STATE OF VERMONT
SENATE HEALTH & WELFARE COMMITTEE

Re: Senate Bill 115
Date: Thursday, March 1, 2007
Senate Health & Welfare Committee
Committee Members:
Sen. Doug Racine, Chair
Sen. Ed Flanagan, Vice-Chair
Sen. Sara Kittell
Sen. Virginia Lyons
Sen. Kevin Mullin
Sen. Jeannette White
Robin Lunge, Legislative Counsel

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and track language of the bill and then our testimony.

Let me just also say, before I get started on the particular pieces, is we have been in touch with the Oregon Health & Science University that you mentioned in the bill and actually had some very productive discussions with them, some opportunities that lay out kind of what those opportunities are going forward and how they might be used in our work here.

And then I also want to spend a little bit of time on talking about what AHEC, the Area Agency Health -- Area Health Education Centers, are already doing with -- for us and with us through the health department, what's already kind of in place and how we can kind of maybe jump off the platform they've already created for us, particularly in the educational aspect. And I think again Dr. Swartz can speak of that too from more of a practitioner experiential point of view.

So the memo that we have to you essentially just lays out a couple -- some particular areas that we wanted to offer comment on the bill and suggestions and some areas of -- perhaps I'm going into a lot of detail.

But the -- the first area in terms of to -- the director of the office of health access shall establish and maintain a pharmacy best practice and cost control, essentially the essence of what you have here. What we wanted to do is just make -- and again, hopefully the committee already has this way on their radar screen. But beyond the cost control aspects of it, what we see and experienced and are aware out there in the practice fields are the complexities that the individual patient needs to be on the cost, actually even as they have to deal with formularies, and then actually challenging formularies, if they are on one formulary and then how they have to actually go through and show that that particular drug on a formulary doesn't work for them, try another drug, and then finally get approval on the drug they have.

And we saw this particularly around the Medicare Part D in -- in that whole different formularies being used.

Don, do you want to speak a little bit to this because this really comes from the consumer point of view that we're hearing around that.

DR. SWARTZ: Thank you. For the record, I'm
Donald Swartz, the medical director of the health department, and until fairly recently have been in -- in practice, so that a lot of the issues that I'm talking about come out of my own memory bank and my own experience with patients. I think that cost is critical. We have to figure out how to harness that. We have to figure out how to make our health system more efficient and more effective.

When administrators try to do that, of course, it's done at a fairly high level, and sometimes the impact on individual patients gets kind of lost or doesn't -- doesn't get adequately factored into the system. And one place is the -- the difficulty that providers and patients have in managing their way through a formulary prescribed by a pharmacy benefit management process.

The formulary may be absolutely right and absolutely well-constructed, but it's constructed based on the evidence. And the evidence is designed to iron out the differences between people and show what applies to everybody the best. Well, if you're not everybody, the drug -- the formulary may not be the one that works for you.

In order for you to get that, under most of

the rubrics that are in place now, you have to demonstrate that you failed on the recommended drug, and maybe on the second choice drug, before you're finally allowed to have the drug that works for you.

Now, if you know from past experience what that drug is, then we're kind of asking people to go through a period of two weeks, four weeks of having their problem not treated.

CHAIRMAN RACINE: I'm sorry. I'm having a hard time following you, Doctor. Where on the bill is that?

DR. SWARTZ: I'm still on the first page.

MS. LUNGE: No. In our bill it's on page 2 and 3.

DR. SWARTZ: It's kind of a philosophical -- I think it's something we ought to be thinking about under the heading of pharmacy benefit management, and this isn't a specific...

FEMALE ATTENDEE 2: This is not -- the bill we were doing is -- is licensing and PBM.

CHAIRMAN RACINE: Robin can -- maybe you could enlighten us a little bit.

MS. LUNGE: In a part of the statute that isn't introduced in the bill, it talks about the exceptions process for Medicaid. So the part that I'm not clear about your comment on this part is whether you're commenting on that existing law on the Medicaid process and problems that you've seen in the Medicaid process or whether you're commenting more generally because my understanding is that the Medicaid process is -- there is an exceptions process where you can ask for an exception for a drug not on a formulary.

DR. SWARTZ: Yeah. That's correct. So my comments really are not that, what's in place now.

MS. LUNGE: Okay.

DR. SWARTZ: And how we might want to at least think about that as we're massaging other areas of that bill.

CHAIRMAN RACINE: Are you suggesting we get rid of the formulary?

DR. SWARTZ: The formulary is important.

CHAIRMAN RACINE: Okay.

DR. SWARTZ: What I'm trying to figure -- and suggesting that we assure that people who don't fit the formulary can reasonably, easily get the drug that works for them. And --

CHAIRMAN RACINE: Okay. Is it -- I'm sorry.

I'm truly trying to focus on the bill. Is there something in the bill that affects that or are you going to be suggesting amendments to this bill which would solve the problem that you are raising for us that's not covered by this bill? I'm not sure I'm asking the right question.

MS. MOFFATT: No. I think -- you are asking exactly the right question, and we can go deeper or not. But I think we just are raising awareness in terms of the overall impact to the consumer. So no, we're not suggesting -- we're not making suggestions for the changes and all. Supporting the essence of the bill, we want to all fully understand then how any decision we make, as this bill unfolds, impacts the actual client at the receiving end.

FEMALE ATTENDEE 2: I guess I don't -- I don't understand that because we're -- the part that you quoted here related to that is "maintain." We've added the words "maintain." And -- and there is a process for --

(Inaudible.)

FEMALE ATTENDEE 2: Right. I mean we already have that in place. This doesn't affect that at all.

MS. MOFFATT: So that's where we're agreeing
but want to make sure that, as we maintain that, it's across all the system, not just a particular area just for Medicaid, for example.

FEMALE ATTENDEE 3: I have a comment on that. I had a constituent this last fall calling me, and her daughter was on the -- on the state Medicaid program. And she could not get this pharmacy preferred drug because it wasn't on the formulary or whatever, but it was something that worked, and she'd never had the trouble before. But you know, there was just what you're talking about. They didn't maintain the service for this pharmacy benefit.

You know, I did call down and talk to Joshua Slen and all of them: And -- and you're right, that she should've had it, you know.

And she did demonstrate that she tried other generics and they didn't work. So it's maintaining --

CHAIRMAN RACINE: So Doctor, your comments are more general in nature and you will get into the bill?

MS. MOFFATT: Yes.

CHAIRMAN RACINE: Okay.

DR. SWARTZ: Yep. And I think I've made the point. And I won't -- I won't take any more time.

Thank you.

CHAIRMAN RACINE: I'm quick. I'm just trying to figure out where it fit in.

MS. MOFFATT: Certainly.

CHAIRMAN RACINE: We spent three hours yesterday on details of the bill. So you just sort of shifted gears on me.

DR. SWARTZ: I'm sorry.

CHAIRMAN RACINE: But you can proceed. No, that's okay.

MS. MOFFATT: So we can continue to kind of walk through our memo, which I think overall what you'll see here is not necessarily suggestion for changes, either support in particular areas or areas that we wanted to just bring attention to. So the next area in our memo related to the federally qualified health centers. Robin, I'm sorry. We don't have it.

MS. LUNGE: Page 5.

MS. MOFFATT: Page 5, thank you. And again, we understand that Hunt Claire provided testimony on that yesterday. We support that testimony and again just raising awareness of the impact though to FQHCs as we move more people through there. So that's all this comment is is mainly supporting the testimony that Hunt had before you. So do we have it?

FEMALE ATTENDEE 4: Can I ask a question about that? Is -- I actually don't like this. And I -- when I read this, it looks to me as if we're -- we are, as a state, encouraging -- trying to encourage Vermonters to leave their private docs --

MS. MOFFATT: Bingo.

FEMALE ATTENDEE 4: -- and go to the FQHCs. I don't like this, and I'm not going to support this.

FEMALE ATTENDEE 3: -- marketplace (inaudible) have better pricing (inaudible) --

FEMALE ATTENDEE 4: No. They only -- they only have better pricing on the drugs. I don't think that's -- anyway...

MS. MOFFATT: To your point, Senator, (inaudible).

FEMALE ATTENDEE 1: That's the point they were making initially.

(inaudible.)

MS. MOFFATT: Yes. Yes. That is our -- we have that shared concern.

CHAIRMAN RACINE: Could you explain it from your point of view, please.

MS. MOFFATT: That if you have the incentive to go to an FQHC for pharmaceuticals and they leave their private health care provider, then there becomes a disincentive to use the -- if you will, the single health care provider out there. You begin forcing -- maybe that's too strong a word -- but directing people to use the FQHC or the FQHC lookalikes, and I just don't know that this is a methodology to do that.

CHAIRMAN RACINE: So to take advantage of lower drug prices, you would have to change your doctors?

MS. MOFFATT: Right.

CHAIRMAN RACINE: That's the only way you can do it?

MS. MOFFATT: Right.

CHAIRMAN RACINE: You can't just go there?

MS. MOFFATT: No.

FEMALE ATTENDEE 4: You'd have to be a patient.

MS. MOFFATT: Right. You can't. You have to be a patient. So you'd have to leave your primary care doc to do that. So what we do is undermine the solo practice out there, or even the small practices, that aren't FQHCs.
MALE ATTENDEE 1: So there is no way to keep your doctor and get --
FEMALE ATTENDEE 4: No.
MS. MOFFATT: No. And actually, there's particular laws regarding that at the national level. And again, I don't want to speak for -- I mean this is an area of expertise that -- that Hunt has, so yes.
DR. SWARTZ: I would refer you to his testimony which goes into this in some detail.
CHAIRMAN RACINE: Okay. All right.
DR. SWARTZ: And explains it very thoroughly.
MS. MOFFATT: The next area, which I believe is on page -- bottom of page 6. It's section F.1 just below the stars where it talks about the utilization review board and talks about adverse effects, safety, appropriate clinical use of controlled substances for the management of pain. Again, we just want to offer up a little broader scope in that area. That may have been the intent. We just read it a little bit more narrowly. So we wanted to just offer that as a consideration there.
DR. SWARTZ, do you want to speak about -- to that part of it --
DR. SWARTZ: No. I think that's --
MS. MOFFATT: (Inaudible.) Okay. The next area -- oh, gosh, I'm sorry. I'm flipping here. I should have had our page numbers on here to reference. Well --
(Inaudible.)
MS. MOFFATT: I'm trying to find in the bill, what the page number is. It would have made it easier for us. I'm flipping. Next time we'll get this format a little tidier for you.
MS. LUNGE: It's on page 23 I believe.
MS. MOFFATT: Page 23, thank you. So again, the department -- and particularly they're referring to the health department -- shall establish an events based prescription drug education program for health care professionals designed to provide information, education, and therapeutic costs. The department shall collaborate with other states in establishing these programs.
And then this is also where that reference is to the Oregon Health & Science University and the
are also starting to work with Maine and New York to actually further develop these academic
detailings. AHEC and the College of Medicine are actually ahead of the curve in terms of providing
these types of sessions. They're actually also using some additional money, not only the health
department money but they're also using money from Fletcher Allen, Blue Cross Blue Shield, and
actually the College of Medicine to actually provide it.

When -- when -- in speaking with Liz Cote, who is the executive director for AHEC, in terms of the challenges, they say they're very well-received. Actually, there are CMEs available, which is another opportunity for providers to come.

But in addition to that, one of the barriers they have is they can't get out fast enough to meet the need. So although they hold about twenty-five sessions around the state, ideally, if they had another team of experts -- they only have one team of experts that go out now and present this -- that would be the gap that's out there now.

The research that goes behind actually developing the educational sessions actually comes from the attorney general settlement that was done in I believe it was Pfizer. So they've actually used that funding to actually do the research to create the educational tool.

So they have two levels. They have researching, creating the class; and then they have our money and other's money who actually put the class out there, the implementation side.

Yes?

CHAIRMAN RACINE: I'm trying to figure out your point.

MS. MOFFATT: My point?

CHAIRMAN RACINE: Is there --

MS. MOFFATT: There's two points I think specifically is, one, there is some significant work already going on in our state --

CHAIRMAN RACINE: So this is superfluous is what you're saying?

MS. MOFFATT: It probably doesn't hurt to have it, you know. But to direct us to do it I'm saying is we would continue to do it. If there's a gap that I was to identify for you, I would say there's probably a forty or fifty-thousand dollar gap if we were to do it more and faster of their -- and you would use the AHEC existing system to do that.

CHAIRMAN RACINE: So if this -- if this section contains part of the law, evidence based education program, you could -- you could do it based on the fact that you're already doing it --

MS. MOFFATT: Right.

CHAIRMAN RACINE: -- is what you're telling us? Okay.

MS. MOFFATT: Exactly. And if there was additional funding, it would be to fill that gap.

So this --

CHAIRMAN RACINE: Okay. So you don't need additional funding to do what this requires you to do?

MS. MOFFATT: Not this particular piece. There's another piece here though about the Oregon health system that I'll talk about.

CHAIRMAN RACINE: So that's a separate issue?

MS. MOFFATT: That's separate.

FEMALE ATTENDEE 1: When we have -- and I'm trying to remember when we billed AHEC the detailing program was in. So that's already in statute.

MS. MOFFATT: Right. And actually, that's some of the --

FEMALE ATTENDEE 1: And I'm just trying to remember where it is in the statute.

MS. MOFFATT: Liz and I were talking about this --

FEMALE ATTENDEE 1: Yeah.

MS. MOFFATT: -- this morning, and we couldn't put our hands on it. And again, it goes back a ways --

FEMALE ATTENDEE 1: Right.

MS. MOFFATT: -- because it's actually now through appropriations that --

FEMALE ATTENDEE 1: Right.

