society, I think about
five percent of the docs in Vermont, one of the
smallest rates in the country, are members of the
American Medical Association which is the national
organization for doctors. We're a state membership
organization for doctors. We're completely
separate. We take different positions, like on

things like physician assisted suicide, than the
AMA takes. So our governance is just our
governance here in Vermont.

Now, we have a delegate on our board
that represents Vermont docs with the American
Medical Association and we participate with the New
England delegation to the American Medical
Association, and that's one place where there's -
resolutions are brought to try to work on this
issue of the opt in the opt out.

UNIDENTIFIED SPEAKER: How much
overlapping membership is there? Are a hundred
percent of the Vermont Medical Society members of
AMA?

MS. MONGAN: No, no. Very small number
of Vermont docs are members of the American Medical
Association. About two-thirds, a little more, of
practicing docs in Vermont are members of the
Vermont Medical Society, but less than five percent
of docs in Vermont are members of the American
Medical Association.

The docs have a lot of - they have their
specialty societies. They have, you know, their
state society and then they have their national
society. In Vermont I think they first prioritize
specialties societies and then us, and then the
AMa.
SENATOR CUMMINGS: But the AMa has their
numbers?
MS. MONGAN: The AMa --
SENATOR CUMMINGS: That can sell their
information as their numbers, even though they're
not members?
MS. MONGAN: Right.
SENATOR CUMMINGS: Okay.
Okay. Any other questions?
Thank you.
MS. MONGAN: Thank you.
SENATOR CUMMINGS: Herb and Paulette, and
whomever.
Okay. Now, Herb, I know you sent this,
but no one's had time to go counsel and go through
--
MS. LUNGE: Actually, we have a new one
for you.
SENATOR CUMMINGS: Good. A new one will
help. But this will show - this will show the
existing bill and the pages that go into it?
MS. LUNGE: Exactly.
SENATOR CUMMINGS: All right.

MS. THABAULT: Okay. Should I go?
SENATOR CUMMINGS: Okay. Drafted by
legislative counsel, but at your
request? Right? This says --
MS. LUNGE: The bold just looks like the
changes that you saw in 2.1.
SENATOR CUMMINGS: Oh. Okay.
UNIDENTIFIED SPEAKER: The highlighted
is what --
UNIDENTIFIED SPEAKER: Robin has sent us
a draft. So we used that.
SENATOR CUMMINGS: Okay. The highlighted
is yours?
UNIDENTIFIED SPEAKER: Right.
MS. THABAULT: So these -- This is
Paulette Thabault from BISHCA.
MR. OLSON: And Herb Olson, general
counsel for BISHCA.
MS. THABAULT: And so that the changes
that we are proposing here from the testimony
yesterday, and I just wanted to reiterate to the
committee that our concern really is cost
containment and the issue of being clear about the
regulatory authority of the very - over the health
insurers and the PBMs. So Herb's actually going to
walk through some of these changes and the
recommendations, and hopefully answer any
questions.
MR. OLSON: If I can just draw your
attention to the bottom of page 1, there's some
highlighted material there.
SENATOR CUMMINGS: That's your page 1.
It's not lining up with page 1 --
SENATOR CUMMINGS: Okay. So that's
where we need to start.
MR. OLSON: Right. And you would find
the definition in the draft that you just looked at
on page 13, and there's really only one point that
we are trying to make here. In a - the section on
fiduciary duty, we wanted to make clear that the
companies that we traditionally regulate which are
commercial health insurance companies, health
maintenance organizations, Blue Cross/Blue Shield,
that they have the primary obligation to comply
with the statutes in Title Eight and to act in
conformance with the policy of the private
contract.
So in order to accomplish that goal we
are proposing an amendment of how you present the
definition of health insurer by separating out the
different components. I don't think that it is
actually difference in substance than what Robin
has suggested in her draft, but we wanted to
separate out in subdivision 2A the traditional
companies, the commercial companies, the health
maintenance organizations and Blue Cross/Blue
Shield. That's really the only purpose of that.
We also had a question about regulatory
authority and vis-a-vis the respective roles of
Attorney General's Office and the department. We
are continuing to talk with Julie. We're just
running out of time in terms of some of these
issues. And we're not going to ask that you change
what's in Robin's draft in terms of what the
respective roles of our office are, but we would
ask that you give us a little more time to talk,
understanding that you need to act.
SENATOR CUMMINGS: I think this has got
another whole concept.
MR. OLSON: We understand. But we still
have some concerns about that. I think we're
going to have a little bit closer in terms of our issues
and defining those. We're comfortable with having
you pass the bill out on that issue as it is in
Robin's draft, but we would like to have the
opportunity to come back if we're able to offer a
more appropriate resolution.

SENATOR CUMMINGS: It's got to go to the
health committee, and if it can't be resolved in
there, this forum, I know there's some folks here
would like more time to work on it. They may end
up with more amendments too. So —

MR. OLSON: I appreciate that.

UNIDENTIFIED SPEAKER: Madam Chair?

SENATOR CUMMINGS: Yes.

UNIDENTIFIED SPEAKER: Herb, I'm not
sure I understand how the way you've written two
changes what's written in on page 13.

MR. OLSON: I think the best way to
explain it is by all we're doing is separating out
the various components that you have in your draft
on page 13. Right now on page 13 of your draft you
have health insurers defined by subdivision 9429,
and that lists both the traditional companies that
we regulate as well as other entities. Those other
tentities are - we've identified in subdivisions B,
C and D.

And I apologize for being a little
cumbersome. We wanted to zero in on those entities
identified --

UNIDENTIFIED SPEAKER: How does that
reflect in the box though? The box just says -
next to it says BISHCA's proposed changes to the
definition are intended to distinguish between
health insurance companies in subdivision A
concerning which BISHCA should remain exclusive
regulator and others who offer health benefit plans
concerning which BISHCA and the AG's Office will
have joint enforcement. I don't see anything that
says that.

MR. OLSON: Right. We'll get to that in
a minute, but actually what I am saying is we're
willing to let that issue of roles pass by and we
can revisit that, because we're still continuing to
talk with the Attorney General's Office.

SENATOR CUMMINGS: Right. There's still
an open discussion.

MR. OLSON: The next change that we're
proposing, and the next really substantive issue,
is on page three of this document that I just
handed out, lines nine through 15. And there are
two things that we're proposing here.

UNIDENTIFIED SPEAKER: Page 15?
MR. OLSON: Right. Page 15 of the draft

that Robin went through.

And what we're proposing is two
matters. First, on each of these requirements as
Commissioner Talbot testified yesterday, we think
it's helpful to have the parties be able to vary
the terms of the contract if they so choose.

SENATOR CUMMINGS: I think the concern
is to make sure that both sides of the contract
know that they have the right to vary. This is
essentially the fiduciary responsibility. So, if
my PBM comes in and gives me something that says,
you know, we have a contractual, since I'm sure
most health insurers aren't going to be carrying
around a law book, I'm not sure that folks will
know that they have gone to a less than legal
standard.

MR. OLSON: On the contrary. I think
the insurers or at least the ones that we're
familiar with, there are three principal insurers
in Vermont: NVP, Blue Cross/Blue Shield of
Vermont, and CIGNA.

MS. THABAUT: Are they the only ones
that have contracted PBMs in Vermont?

MR. OLSON: Well, again, when we're
looking at the health insurers that we regulate --

SENATOR CUMMINGS: Yes. But I think,
you know, what we're trying to get a handle on is
are there other groups that are contracting with
PBMs that are not health insurers, you know, or a
self-insured group that may be a small union or,
you know, in a business association? And they may
arguably be not as sophisticated in this realm as a
professional insurance agency.

MR. OLSON: You know, I think that since
the last time we revisited this provision I think
things have come a fair way. And I think that
certainly the health insurers have the
sophistication to contract the way they want to
contract. I think that in the plans that the
companies or the organizations that are large
enough, including self insurers are very big,
you're not going to find the Chamber of Commerce
self insuring itself.

SENATOR CUMMINGS: The City of
Montpelier self insured itself.

UNIDENTIFIED SPEAKER: Through us.

SENATOR CUMMINGS: No. The City of
Montpelier has self insured itself. They may have
changed, but they were a holdout on the league and
I don't know if they're still doing it, but they
MR. OLSON: Those are the issues that we wanted to raise.

The next sentence there goes to why we propose to amend the definition of health insurer, and what we wanted to make clear in that sentence in the case of a health benefit plan offered by a health insurer as defined by subdivision 94712A. Those are again the health maintenance organizations, Blue Cross/Blue Shield, and a commercial company. But those entities shall remain responsible for the administration of the benefit plan in accordance with the policy and in compliance with our statutes. We wanted to make sure that the health insurers' feet are held to the fire. They are the ones primarily responsible, and we wanted to make sure that this isn't diluted by focusing on the PBM.

SENATOR CUMMINGS: Okay.

MR. OLSON: Bottom of page two, again you'll see that theme throughout, that we think that the parties should be able to vary the terms of contract if they so desire.

SENATOR CUMMINGS: Okay.

MR. OLSON: Over on page 4, there is an issue about information. And there was some protections built into this particular subdivision about the PBM being able to designate certain information as confidential and trade secret, and then there's an exception that was in the draft that Robin walked through with you. We are asking that you include a further exception that would recognize that when the commissioner seeks to regulate the health insurance company that information that might have been designated as trade secret would still be available to the regulator for our purposes.

MS. BRILL: That's fine.

SENATOR CUMMINGS: Go get them.

MR. OLSON: And you see the language in subdivision three and four again about the ability of parties to vary the terms of the contract; and again over on page 5 with respect to the disclosure of revenue.

Over on page 6, that's an information issue again, and if it's designated as confidential that's fine and it should be, but if the commissioner needs to have that information available to her in connection with a financial exam for example that that should be disclosed for her information.
Okay. Now, at the bottom of page 6 is the item that we're willing to pass over while we continue to talk.

SENATOR CUMMINGS: Okay.

MR. OLSON: It is an important issue for us. It's really critical.

SENATOR CUMMINGS: Isn't the language that's in there? Because I know we worked out --

MR. OLSON: I agree.

SENATOR CUMMINGS: It held up the bill for three days, there were so many e-mails. And I thought we had reached an agreement. But that was two years ago. So --

MR. OLSON: It was two years ago, and we think we can improve on that language. But we need a little more time.

SENATOR CUMMINGS: Okay. I have reservations about having one commissioner need to have permission from another commissioner to perform their duties or what they see as their duty.

UNIDENTIFIED SPEAKER: Right.

MR. OLSON: We appreciate that. We just want to make sure that the health insurers are regulated as effectively and as efficiently as possible.

SENATOR CUMMINGS: I think that yes. They're preserving your privacy of inspection in regulating insurance companies, but I wouldn't have any problem with, you know, reiterating in the law and that, you know, administrative remedies would generally go before criminal remedies. But I think there's also a point at which the Attorney General's Office has to do what they feel their duty requires.

MR. OLSON: And we welcome that as well. We refer a number of matters to the Attorney General's Office, and we wouldn't able to do a lot of what we do without their help in the courts.

Most of what we do is in the administrative sphere of things.

MS. BRILL: And well I'm told.

MR. OLSON: Thank you.

Can I move to page 8? Page 8 is - tracks 7, which is actually the medical language that you have in the Robin's draft. And the only comment that we have in that little text box there is we're not sure that this section is absolutely necessary. We do, because of the provision for registration of PBMs that was authorized last year,

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CERTIFICATE

I, GARY F. MONZILLO, RPR-CP, DO HEREBY CERTIFY THAT I WAS AUTHORIZED TO AND DID LISTEN TO CD 07-S1 & T2, THE SENATE COMMITTEE ON FINANCE, WEDNESDAY, FEBRUARY 21, 2007, PROCEEDINGS AND STENOGRAPHICALLY TRANSCRIPTION FROM SAID CDS THE FOREGOING PROCEEDINGS AND THAT THE TRANSCRIPT IS A TRUE AND ACCURATE RECORD TO THE BEST OF MY ABILITY.

DATED THIS ___ DAY OF _______ __.

GARY F. MONZILLO, RPR-CP
TAB I
SENATE COMMITTEE ON HEALTH AND WELFARE
Prescription Drug Legislation—CD 45 & 46
Tuesday, February 27, 2007

COMMITTEE MEMBERS:

Sen. Doug Racine, Chair
Sen. Ed Flanagan, Vice Chair
Sen. Sara Kittel

Sen. Kevin Mullin
Sen. Virginia Lyons
Sen. Jeannette White

SPEAKERS:

Sen. Ann Cummings, Chair, Senate Finance
Robin Lunge, Legal Counsel
Julie Brill, Assistant Attorney General
Hunt Blair, Director, Bi-State Primary Care
Linda McIntyre, Committee, Human Resources
Kathy Callaghan, Director, State Employees Health Benefits
Paulette Thabault, Committee, BISHCA
THE CHAIR: Today we have SB 115 as reported out by the Senate Finance Committee and we are honored this afternoon to have the chair of the Finance Committee with us. Ann, if you could take us through it and I know Robin is going to probably do more of the details.

MS. CUMMINGS: For the record, Senator Ann Cummings for the Senate Finance Committee.

I'm working off a section by section. I don't have the bill yet in front of me but it's really two new sections to this bill. The rest of it is things that we have done before. We've updated them based on current court findings, other states, so some of it is just defining what we've done and others are new.

Okay, the first section is just best practices, cost control, PDL should be evidence based, and there's more and more of that coming up. There's a couple of places here because the FDA does tests and it says, "Yeah, but this pill cures headaches." It doesn't say, "This pill cures headaches 50 percent better than this other pill." And so when we're doing a cost, it might cost 10 percent less, but if it's 40 percent more effective -- or 10 percent more, if it's 40 percent more effective, you can do a cost benefit, so a couple of places here as those tests are being done -- and I believe it's the University of Colorado that's doing -- is it Denver? Colorado?

Washington? Oregon. One of those western states, they started to do these tests so we've asked the state to kind of keep an eye on them.

SPEAKER2: Is that the definition of evidence based, that somebody besides the FDA is doing it?

MS. CUMMINGS: Evidence based is a comparison of drug to drug for effectiveness. Not just that it works but that it works better or less better than something else.

It's a ranking of their effectiveness.

SPEAKER2: And that -- and I'm just trying to get -- understand the word. "Evidence based," is that defined in here?

MS. CUMMINGS: No.

MS. LUNGE: No, that term is not defined in the bill although I believe that it is a term of art that is used in that area. And my understanding of the term is that it means that you're making your decisions based on scientific research and clinical evidence, so it could include the FDA information as well as this Oregon project --

SPEAKER2: Okay. If all that's out there is the FDA, that's still evidence based?

MS. CUMMINGS: Oh, yes, yes. It's just that more and more -- they're a very narrow set of evidence and we're trying to broaden it so we made sure that we are getting the most effective drug at the best price.

MS. CUMMINGS: Okay. Section 2 just directs over to seek out this research when it's available.

Section 3 allows the attorney general to disclose marketing information to the Department of Health. We're switching the anti-detailing, the evidence based. Education program for physicians, we created it a number of years ago. It got put in OVA. It has never gone anywhere. This still switches it to the Department of Health, but the reporting from physicians and from pharmaceutical companies on what they're spending and what they're doing for detailing comes to the attorney general. So this section allows the attorney general to share that information with the Department of Health because the two of them will be working in this anti-detailing campaign, and there's some discussion about perhaps maybe New Hampshire or Vermont working together to do a region wide anti-detailing.

SPEAKER2: When you say "reporting," are you talking about the reporting of marketing expenses?

MS. CUMMINGS: Marketing expenses.

SPEAKER2: What's the cap on that?

MS. CUMMINGS: I don't remember offhand.

MS. LUNGE: On the marketing expenses? I have to double check because I don't have all the details but it has different -- I think there's a gift disclosure and marketing expenses and I thought it was the gift disclosure but I'll double check the statute.

SPEAKER2: Do you know if there's a cap.

MS. LUNGE: I don't know off the top of my head. I can check.

MS. CUMMINGS: I don't remember a cap. And this bill also removes the exemption for paid education --

MS. LUNGE: Continuing medical education.

MS. CUMMINGS: Continuing medical education. We're not sure why that was exempted in the first place.

SPEAKER2: Why it was exempted?

MS. CUMMINGS: Yes.

SPEAKER2: Because if I remember right, we tested it because there was a lot of testimony saying that nurses and others were receiving monies from the companies to help put on courses that the hospitals weren't able to afford to put on otherwise if they didn't have that money coming in in that we were trying to make sure that people were still kept up to date as much as possible through continuing education classes, trying not to put any --

MS. CUMMINGS: So this may be one you might want to amend.

Let's see, price disclosure and certification, we've done this before. Requires that the drug manufacturers disclose to OVA certain prices for drugs
Medicaid has become a dinosaur and we changed that designation to the manufacturers wholesale -- from the average wholesale price to the best price, and we're still working on what is the best price -- what is the best price to get in there, but this requires that they disclose, and we've done it, I think it's one -- what are we doing?

MS. LUNGE: There are three different prices.

MS. CUMMINGS: Three different prices.

Oh, here it is, the average manufacturer's price is defined. The manufacturer of prescription drugs under health program form the basis of -- reported by the National Drug Code, the pharmaceutical pricing, the average manufacturer's price, the best price, and the price that each wholesaler in the state pays the manufacturer for the drug. So we're trying to get the broadest view of what the range for pricing is again, trying to get some transparency into this.

SPEAKER2: Mr. Chairman, since we just have language that this has "as defined," could we get Robin to give us a cheat-cheat that tells us how those are defined in each of those sections?

SPEAKER4: Sure, anything you want to ask for is okay.

MS. CUMMINGS: And also the disclosure for methodology they use at calculating those prices, and the balance to make sure that the folks that are sophisticated can still write their own program, but that there is some protection to make sure that folks that aren't and can't afford to hire a specialist to write their RFPs get the kind of transparency to get told what's available.

So unless it's contracted, the PBM has to tell the customer that they have to work under prudent standards, provide utilization information, satisfy any conflict of interest.

Drug substitution requirements, this requires that if a drug is substituted for a more expensive drug, and the reason for that is that there's a rebate coming from the manufacturer to increase utilization that you have you have to tell your customer, "This is why I'm replacing, not because it's no longer available." It may be a better drug but you have to tell them, "Oh, by the way, I'm also getting a rebate for increasing the market share of this pharmaceutical."

A couple of things in here about information. The PBMs are very concerned, you know, about the privacy of their information because this is now they make deals with the manufacturers and so they disclose it to the customer, but there are several things about keeping it under seal, keeping it private, if it goes to court, again defining how it's protected and its privacy is protected under those situations so they do have to reveal it but there are privacy protections.

The attorney general and BISHCA are still working out language. We thought we solved this about three years ago but they're still working out language. There's a dual responsibility here and they're still having discussions about who does what when and who has privacy and they think that will become a factor. Section 8 -- SPEAKER2: Right now it just says they're going to talk to each other.