MS. MOFFATT: -- the funding moves --

FEMALE ATTENDEE 1: It actually did go. I think it was taken out of here and put in there. I'm trying to remember what it was. So -- so I mean the question is, if it was only an appropriation for that program, maybe it makes sense to include reference to the AHEC here. I don't know how to do that. Robin (inaudible).

MS. MOFFATT: What we could do is suggest some language, if you want to capture what's happening in the infrastructure that we're already working on.

CHAIRMAN RACINE: Okay.

MS. MOFFATT: Okay.
MS. MOFFATT: So we can do that.
(Inaudible.)
MS. MOFFATT: And -- and then the next area is --
DR. SWARTZ: The next one down.
MS. MOFFATT: The next area down is D on page 24. Thanks, Don. And this speaks to, in part, the --
DR. SWARTZ: Marketing activities.
MS. MOFFATT: -- marketing activities and, again, the reference to the attorney generals. And to your point, Senator, that is -- that is essentially what we are doing now, that it is already happening, that money has already moved over to -- now, I wasn't sure if you were implying if there were additional findings from the attorney general if that would move forward. But just so you know, there's about 300,000 right now that moves from the attorney general settlement to AHEC. So that's already, again, happening. So I wasn't sure if you were referring here to any additional future dollars that came forward. So I don't know --

MALE ATTENDEE 1: This may be a (inaudible) point, but the pharmaceutical companies have (inaudible) you know, on the education of particular drugs and its (inaudible). There's a question of their involvement in the presentation and education of the doctors.
MS. MOFFATT: No, no. Pharmaceuticals it's done -- it's done through university based. There's no dollars involved. Any of the dollars were actually through -- that are around the attorney general were related to a settlement. So that's the only -- but...

MALE ATTENDEE 1: But the pharmaceutical companies aren't involved in the education now?
MS. MOFFATT: Not in this academic detailing, no. That's all done through the College of Medicines through the area and the health education center. And the whole curriculum is done not with the pharmaceuticals.

What they really do is look at a disease entity and what's the best evidence based practice for managing that and what are the -- for example, what are the generic drugs of choice if you were to use a -- if you need to use a pharmaceutical. So they're not involved either in the curriculum development or in the delivery of that or in the feeding of individuals who go to those events.

Okay?

CHAIRMAN RACINE: Okay.
MS. MOFFATT: So I think the next area, if I could, that I want to speak to is the Oregon, which is actually in the sentence above on page 24.

Is the committee familiar with what -- what they actually do at the Oregon Health & Science?
You had mentioned reference to that.
CHAIRMAN RACINE: I don't think so.
MS. MOFFATT: So I'm going to do this very, very briefly and all. But just so that they are, there are several states, well over 15 and more coming on. Actually, New York is the only one more on the east coast. It tends to be more on the west coast.

Essentially what their -- they do is they go and do detailed research on the -- what are the best formulary -- what are the best opportunities within using pharmaceuticals.
And then they create reports, extensive reports. It takes them almost thirty months to develop, to do all the research behind it. They're essentially a research entity. They research that, put a report together. The reports are sometimes almost two hundred pages in length. And then they send them to -- well, if you're part -- if you're one of the states involved, you can get that report, and then actually you get technical assistance that could come to, for example, a utilization drug review committee. So you'd have actually the expertise in terms of what the evidence based.

Now, they -- they -- they have a charge. It's about -- it's $250,000 for three years. It's a little over $80,000 a year to be a member state.

FEMALE ATTENDEE 1: Even though -- regardless of population?
MS. MOFFATT: Regardless of population. They decided quite a while ago that it's just going to be: Here's what it costs us to do it, and everyone takes a share.

They -- and then they have a targeted number of reports or -- or drug areas that they focus on and -- and actually have a whole timeline. They actually have several, for example, coming up in the coming year, drugs related to treatment of ADHD, hormone -- hormone replacement, beta blockers. Several of these are the reports one would expect if you were coming on. If you came on as a new state, you'd also have access to all the
old reports. But I want to make sure the committee is aware actually some of this is in the public domain. So you could go and get the report.

What you get for that -- from them for $80,000 a year is the opportunity to work with other states, see how they're applying, get technical assistance around how to use the report. You actually get a condensed report from the 200-page report that actually gives you specific guidance.

And then I think in particular what Dr. Swartz and I are concerned about is, so you have this information: How does it actually impact the consumer and what's the consumer education that needs to happen around that?

So it's more than just getting a report. It's really actually helping understand what the implications of that report is in the state. So one recommendation would be, although you already have it here, that we would coordinate with them to consider whether we would actually, as a state, want to invest in being a member organization. That would be a recommendation.

CHAIRMAN RACINE: And this is permissive language that, if you wanted to do it, you would have to be asking for appropriations to do it?

MS. MOFFATT: Right, right.
CHAIRMAN RACINE: All right.
MS. MOFFATT: Okay.
(Inaudible.)
MS. MOFFATT: And then the actually last particular point we have -- and again, it was a bit back to the discussion we had around the attorney general settlements and all weren't -- I guess that question was was that redundant or was there a need for the 100,000 -- $100,000 -- I wish it was a hundred -- thousand dollars for the manufacturers and all. We just were given that there's money in the system and all.

So those are generally our comments and all.
I'll be happy to --
(Inaudible.)
MS. MOFFATT: Actually, we've done -- we've done full consultation, myself, Dr. Swartz, and actually Bill Wargo, our legal counsel. And they're providing more information to us. They've actually -- they have about a once-a-year consortium meeting that you can go and get additional training at. That comes up in May. We found them extremely responsive and available and ready to work with us.

And I -- I will say I'm in the process of continuing to connect with a couple of my counterparts in other states that are state health officials. Particularly Washington has had a fair amount of experience with them. And we also have contacts in Oregon to see, from their on-the-ground experience, are they satisfied with it. They're -- they are kind of the organization, the research academic agency or setting that actually does this extensive amount of work. So --

MALE ATTENDEE 1: How long have they been working with us?

MS. MOFFATT: They're -- actually it goes back well over six years now. More of their extensive work started in 2000 when they actually produced about -- I think in that -- they had a three-year period of time, and their target was about eight reports they accomplished. And when I say reports, in those specific drug areas. And then actually, if you check their Web site, they have a list of timeline. So...

CHAIRMAN RACINE: Thank you very much.
MS. MOFFATT: Thank you. Thanks for having us.
CHAIRMAN RACINE: And if you have other comments, please let us know.
MS. MOFFATT: Okay.

CHAIRMAN RACINE: (Inaudible) concern (inaudible) education program and it was a huge, new burden on you, and I'm pleased to find out that it's not.

MS. MOFFATT: And thank you for asking us.

CHAIRMAN RACINE: Okay. All right. We have seven witnesses left over from yesterday, and we have about two hours. So that means sixteen minutes and forty-three seconds each. And if we could -- if the committee members could really try to limit their questions to something that's really --
(Inaudible.)
CHAIRMAN RACINE: No, no.
(Inaudible.)
CHAIRMAN RACINE: I'm looking -- all of us, we've all asked questions and -- and --
FEMALE ATTENDEE 1: Can I ask something?
CHAIRMAN RACINE: No.
FEMALE ATTENDEE 1: Please?
CHAIRMAN RACINE: What?
FEMALE ATTENDEE 1: You had asked us if we had suggestions (inaudible.) And how do you want us to
do that? Leave them with Jan? I've e-mailed to Robin already, and we have copies.

CHAIRMAN RACINE: Yeah. Leave them with Jan and Jan will get them out to all of us and get them in our -- in front of us --

FEMALE ATTENDEE 1: Okay.

CHAIRMAN RACINE: -- so that we do, indeed, see them. That'd be fine. Okay.

Madeleine, thank you. And for all of you who were here yesterday, I thank you for your indulgence in letting those folks who had plane tickets get out of here on those tickets.

FEMALE ATTENDEE 1: Because if they waited until tonight they wouldn't get out probably.

CHAIRMAN RACINE: They wouldn't go anywhere until (inaudible) again. Okay.

MS. LONGAN: I don't want to waste any of my precious minutes here.

CHAIRMAN RACINE: Okay. Go.

MS. LONGAN: But I'll start out following up just briefly on a comment that Dr. Swartz and Sharon Moffatt were making. The first on page 2 of the bill --

CHAIRMAN RACINE: And for the record, before you --

resources talked a little bit about it last time, and I think it had to do with labor negotiations.

That's my limited understanding.

CHAIRMAN RACINE: Okay.

MS. LONGAN: I don't really know why, but --

FEMALE ATTENDEE 1: It has to do with the lowest price, doesn't it?

MS. LONGAN: -- I'm just sort of mentioning it, because, as Dr. Swartz said, having all the different formularies adds to the complexities that doctors face every day. But really the biggest complexity is the Medicare Part D with its fifty-seven formularies. So anyway, and I want to --

FEMALE ATTENDEE 1: Fifty-seven?

MS. LONGAN: Mm-hmm, or something, seventeen companies and fifty -- it might be fifty-one. I'm not giving -- I'm not sure of the exact number.

CHAIRMAN RACINE: Okay.

MS. LONGAN: We're also here to support Section 12 in particular, which is the academic detailing section that Sharon Moffatt and Dr. Swartz were speaking about. And I have some handouts for you. I have three different handouts for you on that. But because they've done such a nice job, I'm not really going to spend much time on it.

CHAIRMAN RACINE: So you agree with the previous testimony?

MS. LONGAN: We agree with it, and we support this -- this section which focuses on evidence based prescribing. And there's a -- there's an article from the Boston Globe from I think it was a couple days ago that describes how it works in Pennsylvania. They --

CHAIRMAN RACINE: How do you feel about the Oregon piece?

MS. LONGAN: The Oregon piece we think is good. There are other alternatives. I've heard from other doctors. There's one in British Columbia another doctor told me about. So we'd like that "such as" language.

We don't really have a position on contracting with them versus, you know, using what's in the public domain. But we think that having an evidence based program is important.

The other two things I'm handing you are the AHEC list of what the Area Health Education Center is doing this year, which is hypertension and depression. Depression is their new focus for this
year. And then last year they had cholesterol,
and -- I don't know the -- Nexium -- I probably
need to save my own handouts. But -- but what was
it? Last year they had hypertension, cholesterol,
and heartburn; and this year they have depression
and hypertension. So we think they're doing a
great job, and there are some comments from doctors
supporting that program.

And as Sharon said, the challenge is to get
out to more than twenty-five practices just to kind
of spread this kind of evidence based prescribing.
So we're strongly supporting of that. Those are my
handouts.

We're also participating in something called
prescription policy choices, which is a 501.C.3
based in I think it's Maine. It might be New
Hampshire. I've only talked to them on the phone.
But that looks at evidence based prescribing. So
we're getting together with the New Hampshire
Medical Society, the Maine Medical Society, and the
area health education center to see if we can get
some economies of scale just in our three northern
New England states. So that's another thing we're
doing along those lines.

And now I'm going to shift gears and go to the

Section 13, which is the privacy of prescription
information section, and that is on...

CHAIRMAN RACINE: 24.
MS. LONGAN: Okay. The first handout I have
is our policy, the medical society's policy, which
we just really found out about this.

The reason that we support this section is we
believe that having this information going as it --
I think you have a pretty good understanding of how
it works, which is it goes from the AMA and from
the -- the chain pharmacies to the data mining
company which forms the profile and sells it to the
manufacturing company.

We think giving this money to the
manufacturing -- giving this information to the
manufacturing company for its sales force is a way
to undermine the evidence based program that we've
been really working on having the evidence based
programs because I think Helen Really [phonetic]
was in this committee years and years ago. And it
was first de novo, and we support it going to --
CHAIRMAN RACINE: Years and years ago. That
was long after I was, but anyway. Okay.

MS. LONGAN: Yeah, okay. So that's our
policy. We just found out about this when

New Hampshire passed the laws. It's not something
that I think was widely known. And here's an
article from the Boston Globe that describes the
sort of two things that -- I think at the beginning
and the end of that article that are important.

One is sort of like the president of the
New Hampshire Medical Society describing why they
support the bill, which is because he felt that
the -- that the drug detailers and sales reps knew
more about his prescribing than -- than he did
because the data isn't really shared with the
doctors, only with the pharmaceutical marketing
companies.

CHAIRMAN RACINE: And we're hearing, and I
think we're going to continue to hear, that there
are also other uses for this.

MS. LONGAN: Right.

CHAIRMAN RACINE: We heard this testimony
yesterday, and you were probably in the room.

MS. LONGAN: I was here.

CHAIRMAN RACINE: It helps with research. It
helps to alert physicians when they need -- they
need information about some bad combination of
drugs, bad reaction. What -- what -- I'm surprised
that the medical society likes this section given

all the benefits that we understand doctors get
from this.

MS. LONGAN: Well, I'm not sure that doctors
get --

CHAIRMAN RACINE: That was the testimony. I'm
not saying I agree or disagree with it.

MS. LONGAN: Yeah.

CHAIRMAN RACINE: But I think that's --

MS. LONGAN: Well, what we heard yesterday was
there was -- there was a chart with a list of drugs
and a linkup to the -- the FDA I think in talking
about the safety issues. Ann Rugg testified in
finance, they asked her this question, if there was
a recall would she -- she said she didn't -- and I
hope I'm correctly stating this -- she didn't think
that they would use the pharmaceutical
manufacturing companies to get the word out to
doctors; they would use their own data.

So I think my main point is that there are
better ways to address both the safety issues and
the research issues than -- than using this -- this
information.

And in terms of the FDA, this is an article
that was a couple days ago written by a professor
at Harvard Medical School and the former editor of
the New England Journal of Medicine, Marcia Angell, who some doctors in Vermont are trying to bring to Vermont to talk about these prescribing issues.

But it kind of explains the relationship between the pharmaceutical manufacturing companies and the FDA, which is that the pharmaceutical manufacturing companies, since 1992, have been paying user fees to the FDA to the tune of about $300 million a year, which is I think about half of their revenue. I can't remember if it's -- it says in here -- slightly less or slightly more.

But basically what this money does is encourages the FDA to move the new drug applications through more quickly. And what this author says is that it leads to a backlog in the generic drug applications, which, of course, of benefit to the pharmaceutical manufacturing companies. And also, it -- because the funding is coming from the manufacturing companies for the purposes of encouraging the drug applications to move through more quickly that the safety aspects of the -- of the FDA are being sort of a little bit -- getting a little bit sort of short.

So we think there are better ways to do that, and that would sort of be our point, in fact.

CHAIRMAN RACINE: Incidentally, if the doctors feel that way, why aren't they all just opting out?

MS. LONGAN: There are three reasons why we think the opt-out doesn't work very well. The first one is that the opt-out is -- is too limited.

The way the opt-out works is that the information would still go from the pharmacy, chain pharmacies and wherever else, to the drug mining company about the prescriptions. It would -- it would not go -- the AMA's list of, you know, its numbers for identifying doctors would not go for those doctors that opted out. The profile would still be created.

Well, actually the AMA information -- the pharmacy information would go. The AMA information would go. The profile would be created. The profile would be sold to the manufacturing company. The manufacturing company, by a contract with the data mining company, would not be able to share that information with its sales marketing force.

So it's within the corporation but not going to the sales marketing force.

So -- so that information can be used for other purposes. So we think that that's too limited. It could be used by the marketing division inside the corporation. And if you -- I've been trying to penetrate the -- if I can find it in my stuff here.

MALE ATTENDEE 1: Madeleine, (inaudible) suspicious -- let's say healthy suspicion of the pharmaceuticals.

MS. LONGAN: Well, I don't mean to be suspicious, and they do wonderful work in developing drugs. But -- and this is really the first time that I've waded into this. And we were -- New Hampshire started us out with this law, and then, just trying to understand the answers to these questions, I'm just trying to give you the best information that I could find.

CHAIRMAN RACINE: You said there were three reasons why the opt-out doesn't work. That was the one.

MS. LONGAN: Okay. So getting back, that -- so that's one reason.

CHAIRMAN RACINE: I wrote down No. 2 already. Fill in the blanks.

MS. LONGAN: Okay. So -- so No. 2 is opt-outs in general, don't work very well. And if you -- you probably remember, many of you, that Vermont chose an opt-in on the banking and insurance information, not an opt-out.

You heard yesterday that 6,000 in Vermont out of the -- I mean in the United States out of the 800,000 -- that's less than -- so that's three-quarters of 1 percent of docs have opted out.

Why don't they opt out? I mean we send out information in our newsletter letting them know about the opt-out. We think the opt-out is a good thing. It's limited, but it's a good thing.

They -- they don't know about it. They don't read our materials or other people's materials or they don't think it's meaningful.

FEMALE ATTENDEE 1: (Inaudible.)

MS. LONGAN: Well, they're not really isolated. If they opt out, their information -- their prescribing information would not go to the sales rep. It goes to their office. It would go everywhere else.

CHAIRMAN RACINE: Okay. No. 3?

MS. LONGAN: No. 3, okay, this is kind of a follow-up to what Julie Brill said, which was that the data miners can use another identifier, if they don't have the AMA identifier, and then the information can still go. And -- and the other
Identifiers are things like the licensing number, which is publicly available on the Web site. And just to get back for a moment to We've been trying, as I said, to penetrate the IMS, which is one data mining company, their annual report. And what -- mostly what they use this for is what they call their sales force effectiveness offerings which has to do with selling the information to the pharmaceutical manufacturers to measure, forecast, and optimize the effectiveness and efficiency of their sales representatives to target the marketing and sales efforts of the sales forces into managed sales territories. And one part of sales force effectiveness offerings is something called prescription tracking reporting services that monitor prescription activity and track the movement of pharmaceutical products out of retail channels. And they have this thing called exponent, which monitors prescription activity from retail pharmacies, long-term care, which I didn't know about, and mail service pharmacies. And they have this thing called early view which provides a weekly prescriber level activity highlighting competitive prescribing transfer, key identifiers.

Prescribers -- okay. Anyway -- and then it says that they -- IMS Healthcare provides their clients, the manufacturing companies, with timely and comprehensive information on 2.4 million health care professionals, including the health care professionals' names, addresses, organizational affiliations, license numbers, expiration dates, and authorization statues. So my point is, just as -- they have many other ways of kind of -- they don't necessarily need this CME number from the AMA. They're -- they're very --

CHAIRMAN RACINE: Okay.

MS. LONGAN: So -- so anyway, so they -- so those are my reasons we don't -- we support the opt-out, but we don't think it does what we're looking for.

CHAIRMAN RACINE: Okay.

MS. LONGAN: Okay.

CHAIRMAN RACINE: Anything else?

MS. LONGAN: And the research, I talked briefly about the research. I'm trying to get organized here.

One thing that we've already financed was that -- was an argument that the docs are not looking for transparency or trying to avoid transparency of their own prescribing. And that is -- I just would like to say that's not true.

There's complete transparency of the doctors' prescribing through -- the one that I know -- I know about the public programs because they're -- so I know that the DUR board, OVHA, has every -- every prescription that every doctor writes for a Medicaid patient. I would guess that the PBMs and Blue Cross and Blue Shield and MVP have that information or could have that information for their -- for the doctors that prescribe for them. So that's one form of transparency that we support. The other one is Vermont is in the process of creating a multipayer claims data system through BISHCA. That system is going to get information from Medicaid, from all the PBMs, and is going to create a public data system that will have all this information.

We're very, very supportive of this. It's going to be done through a public process. There will be rulemaking. It'll be out in the open. They'll be -- you know, we'll have kind of pros and cons about what the data is, how the data is used.

We'll have -- we'll probably have some concerns about, like when New York did reporting of mortality on heart surgery, doctors were concerned that it might cause doctors to take less of the more difficult patients.

So we'll have some concerns, but it'll be a public process. We'll get it all out there. We'll talk about it and then talk about what makes sense for the people in Vermont.

So we completely support that type of public transparency and think that's the way to go, and you know, don't -- don't like this in-the-shadows sort of thing.

The last handout that I have for you, this is something that's kind of -- we found kind of interesting. It's something that we found out about because of this process, which is Paul was invited to be -- Paul Harrington was invited to be on a panel where the pharmaceutical manufacturing groups are getting together to talk about their marketing strategies. And they are already looking ahead to things like what they're going to do if they don't have this data.

So they're already -- I mean there's a bill in Congress that would sort of prohibit access to this
data. And I don't know whether it will pass or not. But -- and I know that Vermont is fairly a rounding error in, you know, the kind of stuff that -- that we're talking about. But -- but they're already looking ahead to how they can deal with this.

And the last point I want to make and sort of mentioned here is they do mention something called patient scrape and patient level data. And one of the things that was part of the finance testimony, and may come up here as well, was that doctors are using the patients as a red herrings. It's really a patient issue because of HIPAA.

Well, we don't really know whether it's a patient issue or not because we can't penetrate what's going from the pharmacy to the data mining company. There are exemptions to HIPAA. And I'm sorry to be sort of suspicious-sounding, but there are exemptions to HIPAA. One is a business associates agreement exemption, and another is a health care operations exemption. And this is kind of broadly stated. And I don't know, but it's possible that patient information could be going to them. And so my request would be to keep the patients in the bill because it doesn't do any harm to keep them in the bill if it's just duplication. If it's -- you know, if it's needed, then it would be helpful to keep it in the bill.

And the last thing I want to say -- and I'm almost done. In fact, I'm going as fast as I can -- is that in finance I learned one more thing, which is apparently the manufacturing companies and others go to the office of Vermont Health Access and ask for prescribing information as a matter of public record.

So Ann Rugg testified in finance that they would like to see a public records exception for this prescribing information, and there wasn't I think time to work that out in the language in finance. And I think it was sort of -- Robin would probably know more, but I think it was kind of deferred for this committee. But I just wanted to sort of mention it. It was at the last paragraph in Josh's memo.

So I think that's all that I have, and I'm sorry to sort of rush through.

CHAIRMAN RACINE: Don't apologize. We're happy to have you rush through.

MS. LONGAN: How did I do on my sixteen minutes?

CHAIRMAN RACINE: I don't know. I wasn't paying any attention.

MS. LONGAN: Well --

CHAIRMAN RACINE: I've known you many years.

I've never heard you talk so fast.

MS. LONGAN: So if I have any left over, can I reserve for rebuttal?

CHAIRMAN RACINE: What we're trying to do is get through all of this, and then I've asked Robin to identify the issues that are the most in dispute and sort of outline the arguments, and then we'll go through them one -- each of the issues one by one. So if we need more information, we'll hear from you.

MS. LONGAN: Okay. Thank you.

CHAIRMAN RACINE: Okay.

MALE ATTENDEE 1: (Inaudible.)

MS. LONGAN: What?

MALE ATTENDEE 1: (Inaudible) as far as I'm concerned.

MS. LONGAN: Great PR?

CHAIRMAN RACINE: Okay. Bob Feeneey, we're doing that by phone? Is that --

(Inaudible.)

CHAIRMAN RACINE: (Inaudible) pharmaceutical company. Who's representing Mr. Feeneey? Is anybody?

FEMALE ATTENDEE 1: I think -- is (inaudible) here? While I'm calling him, I will give you the (inaudible).

CHAIRMAN RACINE: Okay. Maybe we should -- maybe we should move on; and as we get close to the end of the next piece, you can make the call so we don't wait while you try and connect and make --

FEMALE ATTENDEE 1: Okay.

CHAIRMAN RACINE: -- make the -- and try and get that schedule on board.

All right. Trinka?

MS. KERR: And I'll be very brief.

CHAIRMAN RACINE: And if you could give us like a thirty-second warning, and then Jan can call and get the next witness here. Thank you.

MS. KERR: Trinka Kerr, the state health care ombudsman. And first of all, I wanted to let you know that we are generally in support of almost everything in this bill.

Prescription availability for consumers in Vermont is still a big issue. Of the 2,500 calls that we got last year, about 21 percent of them...
were access to care calls; and of those access to care calls, 28 percent of them were about prescription drugs; and that's not including any of the Medicare Part D calls that we also got. So it's still a huge issue for people trying to access prescription medications. So we're -- the Office of Health Care Ombudsman is in favor of anything that really improves access to drugs. And --

**MALE ATTENDEE 1: (Inaudible.)**

**MS. KERR:** What?

**MALE ATTENDEE 1: (Inaudible.)**

**MS. KERR:** Right. And the ability to get medications which is, you know, part of -- I think this -- some of the parts of this bill will improve that.

We also support just about everything that the attorney general's office was in favor of. And rather than repeat everything Julie said, I just would state that. And also, basically what the medical society is in favor of we're also in favor of. The one --

**CHAIRMAN RACINE:** I'm sorry, Trinka. Who do -- who do you work for?

**MS. KERR:** Okay. I --

**CHAIRMAN RACINE:** I'm just not clear on what this and that was --

**MS. KERR:** Well, you know, I think that would be very difficult. And if the legislature wants to expand Healthy Vermonters, which would be a good thing, I would suggest that you just increase the Federal poverty level. You know, if you can't go up to 350 percent, then maybe 325 or whatever.

But that whole system of having beneficiaries keep track of how much they're spending, I mean they -- they do that for another part of a Medicaid program, and it's very, very difficult for everyone involved.

**CHAIRMAN RACINE:** Okay.

**MS. KERR:** So that language about the 5 percent and the 15 percent is in the existing statute. So -- right, Robin? I have that right?

So I think that -- I understand why OVHA thinks that's administratively burdensome because we actually think it would be too.

**CHAIRMAN RACINE:** Okay.

**MS. KERR:** And unless you have any questions?

**CHAIRMAN RACINE:** Questions? No?

Thank you.

**MS. KERR:** Thank you.

**CHAIRMAN RACINE:** Okay. So next we're trying
of the letter that I had provided beforehand.

CHAIRMAN RACINE: Yes. It's right here, and it is now in front of the committee members. Go ahead.

MR. FEENEY: Okay. I'll refer to some of the contents of that letter. One of the things that was touched upon was the -- the operational impact legislation could have. Obviously there's potential for a negative impact on operations in terms of how companies are able to operate. And I think it's worthwhile to mention in terms of the additional uses the prescription data is also put to, which I believe the other individuals who have testified spoke to at length. Like I said, there definitely is commercial applications for this as well.

But we don't see that in a negative fashion; we see that as a means for us to operate as a company, as an industry, more efficiently. If this data was not available to us, we could not stop functioning in promoting our products; we'd be forced to rely on very cumbersome and inefficient methods, however, which we don't see as serving -- anyone -- anyone's end really. We would be forced into a position, actually forced back to a position, where the industry probably was forty years ago in terms of using very, very inexact methods, very unreliable methods to aggregate the evaluation of data which actually would have a negative impact on operating efficiency and could actually create the potential for upward cost pressures.

One of the other points that I had stressed in the letter deals with the utility of this data in terms of -- specifically in terms of us -- giving us the ability to identify those cohorts in the physician community who have patient populations that we think could benefit from our therapies. Again, we do not see this as a bad thing.

And I specifically in the letter used an Alzheimer's therapy Aricept, which is the leading product in the market. Millions of people have benefited from that. And this is -- you know, to use that a specific example, Alzheimer's is a disease state where the greatest impediment to growth, historically, has been a continuing lack of awareness and diagnosis and treatment.