MS. CUMMINGS: That's right. It came to us originally saying that the AG couldn't act without BISHCA's permission. That didn't go over really well. They are still talking and the language that's in there now is the language that I thought we all agreed on a couple of years ago but apparently we are re-agreeing so they will probably, if they work an agreement, have something in. If not, we have what they agreed to in the past.

And again unless specified by contract, Section 8 requires PBMs to allow health insurers plans to audit contracts. PBMs have to register with BISHCA and they have to notify plans that an administrative service only contract is an option.

SPEAKER2: How does that compare to current practices?
MS. CUMMINGS: Currently they will tell us they respond to an RFP and somebody tells them what they want. Our concern is that's nice if the person or group writing the RFP is sophisticated enough to know what other options are out there, and so we want them to know they have the ability to audit the PBM and that they have the ability to get a more transparent -- a disclosed contract or that if they're asking for disclosed, we want them to know that they can also have an administrative -- you know, an administration only, "We just guarantee you 20 percent less than you are paying now and 20 percent less of whatever number is chosen and that's what you get. No disclosure. We just administer your plan. You get a 20, 30 percent discount, end of story."

We wanted to allow as much flexibility but at the same time make sure that there is a push for transparency and this rule making authority, confidentiality, proprietary and bill back. Yes, Robin has done some reorganizing of the statutes to get all of this stuff in one section.

So we get into Section 12, which is the evidence based education program. As I said before, this moves that anti-detailing providing doctors with information, and if you haven't, Dr. John Matthew from the Plainfield Health Center does a really good job of explaining how the new drug, you know, frequently is no better than the old drug or, you know, for half price you only have to take one and a half of the old drug you needed but a lot of the stuff that -- unless somebody can get it to them, you know, any information, they don't know and so it's just trying to get balanced information out there.

This moves that whole thing to the Department of Health. Loss of support by independent research organization --

SPEAKER2: I'm surprised how little we have done.

MS. CUMMINGS: We haven't done anything. We put OVA and it went nowhere so we're moving it out and we're giving the Department of Health and the Attorney General's Office dual ability to move it. There's also movement in surrounding states and so we think those two departments are much more likely to move it than OVA was. I think it may just be a matter of mission.

SPEAKER2: Did you hear from the Department of Health about their ability to do that? Do they have a staff?

MS. CUMMINGS: I don't think that we did. We heard from the AG.

SPEAKER2: But you're moving it from OVA to --

MS. CUMMINGS: The Department of Health.

SPEAKER4: Let's hope they don't move it and find out they don't have a staff to do it either.

MS. CUMMINGS: That's why it comes to this committee.

THE WITNESS: Is there an appropriation window?

MS. LUNGE: There is a fee.

MS. CUMMINGS: I don't think there's an appropriation at this point.

SPEAKER2: We don't have the Health Department testifying here. I'm not sure if they are unaware of this bill.

MS. LUNGE: There's a fee that was added in Section 18 on the pharmaceutical manufacturers of $1,000 and that would be used to fund the evidence base education program so maybe I need to add an appropriation section the appropriation money after the fee is collected.

MS. CUMMINGS: Actually my memory is coming back. The AG testimony there was funds that come -- settlements with some drug companies. There's settlement money that can be used in the AG's office.

MS. LUNGE: And they were -- you heard a little bit about the APAC detailing program and the money that they received from the AG.

SPEAKER4: So is this a new fee or an old fee or what are we talking about?
working on that one.

Section 15 requires pharmacies to collect the co-pay, the retail price, whichever is less, some concern that with the four dollar generics that Wal-Mart or similar offers that you may be getting charged the $10 co-pay rather than the $4 pharmacy price. Payment to the usual retail cost of it is less than the co-payment amount.

Same deal.

17, unconscionable pricing of prescription drugs. This is a new section. This is one we've worked on. We started out with this bill six years ago, eight years. The first time we did it, probably the most controversial thing we did was say if prices don't come down X by X year, we will set prices. We did a price fix. That has lots of trouble with interstate commerce. Robin can go into detail but basically what we have been told again is that states can regulate interstate commerce if there's an overriding, you know, state interest. If there's something large that impacts the state that you can do that.

This is a D.C. law, is that right?

Ms. Lunge: Based on.

Ms. Cummings: Based on. We're learning from their courts. And what this says is that it would prohibit -- it would regulate the prices of pharmaceuticals used to treat specific health conditions. And the way this would work is there would have to be a finding of a serious health epidemic. You might want to think about when there was a shortage of flu vaccines and suddenly the prices of flu vaccines went up.

If we had a similar flu going through here,avian flu and the price suddenly went up, this would give the state the ability to say this is an overriding public health issue for the state of Vermont and we therefore will control the price of that pharmaceutical.

Speaker 4: What triggers it?

Ms. Lunge: It would be the Department of Health would declare that a particular condition was a serious health problem, then it would go to court.

Speaker 4: So it would be like the price gouging of petroleum.

Ms. Lunge: But the state itself wouldn't satisfy itself before it went through a court process. The court process would happen first and the AG could bring the action to court to ask the court to -- for a remedy, one of which might be --

Speaker 4: And what's the threshold for something to becoming unconscionable?

Ms. Lunge: I was going to go through all the details. I can do it now if you want.
they have the doctors' ID number on the prescription. They buy the AMA doctor list. They put the two together, and then doing that you can track a doctor's prescribing practice.

There are good reasons to do this. The concern is that when you go in and you count your detail, or the detail, that the detailer can find out, "Gee, I spent 20 minutes in there with him. I bought him lunch and he didn't send -- you know, prescribe anybody my new pink pill I was pushing." So either you get a second visit from the detailer saying, "Gee, what's the matter? Can I give you some free samples" or you get a bunch of mail, you know, from the home office and it's just a way of again trying to get a handle on the counter detailing and advertising we're told works.

MS. CUMMINGS: The AMA will allow a opt out for the detailers not to get the information and that just started. I think 6,000 nationwide have opted out so far.

SPEAKER2: You said there were some good uses for this.

MS. CUMMINGS: Yes, this is why I tried to send it to you because the testimony you'll hear is that if you limit the commercial use, advertisement, that's why it's put together, and if it's not put together it's not going to be there for medical research. They'll tell you available -- yes, medical research and notification side effects is not something that we do.

SPEAKER2: What power does the AMA have over the -- is it voluntary?

MS. CUMMINGS: No, they have contracts. They sell this. It's is major fund raiser for the AMA. They sell their doctors list which makes us think they've got a conflict of interest if they're the ones regulating --

SPEAKER2: Does the Vermont Medical Society sell their list?

MS. CUMMINGS: I believe -- I don't know.

They're saying no vigorously and you can talk to them but those are what's going on there.

SPEAKER2: It doesn't make any difference if they do it. The AMA is selling it.

MS. CUMMINGS: And if Vermont doesn't sell theirs, you know, pull theirs off the AMA, that's all we can do.

The other section in this that I think is a lot less controversial now than it was when we started out -- and that's just because our language and our statute is somewhat archaic -- is right now if the FDA finds out that pharmaceutical advertising is fraudulent in some form, that they send them a letter but that they don't -- it has to get really bad before they actually pull -- it's not just what they do a lot of.

This will allow the attorney general to enforce the FDA's finding, and so in Vermont it will allow the Vermont attorney general to sue on behalf of the citizens of Vermont if that fraudulent ad continues to run in Vermont, and we had testimony from broadcasters there. They're concerned that nothing originates in Vermont. They are not liable. This does not hold them liable. This is a direct action against the person that's putting the ad on, and it merely allows our attorney general to enforce the FDA's finding. We don't fine so we're not different than anyone else. Again it's trying to get attention that the advertising sells a lot of pharmaceuticals.

SPEAKER2: Two years ago we didn't think anything was being done directly in Vermont, but when CAX did the story, they disclosed that they had -- I can't remember if it was 10 or 15,000 worth or --

MS. CUMMINGS: They had one. They had one advertisement that they said they did directly. Twelve to $15,000 is a drop in the bucket.

(Discussion.)

MS. CUMMINGS: So anyway it's about as archaic as that list of things you can keep when you go bankrupt like your chickens, your hens. Yes. That I think is all about all of it. Did I miss anything important? Thank
SPEAKER2: Thank you.

MS. LUNGE: Good afternoon. Robin Lunge for the state counsel. I think you have -- what version of the bill do you have?

SPEAKER2: The bill that was introduced.

MS. LUNGE: Let me see.

SPEAKER2: There should be one version.

MS. LUNGE: I know but there's -- depending on where you print it out, the page numbering is different so I just want to make sure that I use something the same.

Sandy, do you have one more copy of what this committee has so I can just --

SANDY: No, I don't. I'm sorry.

SPEAKER2: We can follow the sections.

MS. LUNGE: So I'm going to start at the beginning with Section 1, but before I do that so I can answer Senator Mullin's question, the pharmaceutical marketer gift disclosure is limited to gifts over $25 so the way it's structured is that it broadly says you have to record nature, value and purpose of any gift but then there's an except exemption of anything under $25 and there's also a number of other items that are exempted.

SPEAKER2: Is that cumulative or per individual?

MS. LUNGE: I would need to double check the AD rules because I'm not sure I can tell that by reading the statute. I'll check on that. And also Julie Brill I think will be here and she will know that I'm sure of off the top of her head.

Section 1 starts on Page 2. This section is based on the provisions that were in H-524 and S-288 with some modification and, as Senator Cummings said, one of the major shifts is to include the concept of evidence based practices around our PDL or prescription drug list, and that is something which I think OVA is currently doing with their Drug Utilization Review Board, it's looking at available evidence in determining what should be on the list.

SPEAKER2: So why are we coming up with?

MS. LUNGE: Partially because it would make the statute reflect their practice and also partially because in the section on the evidence based education program I think it makes the two sections kind of more tailored, so you can decide not to do it but in terms of having sort of a consistent uniformity to our policy, it does lend uniformity between evidence based education program.

SPEAKER2: Could two people look at this term "evidence based" and look at the evidence and come to two completely different conclusions? How specific is this?

MS. LUNGE: Well, I'm not an expert in medical research and clinical evidence so I'm not sure really the answer to that question. I think that my understanding of the term is that you look to the research. Whether or not two doctors looking at the same research study could come to different conclusions is kind of beyond my scope of expertise but that might be something you can ask.

SPEAKER2: What about if there were two drugs and both doing the same stated purpose but one has terrible side effects but it's a lot cheaper?

MS. LUNGE: I would think that would be part of what you would look at with the evidence based comparison because the point is to look at the scientific research and what is actually proven to work or not work or have side effects based on the research. That's my understanding of the term.

SPEAKER3: I think it has a pretty specific meaning in the health field. My problem has nothing to do with the definition, and none of our pharmaceuticals since. The pharmaceuticals pay for all the evidence, research, they're the ones that are going to show the good results but, anyway, it has a very particular meaning in the health field I believe.

SPEAKER4: And if I could comment too, that would be my comment, that we had someone from the FDA come and talk with the USDA. They work with the FDA -- I think it's the FDA as compared to the biotech industry and what was going on and so what they shared is that there was no third party -- independent third party doing any evidence research on these tests for pharmaceuticals, for other agricultural products. That it was really just Monsanto and the industry did it all and they just -- my understanding was that they would submit their evidence and then the FDA would look at it and say if it was a complicated or something that needed this kind of permit and if it was a simpler thing, then you went in to this other pile and it would be simpler as to what you submitted. So it wasn't anything the FDA ever did for research. It was all done by the interested parties.

SPEAKER2: How is that different? So you are applying for an act of 50 permits. You want to build a store on Route 2. We tell them you have to provide us with a study on traffic and study on this. I mean, that's typical. The burden is on the person that's going to have to --

SPEAKER3: Except that you're in this complicated area so it's only as good as both people looking at the evidence, if they understand -- you know, how much you supply. It's asking the questions.

MS. LUNGE: I think in the case here, if you're talking about evidence based medicine that's one thing
because the pharmaceutical companies generally fund the
research so you don't have any evidence based conclusions
for any kind of alternative health care.
However, here what you're doing is you're
comparing drugs to drugs so it's a little bit different.
You're talking about evidence -- they're all
pharmaceuticals here that we're talking about.
SPEAKER2: Isn't the burden on the person that's
supporting the alternative source to prove --
MS. LUNGE: No, but I don't want to get into
that here because that isn't what we're talking about here.
All we're talking about here is evidence based preferred
drug list so we're already talking about a subject
section -- we're already talking about the pharmaceutical
industry so I think evidence based is -- I mean.
SPEAKER3: I don't think we know how deep we
have to go. We're hearing now pharmaceutical companies
have drawn something because they knew they didn't get the
gravamen they should have to the side effects or something,
you know, didn't they run enough tests.
MS. LUNGE: But that's not going to make any
difference here.
SPEAKER2: We already have PDLs and they've
already making judgments. They're saying use the 4040
which is information which you said they're doing already

so it's probably not the major section of it.
SPEAKER2: No, I don't think so.
MS. LUNGE: Sarah, at the bottom of Page 2 I
struck language that had directed BISHCA and the
commissioner of human resources to join in a statewide PDL
with Medicaid because the idea would be to move away from
that approach which is not happening and which I think
there have been various.
SPEAKER2: Why didn't it happen? I mean, the
whole purpose was to have bulk purchasing power; right?
MS. LUNGE: Right, that was the purpose and
that's part of why I think the Finance Committee reworked
it into a different bulk purchasing model. I think the
resistance came in having the exact same preferred drug
list -- the same employees as the Medicaid folks.
And there was -- the commissioner of
human resources at the time did do a presentation to help
oversight access -- help access the Oversight Committee
basically saying, "We don't really understand how you
expect us to do this. We don't think we can do it" and I
think Finance took the practical approach of, "Well, it's
not happening. People don't want to do it so why don't we
try this other concept of a joint purchasing consortium,"
which clarifies that you can have different PDLs, but where
you have overlap, all the state purchasers should be

working together to try and get purchasing power.
SPEAKER2: A generic alternative is the most
cost effective means in the Medicaid program, why shouldn't
it be the most cost effective use for the state employees
and why wouldn't we want to concentrate on just getting
that as the preferred drug? I guess I don't understand
that.
MS. LUNGE: Well, I think part of it is that
Medicaid has some federal law behind them in terms of what
they get per pricing so they will always have a better
price than state employees by definition because they're
required to have the best price so that's one piece of it.
It doesn't mean that you couldn't leverage your buying
power to still negotiate a better price for the state
employees if you had the state employees and the OVA
working together to do that in a joint negotiating
strategy.

And I don't -- and otherwise I think the
concept of the statewide PDL could still work but I think
the Finance Committee's perspective was, "We've told them
to go do it. They haven't done it so let's try a new
approach that maybe people will be receptive that will
still reach our goal of leveraging better prices for our
state purchased areas but will perhaps move us forward
instead of just in the stalemate." So I think they took it

as a practical kind of approach.
SPEAKER2: Do you know why they're not doing it?
It seems like if they dig in their heels for two years, we
will do it a different way.
SPEAKER4: This goes back more than two years.
This is going back to what?
SPEAKER3: You can have the same list but not
the same price.
MS. LUNGE: They're not using -- the concept
behind the original language was to have a statewide
preferred drug list which means any state purchaser would
use the same preferred drug list and that way -- because
all those lives were using the same drug list, then all our
negotiations could happen together and then we could
leverage more lives and more people. I think you have to
really ask human resources why they don't want to do it
because I don't think I can explain that very well because
I don't really understand why they don't like it.
SPEAKER3: We have human resources at 3:15 and
tell me where statewide drugs preferred drug list would be
for Medicaid, ZHAB, Dr. Dinosaur, the V Script.
MS. LUNGE: All those but also the
Medicaid/Medicare waivers, they already had one for
because that's all through OVA, but this section has also
directed BISHCA to voluntarily encourage health insurers to
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1. participate and the commissioner of human resources with some caveats about assessing to make sure it would make sense for state employees.
2. SPEAKER2: Has the health insurers expressed any interest in doing that, do you know?
3. MS. LUNGE: I don't know. That would be a good question for them or OVA. And then the director of OVA would encourage again health benefit plans, both private employers and insurers to participate by inviting them to participate in the Drug Utilization Review Board. I don't know if they invited people and they didn't come or if OVA didn't invite people or exactly what happened to them.
4. SPEAKER3: So OVA was almost the person in charge, I would say.
5. MS. LUNGE: Right.
6. SPEAKER2: Under you model, it still would be.
7. MS. LUNGE: Yes, that is true. On Page 4 --
8. SPEAKER2: I'm sorry, but did you get testimony from anybody in OVA that they would work better for them?
9. MS. LUNGE: I think OVA did testify and I'm trying to remember if I was there when they testified and what they said about this section. I'll double check my notes because off the top of my head I don't recall what they said about this. They didn't say, "No, no, we don't want to do it" I don't believe.

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1. SPEAKER2: Probably didn't when this passed originally.
2. SPEAKER3: Where is the language giving them the --
3. MS. LUNGE: That's on Page 6 so we will get there in a couple of pages.
4. On Page 4 I struck -- this was the section that set up the Evidence Based Research Education Program in OVA. It says this language is struck and then it's later in the bill that is pursuant to the Department of Health.
5. So on Page 5, another addition to the Cost Containment Program that overrun is Subdivision 7 which is section to use QAC look alike when prescription drug pricing is more affordable. OVA did testify at senate there were circumstances when they didn't think that was the best use and it wasn't clear to me how they did the financial modeling but Finance added that language to clarify that the point was to leverage the 340-B pricing when it's better for the state and you may remember from some of the earlier presentations that 340-B pricing is generally lower than other sources of pricing. That's the special pricing available for the lot.
6. SPEAKER2: Are there any limitations of who can access 340-B? We've got a new on the western side.

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1. MS. LUNGE: There are specific entities that are allowed to access 340-B and I think Hunt when he testifies can give you more detail on that. I can also look up the definition of that. I don't remember off the top of my head.
2. MS. LUNGE: I think they have to be a patient.
3. SPEAKER3: Was there testimony taken in finance to your knowledge about the capacity of FQACs that we currently have in the state to do everything. All these people already made a run on FQACs for prescription drugs.
4. Do we know that we have that capacity?
5. MS. LUNGE: No, Finance did not take a ton of testimony on this section because they were really focused.
6. They thought this was more your purview.
7. SPEAKER2: They only spent two weeks.
8. MS. LUNGE: And then in Subdivision 8 on Page 5, Line 15, it establishes the Joint Pharmaceutical Consortium as provided for in more detail in Subdivision C-1 which is on the next page. "The current law allowed OVA to implement this program, the pharmacy best practice and cost control program for any other health benefit plan within or outside the state that agree to participate," so that would be health insurers or employers who voluntarily joined with it.
9. And so this new language would establish that for entities in Vermont, the director shall directly or by contract implement the person join pharmaceutical purchasing consortium offered on a voluntary basis no later than January 1st, 2008 with mandatory participation by state of publicly funded, administered or subsidized purchasers to the extent practicable and consistent, which was language Finance wanted in there in order to allow for some variations depending on if there really was an operational problem, so that would be mandatory by January 1st, 2010. "State or publicly funded purchasers shall include the Department of Corrections, Division of Mental Health or Medicaid, all the other Medicaid extension programs, Workers' Compensation and any other state or publicly funded purchaser."
10. At the bottom, this section amends the current law on the drug utilization review board which is a board that operates similar to a -- it's a board that has physicians and pharmacists on it which look at the different drugs that could go on the preferred drug list and they make recommendations to Joshua Slim, the director of OVA, about what should be or should not be included in the PDLs.
11. SPEAKER2: This answers a lot of our questions because it refers you have to take in account the adverse side effects. Apparently "evidence based" must be
compliant under Section 4261.18.

MS. LUNGE: I forgot about that so I can make a copy for you. I think we've defined -- actually that's in here. I'm sorry, it's coming back to me. My head has been in Welfare this morning and it's not quite reoriented to prescription drugs.

Later in the bill I think that refers to the definition that we used in the evidence based education program so I think that's what 4261 is but I'll double check that.

And then on Page 7 you'll see the rework language where the director is encouraging participation in the joint purchasing consortium by inviting representatives from the entities in AA. That was -- actually I think perhaps our site there is wrong, sorry. I think that should be C1 -- to participate as observers or non-voting members. So again the idea is to encourage voluntary participation at the private markets and private industries.

Section 2, OVA is directed to seek assistance from MDs conducting independent research into the effectiveness of prescription drug such as the Oregon Health and Science University Drug Effectiveness Review Project. You heard a little bit about this earlier. Steve Capelle talked about it a little bit. This is a project at this Oregon University which is comparing two, for instance -- for example, it could be two brand name drugs to see which of the two brand name drugs is more effective as compared to the other.

You may remember that in FDA approval process, it's the drug compared to the placebo effect I believe so drugs aren't compared to each other generally when they get approved, so that's what this Oregon Project is trying to do. Oregon did testify that they used the information when it becomes public. There is a possibility of getting a contract with them and getting the information earlier but OVA didn't feel that they needed the information before it became public, so this section is just to direct them to use it but they aren't required to contract.

SPEAKER2: They don't even have to use them. They could use anybody according to this.

MS. LUNGE: Yes, and that was something the Senate Finance wanted it to be broader, because right now this Oregon Project is one of the leaders in this area but, of course, there may be others and there may be others out there now that we're not aware of.

Section 3, the Pharmaceutical Marketer Disclosure, this is again the section that requires gifts to be disclosed to the attorney general. The Section 3 would allow the attorney general -- right now all that information is confidential if it's a trade secret, and this would allow the Office of the Attorney General to disclose the information to the Department of Health for the purpose of informing the Department of Health in their activities around the evidence based education program. The Department of Health also has to keep the information confidential so it's meant to help them develop their capture detailing program but not to disclose the information publicly.

Section 4 would amend the current gift disclosure. As we said before, everything has to be disclosed except -- and there's a list of exceptions or exemptions. One of the exemptions currently you'll see on restricted grants for Continuing Medical Education Program. This would eliminate that exemption, which would mean it would have to be reported, and you can see that it's clarified in D that disclosures of unrestricted grants for these type of programs would be limited to the value, nature and purpose of the grant and the name of the grantee. It would not disclose the individual participant in the program. So, for example, if UVM or Fletcher Allen got a grant to put on a program, it would disclose the value, nature and purpose of the grant so as to have the program -- how much it cost, the nature of what the program was doing and then Fletcher Allen or UVM. It would not be the individual doctors or nurses or whoever.

SPEAKER2: What's the problem or potential problem that we're trying to solve?

MS. LUNGE: Well, again this was from H5. 24 is from F288. I didn't cover it when it was originally written so I don't recall the testimony.

SPEAKER3: So I think that originally the question was that, you know, gifts are coming from pharmaceutical companies and we try to carve out those that made sense, how some of the money that's provided for medical education is critically important and it's one thing to have a report of how much money. It's another to identify each person and the course given.

SPEAKER5: I think it was the same thing as getting out -- disclosing any other gift. If a pharmaceutical company is giving large amounts of money to any institution or any -- whether it's a hospital or UVM or whoever, that should be disclosed because they're promoting it. It's continuing education for the people that are there but it is being underwritten by a pharmaceutical company.

SPEAKER2: They can run an ad someplace that Merck has spent X amount of dollars in Vermont trying to
influence prescribing practices, so the next time they get
asked to help with a continuing education program they'll
just say, "We don't need this."

SPEAKER5: Well, I thought we heard from -- when
we did this before, I thought we heard from everybody and
everybody was okay with it the way it was written here
because originally it was --

SPEAKER2: Maybe it's no big deal.

SPEAKER R: I thought we heard that from
everybody but I may be wrong.

SPEAKER4: Sponsorships of legislative events
that we go to and they all contribute large sums of money
to chat with us and offer us continuing education.

SPEAKER3: There's big banners on the wall in
the meeting, who put it on.

MS. LUNGE: From Page 9, Section 5. This is the
section that requires manufacturers of prescription drugs
dispensed in Vermont to report on a quarterly basis by
natural drug code the average manufacturer's price, the
best price and the price that each home filler in the state
pays, the manufacturer who purchases the drug. This
section is based on a Maine law.

SPEAKER2: This is new from what's been in the
past years?

MS. LUNGE: No, this was included -- I'm running
two copies. This was included in S-288 and H-524. I did
double check it against the Maine law. Originally it was
based on a Maine law and I did double check it to see if
there had been some changes to that law so I'll go through
it and tell you about that.

Also the third price, the price that each
wholesaler in the state pays to the manufacturer is based
on the Texas version of this law that passed, so in Texas
they require -- I believe it's the AMP price to each
wholesaler so finance went with a combination of what Main
requires and what Texas requires.

SPEAKER2: So if I'm reading this right, the
conditions are the state health program directed or
administered by the state, so what we're really talking
about is OVA, the state employees plan. What else falls
into that?

MS. LUNGE: I think it's actually -- because of
the end of that sentence, I think it's really Medicaid
because it says that a health program directed or
administered by the state report to OVA for each of "its"
drugs. So the report -- and I can clean that up if you'd
like that to be a little more tailored and reference that
it's a Medicaid program, but I think the way the end of
that sentence is written is pretty much --

SPEAKER2: Is the intent just Medicaid?
OVA buys a drug -- buys drugs for clients, they're buying them through our state's wholesaler. I mean, you don't deal directly with the manufacturer. We deal with the state wholesaler.

MS. LUNGE: Remember we're in a multi-state purchasing pool, so I think the multi-state purchasing -- I don't know exactly how the negotiations have been, whether we direct the PBM that works with the purchasing pool to do the negotiations or whether we do that, "we" being the purchasing pool does that, so I don't think we do operate through the wholesaler. I think OVA operates through this multi-state purchasing pool.

SPEAKER3: We have to hear how our wholesaler feels about that.

SPEAKER 2: We have to hear from them. No question about that.

SPEAKER3: Are we checking on the PBM -- I mean, the person administering all these drugs -- purchasing all these drugs to look to that and if all of this would be transparency -- background transparency too.

MS. LUNGE: I don't think this would allow our PBM to necessarily know this information. It would allow OVA to get the information directly from the manufacturer.

SPEAKER2: It looks like they're providing that information to the federal government.

MS. LUNGE: Yes.

SPEAKER2: So why did we put this little clause at the end saying that OVA could set up our own rule for the cost accounting information?

MS. LUNGE: That's directly from the Maine law so we modeled this on Maine and I can't say why Maine thought -- perhaps the Maine Medicaid office thought they one want slightly different standards but I don't know.

SPEAKER2: We are very quickly falling out of schedule here. We have five more people we are going to talk to and obviously we have a lot more questions to ask so I just want to know if your pleasure is run right through this and not ask questions, ask questions? Okay, that's agreeable? Okay. Otherwise I'm going to suggest we can plan for a couple of meetings this week or even come back next week.

SPEAKER3: We can make a list of our questions.

SPEAKER2: So, Robin, we will try not to interrupt and we can get through this as quickly as possible.

MS. LUNGE: Sure. So basically the rest of this section on Page 11 allows for confidentiality at OVA keeping the information confidential and ADS enforcement. Section 6, Healthy Vermonters. Remember
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<td>1 interest, consideration of the best scientific evidence does not preclude considering of treatment or services. 4622, Line 6 page 23 establishes evidence based education program in the department of health which will collaborate with the F.G. The program is designed to provide information, education on therapeutic and cost effective utilization of prescription drugs to prescribe err and the department is allowed to collaborate with other states if they would like to. The department is going to request information and collaboration from a number of parties including doctors and other prescribe errors on developing the program and will also contract with technical and clinical support from entities conducting independent research effectiveness of prescription drugs such as the Oregon Project. The department and the AG shall collaborate and review the marketing techniques of the pharmaceutical companies and will also collaborate sources for the program including awards or receipts brought by the AG. Prescription drug confidentiality section 13. This section would establish that prescription drug information is confidential for certain types of uses. As senator sum goes explained this is the section which would make it much harder to match up prescription information which has a prescriber identifier in it with lists of</td>
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<td>raised in a lawsuit in New Hampshire based in Vermont based on regulated records section. So in C this is the prohibition. The health insurer, a self insurer and electronic intermediary pharmacy or other similar entity shall not transfer or sell regulated records which includes prescription identifiable and prescriber identifiable data for any commercial purpose so that section references you back to the commercial purpose to narrow the prohibition from any transfer or use to those uses for any commercial purpose.</td>
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<td>SPEAKER3: So it's just the date of. MS. LUNGE: D has a list of exceptions or clarifications so it shall not apply to license transfer use or sale of regulated records for pharmacy reimbursement, compliance, patient care utilization review by health care professionals, the health insurer or patient of either such as a an agent may be a chronic health care or someone doing chronic care management or health care research. It doesn't apply to dispensing immediate to a patient. It doesn't apply to prescription medication between the doctor or the prescriber or the pharmacy or between pharmacist in certain circumstances. It doesn't apply to care management educational communications provided to a patient about the patient's health condition. Adherence to course of therapy or other information relating to the drug. Treatment options recall or patient safety notices or clinical trials. It also doesn't apply to the collection you'd or disclosure information or other regulatory activities as authorized by chapter 84 which is our chapter. This is section is all our current laws where we tell people to collect prescription drug data to do certain things including law enforcement. Six is is a specific exemption for law enforcement purposes and 7 is an exemptions excuse me an exception which says you can use this data for commercial purposes if the data does not identify a person, meaning a patient or a prescriber, and there is no reasonable basis to believe that the data provided could be used to identify. So the data could still be used commercially in the aggregate for instance so you can still determine how many of those particular.</td>
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<td>doctors and their identifier to come up with prescribing habits. The first section is general a general finding and purpose. That's Subsection A under succeed Section B under 25 there are several definitions the first of which is commercial purpose which includes advertising promotion or any activity which is intended to be used or is used to influence sales or the market share of the pharmaceutical product. Influence or prescribing behavior, market, patients or evaluate the effectiveness of the professional detailing sales force. Electronic transmission intermediary. It basically means somebody who can connect the data together electronically or transfer stuff. Health care facility professional insurer, I'll have the usual definitions that we use in title 18. Pharmacy. There's a reference to the professional licensing chapters. Prescriber an individual allowed to prescription drugs in the course of professional practice. Regulated records is an important definition information or documentation a prescription doing business in Vermont or prescription dispensed to Vermont and that's the mechanism by which the section limits activities to inordinate activities and attempts to avoid interstate commerce. This section of the bill is based on New Hampshire law. There are changes from the New Hampshire law that were meant to address some of the issues that were</td>
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<td>relating to the drug. Treatment options recall or patient safety notices or clinical trials. It also doesn't apply to the collection you'd or disclosure information or other regulatory activities as authorized by chapter 84 which is our chapter. This is section is all our current laws where we tell people to collect prescription drug data to do certain things including law enforcement. Six is is a specific exemption for law enforcement purposes and 7 is an exemptions -- excuse me an exception which says you can use this data for commercial purposes if the data does not identify a person, meaning a patient or a prescriber, and there is no reasonable basis to believe that the data provided could be used to identify. So the data could still be used commercially in the aggregate for instance so you can still determine how many of those particular.</td>
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<td>SPEAKER2: We have to make a decision whether we are going to and decide the details out. MS. LUNGE: 14 is a confidentiality provision related to that. That's in the multi prepared database. 15 and 16 basically say if I have a 10 dollar co-pay and the retail price for the drug is four dollars, I pay four dollars not 10 dollars. One of these sections addresses pharmacy. One addresses the insurer. Section 17 is the unconscionable pricing</td>
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13 (Pages 46 to 49)
MS. BRILL: I would be more than happy to answer any questions you may have about my name is Julie Brill. I'm an assistant attorney general for the State of Vermont. I do a lot of pharmaceutical work.

Bill Sutrell didn't come in here at the beginning of the session. He did go into senate financing, introduced to that committee all the work that we do in the pharmaceutical area. Because we're so pressed for time and there are so many witnesses here I won't go through that litany for you but I probably spent a good 30 to 40 percent of my time on pharmaceutical issues so it's a tremendous amount of time.

With me today I have two other people from my office. Chris Burlow is an investigator with our office and also a newly admitted attorney and she will be here throughout the discussion to make sure that any questions that come up get relayed back to me.

And Ana Lobb is an MPH student at Dartmouth and works with us also on pharmaceutical matters, so we have a really good staff, people who know a lot of things and I'm going to try to be as helpful as I can to you through the process despite the fact that I'm going to be traveling to deal with pharmaceutical issues over the next several days.

Let's see. There are some sections of this bill that do not affect our office and I thought I would skip over those and talk about the ones that affect our officers.

I can say overall we support the bill.

We think it adds important provisions to Vermont law that we think will improve our ability to enforce the laws with respect to pharmaceutical matters and with respect to PBMs. We also think that the overall affect of these laws will very likely be to hopefully reduce -- continue our efforts to reduce pharmaceutical prices here in Vermont. Obviously we can't guarantee but that's what our overall effort is about.

Okay. The first section that involves us is Section 3 which are relatively minor amendments to the Gift Reporting Law. I have Page 7. Am I working with the same version as you are? This is F1-15 that I printed off the website. So Page 7.

What we call the Gift Reporting Law is more formally known as the manufacturer's -- the Pharmaceutical Marketer's Law, I think. Anyway the practical market disclosure, they have to report to us payments they've made to anyone who authorized to prescribe in Vermont. The payments can be gifts, travel, that kind of thing. It can also be consulting fees.
There are certain exceptions that don't get reported to us, including payments under $25, so there's actually a fair amount that gets under the radar literally and figuratively, but these are some relatively minor amendments.

The first issue would be to allow us to share with the Department of Health information that we get on these gift reporting disclosures so that we could work on them based on the evidence based system that they are going to be setting up. In other words, we want to tell them what's actually happening here in Vermont in terms of whose being marketed for what product so they can set up a good evidence based education program.

SPEAKER2: And this does that?
MS. BRILL: Yes.
SPEAKER2: You don't do anything additional?
MS. BRILL: No. This amendment that you see on Page 7, because otherwise the law generally allows the manufacturers to declare the information trade secret and one can debate whether that is appropriate or not but that is the current law. We are not seeking to amend that but there are certain entities that we do want to share with and DOH is one.

On Page 9, this is actually not something that we're necessarily asking for. We're fine with it, but Page 9 would remove an exemption for payments relating to continuing medical education programs. This was actually I think a proposal that came out of this committee a few years ago. There were some people on the committee who didn't like that exemption. We're fine with it, but by deleting the exemption so that we could get information and be able to report it to the public.

But I think also part of the proposal that came out of this committee a couple of years ago on Lines 7 through 10 was that we would not receive specific recipient information about the CLE -- excuse me, CME, continuing medical education, CME. So that's the gift reporting law.

Section 5 is an attempt to bring to Vermont to laws of a couple of other states that require more specific price reporting that we have heard from these other states, seems to be a very good way to help get prices down and prices that are paid by Medicaid and other state entities down. It requires reporting at certain actual prices and you've already heard the walk-through of it so I don't think I need to go through that again. Our office would enforce it. We like it. We think it's good. It's based upon recalling a combination of Texas and what else? Maine. It was originally going to be just Maine and I added Texas to it.
of them. We think the law that sets the ground rules and
sets the floor makes a lot of sense.

Most of what this bill -- this section of
the bill does it requires the PBM's to give their clients
notice about certain activities. It is basically a notice
bill and we think that is appropriate.

We think that the PBM's ought to be more
transparent in terms of their activities, and ought to be
providing clear information to their clients to help their
clients understand the complex transaction that they're
about to enter into.

Another thing that you're going to hear I
think from a number of the people here representing PBM's
is, well, all their clients are sophisticated and all their
clients understand all this stuff. I do not believe that
16 to be the case.

I have looked at the client list of some
of these very large PBM's and the client lists are all over
the map. Some of them are extremely sophisticated clients,
you know, along the lines of GM and IBM, etcetera, but they
also have some very small entities that are their clients.
Sometimes these small entities operate through what are
known as third-party administrators, TPAs, but sometimes
they don't.

And I think that's important to realize,

that just because there's a sophisticated clientele out
there does not mean that everybody is that way. And what
this bill will provide is clear information so that all the
clients will have an understanding of what this
transaction is about so we support it.

I'd be happy to go through it although
you have now gone through it a couple of times, but if you
have questions about it, you know, I'll be happy to answer
those, either now or as they come up.

So, anyway, the bill also does state --
in addition to having disclosure requirements, the bill
does state that the PBM has to act -- and I'm now on Page
15, Line 4 -- has to discharge its duties with the care,
15, Line 4 -- has to discharge its duties with the care,
skills, and due diligence under the circumstances that a
prudent pharmacy benefits manager acting in a like capacity
would use.

I mean, that is setting up a standard for
behavior -- a general standard for behavior. It's similar
to a fiduciary duty on using many of the same words without
actually using the word "fiduciary duty." Maine's statute
does use the word "fiduciary duty" and was withheld.

So there is nothing inappropriate with
creating this kind of standard, and again with respect to
the unsophisticated clients and certainly with respect to
consumers we think this is good.