We have never reached a point where more than 50 -- we estimate more than 50 percent of the afflicted Alzheimer's population has been
Effectively diagnosed and treated. That has not just been on our own research; that actually is by third-party sources, including the Alzheimer's Association.

In that case, being able to identify physicians with a large geriatric population, including those individuals that maybe have manifested the early symptoms of Alzheimer's disease, gives us an opportunity to engage those physicians directly, allows -- educate them appropriately. It's not an attempt to interfere in the physician/patient relationship but make sure the physicians are armed with the appropriate data, including the therapies that are available to treat specific disease states, like Alzheimer's disease, so the patient population can be effectively treated.

And in the case of Alzheimer's, we have -- you know, we see repeated evidence -- and this is supported by specific studies that we have commissioned -- that show effective early diagnosis delays nursing home placement by a year and a half, and in specific cases, up to two years. So there's not only a human element that's being -- that's being served there, but there's obvious pharmacoeconomic benefits by sharing proper treatment in order -- in order to keep people out of long-term care centers.

And without this data readily available to us, we would not -- we would be -- we would not be able to engage in that exercise either, not be able to target these physicians and specifically address these patient populations that we think can directly benefit from our therapies.

CHAIRMAN RACINE: Excuse me. If I can ask a question there: Are there not other ways of identifying physicians who deal with those populations who are likely to have Alzheimer's?

MR. FEENEY: Potentially. But again, they're very -- very ham-fisted approaches. There are ways of identifying, for example, just -- just physicians that deal with the geriatric population, you know, that could -- that could represent a very -- that the patient populations they serve could be very broad based however. And we wouldn't know specifically if there was a physician that actually had a large -- a large proportion of their practice that was -- that included people with -- with Alzheimer's and with -- or with precursor symptoms of Alzheimer's, for example. And that's evidenced sometimes by comorbidities. So again, it's not impossible.

But this gets back to the first point. The way we would need to do that would potentially I think be even more -- even more disruptive and would definitely be incredibly inefficient.

CHAIRMAN RACINE: Okay. We have another question.

SENATOR KITTELL: Well, I guess just along that same line, Senator Kitnell, I was just trying to think when I just heard, you know, what's wrong with sending a company -- or you would like to target a certain population using your drug and you could send a letter to them all. You could do a number of things. And if they're interested, they will get back in touch with you.

You have -- you know, the pharmaceutical industry has vast resources; and if it's that important, I would think you would use some of your resources to be in touch with the population using your product or not. I mean I think that's -- you know, there are -- you could -- you know, you could have a colored letter. You could have a letter that says, "I'm here for you," you know, all sorts of things to get their attention to say that, "I want to help those who prescribe Aricept," something.

MR. FEENEY: And you're talking a letter writing campaign to individuals or to the physician community?

SENATOR KITTELL: I think anybody that prescribes -- I mean I'm just being facetious here. You know what you want to do. But I'm just saying there are other ways to get ahold of a population using your drug.

SENATOR WHITE: And can --

MALE ATTENDEE 1: (Inaudible) fewer commercials.

SENATOR WHITE: Right. Can I suggest -- this is Senator White. I just -- I know that you find that it would be cumbersome and less dependable, therefore, probably more expensive to use other methods. But the pharmaceutical industry spends a fortune on TV ads to convince me that I should ask my doctor about the purple pill or I don't know what color yours is.

But I would think that if -- if you're really interested in getting to that population, and getting to the people who actually write the prescriptions, take the money that you have on
public -- on the airwaves and put it toward the marketing to the physicians instead of marketing to me. I mean it isn't -- I don't believe that it's a lack of money and resources.

FEMALE ATTENDEE 1: Just redirect it.

SENATOR WHITE: Yes, redirect it.

MR. FEENEY: I didn't mean to imply that it was a complete lack of resources. But to clarify the amount spent on direct consumer advertising -- and I don't know that that's what we're here to speak about today -- is actually a small fraction of the overall promotional budget for companies. I don't have those specific numbers in front of me. But it's still -- it's still -- it has increased significantly over the last number of years to be sure, but it's still a relatively small component of the -- of the total promotional budget.

SENATOR WHITE: I wasn't meaning to imply that -- that it -- it was a large portion of the budget. But what I'm saying is, if you have a limited amount of money for promotion, it would -- you would -- you make the decisions of where to put that -- those resources and perhaps the decision to put those resources to the public as opposed to the physicians. I mean that's a decision you've made, and maybe the decision needs to be -- you need to rethink your decision.

MR. FEENEY: And you know, I see the point you're trying to make. I guess I would say some people have criticized direct consumer advertising because it does directly target the patient population rather than the -- rather than the physician community. It doesn't -- it's not an imposition to communicate a lot -- a lot of detail in terms of product profiles and in terms of their efficacy and side effects so that people have -- you know, a lot of people would, you know, see physician detailing as actually preferable because, however it might be undertaken, it actually does -- you know, all it does is arm the physician with data. It does not intend to undermine the patient/physician relationship, and probably that's an overly pejorative word because we don't necessarily think TV advertising does that either.

But it -- but, you know, the engagement of physicians directly does nothing more than just arm them with the -- with the data that they need to then make educated and informed physicians -- decisions for their patient population.

CHAIRMAN RACINE: Okay. Anyway, you may continue.

MR. FEENEY: Well, actually those were based on the written correspondence that I provided.

CHAIRMAN RACINE: Okay.

MR. FEENEY: Those were the two -- the two major points that I -- that I really wanted to make. I don't want to -- you know, I don't want to get into subject areas where I'm not -- you know, what they were aware of where the data -- the data has utility as well, including its use from a public policy and health economics perspective, from a safety perspective, and a regulatory perspective as a tool to help implement and pay for performance models, such are indicated under the Medicare Modernization Act. I'm sure the other witnesses have commented on those -- on those elements at length. But just, you know, suffice it to say that we -- we concur with those arguments as well.

CHAIRMAN RACINE: Okay. May I ask who represents you here in Vermont?

MR. FEENEY: Doveco represents us.

CHAIRMAN RACINE: Who's that?

MR. FEENEY: Doveco Worldwide is our lobbying firm for federal and state and local government affairs.

CHAIRMAN RACINE: Okay. So you don't have a presence here in Vermont?

FEMALE ATTENDEE 1: How do you spell it?

MR. FEENEY: We do not.

CHAIRMAN RACINE: You do not. Okay. How did you find out about us? We're just sort of a little -- a little state legislature here.

FEMALE ATTENDEE 1: From this.

(inaudible.)

CHAIRMAN RACINE: How did you -- how did you find out about this bill?

MR. FEENEY: We track -- we track developments in all fifty states.

CHAIRMAN RACINE: Okay. And you made the contact with us?

MR. FEENEY: Exactly.

CHAIRMAN RACINE: Okay.

MALE ATTENDEE 1: Good work.

FEMALE ATTENDEE 1: Good to see you know how to do it.

CHAIRMAN RACINE: Okay. Any questions?

Okay, Mr. Feeney, thank you.

MR. FEENEY: Thank you very much.

CHAIRMAN RACINE: Thank you for participating.
here.

MR. FEENEY: Okey-doke.

CHAIRMAN RACINE: All right. Thank you.

(inaudible.)

CHAIRMAN RACINE: Man, these guys are good.

FEMALE ATTENDEE 1: They know how to -- they
know how to find what they're looking for. They
can find the -- they can find the documents.

CHAIRMAN RACINE: You'll probably have a
personal phone call waiting for you when you get
home.

(inaudible.)

CHAIRMAN RACINE: They can find us.

Okay, Mr. Otis.

FEMALE ATTENDEE 1: We are listed right on
here on this thing too.

CHAIRMAN RACINE: Are we?

FEMALE ATTENDEE 1: Paul Harrington is listed
as a presenter.

CHAIRMAN RACINE: Okay.

FEMALE ATTENDEE 1: Yeah. Yeah. Right. So
that's how they found us.

CHAIRMAN RACINE: Okay. I don't know if you
were in the room when I said we're trying to limit
it to fifteen minutes.

MR. OTIS: Oh, I don't even want fifteen.

CHAIRMAN RACINE: Then --

MR. OTIS: I don't even want ten.

CHAIRMAN RACINE: Okay. Then keep going.

MR. OTIS: Five. Anthony Otis today
representing the Vermont Pharmacists Association,
the Vermont association of the chain drug stores
and Vermont retail druggists. If you will move
quickly, so I can stay on schedule here, to a
page -- I think it's page 28, you'll see Sections
15 and 16 in a slimmed-down father of S.115, which
was directly request of 1148. These two sections
were referred to in the Senate Finance Committee as
the Wal-Mart provision, and I want to be very clear
with you about what they don't do and why they're
unnecessary.

At the present time, I talked to two major
chains and to two independents, and they tell me
that they don't know of -- but they probably
wouldn't necessarily know -- if every community
retail pharmacy in the country insurers provide --
that you want the usual customer. So if you go in
the universe of PBMs and health care insurers, they
don't know of any who don't ask for and don't get
their usual customary price.

So every time you adjudicate online, the
computer knows, and the PBM and the health
insurance knows, what your usual customary is and
what their copay is. And so we're basically
putting something in the statute that essentially
happens now without any statutory requirement.

MALE ATTENDEE 1: (inaudible.)

MR. OTIS: I guess that's a public policy
decision whether you think it's necessary to put it
in when it accomplishes what already exists. I
mean the books would be full of things if you -- if
you, you know.

CHAIRMAN RACINE: Let me ask this. I mean why
if -- you have come in here to suggest we take it
out. Do you -- do you worry that if it -- would
you worry if it's still in here? Are you -- are
there -- are you able to represent who would like
to at some point charge the full usual and
customary rather than the lesser? I mean what's
the concern?

MR. OTIS: Well, I'm sorry. First, let me
apologize to Senator Flanagan. I didn't mean to
appear to be flippan in my -- in the answer to
that. We could have that, you know, in social
time.

This is what happens in adjudicating
prescription drugs by pharmacies, of the ones that
I represent and of the similar ones around the
country.

FEMALE ATTENDEE 1: Can you use a different
word than adjudicating prescription drugs because
I'm not sure that I --

MR. OTIS: Electronically transferring the
information to the PBM or to the health insurer for
permission to pay -- to fill the prescription at a
certain price.

FEMALE ATTENDEE 1: Okay. So that's
adjudicating?

MR. OTIS: That's adjudication. That's what
we call it.

FEMALE ATTENDEE 1: Okay. I thought it was
that, but that's --

MR. OTIS: Well, it is in other places.

CHAIRMAN RACINE: Okay.

FEMALE ATTENDEE 1: That's what I thought you
were saying.

CHAIRMAN RACINE: Okay. So what you're saying
is it's unnecessary. If it stays in, you think
we're putting unnecessary words in the green books,
but it wouldn't harm who we are representing?
MR. OTIS: As far as I know, it does not harm who you are representing.

CHAIRMAN RACINE: Okay. Thank you.

(Inaudible.)

FEMALE ATTENDEE 1: I thought that too. It was.

MR. OTIS: Well, the person comes to the pharmacy, and they present their personal information. And by providing that personally identifiable information, the computer knows whether they have -- if they’re covered by someone, unless, of course, they say, "I'm a cash payer. I don't have Medicaid or Medicare or don't have any private insurance." Okay. So the computer can find them through this system, electronic system, and determine whether, in fact, they can purchase this drug and what is the price that they pay. The pharmacist, of course, runs out what the pharmacy will receive as the formulary price for filling a prescription.

(Inaudible.)

CHAIRMAN RACINE: That's what I thought.

(End of CD 07-49/Track 2.)

CERTIFICATE

STATE OF FLORIDA )
COUNTY OF INDIAN RIVER )

I, Kristen A. Houk, Registered Professional Reporter and Florida Professional Reporter, do hereby certify that I was authorized to and did listen to CD 07-49/Tracks 1 and 2, the Vermont Senate Committee on Health & Welfare meeting of the Thursday, March 1, 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 3rd day of December, 2007.

__________________________
Kristen A. Houk, RPR, FPR

Job No.: 907521A
STATE OF VERMONT

SENATE HEALTH & WELFARE COMMITTEE

Re: Senate Bill 115
Date: Thursday, March 1, 2007
Senate Health & Welfare Committee
Committee Members:
Sen. Doug Racine, Chair
Sen. Ed Flanagan, Vice-Chair
Sen. Sara Kittell
Sen. Virginia Lyons
Sen. Kevin Mullin
Sen. Jeannette White
Robin Lunge, Legislative Counsel

CD No: 2007-50/Track 1

Transcribed by:
Kristen A. Houk, RPR, FPR
Esquire Deposition Services
800.330.6952
Job No: 907521B
And the way these -- this industry works, they contract with large, sophisticated entities who are able to obtain -- like my client, who are able to obtain all of the information that's required under this bill. These are fully transparent contracts, and we're able to -- to negotiate for all the information that's provided here. So it's -- it's always been a bit of a puzzle to me as to why this has been proposed and has continued to resurface. We --

CHAIRMAN RACINE: Who do you see as being proposed? It seems like more of almost an informational thing.

MR. HOLLAR: Well, there's a new regulatory scheme and then a bill-back requirement and a cause of action against the PBMs. You know, it's pretty significant. I mean, to be honest, I haven't spent a lot of time trying to study every in and out of it because it's not going to apply to my client. We looked at it, and have in the past, and said: You know, this is intended to protect, presumably, insurers like us.

So the question that MVP had is -- or the response is: Well, we don't really need it.

And so then I guess the question is: Well, is it going to do any harm?

And you know, it's not -- on the list of priorities for us, it's not huge. I mean -- but ultimately we think that, to the extent that PBM costs go up, then the people who buy their services, the cost to those people will go up. I mean it's just kind of a basic law of economics.