1 Shall I move on or are there questions
about this?
2 SPEAKER2: Please keep going.
3 MS. BRILL: And if I'm going too fast let me
know or too slow, definitely let me know.
4 On Page 18 there's a section dealing with
PBM enforcement. We support it strongly in its current
form. There's been a lot of debate.
5 SPEAKER2: In this current form?
6 SPEAKER2: Correct, in the current form as it
appears on Pages 18 and 19.
7 There's been a lot of debate between our
office and BISHCA over who ought to be dealing with
enforcement of PBM. We worked very hard up to two years
ago to come up with the language that you see here, in
particularly the language in B, which is at the very
bottom of 18 and the top of 19.
8 It basically gives BISHCA some joint
authority with us and says that to the extent that they
have made interpretations that deal with PBM's, we would
have to follow those interpretations. We are fine living
with that.
9 We want to work closely with BISHCA on
these enforcement matters. To our knowledge, we are the
only ones really doing the enforcement now, but if BISHCA
wants do jump in, we welcome them because it's a very
complex industry and we welcome them.
10 I have not yet had a chance to connect
with Herb. Herb and I were suppose to speak yesterday but
I was dealing with a family matter. We just didn't have a
chance to connect. After we were suppose to connect on
Friday, he needed to wait to Monday. I couldn't connect
with him.
9 They may come in and ask for some greater
authority on their behalf at the expense of our authority
in aid and ask for some new language. We don't think
that's appropriate. We really think this compromise does
it. We also think you guys don't want to hear this issue
between the AG and BISHCA, and so I'm hoping that we have
worked this out and we're done. I promise you I will
endeavor to work it out with them, okay, but I really think
this settlement that we came up with between BISHCA and the
AG's office two years ago really does the trick.
19 Okay. Let's move along. I think the
next section that really deals with the AG is on Page 24,
the Prescription Drug Data Confidentiality Section. We
strongly support this provision.
23 As you may have heard, this section
dealing with prescription drug confidentiality is currently
being litigated or very nearly identical or very similar
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| law is being litigated in New Hampshire. That decision has not yet come out. When it does come out, it will just be a trial court decision.  
  I'm guessing there will be an appeal so we really won't know the legal status of this kind of provision for at least several months, if not a year or more depending on whether or not there's an appeal. We were told there would be a decision from now to say maybe 30 days but I never hold my breath when it's up to a judge as to when we get a decision.  
  SPEAKER3: Where is the decision being made?  
  Which court?  
  MS. BRILL: I believe it's federal district court in New Hampshire.  
  SPEAKER3: So first circuit.  
  MS. BRILL: It would be within the first circuit, absolutely. That's exactly right. So once again any decision made by the first circuit on an appeal would be persuasive authority with respect to Vermont. In the circuit that we're in, it would not be binding precedent.  
  SPEAKER3: One other question. You said that it would be within 30 days to three months to a year.  
  MS. BRILL: It depends on whether there would be an appeal.  
  SPEAKER3: That's just dependent on the appeal? | billions of dollars nationwide marketing to doctors. That is their number one expenditure far greater than direct-to-consumer advertising. We see the direct-to-consumer advertising so it's a hot button issue, but that's not where the vast majority of their money is going.  
  They're spending this money because it's effective. They're not charitable organizations. They're not giving out a charitable message. They are saying to doctors, "We have a new drug. It was costly to develop. It's does great things. It's been approved for some things. We think you ought to be using it."  
  They're trying to market new, expensive drugs. That's what the detailers do. They're not out there just blowing hot air. They're marketing. And the reason they do it, we think, is because they think it's effective. In other words, they're spending this kind of money sending detailers out, giving out samples, you know, holding seminars and whatever because it works.  
  MS. BRILL: Right, the detailers. I mean I actually had a tennis partner who was one so I would not call them but there are lots of people going out and selling and they're very effective. They're very effective at what they do.  
  You may hear that the industry is ratcheting down and firing their detailers and trying not to focus so much on doctors on an individual basis. That may be true to a certain extent but I think like with PBMs things have been slow. I think that will come and go.  
  The manufacturers may -- some of them may start to ratchet down their sales force and they may ratchet it back up again. So clearly, in any event, they're doing this because it's effective.  
  Another argument that you'll hear is you don't need the law because the American Bar Association which provides -- did you guys hear about this already, the ABA number that follows the doctor from getting their white jacket to the grave?  
  SPEAKER2: You mean the AMA.  
  MS. BRILL: Excuse me. I keep doing law. I'm so sorry. I have no idea why. Because I'm rush, I'm sorry. The AMA the -- I'm so sorry. The AMA, the American Medical Association, assigns to each doctor a number which is used for their CLE identifier -- CME. There I go again.  
  CME identifier.  
  This number follows the doctor throughout the doctor's career. It is the critical link currently being used by the data brokers to match up the prescription data with the particular doctor. They need to have some identifier to match up the doctor. |

17 (Pages 62 to 65)
What you're going to hear by the lobbyist for the data brokers or from some people that work for the data brokers themselves is the AMA has recently instituted an opt out provision so the doctors can opt out and don't have to have this identifier that follows them, and if they opt out then their information can't be linked.

And it's just an inaccurate argument. I mean, it is true that the AMA does now have an opt out provision but there are many other identifiers out there or there are other identifiers out there that the data brokers will be able to use to marry up the data about prescriptions with particular doctors.

The most relevant identifier that I'm aware of is the state licensing number and, frankly, our office uses that when we prepare our gift report. That's how we figure out which gifts are going to which doctors and which doctors are really the same person. There's a J. Brill, a Julie Brill, a J.S. Brill, J. Simone Brill. Is that all the same doctor or not? We look at the licensing to see how many J. Brills there are out there. There's that.

There are DEA numbers that doctors have when they are prescribing certain drugs and certain schedules that are on certain schedules, so there are other ways in which the data miners will probably be able to marry up the data, so the AMA opt out is not one that's going to prevent this kind of data mining.

I think another argument you'll hear on this issue has to do with research and the ability of researchers to access this data.

I personally in my heart of hearts do not believe that this data is going to dry up if Vermont happens to enact this law. I think we are way too small a player in a huge national market that will lead to the inability of researches on a national basis to access this data. I just don't think this is going to happen.

But I guess one could argue, well, first there's New Hampshire and then Vermont and as New Hampshire and Vermont go so will go the nation and I wish that were the case.

But let's assume that argument is true. I do think that there will be other ways and other markets that the data brokers can have in order to provide this information to researchers. I mean, maybe they'll have to sell it to researchers for a greater amount of money.

Maybe they will have to develop other markets. These folks, IMS and Barrett Spanners, the two largest of the data brokers, they're very smart people and I don't think they're going to give away the data that much if they don't have the market for it, but I think they will develop the market for it.

SPEAKERS: They can and ask.

MS. BRILL: Ask them whether they will.

MS. BRILL: It should be an option because the doctors get to choose in the initial instance whether their information is shared and we would fully support that. I don't think that's what they want.

Oh, absolutely. In many instances the doctors get a lot of information from the reps to the extent -- I mean, some doctors don't let reps in anymore, you know, the detailers. They don't let them in but what they will do is they will go to lunches or dinners where a new drug is described or a new class of drugs is described and, yes, they absolutely get a lot of information that way.

Doctors are very busy and it's very hard for them to get information or to read studies so they get the digesting of the new studies that are out there from the people that they're talking to and often that's the reps, absolutely.

So, anyway, those are the major arguments that I've heard against this provision. You may hear others. I'll be happy to respond to them as they come up.

Unconscionable Pricing, Page 29, Section 17. This came from D.C.'s law. Currently the district court in the District of Columbia I believe has an injunction against the enforcement of this law as it was enacted in the District of Columbia. I have endeavored to work with Robin to improve this section, to try to remove the concerns that the district court judge had with respect to D.C.'s law and I do think we were effective in doing that.

One of the biggest things I think we did was we greatly narrowed the applicability of the section so that there would have to be a finding that the drugs unavailability led to a, quote/unquote, serious public health problem. That is different than the District of Columbia's statute, and it requires a finding not only of the things that you see at the bottom of Page 30, but also at the top of Page 31 whether the consumers affected with a health condition are unable to afford the prescription drug at the current price. I thought that was an important point to ensure that we had a sufficient state interest in this section to overcome a commerce clause challenge.

I'm trying to think are there other -- there's a provision here on Page 34 that would put within our consumer fraud law our ability to sue in the event that an advertisement met the definition of misbranding under federal law. We think that that's a good provision. It gives us extra authority and makes some sense.
Subsection D on Page 35 is what Robin described as prohibiting pop-up advertising. That's a new and upcoming wave for advertising. We think this is a really good provision and we like it a lot and that's it for our office. So again --

SPEAKER2: One quick question. How does Vermont prohibit advertising coming in from another state or things that are being printed in other states and then sold here?

MS. BRILL: We do it all the time. We enforce -- first of all, it depends what kind of ad you're talking about. If you're talking about a television ad and the advertising is blocked for national distribution, we believe we have both general and specific jurisdiction.

I don't want to get too technical but most of these pharmaceutical companies are present in the state in a way that allows us to enforce our consumer protection law against them. We have jurisdiction over them, and then the question becomes have they intentionally entered the state with respect to that particular advertising.

When it comes to the Internet, there's a sort of split as to whether that's directed at any state, but when it comes to television advertising, it's pretty clear that we do have authority there.

Does that respond to your question?

SPEAKER2: It does briefly.

MS. BRILL: I'd be more than happy to talk to you about this some more. If anyone is saying to you that we won't have authority to enforce against either consumer advertising that comes out over the television or radio or against activities that are directed at doctors here in Vermont, you know, I'd be more than happy to talk to those concerns as they're raised.

SPEAKER2: Okay.

MS. BRILL: Thank you very much. Sorry I took so long.

MR. BLAIR: Good afternoon. I'm Hunt Blair from the Bi-State Primary Care Association and the director of public policy. I have few remarks and the good news is that what you asked to have happen in the past has happened.

So in Section 1, sub 7, which is on Page 5, there's a short paragraph talking about a plan to encourage for moderate use of federal care centers. 218, prescription drug pricing, is actually the 340-B direct pricing program, and so one recommendation I'd have, and I have a sample language would be just to add the words 340-B and so that's clear.

In terms of the plan that the 2004 budget bill called for federal discount program studies. OVA did that in collaboration with Bi-State and a number of other organizations including Planned Parenthood around the state. They did a report and it was brought to the legislature in January 1, 2005, and the primary conclusion of the report was of the various vehicles that you can use to expand 340-B pharmacies, the best vehicle is to expand the number of health center sites.

Basically because the other vehicles, they're called covered entities, are not as present or easily present in a disproportionate share of hospitals. They have to meet a certain threshold in order to qualify and at the present only qualifies for that provision.

So following up on the recommendations of that report, in the 2005 budget bill there was a total of $100,000 appropriated towards promoting the expansion, development of 340-B.

And we in and our partners of Bi-State Primary Care and Health Department -- that's where the money was appropriated, through the Health Department have been working diligently ever since in moving that forward. We actually have been fairly frugal in spending that appropriation that would carry it forward into the current fiscal year.

During this same period of time the number of health centers around the states have expanded dramatically. In 2001 one we had two HQHDs with seven sites. We now have seven HQHDs with 26 sites. Of the seven five are full. Section 330 grantees, they got big federal grants. Two are called HQHD look a likes. The look a likes are also entitled to 340-B pricing.

Through the consensus building, the consensus building process that actually started with the drafting of this report and continuing on through last summer, we got to the point where our members and our state partners all identified common goals and where everybody was in agreement when looking forward to expand us.

The reason that accuracy have not been as big utilizers of 340-B as they could be is because it's a very complicated program. One of the biggest requirements is a very strict audit trail to make sure that only those people who are entitled to get the discounts get the discounts, and the burden of that, particularly on a small organization or on a small community pharmacy, can be so overwhelmingly that it keeps it from moving forward.

The other complication is that there are many, many, many different ways to implement 340-B. You can have an in-house pharmacy or dispensary. You can contract with a local pharmacy. You can have a mail order system. There's just a million different ways to do it.

And part of what we were working for is
having a unified statewide system so that with this growing
number of health centers it would be easy as more come
on-line for everybody to be part of the simple statewide
system.

The Primary Care Association in Utah
does -- plays this role of this audit back office for all
of their health centers. A little bit easier because they
have a single chain that is throughout the state and we
don't have the same opportunity here. Actually we're
working very closely with local communities and pharmacies
because part of what we want to do is make sure that we're
supporting local pharmacist as opposed to using some other
mechanism that would be threatening to them, which again
further complicates it.

Last summer I was in a 340-B conference
and I saw a gentleman by the name of Jeff Lewis. Jeff is
the president of the Heinz Family Philanthropy and his
opening remark was, "I hire a lot of consultants. I know a
lot of you in the audience have probably hired a lot of
consultants and I'm here to tell you that most of them are
no good," which actually validated my own experience hiring
a couple of consultants. They're just all over the map.

And what the Heinz Family Philanthropy
do is they use philanthropy as a venture capital. And in
contrast to a RWJ grant or something where you go, "And
here's how it's going to be sustainable, and once the grant
money dries up" -- so Heinz' philosophy is let's make it
sustainable from the beginning.

So what they've done is provided -- after
a series of discussions and not even a long application,
just a handshake, they have provided us with -- well,
technical support and financial support for creating a
340-B network entity which just last Friday we issued a
request for proposals -- and I'd be happy to get you copies
of this if you really want copies -- that's going out to
vendors to get some support for implementing, and again it
could be done a lot of different ways so we are going to
see what kind of proposals come back, the state-wide
infrastructure for moving this whole thing forward.

A couple of points related to that. This
created something called the Vermont Health Alliance to
help support this and part of what we're doing is creating
an infrastructure so that again if they're new health
centers or even new primary care centers or existing
primary care centers that want to contract with HUFC in
order to help gain the benefits, then we will have this
infrastructure there, and we actually just yesterday got a
notice of grant award from the Office of the policy for a
Plan-O-Gram to help support that work so we're moving all
this forward.

Finally in the last phrase of the
language there's -- it says including contracting with one
or more accuracies, to provide record management services.
This is based on a model of utilizing 340-B, sort of
stretch 340-B through contract. The federal register of
January 12, 2007 issued a new definition of what a
patient -- how you define a patient and it basically
limited it more closely so you can't just say that --
patients can't just be considered patients because there's
no case management done. They actually have to be patients of
record of the covered entity or -- of covered entity and
get them direct patient care.

So it's not to say that, for instance,
prisoners in corrections couldn't get the health services
from an HQFC and get 340-B pricing but there are several
steps along the way. In fact, we have been in conversation
with Dr. Wary at the Department of Corrections about a
process because this is something that's come up a number
times, kind of like a lot of the material in this bill
and basically it hasn't moved forward in the previous times
because it's a complicated line of business for the health
centers to get into.

In a lot of ways it makes a lot of sense
because many of the folks in corrections are also patients
at health centers so when they come out having that
continuity of care would ideally be good.

So again Heinz, our benefactor in this area, are going to be providing some funding to bring a couple of national experts in the field. We are going to have a day long seminar, invite lots of doctors, and by the next proposal for a new corrections health service contract comes up we will be ready to at least propose a pilot like maybe carved out in the women's prison or something, so we're moving that forward.

But because of the definition of patient issue, I would recommend striking that very last especially ending that section with the "prescription drug" period and not including "contractor."

SPEAKER3: Where are you?

MR. BLAIR: Page 5.

SPEAKER3: Which sentence are you?

SPEAKER4: Sentence 13.

MR. BLAIR: Yes, starting at the last word on 12 including "contracting with one or more."

SPEAKER3: So just eliminate that? Is that what you are suggesting?

MR. BLAIR: Yes, that's what I suggest. The very last thing, we support the bill.

MS. MCINTYRE: Linda McIntyre. I'm a commissioner with the Department of Human Resources.

Actually we have a very small part in this bill. My purpose in coming over and listening to all of the testimony is to better educate myself on the entirety of the bill and to say that we did support where we are, which in my version is on Page 4.

But in the course of listening to the testimony, you had questions about a provision that was struck and I'm not prepared to testify about so I called Kathy Callaghan, who is the director of Benefits and Wellness. She was here in 2004 when -- because I believe you had questions why we didn't follow this provision and about my predecessor's report, and I will try very hard to get my hands on that report. If I had known that was going to be the question today I would have done that.

So we do support the bill with respect to the small section that we're included in, and if you would like to hear from Kathy --

SPEAKER2: Which is which?

MS. MCINTYRE: Well, I have a different -- it's in Section 1 and it's C1.


MS. MCINTYRE: So again we would not be players in this bill but we support this provision. Would you like to hear from Kathy about 2004 and why this wasn't something that was --

SPEAKER2: Sure.

MS. MCINTYRE: Unless you have any more questions from me. Thank you.

SPEAKER2: Well, you sat through all this.

MS. MCINTYRE: Well, I wanted to educate myself.

MS. CALLAGHAN: Thank you, senator. For the record, I'm Kathy Callaghan and I'm the director of the State Employees Health Plan and I too will be mercifully brief.

The language that was struck says that "The Commissioner of Human Resources shall use the preferred drug list and the state employees comp. benefits plan only if participation would provide economic and health benefits to the state employees plan and beneficiaries and only if agreed to through the bargaining process between the State of Vermont and its union."

You probably know the rest of the story.

What happened was that then Commissioner Malaire was asked to give a report on November 1st of 2004, which she did do, and her report concluded that it certainly would be beneficial to have a PDL or a prescription drug list program in the state employees health plan.

And at that particular time we were in bargaining with the union. Now, I have to say that I wasn't part of bargaining and I wasn't part of the legislative process when Commissioner Malaire was commissioner because she insisted that those were her duties and she wanted to be the person who would appear.

It appears to me, though, that she reported out on 11-04 and I do know that we have a copy of that report and I'll be happy to get it to you.

SPEAKER2: That would be good.

MS. CALLAGHAN: And then effective July 1 of '05, which was seven months or so later, we had concluded bargaining with the union and we have a PDL program, a prescription drug program.

Now the question might arise because just in Section 8 prior says, "The director of OVA and the Commissioner of BISHCA shall implement the preferred drug list as a uniform statewide list." To my knowledge and recollection, there never was such a list put together and presented for common consumption and that's to my knowledge and recollection.

I don't recall that during our bargaining process we had an option to use what we would receive or that we had anything really that would. What we did use was a fairly cost effective PDL which saved the plan 2.8 million dollars in first year of implementation, and by using Express Script PDL -- and they're a PBM -- we have
the bargaining power of 50 million lives -- the purchasing
power of 50 million lives and I think that helps our
position and right now it's working well. The employees
are happy with it, generic drugs are being used fairly
highly and we served 2.8 million in cost.

SPEAKER3: So what does that mean for the strike
out that we're seeing, for example, on Page 3.

MS. CALLAGHAN: Well, that's all going to come
out. It's going to be replaced by language on Page 4.

SPEAKER3: Right.

MS. CALLAGHAN: Because it's sort of history, I
guess.

SPEAKER3: It's out.

MS. CALLAGHAN: But I think -- and we support
the new language. I think the senator just had a
question.

SPEAKER2: You support the new language?

MS. CALLAGHAN: Yes, absolutely.

SPEAKER2: In Section 1?

MS. CALLAGHAN: In Section 1?

SPEAKER2: You support the new section?

MS. CALLAGHAN: Yes, we do.

SPEAKER2: Any other questions? Thank you.

MS. CALLAGHAN: Thank you.

SPEAKER2: Paulette.

MS. THABAUT: Good afternoon.

SPEAKER2: Good afternoon.

MS. THABAUT: I'm Paulette Thabault, commissioner from Banking Insurance Administration.

I'm going to just give some testimony on
the parts of the bill that are relevant to BISHCA, and I
would just preface my statement by saying that our concerns
when we look at this bill work around making sure that what
was in the legislation wasn't going to increase health care
cost inadvertently because I'm sure that's not the
intention here.

So with that being said I would refer
first to Section 7 on Page 115 -- I'm sorry, Page 15 of the
copy that I have, and this concerns -- this is 9472 and it
delineates the types of information that should be included
in a contract between a physician -- between a pharmacy
benefit manager and another contracting party which would
be a health insurer for the most part.

And the language that was added in the
Senate Finance Committee is in first Paragraph A unless the
contract provides otherwise, and we're supportive of these
provisions because we think this language is key in
allowing the parties to contract and vary the terms of the
contract and not be tied to specific provisions.

Every time there's a contract when there
are provisions they come at a price and the parties should
be allowed to vary those terms so we are -- I'm happy with
the way this came out?

SPEAKER3: So you're happy with all of 4972?

MS. THABAUT: Yes.

The next place that I would go to is
under the enforcement area and that's on Page 19.

Generally we are accepting of the language in this
provision. It is the language that was worked out several
years ago. Actually when I was here before as a deputy we
were working on this language, and it does identify the
roles of the Attorney General's Office and the commissioner
of BISHCA for enforcement. We would like to keep talking
with the Attorney General's Office.

SPEAKER2: I think you heard Julie Brill you can
keep talking.

MS. THABAUT: Right. With respect to health
insurance companies, we really feel that we are the
regulate agency and have more than one body regulating an
entity can oftentimes be confusing and not really very
helpful, so with respect to health insurers, we would like
to maintain our ability.

The next piece -- actually on that same
page, refers to -- Paragraph A there refers to the
requirement for the pharmacy benefit managers to register
within 30 business days with the state and we are glad that
that's there. We are beginning to see the pharmacy benefit
managers register now through our multi-payer claims
database project. That's a important employee project that
will allow us to really look at health care costs from all
sectors of the state, both from the private and public
sectors and is important when you're doing analysis on
health care cost so that's a very helpful provision.

SPEAKER3: They are not registered now?

MS. THABAUT: They are beginning to register
voluntarily and they will be mandatorily soon through the
multi-payer project and this language preserves that.

SPEAKER3: Isn't that interesting that they're
not -- I mean, you've been doing this for a few years and
the whole middle approach to pharmacy.

MS. THABAUT: They have not been required to

SPEAKER3: They're making deals all the time.

They have a lot of power, don't they?

MS. THABAUT: Well, one of the things that I
would just try to keep in mind is that we have to some
extent regulated pharmacies through our regulation of the
health insurance industry so there has been some regulation
versus none at all, and I will show an example of that in a
minute.

SPEAKER2: When you started I was writing notes
on what you said, the previous section. You are supportive of Section 8?

MS. THABAULT: Is that the --

SPEAKER3: So it's okay the way it is?

MS. THABAULT: It's okay.

SPEAKER2: That's Section 8.

MS. THABAULT: Then if you turn to Page 27 -- actually it starts on Page 26 which is Line 10 at Paragraph D, the preceding section refers to the kind of -- a lot of confidentiality language and this outlines where it does not apply, and Paragraph No. 5 refers again that section preserves the requirement that the pharmacy benefit managers will register and provide data to the multi-payer claims database, which we think is really important so we are happy that that is there and are supportive of this section.

SPEAKER3: The whole section?

MS. THABAULT: Yes. That's really the piece we were concerned about.

On the next page, on Page 28, Section 16, it's the prescription drug co-payment section requiring that the pharmacies --

SPEAKER3: I'm sorry, I didn't hear the page and line.

MS. THABAULT: Page 28 at Section 16, starts at 16, at least in my copy. This requires that when a person goes to get their prescription, if the cost of the drug is less than the co-pay, they pay the lessor of the two.

Now, we're not really sure that needs to be there because that's already the practice, and I have an example for you that shows you the language.

This is an example of the contract language that came from Blue Cross/Blue Shield and it clearly states that the member has the benefit of the lower of the two prices, of either the co-pay or the discounted rate that the plan had negotiated with PBMs.

We have a role in consumer protection and we have not through our consumer complaint process experienced anyone complaining that they're being charged more than the co-pay. It's in the contracts with the PBMs so the piece -- this language for us is something that's already been done and doesn't seem that it needs to be there.

SPEAKER3: Is that something that's done in every contract, this sort of a standard criteria?

MS. THABAULT: This is consistent with our bulletin on PBMs.

And then the last piece that I was going to speak to is on Page 35 and it's under the Insurance Marketing and we are supportive of these provisions as they exist today. It describes the type of marketing and advertising that can be carried out with respect to assisting individuals with their Medicare Part D and just the transparency when an insurance agent is meeting with someone that they must identify what their purpose is and that when it's for the purpose of insurance that they were identified up front, so we are supportive of this provision as is.

MS. THABAULT: Very good, Thank you.

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CERTIFICATE

STATE OF FLORIDA )

MIA MI-DADE COUNTY )

I, ANA REID, a Shorthand Reporter and Notary Public within and for the State of Florida, do hereby certify:

I reported the proceedings in the within-entitled matter, and that the within transcript is a true record of such proceedings.

I further certify that I am not related, by blood or by marriage, to any of the parties in this matter and that I am in no way interested in the outcome of this matter.

IN WITNESS THEREOF, I have hereunto set my hand this day of August 28th, 2007.

ANA REID
Commission Number: DD694179
Commission Expires: July 15, 2011
STATE OF VERMONT
SENATE COMMITTEE ON HEALTH AND WELFARE

RE: Senate Bill 115
Senate Bill 7,
DATE: Wednesday, February 28, 2007

Type of Committee Meeting: Standard

COMMITTEE MEMBERS:
Sen. Doug Racine, Chair
Sen. Ed Flanagan, Vice-Chair
Sen. Sara Kittell
Sen. Virginia Lyons
Sen. Kevin Mullin
Sen. Jeannette White

CD Nos: 07-47
07-48

Transcript Prepared from Audio on CD

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Job No. N887545
PROCEDINGS

CHAIRMAN RACINE: Why don't we get started. Senate Health and Welfare Committee. It is Wednesday February 28th. We have before us S-115 dealing with prescription drugs. The bill as passed by Finance is now sitting in here. And folks from out of town, it is Terry --

MR. LATANICH: Latanich.

CHAIRMAN RACINE: Latanich. Why don't you come on up and get us started. I still ask you to. even though I'm changing one rule, I don't want to change the 15-minute rule if we can for your testimony. I will try to be flexible enough if the Committee members ask you questions, that could go over 15 minutes. I ask that the questions to be brief and to the point if we all could.

MR. SMITH: Mr. Chairman, my apologies. Bill Smith for Caremark. Tracy Baroni-Allmon from our Caremark (inaudible) for policy asked if she could be in by phone with Terry and with Brian in case that might speed things up for the Committee. If she didn't have to say the same thing the other two guys said, then that might speed things up. So she asked to be called when you began the PBM testimony, if that will be all right.

CHAIRMAN RACINE: That's what we're --

ATTENDEE: That would be now.

CHAIRMAN RACINE: That's what we're doing right now.

ATTENDEE: That would be now.

CHAIRMAN RACINE: So let's get her on the phone.

MR. SMITH: Thank you. [Ms. Baroni-Allmon joined the meeting via telephone conference call.]

CHAIRMAN RACINE: Do you want to wait for her, him?

ATTENDEE: Yes.

CHAIRMAN RACINE: Terry Latanich, the floor is yours.

MR. LATANICH: All right. Thank you.

Again, for the record my name is Terry Latanich, I represent Medco. For fifteen years I was the senior vice president for Medco and I ran part of the business and I ran the regulatory function. I now represent them as a consultant.

I want to talk a little bit about, there has been a lot of discussion about PBMs as middlemen and, you know, exactly what role did PBMs plays in that middlemen process, because it's often used pejoratively as though we're not adding value to the process. And then I want to talk just briefly about three or four provisions in the bill that we have some concerns about.

But let's just start with a little bit about Medco. And please do interrupt me any time you want to. I much rather have a dialog with the Committee than some depleted talk. So I would rather talk about what you want to hear and I'll make sure I get my three or four key questions in here.

Medco is one of the top two or three PBMs in the country. We live in an industry that is highly competitive. We report to the SEC annually on operating margin pretax of about 1.7 percent. So when -- I, mean you're going to hear people saying, you know, PBMs are getting hundreds of millions of dollars and keeping them in rebates. In our SEC filings, which are signed under Sarbanes-Oxley, we have 1.7 percent operating margin, so that's the business that we're in.

If you look at the competitiveness of our market, there are about at least 70 PBMs in the United States. There are three very large ones, Medco, Express Scripts, and Caremark. But you also have the drug chains like Walgreens, CVS, insurance plans like WellPoint and Aetna and Cigna operate PBMs. You have very small ones that have very big clients. So the Blue Cross plan here uses a small PBM by the name of RESTAT. So the competition within the industry is very fierce.
And I spent a good part of my fifteen years as senior officer of Medco negotiating contracts with health plans and with individual employers. And I can tell you that when you sit in a room during a competitive bid situation and you don't know what somebody else is bidding, that the price competition is absolutely intense because you know if you lose, the price of losing is very high.

So the idea that there is not competition in this industry, that it's, that somehow we're able to extract unreasonable profits, simply is not the case, and you can just look at anybody's public filings.

We are a licensed Medicare provider, we are licensed under Vermont laws as a health insurer to provide a Part B benefit. We're one of the handful of plans that offers a nationwide Medicare Part B plan. And we do have a very high percentage of the Fortune 500 employers and a fair number of state and government plans and health insurers.

The same thing is going on now with electronic prescribing. It's the PBMs by and large and the health plans that are driving the effort to get rid of prescribing errors by putting point of sale technology in the doctor's office.

So when the doctor writes a prescription you don't have sloppy handwriting, you don't have incorrect information; what you have is the right drug and the right quantity. And you can prompt the doctor if the prompter is prescribing something that is inappropriate for that patient, or at least get the doctor to think about it.
whether he or she is making a conscious
decision to mix and match a couple of
drugs.

The other thing that PBMs have done
a very good job of is accelerating the
usage of generic drugs. Generic drugs is
the simplest best way to save health plans
money and to save payers money. It is by
far the best thing you can do. And the
PBMs have a track record, as evidenced by
a number of studies, that generic drug
adoption occurs faster in a mail service
environment, it happens faster with PBMs
that are administering health plans than
the (inaudible). The reason is the
incentives are (inaudible).

PBMs make money by dispensing
generics and managing generics, and the
health plans save money every time they
can substitute a generic for a brand.
So, you know, these are the middlemen
functions that we perform.

I suggest that without PBMs we would
be filling prescriptions through major
medical and paying the highest possible
prices. So I think that when you look at
this regulation, you got to think about
whose driven innovation in this market
and what is going to happen if that
driver innovation has unnecessary cost
imposed on them.

There are — before I get into
provisions of bills there is one last
thing I would like to talk about, and
that is transparency.

You hear so much about transparency
in healthcare today. And people say,
well, how can you be against
transparency. Usually when people talk
about transparency and other aspects of
health care, they're talking about
visibility to the price of the service
you're offering.

So if I'm in a consumer-driven
health plan and I want to know what my
hospital is going to charge me, I should
be able to find that out. In this case
health plans and employers have complete
visibility to what the prices that
they're being charged. The issue here on

transparency is should they see the input
costs that result in my price.

So I'm giving an example, using, I'm
a lawyer so I'll use lawyers as an
example. If I'm a health plan and I
contract with a law firm to represent me,
they quote me what they're going to
charge me for a partner and for an
associate, and we negotiate and we reach
an agreement.

The equivalent of this bill is to
say I want the law firm to tell me what
you're paying the associate. I want to
know what the partners are making because
if I know what they're making and I know
what you're paying people, then I can
make a more informed decision about how
much I'm willing to pay you.

And as a buyer I have the right to
ask any law firm, I want that
information. And the law firm has the
right to say back, sorry, that's not the
way we do business. We'll tell you what
we're going to bill you, but we're not
going to open up our internal operating
structure.

That's the kind of transparency that
you're looking at here. It's not the
client knowing what they're being
charged. It's looking inside the PBM and
saying, okay, break down everything that
you make, show us what your costs are.
And that's a very different kind of
transparency.

The other key to transparency is
that if a client wants it, we give it.
Well over 60 percent of our clients today
want bids fully transparent using this
definition of transparency. They want to
see the rebates. They want to know what
they are. And they want us to bid often
times with no rebates because they just
don't want to deal with them. They want
any risk of not being able to get the
rebates to us with (inaudible) PBMs.
They don't want to carry that risk. They
just want the value of it put into their
pricing and we carry the risk if we can't
negotiate with the manufacturers, sorry,
you lose, it's a risk you took.
So we're seeing more and more clients saying, well, we like to see you bid this way, we like to see you bid this way. And we suggest that, you know, this is, in some respects this is a solution searching for a problem because payers today have the right to say how I want a contract. You know, we don't see the health plans or the employers or the TPAs in here saying we are at disadvantage in negotiating because we see these kind of bids all the time asking for alternative bids.

I would like to address three or four specific provisions of the bill and hopefully stay within my time limit. And those are the opt-out provision. The second is whether there really is a need for licensing. There is a question in the licensing provision about whether it's creating a conflict with the opt-out right. There is the issue of the dual jurisdiction of the Attorney General and the Department.

And, finally, the fiduciary issue on prudent purchase or prudent PBM.

I'm going to defer the jurisdictional questions and the prudent PBM to one of the other witnesses from Express Script so that we don't duplicate our testimony.

The opt-out provision that I want to talk about, we strongly support. That's page 15, line 2. Which essentially says that there are certain provisions that apply unless the parties contract and agree otherwise, which makes a lot of sense in a commercial transaction. If two parties come together and say here is how I want to structure our benefit contract, that should determine what the respective rights are. That's the way the market works today.

What we're concerned about is if you then look at page 19, line 20, this is the provision of the licensing bill that says, or --

CHAIRMAN RACINE: Excuse me; are we all working from the same version?
a business. Certainly heard later today
from Ms. Treat (phonetic) that there are
people out there, nonprofit PBMs, other
PBM that do, or as they call them, PBAs,
pharmacy benefit administrators, who do
work on an ASO basis.

ATTENDEE: Is that what that says?
It says you should have to notify them
that there is such a thing available, you
would have to give a quote on it.
MR. LATANICH: Well and, we're hoping
that is what it is. We would simply like
to clarify the language that says shall
notify insurers that a quotation with full
pass-through.

ATTENDEE: Is available?
MR. LATANICH: Is available, right.
But not necessarily from us we're
responding to the bid. Question is, so
we're making it clear, that because we're
contracting on a different basis that they
have a right to look to the statute and
look in the market to see people who are
going to be making these ASO bids, but not
that it's imposing an obligation on
everybody who is responding to Blue Cross'
bid to themselves put forward.

ATTENDEE: Oh, yeah. I mean, I don't
read it that way, but.
CHAIRMAN RACINE: Who is representing
you here?
MR. LATANICH: Who is representing?
CHAIRMAN RACINE: When you're done?
Okay. Because you can help us. If there
is clarification that is needed.
Because I think we're reading it two
different ways and rather than wordsmith,
there is limited time.

MR. LATANICH: That's good. Thank
you.

On the issue of the licensing
structure, there was a registration bill
passed for PBMs last year. I know that
the rule implementing, it has yet to be
implemented. But one of our concerns
about the need for licensure, itself, is
it's not exactly clear what it is that is
being protected against.
The market is offering all these
different options of kinds of benefit
structures. There is no -- there is no
delineation of the kind of rules that
should be adopted here. It basically
creates a structure and says adopt rules.
And that's a very broad delegation with
really no direction about what issues
they should address, what kind of
anyway, so.

ATTENDEE: Where is this on the
licensure?
MR. LATANICH: It's on page 21,
line 13.

ATTENDEE: Thank you.
MR. LATANICH: "Commissioner shall
adopt such rules as are necessary and
desirable in carrying out the purposes of
this section."

There is very little in this section
that delineates the areas that would be
subject to regulation of what it is, in
fact, they're looking for to regulate.
We would suggest that they ought to look
back to the registration statute, give it
a chance to work first. Because you're
creating a mechanism here that allows
people to be aware that there is going to
be an ASO option out there that people
might bid.

We don't see the need at this point
for there to be a licensing statute,
certainly one without a defined scope,
until we see how the registration bill
works. So we would encourage you to
consider that as an option.

I guess one other issue I would like
to point out, and it's, it's really, I
don't think it was intended to be a PBM
provision, but if you look at page 35 on
line -- it's Section D, which is line 7,
it's a section of the drug marketing
piece that deals with pop-up adds and
instant messaging when a prescriber is
writing a script.

We're concerned, one of the things
that we're doing is putting together
technology and software that tells
doctors electronically at the time
they're prescribing is the drug on the
formulary, is there a generic available,
is it covered under the plan, are there
drug interactions. But all of these
things are there with the intent of
impacting what the doctors can prescribe.
Either because the plan is adopted as a
benefit limitation or because there is a
health and safety concern.
There is a, there is a section that
you already have adopted or that is in
the legislation earlier, it's on page 26,
line 11, which exempts out of, which
creates an exemption for DUR, drug
utilization review.
So basically the language that is
here that insulates these kind of good
practices should be put back into this
marketing section just so it's clear that
when you're doing these commendable plan
functions, that it doesn't inadvertently
fall within pharmaceutical marketing
because you do want people -- you do want
the doctor being told that this is the
wrong medication for the wrong person.
You do want them to know what the
coverage rules are.
That's not what we're trying to get

at here really dealing with sort of
dollar-driven instant pop-up messages,
you know, prescribe Viagra now, as
opposed to somebody giving these kinds of
electronic things. So we can get actual
language.
But you need, we believe, this kind
of saving language that is in this
earlier provision back here on the drug
marketing provision as well so that the
health plans and the PBMs can continue to
do what they need to do.
So with that I'd be happy to answer
any questions that you have or --
CHAIRMAN RACINE: Kevin.
SENATOR MULLIN: Mr. Latanich, when
this was reported to us from the Finance
Committee, they said that the reason for
the importance of this is that you're not
just dealing with eight players, but
certainly dealing with eight players, they
should have their own size legal
departments because, and that (inaudible)
-- so I just wondered if you could give us
examples who the smaller players would be
that we're protecting.