So I just would ask you to -- to question -- you know, to determine who really this is intended to protect because technically the role of the legislature, generally, I think is to protect consumers.

This is a little different. I think this is aimed at protecting businesses. And the question is: Which businesses are really asking and feel that they need the protections that this would offer and would it -- I mean is that necessary?

Does that outweigh the costs, you know, that sort of transaction costs that are going to be involved in setting this up, making sure there's compliance and, you know, potential litigation around certain areas?

CHAIRMAN RACINE: Well, then let me ask you:

What could we do to help you?

MR. HOLLAR: Well, lower our cost. I mean I'm
here. This is what I do for MVP is testify in
(inaudible) like this that we think would raise
costs.

CHAIRMAN RACINE: Seriously.

MR. HOLLAR: And I'm being very serious about
that. We, you know, don't pass things like this
that will raise costs.

(Inaudible.)

MR. HOLLAR: I was down the hall talking to --
to the Senate Finance Committee talking about
another bill that will increase costs, not a lot,
but incrementally. And so you know -- so --
CHAIRMAN RACINE: And how do you see this
raising your costs?

MR. HOLLAR: To the extent it raises PBM
costs.

CHAIRMAN RACINE: How do you see yourself
how do you --

MR. HOLLAR: Just I mentioned the bill-back
requirement to this.

CHAIRMAN RACINE: Okay.

MR. HOLLAR: The PBM industry will be
financing a regulatory apparatus to insure
compliance with this -- with this new scheme, and I
think there will be internal costs of compliance to
determine, you know, whether to -- I mean there are
nine pages of statute here that impose different
burdens on the industry and on health plans to -- I
guess to waive certain requirements.

CHAIRMAN RACINE: Okay.

MR. HOLLAR: So you know, it's something --
I'd be happy -- I will talk to you about that, but
really for us it's about trying to provide
affordable health care. And so that's --
CHAIRMAN RACINE: Okay.

FEMALE ATTENDEE 1: So -- well, the first
thing I heard you say was that everything that's
here and required for transparency is already being
done if -- in the contracts between your
organization and -- and a PBM. So that part of it
really reinforces practice. So it wouldn't raise
cost. The part that would -- are you saying that
the part that would raise costs is what? The
regulatory piece?

MR. HOLLAR: Right. And again --
FEMALE ATTENDEE 1: So is the registration the
audit, you know --

MR. HOLLAR: There are also the cause of
actions that are included in here which creates
some --

FEMALE ATTENDEE 1: And each piece is the
enforcement piece?

MR. HOLLAR: Potentially.

FEMALE ATTENDEE 1: Will that cause -- will
that increase costs only because of a need for
consumer -- consumer fraud protection liability
protection for you or for the PBM? How will that
raise cost?

MR. HOLLAR: Well, to the extent -- I guess
the best is really, to the extent it raises costs
for PBM's who do business in Vermont, it will raise
costs for the people who buy the services. I mean
I think that's just --

FEMALE ATTENDEE 1: Why?

MR. HOLLAR: Well, because they will simply
raise their costs for services in Vermont as a cost
of doing business here.

FEMALE ATTENDEE 1: Well, what costs will they
incur as a result of the enforcement section and
then of the regulatory section?

MR. HOLLAR: Compliance costs, so the cost of
complying in Vermont will go up.

FEMALE ATTENDEE 1: The license?

MR. HOLLAR: Well, just internal compliance.
They're going to have to hire people to review the

statute and insure that all their contracts are
consistent with the statute. The bill-back costs,
they'll have to pay for the direct costs of
regulating the new regulatory apparatus, potential
litigation costs.

I guess the point that I would say is I'm
not -- you know, to what -- I'm turning the
question around here and saying: What are you
trying to accomplish here and for whom is really
the question I would phrase.
The cost -- and I would say this is not high
in terms of, you know, MVP's priorities. This
would not rank high. But I thought it was
important to at least tell -- relate to you, since
the bill -- the premise of the bill seems to be to
protect health insurers. But it's not viewed -- we
don't feel that this is necessary from our
perspective. So I thought --

FEMALE ATTENDEE 1: (Inaudible.) One last
question because I know Jeannette wanted to ask a
question. But if you felt that the PBM that you
were working with had done something egregious,
then would you feel that the recourse that you
currently have to address those issues was --

MR. HOLLAR: Per contract, right.
FEMALE ATTENDEE 1: Do you have that?

MR. HOLLAR: Sure.

FEMALE ATTENDEE 1: Do you have that protection?

MR. HOLLAR: Sure, yeah.

FEMALE ATTENDEE 1: Is it through BISHCA? Is it through the attorney general? Is it through --

MR. HOLLAR: It would be through a private --

I mean action through -- under the contract directly against the PBM, and if they were engaged in fraud, then through the attorney general's office presumably, perhaps BISHCA. I don't know the extent of their authority. I think their's is limited. So -- but if it were -- if it were -- I mean typically it would be a contractual matter if we felt that we weren't given the data that was required for under the contract. Then it would be enforced like in business.

FEMALE ATTENDEE 1: Are the contracts that you have public documents or are they private corporate documents?

MR. HOLLAR: You know, I would assume that those are proprietary just because these are competitive -- you know, it's a competitive market, both for us and the PBM against, you know, Blue

SENATOR WHITE: Okay.

I guess the premise is that MVP -- with this information MVP would be able to negotiate a better deal and get lower-priced pharmaceuticals. And I -- we just don't see that, because, again, the information that would be required under this we already get.

So I mean I guess I can -- I haven't been -- I don't know that there's anything the legislature can do that's going to improve on that relationship because I think the PBMs provide a service. They negotiate the best arrangements they can to get lower-priced pharmaceuticals. And we -- you know, and then they provide that service to us, and we negotiate the best contract we can with the PBMs. And it's a competitive market.

I think the last time this bill was up, MVP had a different-- PBM. We have -- so it switches because (inaudible) so they are able to negotiate in this competitive market with the lowest-cost PBMs. So you know, I think it's a pretty competitive market that's acting efficiently to bring down prices. So I can -- I'll explore that. I don't -- I just don't know that I have an answer that's going to be helpful for you on that.

SENATOR WHITE: Okay.

Cross and their people. But I don't know, I could check and see --

FEMALE ATTENDEE 1: Okay. And then check and see also are they -- are they placed with BISHCA?

Are those contracts --

MR. HOLLAR: I don't think those are filed, no.

FEMALE ATTENDEE 1: -- filed with BISHCA?

Okay.

CHAIRMAN RACINE: Jeannette?

SENATOR WHITE: Well, since I think the goal here is to -- the way I look at it anyway is, the goal is not to necessarily protect MVP from Blue Cross because I think they are capable of protecting themselves. But the ultimate goal is to protect the consumer -- the very end consumer and to protect the interests of the -- of the state by assuring lower costs and that a way to do that is the transparency. So how would you -- do you have any suggestions about how we would get to those goals without this by -- in dealing with the PBMs?

MR. HOLLAR: Well --

SENATOR WHITE: Did that make sense?

MR. HOLLAR: Yeah. I mean this bill doesn't give any information to consumers. So the issue --

FEMALE ATTENDEE 2: So when the PBMs do negotiate with different health insurance plans, they will get what -- your operation is for the health insurance, and so it's different. The contracts will be different probably for different companies for their different populations.

MR. HOLLAR: I suppose that's right. I don't know that. That would make sense.

FEMALE ATTENDEE 2: So I mean I'm just trying to --

MR. HOLLAR: MVP is a large -- you know, the Vermont operation is only about 5 percent.

FEMALE ATTENDEE 2: Right.

MR. HOLLAR: It has -- I don't know -- half a million lives or more, so -- in the two -- three-state region.

FEMALE ATTENDEE 2: I don't know how they operate. But I was just trying to think that -- you know, how they would -- you know, how much focus you would put in certain areas, you know, depending on the health plan population, you know, a huge, young group you're insuring or a huge old group, or, you know, they're all equal, what issues, what kind of drugs and what kind of experience is out there. It must be according to
how the PBM was able to -- you know, the last
person on the phone, if they need a lot of Aricept
in this health plan and, you know --
MR. HOLLAR: Right.
FEMALE ATTENDEE 2: -- they really put the
pressure on to get the low price for the Aricept
and et cetera, et cetera.
MR. HOLLAR: Well, yeah. I think that's
right. I would assume that volume would translate
into lower costs, just like in any industry; but I
don't think that would affect -- this bill wouldn't
deal with volume. It deals with transparency. So
I don't think that size is going to make a
difference in terms of the information that you get
or the duties that are required by the --
FEMALE ATTENDEE 2: No. I was just -- I was
just trying to understand how they operate with
insurance plans. You represent the insurance
company --
MR. HOLLAR: Right, right.
FEMALE ATTENDEE 2: -- and how that money
might --
CHAIRMAN RACINE: John, do you have anything
else that you want to --
MR. HOLLAR: Okay.

CHAIRMAN RACINE: -- that you want to?
MR. HOLLAR: That's it.
CHAIRMAN RACINE: Okay. See you.
MR. HOLLAR: Thank you very much.
(Inaudible.)
CHAIRMAN RACINE: We're being very generous
today. You missed your turn and --
(Inaudible.)
MR. KIMBELL: Don't think I don't appreciate
that.
SENATOR WHITE: Can you blame him, however,
for waiting outside instead of in here?
CHAIRMAN RACINE: (Inaudible.)
Steve, I don't know if you were in the room.
We're trying to limit it to fifteen minutes and
opportunities to communicate in other ways. And --
and as we start working through this bill as a
committee, there will be other opportunities, if
there are other issues that you want to explore.
MR. KIMBELL: I think I'll try to speak for
less than fifteen minutes; and if you do have any
questions, that will be fine.
Mr. Chairman, my name is Steve Kimbell. I'm
an attorney and lobbyist in Montpelier. I'm here
today on behalf of the corporation whose name is

IMS Health. IMS Health is in the business of
collecting, packaging, and selling health care
data. They're an e-business. They're not a
pharmaceutical company. They don't make or sell
drugs. They have the health care industry,
including large pharmaceutical companies, as their
customers for data.
It is, incidentally, exactly the kind of
business, as I understand, the general public
policy discussion that we're trying to encourage in
not only Vermont but the economy generally. That's
just an aside and not well within this bill.
I did want to remind the committee that this
section of the bill, Section 13, on -- is a
brand-new section. In my -- in my copy, it's on
page 24.
This is -- and when I was in a committee
discussion earlier this session about the general
subject of the prescription legislation, it was
noted that some of the provisions you've been
considering have passed the senate at least twice,
maybe three times. I'm not sure. But this is not
one of those, and so I hope that you will bear that
in mind as you consider the possible ramifications
of Section 13.
there's any evidence in the record that's been
developed so far in this building that prescriber
identified data and the way it's used increases
pharmaceutical costs.
Assistant Attorney General Brill referred to
expert testimony in the New Hampshire litigation,
and I should tell the committee -- I think you've
heard -- a similar bill passed in New Hampshire
last year. It's being litigated in Federal court.
Some of the issues are similar to what you heard
about in the D.C. case. It's commerce clause. And
I don't know how that's going to come out, and I'm
not asking you to make a decision based on that.
But it is being litigated over there.
Assistant Attorney General Brill said that
one of the experts in that case said that the use
of prescriber identified data did, in fact,
increase pharmaceutical costs, and that's not what
that expert said. He said pharmaceutical marketing
is very effective, and that was his testimony.
These guys really know how to sell, and one of the
tools they use is prescriber identified data.
And I think it's a subtle distinction, but
there wasn't direct testimony that if you take
prescriber identified data away from pharmaceutical
companies, they'll sell -- they won't be able to
sell as many expensive drugs.
The -- the thrust of our testimony is, with
those introductions, this data exists only because
there's a commercial reason to produce it. It's
very expensive to produce, and I'll describe in a
minute how that happens. But all the exemptions in
this bill for research and government projects and
so on, it's meaningless words on paper because the
data will exist. The government has proven time
again that it won't invest the kind of money it
takes to create this kind of database.
And in support of that, I would ask you to not
take my word for it because, as I said, my client's
got a vested interest in this, a monetary interest.
We sell this stuff, and you are proposing to ban
it. So of course, we're not happy.
But if you'll look at the second document --
the first document in your package is simply a
letter from the general counsel of my client
summarizing what I'm going to say today.
The second piece is an e-mail to
Senator Cummings from a physician named Elliott
Fisher who works over at Dartmouth in the Center
for the Evaluative Clinical Sciences. And he urges
cautions based on the need for this data in his
research, which I think some of you are familiar
with. His outfit does the variation research that
allows us to study different practices among
physicians regionally and try to figure out what's
best. So he's urging caution in restricting the
creation and use of this data. He said he would
prefer -- this is the third-to-the-last paragraph:
Although my preference would be for strong
Federal investment in a national private public
claims of prescribing database -- and I have argued
for it -- this is unlikely in the current funding
environment.
So the implication of Dr. Fisher's e-mail is:
I need this data to continue my work and please go
cautiously in legislation that might ban it.
The second document I'd ask you to look at has
got a header on it, right after that, "Northern
Economic Consulting, Inc." That's a company owned
in part, by Arthur Woolf, who is an economist in
Vermont.
I hired Art to analyze this legislation and to
provide this letter. So you should take that into
account. But I think his reputation in this state
is such that he's not going to say what I want him
to say. And I didn't edit this. This is what he
provided to me, and it's his analysis.
In the beginning of his second paragraph, he
says: If it passed, this section of the bill would
effectively end the ability of economists,
government officials, public policy analysts, and
other researchers to evaluate physicians'
prescription drug prescribing patterns. I have
recently been reading through some economic
journals, articles that have used the IMS data --
and by the way, Dr. Fisher refers to these too.
There's simply no way that these studies could have
been undertaken without the data. If the studies
were not done, we would know less than we do now
about characteristics of physicians and their
practices.
So I hope that you will take into account
those two at least relatively impartial sources.
They don't make their living selling this data.
One of them I hired to give me an analysis. The
other was -- spoke on his own volition because of
his concern about his work at Dartmouth, and I hope
you take that into account.
The fourth document I'm going to just point
out to you. You were given this yesterday by
Laurie [sic] Corcoran who was one of your witnesses. It does point out -- this is a description of the AMA opt-out program.