MR. LATANICH: Well, you know, we
were actually kicking around at lunchtime
because if you look at our client base,
you know, that the aggregators of small
businesses are either Blues plans,
isurers, or TPAs, all of which are either
sophisticated or have access to
sophisticated resources. We're not really
aware of small employers or small unions
that are directly contracting with PBMs.
They would have to be awfully small
organizations. I mean, I'm hard pressed
to name one. Certainly we don't contract
with anybody who would fall under that.
And, so, you know, we're sort of
puzzled by who are, you know, if we're
really saying there is a very small
threshold, you know, that you're really
looking at here. But by and large you're
looking at either very sophisticated
purchasers like the state, or you're
looking at Blues or you're looking at the
insurers or you're looking at other
aggregators. And all of them are
capable, and the market is showing that
they're putting out bids today saying bid
it this way, bid it this way. I want to
know which I want to choose.
So I can't tell you who they are,
because I'm not sure they're out there.
And if they're out there, they're not out
there in big numbers.
ATTENDEE: I appreciated your analogy
there going to the attorney and asking for
how much are you going to charge me, but
how much are you going to pay the
attorneys. But I think that there is a
slight difference here when we're talking
about public money.
When we're talking about public
money we, in fact, do know how much
people are being paid, when we know how
much the public defenders are being paid,
we know how much our salaries are, we
know how much different peoples' salaries
are. When we give a government contract
to a builder, we require them to use
Davis-Bacon, and we don't just ask how
much they're going to charge us to build
the thing, we ask the employees, we ask
the carpenters and the plumbers how much
they're being paid.
So when you're dealing with public
money I think there is a, a little bit of
a difference here. Because we're talking
about only public money here; right?

MR. LATANICH: No.
ATTENDEE: No, we're talking about
everything here? Okay, fine.

MR. LATANICH: I agree with you, I
agree with you completely. I mean I think
that as a payer, whether it's in your
title programs or your state
employee programs, you have the right
today through contract to say I want to
know everything there is to know about
you, I want to know what you're paying
Terry as a salary, I want to know what
hotel he's staying in tonight, which is
the Sheraton over by the airport. But you
can ask for all of that without the
statute.

ATTENDEE: That's a nice hotel.

MR. LATANICH: My plane was canceled,
don't use PBMs. 340(b) is for
disproportionate share of hospitals, other
low-income clinics. They have a right
under federal law to access the lowest
available pricing. Generally they do it
on a direct contract basis. And then they
do direct distribution themselves, as best
I understand the program.

So, in general, 340(b) clinics and
those type of qualified plans don't use
PBMs, they do direct contracting.

ATTENDEE: Thank you.
CHAIRMAN RACINE: Okay. Thank you.

MR. LATANICH: Thank you. I'll be
happy to answer any follow-up questions
that you may have after the hearing is
complete.

MR. QUIGLEY: Thank you, Chairman
Racine. I'm Brian Quigley, I represent
Express Scripts here in Vermont. I would
also add I represent America's Health
Insurance Plans in the northeast, that's
the national organization for 1300 health
carriers. And I mention that because the
health plans, as Terry has alluded to,
I had to stay in a Microtel in Greenville,
South Carolina last night, so I guess it
balances out. It was $48.

Anyway --

ATTENDEE: Okay. I --

MR. LATANICH: But in the context of
a public payer, we don't have a problem
with that all. It's a question of
imposing this on private players. So it's
a very different question.

CHAIRMAN RACINE: Okay. Thank you.

And Brian Quigley, please come up.
So are you guys competitors?
MR. LATANICH: Absolutely.
MR. QUIGLEY: Absolutely.
CHAIRMAN RACINE: Are you together in
your testimony here? Do you have the same
representations?

MR. QUIGLEY: No.

ATTENDEE: What happens with the
disproportionate share of hospitals, other
low-income clinics. They have a right
under federal law to access the lowest
available pricing. Generally they do it
on a direct contract basis. And then they
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representations?

MR. QUIGLEY: No.

ATTENDEE: What happens with the
federally designated clinics, do they have
their own public PBMs or the PBMs are not
public, they're private?

MR. LATANICH: Well, the ones that
are entitled to the 340(b) pricing, they
also do not feel this is necessary that
they can protect their own interest,
whether it's the Blue Cross plan here or
MBP or Cigna or whatever. And having
testified in a number of states, none of
our health plan members have asked for
this level of protection.

We appreciate that the draft out of
the Finance allows for an opt-out, as
Terry said. I will be brief. I'm used
to testifying in states where we only get
3 minutes. So I'll try not to go too
far --

CHAIRMAN RACINE: That's okay, we
don't mind.

ATTENDEE: We are one of those state.

MR. QUIGLEY: It's ingrained.

Even though there is an opt-out, the
standard in 9472(a)(1) on page 15, which
is what we refer to as the fiduciary
standard, creates a legal liability that
is inconsistent with both the obligation
of the health plan, which is the
fiduciary, and has this standard, and is
also inconsistent with federal law.
I won't spend as much time as I normally would because you do have an opt-out, but it will create a legal confusion between the health plan and the PBM. So if that one could be stricken, that would be helpful.

The other thing I would like to focus on, which Terry mentioned briefly, is the enforcement provision on page 18, starting at line 14. And this makes the PBM activity subject to the consumer fraud law. And we're very concerned about that.

These benefits are regulated under the Insurance Code, all the rights of the Insurance Code in terms of internal and external review, Unfair Claim Practices Act, et cetera.

ATTENDEE: Sorry; what line are you on?

MR. QUIGLEY: I'm sorry. Starting on line 15. Line 14 is the title, on page 18.

Would apply the consumer fraud provisions including private right of

action and punitive damages to the PBM activity. And as Terry has stated, we're an administrator, we don't accept the insurance risk, that is borne by the health plan or the employer or in the case of our client, the state of Vermont.

The insurance benefit is exempt from the consumer fraud provisions because of all the protections that exist under the Insurance Code.

So you would have the anomaly that the benefit that we are administering is not subject to the consumer fraud provisions because it is regulated by BISHCA under the Insurance Code or regulated under ERISA in the case of a self-employed benefit plan. But somehow the PBM would be subject to consumer fraud actions by the Attorney General or by private rights of action. We have a very hard time figuring what cause of action that would be.

The cause of action that is already available to our consumer, which is the health plan, the employer, or the state, is a contract action, and is more than sufficient to enforce their rights. And they do that all the time. They have the right to audit everything, they have the right to ask for all the rebates.

So we're very concerned as to what the enforcement would be about if it's not about enforcing the contract that you did provide the rebates if that was what you requested, that you did provide the financial information, that you did allow an audit. And because we don't know, it creates a legal uncertainty that, frankly, has to be priced for in the administrative fee.

And because there is a private right of action, by whom we're not sure. Again, we don't have a contractual relationship with the member who is covered by a health plan. Our contractual relationship is with the health plan. They determine the formulary, they determine the level of reimbursements, whether or not it's a mail order or not, what drugs are on, what brand, et cetera.

We don't know what the causes of action would be; therefore, it creates a tremendous level of legal uncertainty and a tremendous potential for liability on something that, again, is contractual in nature.

So we would urge you to delete the enforcement provisions that apply the consumer fraud and leave this to BISHCA where it currently resides. Again, there is already a registration requirement for the PBMs, and the benefits are already regulated by BISHCA. So we see no need for it and a potential cost implication.

ATTENDEE: I'm just trying to put it all in context and it's later in the day, I'm a little slow in all this. So you're an independent contractor, PBMs are?

MR. QUIGLEY: Correct.

ATTENDEE: And you're just being licensed for the first time, before you were registered in the past?

MR. QUIGLEY: There is on the books now from last year a law requiring
registration. It hasn't occurred yet
because it's dependent on rules that have
not been finalized.
ATTENDEE: So you've just been out
there as a new entity in the --
MR. QUIGLEY: Right.
ATTENDEE: -- in the health care
industry, brokering for health care
companies, of insurance companies to,
actually we heard from the last witness,
all the new technology going on and the
increase in prescribing drugs and how we
look at them all and electronic
prescribing.
And, so, you are the independent
contractor. But we had no relationship
with you in the past otherwise?
MR. QUIGLEY: The relationship would
be through the benefit plan.
ATTENDEE: Through the --
MR. QUIGLEY: Through the insurer.
ATTENDEE: Through the insurance
company.
ATTENDEE 2: (inaudible) legal
liability?

MR. QUIGLEY: For the benefits?
ATTENDEE 2: Yeah.
MR. QUIGLEY: No, that would be a
health plans.
ATTENDEE 2: Why do you say that so
(inaudible)?
MR. QUIGLEY: Because we don't have
control of the assets. We get a claim
from a pharmacy that says paid somebody
who is covered by Blue Cross. We pay the
pharmacy and then we submit the bill to
the health plan which reimburses us. The
formulary, the term --
ATTENDEE 2: So you're just a
conduit?
MR. QUIGLEY: We're an administrative
servicer, that's correct. Now, we provide
other services that they purchase; disease
management programs, formulary management
programs. But, again, those are all
decided by the health plan. They will say
we want this brand drug on our formulary
or we want to pursue generics more
aggressively by using these techniques
that you have to offer. You know, we want
a mail order benefit or we don't want a
mail order option and what the
differential and the co-pay will be
between mail order.
ATTENDEE 2: I don't see how you can
take on the rather crucial role you're
taking on if paid for it and just act like
that you have no legal liability.
MR. QUIGLEY: We have a legal
liability to our client. If we don't
comply with the contract, then we have a
liability to them, which they enforce
under contract.
ATTENDEE 2: How about the
beneficiary?
MR. QUIGLEY: The beneficiary has a
contractual obligation with the health
plan, not with us.
ATTENDEE 2: You are participating in
the delivery of benefits of the health
plan to the beneficiary.
MR. QUIGLEY: According to our
contract with the health plan and
according to their contract with the
employer or the individual.

ATTENDEE 2: Yeah, but that's like
just tying loops and circles around.
MR. QUIGLEY: I disagree because we
have to follow whatever laws they have to
follow. If the law says you have a right
to internal appeals processes within
certain timeframes for benefit
determination, whether it's medically
necessary, and if it continues to be
denied on the internal utilization review
process you have a right to an external
review. That's what Vermont law says as
to any benefit including the pharmacy
benefit.
If for some reason we're not
allowing that process to occur and, in
fact, that process occurs at the health
plan level, we're in violation of our
contract with the health plan or the
employer. And it would be liable --
ATTENDEE 2: Private contracts, the
provisions of private contracts can't
preempt legal obligations created by
statutes.
MR. QUIGLEY: That's absolutely
right. And the legal obligation is on the
health plan.

ATTENDEE 2: You're just saying that.

MR. QUIGLEY: Pardon?

ATTENDEE 2: You're just saying that.

MR. QUIGLEY: I'm not sure

what you're --

ATTENDEE 2: That is conclusory,
you're just asserting that.

MR. QUIGLEY: I mean, that is the law
of the state of Vermont. When a health
plan provides a benefit, they're subject
to the laws. If we're administering that
incorrectly --

ATTENDEE 2: What laws?

MR. QUIGLEY: The laws of the state
of Vermont.

ATTENDEE 2: Which laws, what statute?

MR. QUIGLEY: The Insurance Code.

ATTENDEE 2: Well, cite it. Do you
have it?

MR. QUIGLEY: I mean, the entire
Insurance Code is applicable to the
provision of healthcare benefits, whether
it's what the provisions have to be in the

limitation on your obligation, you're not
obligated to deliver a life-saving
pharmaceutical?

MR. QUIGLEY: The health plan,
according to their contract with that
person and whatever the law states, you
know, for instance, under the external
review statute in cases of emergency, the
appeal process is expedited to basically
24 or 48 hours.

So the appeal -- if their doctor
prescribed a drug in a life-threatening
case, and the reason they have
drug was not on the formulary because another
drug was on the formulary, and this
doctor said, no, my patient needs this
drug and it's a life-threatening
situation, the Insurance Code sets forth
the procedure whereby that doctor or that
patient can appeal that issue as to what
benefit is covered and what is on the
formulary under the Insurance Code.

ATTENDEE 2: Have you ever heard of
equitable remedies?

MR. QUIGLEY: They're part of Vermont

contract, what the solvency requirements
are, what the benefits are mandated. I
mean, if the state says you have to
provide coverage for Gardasil, a current
issue before this and many legislators,
that will be part of Vermont law. And we
as the administrator of the drug benefit
will have to provide coverage for
Gardasil.

If a pharmacy paid -- you know, if
you say that it must be covered under a
health plan and someone goes to a
pharmacy and purchases Gardasil, we have
no way to say, sorry, that's not covered
under the benefit plan. It's not our
determination, it's now a part of every
benefit plan in the state of Vermont.

ATTENDEE 2: How about --

MR. QUIGLEY: If the state says --

ATTENDEE 2: How about -- excuse me.

MR. QUIGLEY: Sorry.

ATTENDEE 2: How about if the
beneficiary has a condition that is, just
for example, life threatening, and I can
see that you have a so-called contractual

law. You can appeal --

ATTENDEE 2: Doesn't equitable mean
factors that aren't statutory?

MR. QUIGLEY: I'm not sure what you
mean by equitable remedies, but the
Vermont law already allows for, in its
external review law, a determination of
medical necessity by independent reviewer.
So if the doctor says this is the only
drug that will work for my patient in this
drug, you think a Court would, you know, tap
equitable considerations and --

MR. QUIGLEY: They could; but, again,
it would not be the PBM that would be
(inaudible), it would be the health plan,
because it's their member. They have the
contractual relationship, they're making
the determination.

ATTENDEE 2: You're a crucial cog.
MR. QUIGLEY: We simply refer any appeal, to the extent we got them, and the law would direct that they go to the health plan. In other words, the patient and the doctor would not be coming to us to say, you know, we have a problem, we need an equitable solution. They would be going to the health plan. If we wanted to say we agree with you, this drug will be covered, we can't do that. That's the health plan's decision.

ATTENDEE 2: Well, you act like you're just humanoids with equitable --
MR. QUIGLEY: No, I'm acting like we have contractual obligations and rights and there are things we can't do under that contract. We cannot make benefit determinations, that's the health plan's prerogative.

ATTENDEE 2: Okay. I --
ATTENDEE: You know, I want to ask a question that might, I mean, statement, than a question, but what this section is attempting to do is to make you liable in the system or make you accountable or make --

MR. QUIGLEY: Correct.

ATTENDEE: Or allow for enforcement within the system that currently does not exist.

MR. QUIGLEY: I understand that.
ATTENDEE: Well, no, I'm just sort of clarifying. So, and if, if the Attorney General's office were taken out of the language that is here on page 18 and 19 --
MR. QUIGLEY: Right.
ATTENDEE: -- and we're left with BISHCA, first question is, would that resolve any of the concerns that you have about this section?
MR. QUIGLEY: If the consumer fraud and Attorney General and private right of actions were deleted and the regulation of whatever the final product is, whatever our obligations are, whether it's registration or making financial information available or administrative services, yes, we would be comfortable with BISHCA saying, you know, we received a complaint from a health insurer, from an employer, from the state, that said you were unwilling to provide an audit when your contract provides for an audit.

That would be an appropriate regulatory action and we would, you know, I would argue that the employer, the insurer, the state can simply go to us and enforce that under the contract. But if that is what, if they feel there is another level of regulation that is necessary to protect those sophisticated clients, yes, BISHCA we think would be the appropriate place to do that because ultimately it involves a benefit determination.

ATTENDEE: Okay. Then, is --
MR. QUIGLEY: And that's their prerogative.
ATTENDEE: If -- is the concern that you have that -- is the concern that the consumer fraud provision here might involve an action that might go outside of the contract?
MR. QUIGLEY: Correct.
ATTENDEE: Okay. So your concern is that your organization, your company, wants to be held accountable only within the confines of a contract, period. So that it makes the interpretation of that contract critically important at any stage --
MR. QUIGLEY: Sure.
ATTENDEE: -- of development?
Then, and then -- so I'm beginning to understand your concerns here. And then the other one is, you know, suppose within the contract it, it indicated that you were to deliver a specific drug from a specific, I guess it wouldn't be -- maybe it's a drug that only comes from an individual pharmacy.
MR. QUIGLEY: Right. Gardasil, being an example, it's only available from one --
ATTENDEE: Yeah. And the route that your PBM took, not spelled out necessarily, but the route that you took was to go to another country and to access it and bring it back and it was for one reason or another not of the quality
specified in the contract, then, but you
provided the drug, then would you feel
that you were accountable under those
conditions for a drug that may not have
performed adequately and clinically?
MR. QUIGLEY: We would be accountable
to our client, the health plan employer.
And if they were held -- again, the
benefit would have been provided by them.
If they were held liable for safety
reasons, our contract would specify that
whatever liability they had, we would have
to compensate them for. We would have to
hold them harmless for that, yes. But --
one.
ATTENDEE: But it would only be
harmless in the sense that you -- that
they would not have to pay you for that
delivery, those drugs. But you
wouldn't --
MR. QUIGLEY: No, no, no. If our
actions resulted in liability for our
client, again, these are sophisticated
clients, they will have in their contracts
that if we have provided -- if we have

purchased unsafe drugs, then we would have
liability to them to the extent they have
liability.

Terry, if I'm misstating that.
ATTENDEE: But then going -- I want
to stay right there for a second. So the
issue is around liability. Could I, as a
patient, having received those drugs that
you contracted for, sue you for damages?
MR. QUIGLEY: Under current law, no,
because we don't have --
ATTENDEE: Under this law, if this
were enacted.
MR. QUIGLEY: Well, it's not clear
who the consumer is here.
ATTENDEE: Okay. I mean, is that one
of the concerns?
MR. QUIGLEY: That is exactly our
concern.
ATTENDEE: Okay, I figured. It took
me a long time to get there.
MR. QUIGLEY: Apart from -- I mean,
yours is a very good question that,
frankly, we haven't discussed. But our
specific concern is a consumer is told

this drug that my doctor prescribed is not
covered under the formulary. They would
say, well, we're going to sue the PBM
because they're not going to cover.
We don't cover or not cover. It's
the health plan or the employer that has
made that decision. We will, we will
negotiate with manufacturers once they
decided which drug is on the formulary or
not.

So we're concerned about patients
suing the PBM under the consumer fraud
act because a certain drug is not covered
when, in fact, we don't make the decision
as to which drug is covered and we
can't -- we could not on our own say,
well, we as Express Scripts think it
should be covered so we're going to pay
for it. We can't do that contractually.

ATTENDEE: You see yourself as an arm
of the organization that has hired you?
MR. QUIGLEY: We act on behalf of and
according to our contract with the health
plan.
ATTENDEE: Now, suppose, let's put

the shoe on another foot and let's just
say that you're a contractor to build a
building but you are also held accountable
for workmen's compensation and standards,
safety standards within the work
environment. So even though you may be an
arm of a municipality that is contracted
out and bonded for something to happen,
you're still, you're still responsible.
So this is where the -- this is what we're
trying to decide, this is very helpful.

MR. QUIGLEY: Where you were going I
think is a critical point. We don't
accept risk. It's not like the health
plan says a drug benefit, you know, if
more people use it or fewer people use it
or if the cost of the drugs go up, you,
Express Scripts, or you, Medco, that's
your loss. We could contract on that
basis and there may be PBMs that do.

But, for the most part, the PBMs do
not accept the insurance risk of more
people using a drug or more expensive --
ATTENDEE 2: Just because you take
the position that you don't accept risk or


responsibility, the courts would just defer it to you?

MR. QUIGLEY: To date they have said that PBMs are not fiduciaries and that the contractual issues are the issues of the health plan, that's correct. Both in state and federal court.

ATTENDEE: But going back to her initial question. I think I heard you say that if there was, because of an action of yours, not because it was an uncovered one.

MR. QUIGLEY: Right.

ATTENDEE: But through an action of yours that was deemed to be negligent or whatever, that you would actually be liable through the health plan.

MR. QUIGLEY: To the extent --

ATTENDEE: So the consumer wouldn't necessarily sue you directly for a bad drug, they would sue the health carrier who, in turn, would come to you and say make full.

MR. QUIGLEY: Right. That's correct.

ATTENDEE 2: Just one final. Do you think -- don't you think the Attorney General is a lot tougher than BISHCA, or do you think the Attorney General is a lot tougher legally than BISHCA?

MR. QUIGLEY: I have not followed the Attorney General here versus BISHCA. I know in Connecticut where I'm from the Attorney General likes to get in front of the press all the time and says that he's tougher.

The concern is that the benefits being provided are regulated already by BISHCA. And for the Attorney General to interfere with that and create additional --

ATTENDEE 2: Well, the Attorney General has a statutory responsibility to represent the state in all situations.

MR. QUIGLEY: I understand that, but Vermont law already provides for a mechanism for benefit issues for health insurance, for medical expense insurance, where this is provided.

ATTENDEE 2: Isn't that concurrent jurisdiction with the Attorney General?

MR. QUIGLEY: No. If somebody has a benefit --

ATTENDEE 2: Why do you think the Attorney General is trying to argue that they should be given the responsibility? They want to sue?

MR. QUIGLEY: Quite honestly, I don't know, and that concerns us. Since there already is in place a statutory scheme to provide protection to the people who are getting the benefit --

ATTENDEE 2: But there can be two protections?

MR. QUIGLEY: I think any time you have two protections it creates confusion in who your regulator is, it creates additional expense and additional exposure. And we will price for that. And my position would be, again, also representing the health plans, that the health plans have that responsibility, they want to execute that responsibility with their current regulator, which is BISHCA.

To the extent the insurance company is regulated by BISHCA, subject to the Insurance Code with internal and external appeal, mandated benefits, unfair claim and unfair trade practices requirements, they do not want their benefits as being administered by a PBM to be subject to a separate jurisdiction by the Attorney General. That creates a legal conundrum that is impossible for both the health plan and the PBM to do business in.

The health plan says I will go to external review because the statute requires that. I will pay a claim within a certain period of time because the statute requires that. BISHCA says you did it wrong, you did it right, end of issue, resolved.

The Attorney General separately on the same issue can institute a consumer fraud action or private right of action by individuals with punitive damages on an issue --

ATTENDEE 2: It turns out --

MR. QUIGLEY: But this statute allows for --
ATTENDEE 2: It turns out is representing the state.

MR. QUIGLEY: Well, the bill says private right of action.

ATTENDEE 2: There is another bill that says Attorney General in all instances represents the state.

MR. QUIGLEY: Okay. I'm here on the bill before us. But --

CHAIRMAN RACINE: Kevin, go ahead.

SENATOR MULLIN: I'm sorry. I have a few questions, Mr. Quigley. Can you tell me, do all PBMs operate the same way and assume all the risk?

MR. QUIGLEY: Not assume, we do not assume the risk.

ATTENDEE: No risk.

SENATOR MULLIN: No risk whatsoever?

MR. QUIGLEY: Not the insurance risk, no.

ATTENDEE 2: (inaudible) certain --

MR. QUIGLEY: I'm speaking for Express Scripts, which does not accept the insurance risk. There are 70 PBMs out there. Some manufacturers accept risk.

I'm not aware of that.

ATTENDEE 2: You don't think --

MR. QUIGLEY: Primarily because the insurance company does not want to cede that risk.

SENATOR MULLIN: So I think what I heard you say in your testimony is that this would drive up the cost of a company doing business with a PBM?

MR. QUIGLEY: Correct.

SENATOR MULLIN: Because you do an analysis of your risk?

MR. QUIGLEY: The business risks.

SENATOR MULLIN: Correct.

MR. QUIGLEY: That's correct.

SENATOR MULLIN: Are we talking, you know, one percent, one-tenth of one percent? What type of additional cost are we talking about?

MR. QUIGLEY: We haven't had to do this anywhere, so we haven't had to price it. But to the extent you impose significant legal liability that doesn't exist now, I mean, you could have a million-dollar claim on a case where you're getting a hundred thousand dollars in administrative fees. You got a price for that risk. You know, your business risk people would look at that potential. Maybe they consider it small because it hasn't happened yet. But it only takes a couple of punitive damages claims on an insurance benefit for somebody to say, you know, we got to double or triple our administrative fees to cover this or we can't do business on this basis anymore.

So, as far as I know, no one has priced it because we haven't had to comply with this type of requirement, this consumer fraud provision anywhere.

SENATOR MULLIN: About how many PBMs are you competing with in the market?

MR. QUIGLEY: I don't know how many are doing business in Vermont. We have the state plan and we compete with the other major carriers to keep that business. I honestly don't know how many there are. Again --

SENATOR MULLIN: So Express Scripts has a state plan?

MR. QUIGLEY: That's correct. You know, Blue Cross has their own PBM; Cigna, which does business here, has their own PBM internally. I used to work for United Healthcare, they had a PBM, they decided it wasn't in core business and they sold it. They now contract with Medco for their PBM business.

So, you know, the health plans are very sophisticated. They decide whether they want to be negotiating rebates with pharmaceutical manufacturers or not. They either have it internally or they don't.

SENATOR MULLIN: Same question I asked Mr. Latanich, are there any unsophisticated companies, are there any smaller companies that you're doing business with?

MR. QUIGLEY: Not that Express Scripts does business with, no.

SENATOR MULLIN: Anywhere?

MR. QUIGLEY: Not that I'm aware of.

Again, you know, the classic definition of a small business is either under 25 or...
under 50. I think it's under 50 in the
state of Vermont. We would not do
business with any employer that small.
They would not have the level of
sophistication and we would not have the
systems in place to deal with them. We
would deal with them through their
insurance carrier.
CHAIRMAN RACINE: Can I interrupt
here, please. This has gone on a half an
hour and there are other witnesses who
have to catch airplanes here and we have
somebody on the phone. So if I could ask,
is it Tracy on the phone?
MS. BARONI-ALLMON: Yes.
CHAIRMAN RACINE: Do you have
anything to add to what the last two
gentlemen had to say?
MS. BARONI-ALLMON: I appreciate this
opportunity and I know you're under a time
-crunch, Mr. Chair, so I thank you for
making time.
We do agree that we still have --
CHAIRMAN RACINE: And you being?
MS. BARONI-ALLMON: I'm sorry; I
apologize. Tracy Baroni-Allmon, vice
president of public policy for Caremark.
I'm based out of Washington, D.C., and I
appreciate the opportunity to testify via
phone today.
We still have concerns with the
proposal. Not only based on what PBMs do, which is, you know, in brief we feel
that one of the things -- I feel that one
of the things that the other gentlemen
haven't touched on is the development of
the formulary through a clinical process
after the clinical formulary is
developed.
Then there is the pharmaceutical
manufacturer and negotiations which we
use, and the PBM aggravates, although I
can go to the various manufacturers and
negotiate those rebates and discounts
which are then used to the good of our
clients and, thus, their members.
We offer different options of
benefits based on what the clients want,
what they think is best for their
members. We also only deal with large
clients, and if they're smaller
employers, then they deal with us either
through a health plan, they would join
United and we would service United, or
through a third-party administrator. So
we don't have any contracts with smaller
employers or smaller clients of 50 or a
hundred members.
Even the way that the bill is
amended, we feel that Section 9472
interferes with the contract between us
and the health plan and employer clients
and attempts to create protections that
aren't necessary when there are two
corporate entities agreeing on the
provisions of a signed contract. It's
too prescriptive and it almost presumes
to cover all the relevant aspects of a
PBM and client contracting when really
that is dealt with on a case-by-case,
client-by-client basis based on what the
client wants, what the PBM can offer, and
what they feel is best for their
employees or members. So we do have
those concerns.

I'm not sure that we have any
specific amendment that hasn't been
discussed to offer.
CHAIRMAN RACINE: All right. Well,
thank you.
MS. BARONI-ALLMON: Thank you very
much.
ATTENDEE: So can I ask one question,
if the primary mission of the PBMs is to
buy drugs at the lowest cost, is that the
primary mission of a PBM? Is that why you
exist?
MR. QUIGLEY: It's to set up networks
with pharmacies to get the best price
available. As Terry mentioned, prior to
their existence you paid whatever the
pharmacy charged.
ATTENDEE: So you want the lowest
price for the pharmacies because you care
about the pharmacy people getting them
the -- I mean the pharmacy -- what the
clients are going to pay at the pharmacy
level?
MR. QUIGLEY: The drug benefit is a
significant portion of a health insurance
premium. A number of people do not choose to buy that, and our goal for those who want it is to keep it as affordable as possible. So that involves getting the best price from the pharmacy and also negotiating the best price and discounts from the manufacturers aggregating the people we cover, in our case 50 million people.

You know, if the state of Vermont wanted to negotiate with all the drug manufacturers, with as many people as you have in the state plan, it pales in comparison to what the PBMs can use in terms of market force.

CHAIRMAN RACINE: Okay. I apologize to my Committee and to all of you, but I really would like, there are people here who have to catch airplanes and I would like to give them a chance to testify. And if we want to get somebody back by phone, we can do that.

MR. QUIGLEY: We'll be happy to come back.

CHAIRMAN RACINE: Or by your representative.

Who is leaving by airplane here? And who else has to -- okay. If you have to leave, please come on up. And there are others who I think are just here for the day and we'll get to --

MR. LATANICH: I'll be available tomorrow if you have questions.

CHAIRMAN RACINE: Okay. Thank you.

MS. CORCORAN: Thank you for the opportunity to speak to you all today. My name is Julie Corcoran, I'm deputy vice president of state policy for Pharma, which is the trade association representing the innovative pharmaceutical industries.

I'm here today to talk specifically about three provisions in the bill. Though we have concerns with a number of provisions that are in this bill, I just want to talk about two.

As an initial matter, though, I would like to just say that as in our experience and a lot of the provisions in this bill have been gathered from other states, whether it's Maine, actually primarily Maine, it has been our experience that these provisions, many of them, have not done anything to save the state money costwise. Which I understand is a purported reason for many of these provisions. But we have never seen any evidence that suggests that the approaches taken in this bill get at that very concern.

What I am aware of are programs out there right now that are in existence that do help patients access affordable medicines.

One of them is a program that is sponsored by the pharmaceutical industry, it's the PPARX program. It's the partnership for prescription drug assistance. I'm not sure if you have seen some of the commercials on TV with the orange bus and Montel Williams.

And what this program does is it helps low-income uninsured patients access drugs at reduced price or often free.

That is a wonderful program out there. It helps people. And, like I said, in many instances helps patients get that drug for free. It is in existence in Vermont. I know that individuals who have accessed the program in Vermont, whether through the website, because there is a website, as well as a toll free number, the success rated matches anywhere from 80 to 85 percent.

So I bring this up just to encourage you all. We like to get the word out on this program. When you have a success rate like that, that means the program is working. We like to see more people access that.

ATTENDEE: How many Vermonters take advantage of that?

MS. CORCORAN: Pardon me?

ATTENDEE: How many Vermonters are served by that?

MS. CORCORAN: The last data I have on that was, the number of matches is about 9,000.

ATTENDEE: In Vermont?
MS. CORCORAN: Yes.
ATTENDEE: 9,000 individuals or 9,000 matches?
MS. CORCORAN: 9,000 individuals.
ATTENDEE: Get drugs free?
MS. CORCORAN: Yes. Drugs, or at reduced price.
ATTENDEE: What is your definition of low income?
MS. CORCORAN: In these programs, it depends on the company, but roughly it's about 200 percent of the federal poverty level. In some instances it goes higher.
Each company makes that decision.
ATTENDEE: And how many providers fit under, are under 200 percent? I'm just trying to get a percentage of low-income Vermonters who have been able to access this.
MS. CORCORAN: You know, I don't have that number on me. I'm sure I could find out what that number is.
ATTENDEE: I mean, 9,000 is a lot of people.
MS. CORCORAN: It is a lot of people.

ATTENDEE: But as a percentage, I mean, our job here is to try to help all low-income people. As a percentage I suspect that is fairly small, so.
ATTENDEE: But it is impressive when you compare it to like I-SaveRX and things like that.
ATTENDEE: Which has 67 people.
MS. CORCORAN: Well, our experience --
ATTENDEE: It's 85 percent of 9,000, would be 85 percent of whatever.
MS. CORCORAN: That's roughly a little over 9,000 searches and about just under, about 8900 matches. So it's a very, like I said, it's a very high percentage. To the point about the number of New Hampshires, I don't have it in front of me. If it is, I have too much in front of me to find it. My experience in many states is that the threshold of 200 percent tends to get at a lot of your low-income uninsured individuals. It has been a number that has been out there in terms of use in many states, whether it's the federal government, CMS and HMS. It's kind of become the number by which many people feel like you have done a sufficient job of helping those people who are really in need.
ATTENDEE: Could you or whoever is representing you here get us information about what percentage of the low-income population in Vermont?
MS. CORCORAN: Sure. 200 percent.
ATTENDEE: And find us the state that has got the highest percentage of low-income people covered and tell us what that state government is doing to advertise this program so that more people, so that they achieve the higher number.
MS. CORCORAN: Sure, I can find that information. I'm not aware of any state advertising. We have done aggressive advertising in states in individuals. We hand out pamphlets and stuff.
ATTENDEE: Then let me ask the question after being corrected that way, could you tell us what is being done in that state that has got the highest number or highest percentage of low income so we understand what you're doing in that state and what AARP or whoever else is publicizing.
I mean, you folks have pointed to it, I'm hearing about this, and I would like to know if more Vermonters could take advantage of it.
MS. CORCORAN: Happy to get back to you.
ATTENDEE: Can we also find out, what they are, is this one prescription, am I getting a prescription on here, is it a onetime hit that I get this?
ATTENDEE: Just tell us --
MS. CORCORAN: I can get you more information about the program. You're looking for 9,000 people and a breakdown, on eligibility, yes.
ATTENDEE: We want more information. So why don't you go ahead with your points.
ATTENDEE: I think they do send kits to Health and Welfare members.
ATTENDEE: I'm sure I have seen something.
MS. CORCORAN: But we'll get that information, we have people that help.
ATTENDEE: But they're so lengthy.
ATTENDEE: Why don't you go ahead.
MS. CORCORAN: Two provisions in particular I would like to talk about today, the first being the provision dealing with the unconscionable pricing.
ATTENDEE: Do you have a page number for that?
This provision is closely modeled after a provision that was passed in D.C. last year that was also the subject of litigation in D.C. And on this point it was litigated under a couple of issues. One of them being the commerce clause. The D.C. Circuit Court held this provision, and this provision is very close to the D.C. provisions, it is unconstitutional, based on the commerce clause.

low chance, you tend to appeal it because you're going to take your chances in the next level up. In this case it wasn't appealed.
The decision and the Court were pretty firm that this is an area in which congress has the authority to regulate commerce that occurs outside and amongst states.
ATTENDEE: Can I ask a question? I'm not an attorney. So they're appealing, there was more to the case than just this, and they're not appealing this particular portion of the case?
MS. CORCORAN: That is correct.
ATTENDEE: Is that what you're saying?
MS. CORCORAN: They have, in essence, conceded that the commerce clause, this law is in violation of the commerce clause.
ATTENDEE: Okay.
ATTENDEE 2: How would you compare the D.C. Court of Appeals with the 2nd Circuit Court of Appeals?

MS. CORCORAN: I'm not as familiar with the 2nd Circuit Court of Appeals. I would say that they are both strong court of appeals.
I would argue that, or in my experience, and I was a lawyer, I would like to think of myself as reformed now, that Court is probably going to show deference to the D.C. Circuit. The D.C. Circuit is pretty well respected among the circuits. And the fact that there was a decision not to appeal that aspect is probably going to weigh pretty well with this Court, whether it's the District or even the Second Circuit.
That would be, I mean, that is my experience.
ATTENDEE: Mr. Chairman, I know it's kind of irregular, but five of us are attorneys, and Robin and I were at a conference where this was one of the points being discussed, and I just wondered if you might be able to ask Robin if she had any questions about that, that she might be able to shed some light on so
that we know that we're getting --
CHAIRMAN RACINE: That might -- it's
up to if Robin wants to, if she chooses to
do that, it might be helpful.
My understanding is that those who
drafted this for the legislature and
those who worked on it already drafted
this in a different way than the D.C.
bill was written. And that some of the
constitutional issues may be addressed in
this draft.
So, Robin, do you -- I don't want to
put you on the spot here.
MS. LUNGE: That's okay. I'm happy
to go through that at some point. When I
did draft this section, it was -- I did
start with D.C., but there are a bunch of
changes that I made to the D.C. language
that were meant to at least attempt to
address the congress clause issue. So I
can't guarantee I got it right, obviously.
But I did try to address some of those
issues, and I can talk about those. But I
also want to be sensitive to your witness'
time crunch, too.