It does point out that they did a Gallup survey of physicians, and I won't read it to you. But the net of that was about 84 percent of physicians said that the opt-out option satisfied their concerns about their prescriber data being available to -- to pharmaceutical marketers.

Lastly, Mr. Chairman, I just would like to appeal to your common sense here. It has long been the practice of pharmaceutical companies to try to figure out physician prescriber patterns and to base their marketing on that.

And before this kind of data was available, it was done through legwork. The marketers, the salespeople got out and talked to pharmacists and talked to pharmacists and talked to pharmaceutical companies and figured out -- talked to senior citizens groups, and figure out who was prescribing what.

The availability of this data has made that work much more efficient; and therefore, marketing forces are shrinking. Pharmaceutical companies don't need as many marketers on the street because of the data that my client can provide them. And it has some very useful purposes, as you learned yesterday from that (inaudible) and safety letter about Federal safety programs. But it also -- I think actually, if you pass this bill, you will be increasing the cost of marketing. So that's my last point, and I'd be glad to take your questions.

SENATOR WHITE: I have two that -- to your last point here that they've been able to -- to reduce the marketing forces because -- did that actually -- did that result in a reduction in the prices when they were able to do that because you're saying that if we pass this, so that they have to use that legwork again, it'll increase the prices? But when they were able to reduce the sales force or the marketing force, did it actually result in a reduction of prices because, if it didn't, then there's no reason to assume that it'll increase it if they have to put them back.

And the second question is: I think you're saying that -- and none of these people address the commercial use of this property.

MR. KIMBELL: None of those people -- SENATOR WHITE: It was all in their packet. What they talked about was the need to have the information for research capabilities, and they -- they didn't address the commercial use aspect of it. But what you're saying is that --

(inaudible.)

SENATOR WHITE: If there isn't a commercial use that -- if you can't sell it for a commercial use, there's not going to be the information?

MR. KIMBELL: Both Art Woolf and Dr. Fisher do make that point in their -- and I'm not -- I know you haven't had a chance to look at this, Senator, until just now. But that point about their apprehension, at least, that the data won't at least -- and I think Art Woolf states that categorically that it won't exist.

SENATOR WHITE: But they don't -- they don't address the issue of the commercial use of it as it relates to --

MR. KIMBELL: Whether it's good or bad.

SENATOR WHITE: Right.

MR. KIMBELL: No. You're absolutely right. That's where I'm appealing to your common sense.

If I'm a pharmaceutical executive and I need to market, I need resources to do it. Maybe you'd rather that I didn't, but I do think that at some level they've got a right to do that. And how do they do it? I know, from talking to these folks, they used to get this same prescriber data by just legwork, and now they get it much easier, and they don't need as many marketers.

SENATOR WHITE: And did it reduce the cost?

MR. KIMBELL: Well, that was your first question.

SENATOR WHITE: Right.

MR. KIMBELL: And I think you heard -- and it was a good little snippet but not nearly enough -- from Laurie Corcoran yesterday. The pricing of pharmaceuticals is much more complex than being able to say: All right. This cost was reduced, so we'll reduce prices.

SENATOR WHITE: Right.

MR. KIMBELL: There are a hundred pharmaceutical companies, at least. They sell to three wholesalers, as Miss Corcoran told you yesterday. And the wholesalers sell probably to either PBMs or direct to chain pharmacies. And that pricing depends on neighborhood and the competitive environment, what new drugs are coming on, when patents -- how long patents --

SENATOR WHITE: Right.

MR. KIMBELL: So I don't think I can tell you,
Senator, that there's a direct line between a reduction in marketing force and the cost of drugs.

SENATOR WHITE: But you're -- your supposition is that it will increase the cost. So if it doesn't work this way, why --

MR. KIMBELL: I'm glad you're pursuing this because what my testimony is is you will increase the cost of marketing --

SENATOR WHITE: Right.

MR. KIMBELL: -- with this bill. Now, do those costs get passed on? As I just said, I think that pricing mechanism -- I won't go back to cars.

SENATOR WHITE: Right.

MR. KIMBELL: You know, what you get a car for --

SENATOR WHITE: Right.

MR. KIMBELL: -- isn't always a factor of the costs that went into it.

SENATOR WHITE: Right.

MR. KIMBELL: So I think -- I don't think there's a direct connection. What I do think is clear, common sense should tell you, this section of the bill will increase the cost of pharmaceutical marketing because they're going to market.

SENATOR WHITE: Common sense doesn't tell me that at all because it didn't work the other way when you reduced it. So I'm not convinced about that. And I do have some concerns about that.

MR. HOLLAR: It did reduce -- it did reduce the cost of marketing. That's my testimony, the cost of marketing.

SENATOR WHITE: No. It didn't reduce the cost of the drugs. I'm not concerned about the cost of their marketing.

MR. KIMBELL: Well, that's what --

SENATOR WHITE: I'm concerned about the cost of the drugs. How they -- how they determine how much they're going to put into marketing and how much they're going to put into profits is their decision. So --

MR. KIMBELL: And that's not what this bill is about obviously. I just think this mechanism, as an attempt by the government to do something positive, is actually counterproductive, if I understand your goal. And I realize -- that's why I appeal to common sense because people differ about what good sense is.

I did want to just make one other point. I believe Attorney General Brill testified that the AMA opt-out program was really I think the other committee used the term red herring because the data could be obtained otherwise. That's just not true.

The AMA has contracts with companies, like my clients, that they are the exclusive database that they'll use. And even when those contracts expire -- they're usually two years long -- the conversion to using some other ID for physicians would just be hugely expensive. And the other sources, mostly the state registry lists and the Drug Enforcement Administration lists, are not as complete and they're duplicative. You could have the same number for a doc in New York as you could have in Vermont. So the notion that the AMA opt-out isn't an effective remedy, if physicians don't want to be contacted, is -- is not true.

And the last point is there's no physician in the world who has to see a pharmaceutical marketer. The remedy for obnoxious marketers is don't see them again, and that's in the hands of the physicians.

FEMALE ATTENDEE 1: I just -- I'm just going to read this to you from this conference that's being put out on: The absence of prescriber level data should not be thought of as a bad thing. Pharmaceutical companies can put the spin to work and turn this into an opportunity to develop smarter sales representatives.

I mean it seems to me that the pharmaceutical companies are already -- I mean I know that this doesn't help your client, but the pharmaceutical companies are already trying to figure out how to put the spin on this and -- and use other -- other data sources. Do I misunderstand this?

MR. KIMBELL: Well, I haven't seen that document.

FEMALE ATTENDEE 1: It's a conference that's being held.

MR. KIMBELL: But it sounds like you're arguing on my side of the issue, that you could pass this law -- I mean I don't -- but there are a lot of ways to gather data. I mean you're almost --

FEMALE ATTENDEE 1: Right.

MR. KIMBELL: I mean you're almost putting the finger in the dyke. Data -- the word transparency is probably better in the long run, more information. And by the way, this bill references patient identifying information. It's got nothing
to do with that. HIPAA prohibits that. I don't
know why it's even in the bill. But we are talking
about prescriber data, not patient data.

FEMALE ATTENDEE 3: So the commercial use,
that's what you are already testifying your company
is selling this data?

MR. KIMBELL: Right.

FEMALE ATTENDEE 3: And so if we don't -- if
we pass this, they can't sell the data
commercially. So you want us to say they can sell
it for research or they can sell it for just
certain things?

MR. KIMBELL: No.

FEMALE ATTENDEE 3: They can't sell it just
for, you know, commercial bottom line to increase
the sales of drug companies?

MR. KIMBELL: No. The bill says you can sell
it for research. My testimony is, unless there's a
commercial purpose, the data won't exist because
it's very expensive to produce. So all those
exemptions in the bill are just empty words.
You're putting all of those out of business, as
well as the use for marketing.

FEMALE ATTENDEE 4: I guess some of the
frustration is that, you know, we're seeing data
mining and the data from the health care system
being sold and a profit being made on it, and at
the same time we're not seeing a decrease in the TV
ads and the magazine ads and everything else that's
going on directly to the consumer. So that's kind
of -- there's that tension there with you, know,
information is going from the prescriber to the
company and then back to benefit the company again.

And -- but we're having -- and you say there
have been some cost savings perhaps in that. But
we haven't seen any translation to a need to
decrease the advertising directly to the consumer.

So I think that --

(Inaudible.)

MR. KIMBELL: Pharmaceutical companies are in
business to make money. I mean there's no question
about it.

FEMALE ATTENDEE 4: Yeah, absolutely. They
are in business to make money. And if we don't
have them, we don't have -- we don't have
effective -- clinically effective drugs.

MR. KIMBELL: And I just don't understand
why -- I mean I don't have a commercial television
for the simple reason I got sick of the ads, not
just pharmaceutical ads, but all sectors of the

economy. So I don't know if this is a broad-based
attack on advertising, which I would sympathize
with wholeheartedly.

(Inaudible.)

MR. KIMBELL: They're the best? Okay.

Well --

(Inaudible.)

CHAIRMAN RACINE: Any other questions?

Steve, do you have anything else that you want
to --

MR. KIMBELL: No. Thank you for your
patience. I'm sorry that I was late. I appreciate
the time.

CHAIRMAN RACINE: Thank you.

Now we've got Sharon Street. We're going to
try. She's going to talk about the bill, right?

We've heard her before.

(Inaudible.)

CHAIRMAN RACINE: Senators of the committee,
while Jan is trying to get Sharon Street on the
phone, we have testimony that's arriving by
(inaudible) from --

FEMALE ATTENDEE 4: So I have a question,
Mr. Chair.

CHAIRMAN RACINE: Of just Robin.

FEMALE ATTENDEE 4: The law reads that you can
(inaudible) IMS. I couldn't get this information
about all the docs in Vermont prescribing drugs
from the pharmacies in Vermont?

MS. LUNGE: You want to set up a competing --
FEMALE ATTENDEE 4: Yes. I want to set up a
competing conference with the docs --

(Inaudible.)

MS. LUNGE: You would get the AMA list and
then revise that --

(Inaudible.)

FEMALE ATTENDEE 4: -- to the pharmacies that
I really care about the drug industry and research
and stuff and I'm trying to get a handle on who is
prescribing what here or something. I'm a grad
student or I'm a --

(Inaudible.)

FEMALE ATTENDEE 4: So I could just go to the
pharmacy and get that information? Is there any
law prohibiting that?

MS. LUNGE: The pharmacy would have to remove
some of the information because of HIPAA. So
they -- there's only certain parts of all the data

9 (Pages 30 to 33)
the pharmacy (inaudible). And then I think the
process that was prescribed is that, in terms of
prescriber data, you get the AMA list which has the
doctor's number, and you get the pharmacy data --
(inaudible.)
MS. LUNGE: And whoever you buy that from,
then you would match them --
(inaudible.)
MS. LUNGE: -- and identify who is the
prescriber. That's sort of how --
(inaudible.)
CHAIRMAN RACINE: Was there anybody else in
the room? We don't have any more on the list.
Yes, sir.
MR. FRIEDELL: Yes, sir. I stood around from
yesterday. There was an amendment to the PBM
section that we discussed, and we worked on it last
night, and I'll be happy to go through them now.
CHAIRMAN RACINE: Okay. Please reidentify
yourself.
MR. FRIEDELL: My name is Andy Friedell. I am
a director of government affairs for Medco. We're
a pharmacy benefit manager. Terry Latanich spoke
on our behalf yesterday. I'll pass these around.
CHAIRMAN RACINE: You did not speak yesterday?

MR. FRIEDELL: I did not speak yesterday.
CHAIRMAN RACINE: Okay. Your name is Andy
what?
MR. FRIEDELL: Friedell is the last name.
CHAIRMAN RACINE: Spell that, please.
MR. FRIEDELL: F-R-I-E-D-E-L-L.
(inaudible.)
MR. FRIEDELL: I'd better keep a copy.
(inaudible.)
CHAIRMAN RACINE: Okay.
MR. FRIEDELL: There are three amendments
here. There are three amendments here that we
discussed yesterday. Two of them we spoke about
specifically. One we spoke generally about.
First, before I get into these three
amendments, I would like to say that our preference
for the committee to consider would be that you
strike the PBM section of this bill for reasons
that you have heard from other testimony. This
information is available. It's not necessary right
now. We have an intensively competitive
marketplace.
Our customers -- you just heard who this bill
was presumably intended to -- to assist are not
asking for this legislation specifically. So our

concern is that if this is a bill designed to help
lower prescription drug costs -- and there is no
evidence that this provision of the bill is going
to help lower prescription drug costs -- we would
ask you to consider striking this provision in its
entirety.
In addition to that, if that's something the
committee is not willing to do, we would like you
to consider these other amendments. But we really
feel that's worthy of strong consideration by the
committee given that there is no evidence that this
is going to lower costs.
You may hear testimony from Sharon Shreet that
a bill was passed in South Dakota that allegedly
lowered costs in that state by $800,000. What you
should also know about that piece of information is
that coincides with the state also renegotiating
their contract with their PBM.
People renegotiate their contracts with their
PBM when they want to lower costs. In fact, there
was testimony given to the Senate Finance Committee
that the State of Vermont actually renegotiated
their contract with Express Scripts and recently
lowered their costs by over 10 percent, 2.8 million
on the total drug spend of 21 million.