CHAIRMAN RACINE: I mean, you are
aware it's drafted differently than D.C.
version?
MS. CORCORAN: I am aware of the
subtle -- the differences, and I'm aware
that it was an attempt to address the
commerce clause.
Our read on this, the read also of
the attorneys that handled the
litigation, is that that doesn't cure the
commerce clause issue. And, again, I
would point to the fact that in D.C.
generally when a court rules on a
provision of law as per se on its face
unconstitutional, that generally suggests
that it's very difficult to then go back
and tweak that. In many instances that
probably goes back to probably some of
the thinking as to why the attorneys
weren't appealing that.
It was a very strong decision and
the Court was very strong language was
saying, you know, at the end of the day
what you are attempting to do is regulate
commerce outside your state, and that is
just an area which congress basically
makes the laws. So, I would say that it
would be very difficult under that
scenario to do that. Now --
CHAIRMAN RACINE: Would it be fair to
say even if we did craft this in such a
way that it passed constitutional muster
that you probably wouldn't like it?
MS. CORCORAN: Again, I don't know
how you can craft something to pass
constitutional muster regulating
transactions that occur wholly outside the
state. That's what --
ATTENDEE 2: That's why you have --
MS. CORCORAN: Yes.
CHAIRMAN RACINE: Kevin.
SENATOR MULLIN: Say that the Court
upholds that -- I assume this is an
interstate commerce issues --
MS. CORCORAN: Yes.
SENATOR MULLIN: So say the Court
does that, then am I safe in assuming that
there is only one company in Vermont that
this affects, which is Burlington Drug?
MS. CORCORAN: In terms of
transactions occurring in this state. The
Court, if your Court could make that
determination that there is only one
entity that that would effect. I can't
say how the Court would rule in terms of
the entity in this state. I can only
speak to what I know other circuits have
said about entities and transactions
outside the state. But it could be read
to just be applicable to an entity in the
state.
CHAIRMAN RACINE: Senator Lyons.
SENATOR LYONS: Is the ruling, the
D.C. ruling on its face based on the
patent law extension?
MS. CORCORAN: Well, two parts. The
ruling on its face I have been speaking
about is specific to the commerce clause.
SENATOR LYONS: But was it based on
the passage of the law at the
congressional level extending patent so it
related to --
MS. CORCORAN: In part. The commerce
clause was a separate issue from the
patent issue. And that, the D.C. Court
A-780

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1 did rule on the patent issue, too. And their ruling on that went to the, again, you know, I'm trying not to get too legal, when congress has exercised its authority in a certain area, and a state then in an area of patents, congress has made it very clear that from their perspective this is an area in which they exercise their authority to regulate patents. When states then attempt to pass laws that would interfere or impede with their wishes, those laws tend to, or courts tend to find those state laws unconstitutional under the supremacy clause.

Again, it's similar to the commerce clause where they're saying, again, this is an area where Congress' intent is clear, and that the state, what a state is attempting to do interferes with Congress' intention. So it was, it's kind of a two-four, if I answered your question.

SENATOR LYONS: Yeah, you did. And the second question is the, are there -- one of the issues here, of course, is accessing drugs at the most, at the lowest price for citizens in our state.

And, so, has there ever been a challenge based on price differences within states of similar transportation and other challenges? I mean, you do have price differences between and among states for your products, for Pharma.

MS. CORCORAN: Yeah, they'll be price differences among your pharmacies at different levels, that's not within the control of the manufacturers I represent.

SENATOR LYONS: The price differences are not within the control of the manufacturers?

MS. CORCORAN: Prescription drugs for sale in this state, if I just take pharmacies for example, across, at the level in which they're sold to patients is dictated more at the pharmacy level. Products -- most manufacturers, 94 and 95 percent of the products that the companies that I represent sell to three major wholesalers. They tend to be located in various parts of the US. But 95 percent of the products go to three major wholesalers and then the supply chain, so to speak, goes from there.

So by the time it comes down, at least if you're talking about an individual going into the local pharmacy, the pricing structure has changed along the way.

SENATOR LYONS: So if a PBM goes directly to the pharmaceutical company to establish a price for purchasing for an insurer, whether it's a public or private insurer, then the price is guaranteed at the lower level than it would be if it went through the whole food chain?

MS. CORCORAN: To be honest, I would not know the answer to that. This is a very complex, it's a very intense industry. How one manufacturer negotiates with a PBM is different than how that manufacturer might be negotiating with another entity. Your market forces will come into play on that.

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CHAIRMAN RACINE: So what is your second concern?

MS. CORCORAN: So my second concern -- but on that front too, since I do understand that one of the reasons for this is issues of serious public health or concerns are times of emergency in this state. I would just bring your attention to a law that was recently passed in Maine, since I know there is lot of references to Maine law. It's Public Law Chapter 580 and it deals with, it's called an Act to Prevent Price Gouging. It's nonspecific to the pharmaceutical industry, although we're captured in it.

It's a law trying to deal with necessities in times of emergencies. And this is a law that is on the books and many states have it. And I think that some of the concerns that I have heard, or I heard expressed, might be addressed through something like this.

It's a state of emergency, you know, in an instance, kind of, God forbid, like a Katrina would hit, how the state could,
would react and ensure that patients, individuals, even if it's just kind of gasoline, has access to necessities and there is no sort of price gouging during that period. So it's Maine Public Law Chapter 580.

The second, the second provision I would like to talk to you about deals with the -- and let me grab that -- the prescription. I think it's page 26 -- I'm sorry; it's page 24, the Confidentiality of Prescription Information. And this is an area, too, where we have great concerns.

And I would like to first show you all a chart that we think is representative of how important data that is collected and then eventually purchased by the pharmaceutical industry relative to prescriber data is used for patients.

What you have before you is the chart that lays out disease classes.

CHAIRMAN RACINE: Excuse me. Before you do that. Prepared by Hogan & Hartson?

MS. CORCORAN: Yes.

CHAIRMAN RACINE: Who is Hogan?

MS. CORCORAN: Who is Hartson?

CHAIRMAN RACINE: Yes, who are these people?

MS. CORCORAN: Hogan & Hartson is a law firm. This one came out of their practice in D.C. But they're a law firm that does a lot of work for us. Hogan & Hartson also does a lot of FDA work, they do a lot of health care. So we use them a lot.

CHAIRMAN RACINE: But they're employed by you in this case?

MS. CORCORAN: In this case, yes.

They did this for us. An individual who is from the FDA did this for us, because we thought it was important for people to see. You hear a lot about this use on the sales and marketing front. I think it's important.

ATTENDEE 2: An individual from the FDA whose is also with Hogan & Hartson?

MS. CORCORAN: He was with the FDA.

ATTENDEE 2: Formerly?

MS. CORCORAN: Yes, formerly; sorry.

We thought it was important, too, to really see and understand how this data is used and how it has become an integral part of how in many instances manufacturers work with the FDA on the pre-marketing and pre-approval of certain drugs.

As I'm sure you are all aware, advances in IT and also advances in health care, and, again, having to make certain decisions on the risk/benefit analysis, the FDA and the industry work very closely to make sure the needs of the patients are met and doctors as well as the FDA.

Prescriber data has become relatively important. Actually, it's almost become an assumption in many instances with the FDA that this data is going to be used by the companies to help target doctors on information that is important to the prescribing of certain products.

And this chart kind of gets to that. You'll see, it looks like about 10 different disease classes, the number of patients that fall under that category of disease classes. And also the type of procedures and processes that the industry, because the industry is responsible for ensuring compliance with these programs, are required to do so that a doctor can prescribe a drug for this patient.

So that is why this bill would impede some of the ability to access that information.

So we had this chart in which we think is very important to have that out there.

The other thing on this is --

ATTENDEE 2: What is the purpose of this? Sorry. Is this for the doctors or the pharmaceutical company?

MS. CORCORAN: It's for both. It's the FDA, pharmaceutical company and doctors.

What happens quite often these days,
when you have a new product coming up that might have some kind of severe side effects for a smaller patient population like an MS, where the FDA has made a decision that, yes, there are some risks but the benefit is so overwhelming to those patients with MS we want to be able to have those patients and those doctors prescribe the drug.

However, we also want to make sure, because the risks tend to be a little greater than in many other instances, we want to make sure that the doctors know the risk. So they have a process in which they call risk mass, in which the pharmaceutical industry works with the FDA to come together for a program where the FDA is comfortable with the fact that company "X" is going to do everything in its power -- [End of CD 07-47.] [Beginning of CD 7-48] about the use of this data.

As a result of those concerns being expressed, not only did Pharma enact a voluntary code a couple of years ago by which all the major manufacturers and members of Pharma have committed to adhering to, the AMA recently adopted a program which you have before you, which is the AMA PDRP program, which is the prescription data restriction program. And what this enables doctors to do is doctors who are uncomfortable or concerned about detailers or individuals coming in their office with access to their prescribing data, they can opt out of having that individual gain access.

ATTENDEE 2: And how many doctors did that?

MS. CORCORAN: This program became functional in July of 2006. And my understanding is, I think 6,000, roughly 6,000 doctors have opt in.

ATTENDEE 2: Out of how many --

MS. CORCORAN: Oh, I don't know how many physicians. We understand, that -- again, this is a new program that --

ATTENDEE 2: 20 percent.

MS. CORCORAN: Arguably it is a small percentage, but arguably some doctors do believe that this data is important. So I think, we believe this is a good balance to educate them so that the doctor makes the decision.

ATTENDEE: I think that what we're trying to get at here, and I might be wrong, but my feeling is that we're not, we're not trying to prohibit uses where there is recalls or where people need to be informed of -- it clearly says by prohibiting the commercial use for targeting and trying to influence prescription writing. I mean, I think it very clearly says that. So I'm not sure if that's not what we're getting at here.

I have the same response to somebody who talked about the pop-up adds that are in. It's important to be able to have that on there, but that's not our, that's not our goal here is to try to prevent the pop-up thing that says, wait a minute, did you know that this is a pregnant woman who, da, da, da, da, or who says this will interact with this other person's other drug, but to prevent from commercial use to try to influence prescription writing.

And I -- so am I not -- am I right about that that's the intent?

ATTENDEE: That's the concern.

MS. CORCORAN: Which is why we have been trying to provide people with information about the AMA PDRP opt-out. Because it is our belief, it is the belief of the AMA, too, on balance when you're looking at the issue, that this is a better solution for concerns that physicians might have along those lines without the unintended consequences of precluding that information from some of the other valuable safety areas. And I think our concern is, it would be very difficult to slice and dice without impacting.

ATTENDEE: I'm not sure why it would be, because if we're saying that, if I'm a physician and I need to, I want to opt out of this because I don't want all those pop-up things that tell me what to prescribe, I want the information that
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<td>you're going to give me that says that it's going to interact with this other drug, or that it shouldn't be prescribed to a pregnant woman. But I don't want it for what I see here as a commercial use. I'm going to have to opt out --</td>
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<td>MS. CORCORAN: Yes. ATTENDEE: -- and do it entirely? All I want to do is stop you from doing things that will influence the prescribing patterns of those doctors. I don't want to stop you from doing those other things. So if the drug companies would just say, all right, we won't do any of those commercial -- we won't use it for commercial purposes, but that's different than what you're talking about? ATTENDEE: I think I'm completely missing the point because I thought that what this was selling the prescribing practices of the physician so that they would know who to go to. ATTENDEE: For which drugs. But it also says here that it can have pop-up drugs.</td>
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<td>care provider, not an individual going in and speaking to the doctor and saying you're prescribing this way, but just the letters out, it may or may not by and large come from their commercial division. Those are the divisions that are historically and structurally best able and capable of handling, identifying, and knowing who to get in touch with in a very timely and expedient manner. Like many -- ATTENDEE 2: Also the best entities, they're better able to promote the drug apart from safety? MS. CORCORAN: Sure. I mean, it is a fact. I mean, they have sales and marketing forces and they go in and engage with doctors. And, you know, we'll say if a doctor is uncomfortable with a detailing, an individual from a company coming in their office and they feel that this individual is behaving in a manner that is unprofessional, we would encourage that doctor to tell that individual, you know what, if you want to come and speak to me</td>
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<td>MS. CORCORAN: But -- CHAIRMAN RACINE: Let her answer and see where this goes. ATTENDEE: Data mining; right? ATTENDEE: Yeah. MS. CORCORAN: I think it would be hard to distinguish a company from accessing and giving the information in how they purchase it for commercial uses and noncommercial uses. Yes, it is very valuable for the risk map and the health care. They're also used for health care providers when they're recalls and in other situations where you need to get out information and disseminate it in a very fast way. My understanding of how our companies operate, each one has a system that is very different in how they would get that information out. Some of it would depend on the size of the companies. If they are purchasing this data and the division by which they are going to use it to get out information in a quick way, whether it's just a health about educational material, great. But if you're going to come and talk to me or present me with that kind of information, I don't want to see you. I mean, doctors are quite capable of saying to somebody, I don't want to see you and I don't have time for this. We think that that's a better approach than banning things outright. And that's why we have the Pharma code, which encourages companies to interact with physicians in a manner that does not, you know, cross a line that they might perceive as to be unprofessional. ATTENDEE: Don't get all the advertising on TV and everything from the drug companies, doesn't that come from data mining? How do you know how many prescriptions are written for all the cholesterol drugs or whatever? ATTENDEE: They know what they sell. ATTENDEE: They know what they sell, so can't you go and get that from their numbers somewhere? I mean, these were the (inaudible) office I'm saying, that they</td>
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don't see any reason not to do this, this section of the law, put this language in because you could go and get their license numbers, see what they're selling.

ATTENDEE 2: And the (inaudible) office is encouraging it?

ATTENDEE: Yes.

MS. CORCORAN: I wasn't there, I can't speak to that. I'm sure that there are many ways in which the industry has access to whether how many scripts are written.

What is important from our perspective in terms of this issue, and this is that when it comes to physicians, especially physicians in practices, ones identified on this chart, we believe it's very important that a company can effectively and efficiently get to those top doctors in a timely manner. We're also moving --

ATTENDEE: (inaudible) in here.

MS. CORCORAN: That would, in effect, prohibit the companies from purchasing that data, though.

CHAIRMAN RACINE: Only for commercial purposes, it says.

MS. CORCORAN: It would be very difficult to part --

ATTENDEE: It says it doesn't apply to those.

MS. CORCORAN: But the reason and some of the rationale by which a company is going to purchase goes in many areas.

So, as I understand, a lot of the companies and lawyer are going to be very concerned about what is a commercial and what is not and how that company is structured in doing things. If the concern is how that data is being used with doctors, again, we believe that there are better ways to address that concern then some of the unintended consequences of this bill.

CHAIRMAN RACINE: We want to let you catch a plane.

MS. CORCORAN: Thank you and thank you for the opportunity. And we'll get back to you with the information about the low income, uninsured, and numbers.

CHAIRMAN RACINE: And you're being represented by?

ATTENDEE: Susan.

CHAIRMAN RACINE: Are there other people that need to get out of town?

ATTENDEE: There are a lot of us, or who should. That was not the right question.

CHAIRMAN RACINE: Let me restate the question. Is there anybody who cannot come back here tomorrow? We will continue this at -- we're going to start at 1:30 tomorrow. We have Sharon Moffit (phonetic) coming from the Department of Health whose department was very much impacted and they were not here. I'm hoping we can do that it in a half hour or so.

The rest of you, 2:00 and we will go back to the original order on the list that we had for today. And you folks who have been around here know that this is how it works, and we'll do our best to plow through tomorrow.

As you can see there are lots of questions. So there will be fifteen minutes to tell us what you want and questions will be above that. And try to go through this. And, please, Committee, don't leave, we have one issue that we have to deal with which doesn't have to do with pharmaceuticals.

ATTENDEE: It's called medical marijuana.

CHAIRMAN RACINE: It's called medical marijuana. Unless any of you are in the business of -- Okay. Kevin.

SENATOR MULLIN: Basically there is concern that has been expressed through the Agency of Human Services that see this could possibly --

CHAIRMAN RACINE: Folks, could you continue our committee meeting. If you could have your conversations elsewhere, I appreciate it.

Thank you. Go ahead, Kevin.

SENATOR MULLIN: Okay. The concern is that some of the funding from nursing homes could be jeopardized by having the language in the bill about the nursing
homes.

We at the Committee seem to be that
excited to take ownership of this section
even though they did it in Judiciary, the
Judiciary Committee's position is that it
really is a Health and Welfare issue. So
nobody seems to be that excited about
removing that particular provision that
references nursing homes because,
remember, it's just a feel-good piece of
language because there is nothing in
state law now.

So the recommendation is, and Adam
Craftsman (phonetic) has supported that
recommendation, he is the one that asked
for the provision originally, is just to
remove that provision from the bill.

ATTENDEE: I'm fine with that.

ATTENDEE 2: Move the provision which
says what, exactly?

SENATOR MULLIN: The provision says
that it's not a violation of state law
or --

ATTENDEE: No; state regulation.

SENATOR MULLIN: State regulation to

use medical marijuana in a nursing home.

So basically it's not creating a new law
because it's not a violation now. It was
kind of a feel-good measure that was put
in Judiciary over in (inaudible) County.
The person that brought the concern
to the Committee was Adam. So basically
what we're being told is that nursing
homes are in fear of losing some of their
reimbursement through CNS. They would
like to have it removed, AHS would like
to have it removed. Now Adam is saying
he thinks it's probably the best thing to
do just to remove it.

ATTENDEE 2: So it's simply stating a
fact that exists --

SENATOR MULLIN: Right.

ATTENDEE: Also, the client was
outside the nursing home somewhere that
smokes now.

CHAIRMAN RACINE: We had somebody
representing that individual but --

ATTENDEE: The caregiver picks him
up --

ATTENDEE: And takes him out.

CHAIRMAN RACINE: Basically it's not
going to change anything if the language
were taken out.

ATTENDEE: Right.

CHAIRMAN RACINE: Because the nursing
home still is not going to allow it
because their federal funding could be
jeopardized.

ATTENDEE: You can't smoke in a
nursing home anyways; right?

CHAIRMAN RACINE: So it's just
something to say we care about you but it
could actually cause --

ATTENDEE: And if it has any
potential for killing the bill, I say
let's just take it off because we need --

CHAIRMAN RACINE: So Kevin would have
it amended on the calendar from this
Committee that that come out.

SENATOR MULLIN: Is it unanimous?

ATTENDEE: Yes.

CHAIRMAN RACINE: Thank you, Kevin.

ATTENDEE: And you do have that or do
you need that?

SENATOR MULLIN: I do. Eric drafted

that.

CHAIRMAN RACINE: Eric took care of
it.

Folks, thank you and we're going to
continue this tomorrow. And there are
other bills floating around out there,
HIV and a couple of others that we want
to get back to. Maybe we'll take them up
Friday. The week we come back we're
going to have a lot of work to do.

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CERTIFICATE

4 THE STATE OF FLORIDA )
5 COUNTY OF PINELLAS )
6
7 I, Gerrilyn Facompre, Notary Public,
8 Registered Professional Reporter, do hereby certify
9 that I was authorized to and did listen to
10 CD 07-47/T1 and CD 07-48/T, the House Committee on
11 Health and Welfare, Wednesday, February 28, 2007,
12 proceedings, and stenographically transcribed the
13 foregoing proceedings and that the transcript is a
14 true and accurate record to the best of my ability.
15 Dated this 20th day of August 2007.
16
17 GERRILYNN FACOMPRE, RPR
18 Notary Public - State of Florida
19 My Commission No. DD 328362
20 Expires: June 13, 2008
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