So you renegotiate your contract with your PBM
to lowers costs. You put it out to bid. You try
to get a better deal. That's what happened in
South Dakota. So that was not in relation to
the -- to the -- to the legislation. It was in
relation to a new contract that -- so I would ask
you to consider that when you hear that piece of
evidence or if that's presented.
Specifically there are three amendments we're
asking you to consider here. I will pick first
from Section 9421, Pharmacy Benefit and Management
Registration and Audit. This was the issue Terry
Latanich spoke about yesterday. Our concern here
is that this administrative pass-through only
option is a requirement, and we want to make sure
that -- that this -- is not a requirement on
all PBMs that it's as intended. And you spoke --
yes?
CHAIRMAN RACINE: Which one are you looking
at?
MR. FRIEDELL: It's this one here. It says
9421 Pharmacy Benefit and Management Registration.
CHAIRMAN RACINE: Thank you.
SENATOR WHITE: It's on our page 19 as well.
CHAIRMAN RACINE: Thank you.
MR. FRIEDELL: From our discussion yesterday, I understand the committee's intent here is that the option is available and that it's not that every PBM has to offer. Our concern with the way it was worded is that you have -- because you say, when you offer a bid on a contract, you also have to offer this administrative services arrangement, and that's not necessarily how everyone is going to want to contract.

And so we would like to have language inserted here that would reserve the right for some pharmacy benefit management to not contract on those terms and to -- just to simply make the client aware that, if that's the way they want to do business, then this particular PBM may not want to offer that but that it's available in the marketplace for them.

SENATOR WHITE: Isn't that what it says?

MR. FRIEDELL: It says -- it says that -- our menu is in there.

SENATOR WHITE: No. I mean it says: Shall notify that a quotation for an ASO is available.

That's what it says.

MR. FRIEDELL: When the -- when the pharmacy -- if you look at the strike section of the proposal, it's saying when the pharmacy benefit management provides a quotation for any --

SENATOR WHITE: Right.

MR. FRIEDELL: So our concern is that they're saying it's available from us, and that's --

SENATOR WHITE: Was that the intent?

MS. LUNGE: Yes.

SENATOR WHITE: To say that it's available from them so that what we're -- what we would be doing is requiring all PBMs to offer an administration only, service only contract and you don't necessarily do that?

MR. FRIEDELL: We may not do that. I mean that's -- that's -- we don't want to be restricted in the way that this legislation requires you to offer that. I mean there are PBMs that will do that, and there are PBMs that will compete on that, and that will be something that's available in the marketplace.

SENATOR WHITE: I read that differently, and I guess I read it --

MR. FRIEDELL: And that was our discussion yesterday during the hearing.

SENATOR WHITE: -- the way it wasn't intended.

MR. FRIEDELL: I thought -- from our conversation here yesterday, I thought you agreed, or the committee agreed, that your read of it was correct and that we needed -- we said we'd provide you this language to just ensure that your read was correct. That's the first amendment. And I do want to take questions or PBM issues in general.

The second one I'll bring up is the prescribing piece. This is 2466A, Consumer Protection of Prescription Drugs. This, again, I think was something that was simply a misunderstanding and was not the intent of the bill. But our concern is that the language around marketing and messaging has some language in there that specifically prohibits software that is used.

It says: Electronic software that advertises, uses instant messaging or pop-up messaging, or uses other means to influence, or attempt to influence, the prescribing decision of a health care professional through economic incentives or otherwise.

That's a very broad piece of language there, and we want to make sure that you're not referring strictly to the formula because that formula discussion that the patient and the doctor can have is specifically designed to influence the decision that -- the prescribing decision of the physician.

If there's a lower-cost alternative out there, well, we think the physician and the doctor should have that information to know there is a lower-cost alternative. And we're -- we're fearful -- and I think we said yesterday that that was not the intent of this bill. But we are fearful that the way the language was crafted is too broad and that you need this additional -- this additional exemption at the end which says that it's not in relation to formulary compliance programs.

FEMALE ATTENDEE 3: What page is that on?

MS. LUNGE: 35.

MR. FRIEDELL: The third amendment that we offered is in relation to page 20. This is the registration audit piece, and I think this is one we heard about in the past from testimony from MVP Health that there are additional costs that this bill could add to the pharmacy benefit management provision.

And in here you'll see under C.1, there's a section that says: In order to enable periodic verification of pricing arrangements, ba, ba, ba, we have to verify the following. And there's A, B, and C. There's an incredibly broad piece of
It says: Any other verifications relating to 
pricing activities of the pharmacy benefit manager 
are required by the commissioner.
If this is broadly intended on all business, 
and not simply the administrative services option, 
that's a -- that's a very broad change to the 
statute, and that would have pricing implications 
on business in this state. So we have presented 
amendment language here that limits that C.1 to the 
administrative services -- administrative services 
only contract that's being discussed in that 
particular section.

CHAIRMAN RACINE: Is this your copy offering 
administrative services only contract?
MR. FRIEDELL: I believe we do. We have cut 
arrangements where we'll -- where we'll just offer 
on a -- we'll price on administrative services, you 
know. Basically what happens is we get a request 
for a proposal from a customer. We evaluate the 
terms. The customer will say: We want an 
administrative services contract from you.
We will evaluate that, and we will decide 
whether we want to compete on that business. So 
it's not as though we say we're a company that 

offers administrative services contracts and we go 
knocking on doors with that offering. We wait oon 
requests for proposals that come to us. We look at 
all the terms of it.
And it's difficult to say -- you know, 
characterize one RFP, this is an administrative 
services RFP, this is not one. But you know, 
because they tend to be -- RFP can tend to be 
several hundred pages. We go through, and our 
folks in our proposals department will go through, 
and evaluate the terms of that, and then we decide 
if we're going to bid on that business and what the 
terms of our bid will be.
But we have a variety of different terms on 
contracting. In fact, contracting across our 
industry is very versed. Every customer has 
different contracts, and that's what our concerns 
generally with legislation of this sort is, that it 
can pigeonhole customers into certain arrangements.

MALE ATTENDEE 1: Where do you work?
MR. FRIEDELL: Excuse me?

MALE ATTENDEE 1: Where do you work?
Physically where do you work?

MR. FRIEDELL: Today I'm in Vermont. But I --
I have responsibility for the northeast. Medco is 

headquartered in New Jersey. My office is in 
Province. I drove up from Province yesterday.

CHAIRMAN RACINE: Okay.
FEMALE ATTENDEE 2: And you've got to go back 
before midnight.
MR. FRIEDELL: Well, I hear snow is coming.
CHAIRMAN RACINE: It's not going to come until 
midnight?
SENATOR WHITE: Yeah.
CHAIRMAN RACINE: Okay. Thank you.
MR. FRIEDELL: Great. Oh, the other piece I 
would suggest though, our primary interest in 
striking section -- the other piece we would like 
you to consider striking as well is the enforcement 
provision because that was also mentioned yesterday 
was the dual enforcement division between the AG's 
office and the -- BISHCA.

SENATOR WHITE: And then it would just reside 
with BISHCA?
MR. FRIEDELL: Right.
FEMALE ATTENDEE 3: Let me just ask one 
question. The administrative service contract only 
is -- means what?

MR. FRIEDELL: So basically, when you have a 
PBM contract, you have a variety of ways of doing 
it. But we can now -- you know, we can have an 
arrangement where we will -- you know, where we 
will -- so we negotiate on behalf of our customers. 
We have sixty million lives. We negotiate with 
drug manufacturers. We negotiate with pharmacies. 
We will negotiate rebates with drug manufacturers, 
and -- and that's for our full book of business and 
same with pharmacies, for our full book of 

business.
Some customers will say: We simply want you 
to administer our drug benefit and we're going to 
pay you on a per claim basis, say a dollar a claim, 
and that's -- that's all we want you to do.

That's typically what happens on Medicaid 
contracts. People that get into the Medicaid 
business will -- will just be paid, you know, a 
certain set amount for every drug claim, and then 
that's that little adjudication issue you were 
talking about before. So when a person goes into a 
pharmacy, they swipe that card. You're using our 
system. We're -- you know, we're paying the 
pharmacy, billing you back, and we're just getting 
paid a set fee for that service.

FEMALE ATTENDEE 3: And you are not 
negotiating prices for that drug with the
MR. FRIEDELL: Yes. We can have a -- we can have a component of it that -- you can offer that as well where you can have a discount.

FEMALE ATTENDEE: How about a services only contract?

MR. FRIEDELL: You can have that. I mean that's why it's difficult to comment -- to sort of characterize a contract like this with this kind of, you know, phrase like, as if there's Contract A and Contract B because it really doesn't exist that way in the marketplace today.

A customer can say: We want you to give us a retail network discount. And then we'll negotiate here, but we can offer you AWP minus on brands and AWP minus on generics.

And then they'll look at our competitors and see what they're offering.

And then we can say: You know, we have a mail service option, which your members may be interested in, where we can offer you deeper discounts, if they want to use mail. We can offer you rebates, which we can pass through to you directly, or we can keep the rebates ourselves, in which case we're at risk for the rebates and for which you get a deeper discount on those -- on those network prices.

So those are -- you know, those are all the various questions that go in.

Typically the administrative services contract -- basically it's just a fee on each claim, and there aren't the rebates involved, information of that sort. There aren't a lot of other services provided for the client.

FEMALE ATTENDEE: So I can see (inaudible) population you're --

MR. FRIEDELL: Yeah.

FEMALE ATTENDEE: -- dealing with a lot --

MR. FRIEDELL: Well, but also it's how it works for the client because we respond to the client's bid. If you look in that testimony that was given to finance from the State of Vermont, you changed your formulary; and that was what really generated that $2.1 million savings. You changed -- I think you restructured the tiers so there was better incentives to use generics over certain brands, and that's where you got that savings from. So the customer made that decision.

You know, you, the State of Vermont, was probably working with a consultant, and the consultant probably said to the state: You know, if you change your tiers of your formulary, it could generate savings.

So they talked to their PBM about that, or perhaps they were dealing with the PBM directly on that discussion. But if they were going to put it out to bid, they would talk with a consultant about that. And then, you know, they would set out the terms: We want to formulate the structure in this way so we can try and save more money.

And then we, and all our competitors, will choose if we're going to bid on that piece of business.

FEMALE ATTENDEE: So if we can all negotiate with PBMs rather than insurance companies, wouldn't that be better?

MR. FRIEDELL: Some do that. Some carve out and some -- some don't. It's -- and that's the competitive nature of our industry. I mean sometimes we deal directly with, you know, a lot carve-out business. Large employers will carve out. Other times large employers will use, or smaller employers will use, health plans, and the PBM will be part of it.

For instance, United Healthcare is one of our clients. So people who use United Healthcare will have -- make most cases for their pharmacy benefit. But then other times, if it's Aetna or Cigna, they have their own pharmacy benefit. And then -- and then if you use Aetna or Cigna, you would use their pharmacy benefit manager.

CHAIRMAN RACINE: Thank you.

MR. FRIEDELL: Great.

CHAIRMAN RACINE: Susan, you had something?

MS. GRETkowski: Yeah.

CHAIRMAN RACINE: Quickly, please.

MS. GRETkowski: Quickly, I promise.

Hello everyone, Susan Gretkowski of Maclean, Meehan & Rice on behalf of PhRMA who also testified yesterday.

I would just like to talk briefly to one very specific point in this bill that was discussed yesterday by PhRMA, and that was the unconscionable pricing. I think there was a question of what were the differences that the drafters, Robin, has put into the Vermont bill versus how is the D.C. statute structured and will that make a difference on a ruling of whether the Vermont law would be held to be constitutional or not.

I can run through very quickly some of the
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1 differences between the two laws and then, you
2 know, basically say why did they -- it will not
3 make a difference in terms of the determination of
4 constitutionality.
5
6 One of the differences: The D.C. law pegged
7 the determination of an excessive price to 30
8 percent above what was charged in a high-income
9 country. The Vermont bill talks about 30 percent
10 over the lowest price that could be obtained in
11 state, basically the Federal supply schedule, a
12 Medicaid pricing, something like that. So that's
13 one difference.
14
15 The D.C. law only covered patented drugs in
16 what would be subject to this determination of
17 unconscionable price. The Vermont law covers all
18 drugs, patented drugs, non-patented drugs. Robin
19 said yesterday there was -- she used a different
20 definition of most favorite price. She used one
21 from the Wisconsin statute.
22
23 But probably the most significant difference
24 between the two are, the way the D.C. law works, is
25 it says that: Any drug would be determined to be
26 considered unconscionably priced if it is
27 30 percent or more over the price charged by four
28 defined high-income countries.

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1 What Robin and folks -- and Julie and folks
2 have done here in the Vermont proposal is to say
3 not every drug just determined that way, but the health department will
4 determine whether there is a serious health problem
5 and what goes into those determinations, and then,
6 if there's a condition that's said to be a serious
7 health problem, drugs to treat that condition would
8 then be subject to that 30 percent or more above
9 the Federal supply schedule and all of that. So it
10 appears that that is what --
11
12 MALE ATTENDEE 1: (Inaudible) in light of the
court decision?
13
14 MS. GRETKOWSKI: Yes, which I'm going to get
15 to right now. So basically those changes would not
16 make a difference on a ruling on the
17 constitutionality of the Vermont statute.
18
19 First, it is still a transaction that occurs
20 outside the state. You've still got an
21 out-of-state manufacturer and an out-of-state
22 wholesaler. There is one exception to that, which
23 is Burlington Drug. They are an in-state
24 wholesaler. So for that tiny piece of the
25 business, which is about 20 percent of the drugs
26 coming into Vermont, that you could touch by what

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1 you -- if you pass this section of the bill.
2 However, the 80 percent of the drugs that come into
3 Vermont through out-of-state wholesalers you would
4 not be able to touch. So it's still a problem with
5 the interstate commerce clause.
6
7 However, there is very specific language in
8 the D.C. decision that addresses this police power,
9 compelling state interest, protection of the
10 general health and welfare of folks. And if I
11 could, this is very short. I'd just like to read
12 it. I'm sorry. I have a sucker in my mouth. I've
13 got a cough.
14
15 FEMALE ATTENDEE 1: There's a lot of suckers
16 around here.
17
18 MS. GRETKOWSKI: And this is at the very end
19 of the section on the interstate commerce clause
20 from the D.C. District Court.
21
22 It says: Finally, the District's reliance on
23 its general police powers to regulate matters of
24 legitimate local concern is to no avail in this
25 situation. While the District clearly retains such
26 police powers, creating a public health exception
to the commerce clause, such as the one advanced
here, would, quote, eat up the rule under the guise of
an exception.

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1 It says: The view that an ordinance is valid
2 simply because it professes to be a health measure
3 would mean that the commerce clause of itself
4 imposes no limitations on state action other than
5 those laid down by the due process clause.
6
7 It says: Simply stated, the District's
8 reliance on its police powers, meaning its
9 protection of health and welfare of its citizens,
10 alone cannot overcome the otherwise
11 unconstitutional reach of the law.
12
13 So I would just say to you that again, you
14 know, there were attempts to change this to pass
15 constitutional muster; however, this is very clear
16 language. A lot of the times constitutional law
17 cases are not always that clear on their face to
18 understand what they're actually saying. This is
19 very clear language. So even taking that
20 compelling state interest attempt doesn't appear
that's going to pass constitutional muster.
21 So that's it.
22
23 Now, I know -- I know, Mr. Chair, you said
24 earlier that, as you're going to be working through
25 this bill, you are going to be talking through the
sections where there are issues, and you said there
may be an opportunity for more testimony or
perhaps, if you would like, you know, a legal --
not a real big legal brief but more of a paper, you
know, on something like this.
CHAIRMAN RACINE: Well, you know, you can
leave us what you have. I will warn you that I
don't think of us as a court charged with making
judgments on constitutionality. I understand we
don't want to do something that on its face is
unconstitutional.
MS. GRETKOWSKI: Right. And I --
CHAIRMAN RACINE: But I will listen to other
lawyers who might argue the constitutionality. If
that's what -- if that's what we're going to hear,
then that wouldn't be compelling to me. I'd wait
for the courts to decide that. But I will defer to
other --
(Inaudible.)
CHAIRMAN RACINE: I don't know that I -- I
have not tried.
MS. LUNGE: Yeah, I called.
CHAIRMAN RACINE: Okay.
SENATOR WHITE: Yesterday when --
FEMALE ATTENDEE 2: Julie Corcoran --
SENATOR WHITE: Yeah, testified, did I
misunderstand her or -- because what we're trying
to get here is -- at here I believe is price --
unconscionable pricing when -- when something
happens and then we have price gouging. And we
passed the -- last year the fuel bill. Did I
understand her to say that we could get at this
same -- the result by addressing it under that,
making that a general price gouging law, expanding?
MALE ATTENDEE 2: I think that not in the last
session, but the session before, when John Bloomer
[phonetic] was here, we had some type of emergency
price gouging measure that we passed.
SENATOR WHITE: Yeah. But it was limited
to --
MALE ATTENDEE 2: (Inaudible.) I don't know
if it passed all the way through, but it seemed
like --
SENATOR WHITE: But it was limited to one --
MALE ATTENDEE 2: I don't think so. I think
it was in case of emergency. That's why I --
SENATOR WHITE: It was a general thing?
MALE ATTENDEE 2: I think so.
SENATOR WHITE: I don't remember that one. I
do remember the --
MS. GRETKOWSKI: And that's what she was
talking about, you know, what she was referring to
in Maine, is it covered, fuel, oil, gas,
pharmaceutical drugs --
SENATOR WHITE: Right.
MS. GRETKOWSKI: You know, everything. And
basically the governor could, you know, in a really
severe state of emergency, you know, not a
blizzard, but a really severe state of emergency,
the governor would declare that; and then there
would be a freeze of pricing for thirty to sixty
days and a maximum of sixty days. That's what she
referred to in Maine. Apparently several states
have passed those in light of the Katrina
situation.
So that if -- you know, if that's what your
focus of this is trying to be, if there truly is a
disaster or an emergency of like epic proportions,
if you wanted to protect the price of
pharmaceuticals going up, you know, the avian flu,
that type of thing, the law, like she referred to
in Maine, should do that.
SENATOR WHITE: So it wouldn't have to
necessarily be a Katrina level of --
(Inaudible.)
SENATOR WHITE: Yeah.
MS. GRETKOWSKI: Apparently, from the ones
they tell me, the ones that have passed, they are
very severe. They're not just a blizzard, an ice
storm. It's really severe.
SENATOR WHITE: But since we're talking --
okay. I mean if we had an outbreak of -- I don't
know -- what --
CHAIRMAN RACINE: Bird flu.
SENATOR WHITE: Bird flu or whatever, that
would -- that probably would be. Okay.
Let's get a copy of -- it was public law
Chapter 5.
MS. GRETKOWSKI: I have that. I can e-mail it
to you.
SENATOR WHITE: Okay.
CHAIRMAN RACINE: That would be helpful.
SENATOR WHITE: I would like to see that.
MS. GRETKOWSKI: Okay.
CHAIRMAN RACINE: Okay.
MS. GRETKOWSKI: Thanks for your time.
CHAIRMAN RACINE: All right, folks. Thank
you.
SENATOR WHITE: Thank you.
(Ataudible.)
CHAIRMAN RACINE: Who?
CHAIRMAN RACINE: No, no, not right now, not right now.

So I'm not sure we are going to be here tomorrow afternoon, given the weather. I think some people are planning to head home tonight.

SENATOR WHITE: What is happening? I haven't heard.

CHAIRMAN RACINE: It's supposed to start snowing at midnight. It's supposed to -- depending on which forecast, several inches of snow by sometime in the morning, sleet mid-day, and then snow again. One forecast says up to a foot. Another one says twelve to fifteen, more north than south. But it sounds like it's going to be a very ugly day tomorrow.

MALE ATTENDEE 2: So Burlington will be hit but Rutland won't?

(Inaudible.)

CHAIRMAN RACINE: See, what we have to be more concerned about --

(Inaudible.)

CHAIRMAN RACINE: What we ought to be more concerned about, Senators, it isn't snow. It's Stowe and Killington.

(Inaudible.)

CHAIRMAN RACINE: That would be I think the concern.

(Inaudible.)

CHAIRMAN RACINE: But anyway, I'm going to leave tomorrow open. There are a few things kicking around. We can discuss this bill as a committee. There's still the HIV bill out there. There are other things. One thing I'm -- and we'll -- we'll have to come back to this.

(Inaudible.)

CHAIRMAN RACINE: I don't know if you guys --

MALE ATTENDEE 3: I heard one comment about an amendment that had been offered earlier, but I don't know how to present that to you.

CHAIRMAN RACINE: Okay. Then we'll be back at this.

MALE ATTENDEE 3: I didn't want to interrupt, if you were -- if there would be an opportunity now.

CHAIRMAN RACINE: Okay. We'll be -- we'll be back at this.

SENATOR WHITE: They said we don't need to do a lot of this because BISHCA takes care of all the regulation --

CHAIRMAN RACINE: Right. I'm not sure what you're saying to me. Do you want to do something now or do you want to wait until --

MALE ATTENDEE 3: It was an amendment offered by Josh Slen that he wanted you to think about. We have a problem with it.

MS. LUNGE: And you haven't -- you haven't gotten that language yet.

SENATOR WHITE: Which we haven't seen.

CHAIRMAN RACINE: We haven't seen it yet. Okay.

MS. LUNGE: So Josh just e-mailed it to me. He said it's referenced in his memo, but I haven't made copies of that for you yet.

CHAIRMAN RACINE: Then we'll wait. Okay. That's interesting. Maybe you two guys can work it out, seeing as you sort of work for the same guy.

MALE ATTENDEE 3: Well, that's right. But I didn't know if you (inaudible) --

CHAIRMAN RACINE: No. We aren't going to take any motion today.

One of the things I will try to do in our break and have when we get back is I'm looking for some testimony or some evidence that the various components of this will do what I hope we can accomplish, which is lower consumer costs. And what I had -- what I see in front of us are a lot of provisions, which I have opposition to them, but I haven't heard clearly in many cases that what's in front of us will lower consumer costs.

I understand that there's a hope that they will reduce costs. And I didn't go through what this committee has been through the last several years. So maybe that testimony is out there, and I can read it or I can hear about it. But I need to hear more on many sections of this before I'd say, yes, I can go -- I can vote for this and say this is going to reduce the cost of pharmaceuticals.

That's going to be important information.

MALE ATTENDEE 2: Were we able to get any information from NCSO from the other states of whether or not it's actually lowered?

CHAIRMAN RACINE: Yeah. And Sharon Shreet can -- obviously can help us. But I'm going to work with Robin, and we'll talk about how we can -- how we can get some of this. I need -- I need to hear more because we -- we set this up -- we set this out there. We heard from Robin. We heard from Ann. We haven't heard -- we haven't heard from a lot of people who will say: This will do X, Y, Z and will reduce costs in such and such a way.
And I need -- I need to hear that. So just so -- and that's what I'm going to look for so we can discuss that on the week that we get back. We've got one week when we get back before crossover. And there are a few other things that we're going to try to do in that time, but this is the biggy. So...

FEMALE ATTENDEE 1: I -- I know that we -- people have asked before and had that deadline extended. Given the fact that we lost two and a half days by the other snowstorm, and now we're going to lose another day --

CHAIRMAN RACINE: Possibly.
FEMALE ATTENDEE 1: -- I think it's --
CHAIRMAN RACINE: I'm not cancelling tomorrow.
I'm just saying it's possible.
FEMALE ATTENDEE 1: Yeah.
FEMALE ATTENDEE 2: -- work in reverse order because, as long as it's passed the committee of jurisdiction, it's okay. But it's already passed finance, which normally would go the other way.

CHAIRMAN RACINE: That's a mystery to me, and I'll let the pro tem decide. And in terms of the deadline, this is a pro tem priority. So we'll see if we -- if we aren't done, we will see what he thinks of his deadline.

FEMALE ATTENDEE 3: Maybe we can get him to change it. Well, tomorrow could be something that --
CHAIRMAN RACINE: But I would like -- I would like to keep working on this, and we'll have four more days when we get back before the deadline. So you know -- and what I'm trying to do is through all of this testimony I think we're narrowing down those issues that are the most controversial.

FEMALE ATTENDEE 2: There is a section somebody hasn't asked us for.
CHAIRMAN RACINE: There are lots of sections that nobody has asked us to change or implement.

(inaudible.)
CHAIRMAN RACINE: Okay. Thank you all very much, and we'll --
(inaudible.)
CHAIRMAN RACINE: And for those of you around, if you are around tomorrow, you can check in and see what we're talking about.

(End of CD 07-50/Track 1.)
STATE OF VERMONT

SENATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: March 20, 2007

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

CD No: 2007 83
Esquire Job #928014
companies, because that's their job, but there are others who are -- who are not insurance companies, that the Attorney General would be involved with enforcement actions.

The two bigger changes, and were the subject of a lot conversations in our committee, and I think will be the most -- the subject of the most conversation between the two committees, was the so-called confidentiality of prescription information, otherwise known as data mining.

MS. CUMMINGS: Data mining.

SPEAKER 1: Data mining. And we essentially struck that from the bill, after quite a bit of discussions. And the committee was somewhat split at first, and then came to the conclusion that we should, and for a variety of reasons, I think every committee member had a somewhat different reason for doing this.

It -- from my prospective, it was a concern that I did not see how this reduced costs for pharmaceuticals for Vermonters, and when I started looking at this bill, what I said to the committee and to the assembled witnesses was that I was interested in reducing costs for Vermonters. And I was not convinced, and I don't think anyone

General's office and Fishka --

MS. CUMMINGS: Oh, yes.

SPEAKER 1: -- about who would have primary enforcement. And basically what we did -- what we did is we kept sending them out of the room until they agreed, so this one --

MS. CUMMINGS: Oh, good.

SPEAKER 1: So this one maybe I will let them explain it.

MS. CUMMINGS: Actually, I think we sent that out of here somewhat uninformed. One said that the Attorney General had to have the permission of Fishka to enforce, and we didn't think that was acceptable, and we sent them to the hall --

SPEAKER 1: And I think basically --

MS. CUMMINGS: Yes.

SPEAKER 1: I think basically the way we worked it out, anybody in the room who has followed this, if you want to correct me, I do not mind being corrected, because last week became somewhat of a blur, at least for me.

MS. CUMMINGS: This enforcement is ongoing.

SPEAKER 1: Right, the enforcement provision basically was Fishka would retain primary enforcement for any dealings with insurance
was thinking if I was a physician and I was prescribing a whole lot less of pharmaceutical X than my colleagues, that's information that would be worth having. I can process it. I can decide whether I am right or not, but it would challenge -- perhaps challenge me in my own thinking, and I thought that might be of value. I don't know if any physician in the state of Vermont agrees with that or not. That was part of -- part of my thinking. I think the -- I think the bottom line for the whole committee, I think it came to a unanimous recommendation on this one, was that there is the lawsuit underway in New Hampshire. We don't know how it is going to be resolved. If it is resolved in a way that negates what New Hampshire has done, why should Vermont go through the expense of fighting the same battle, if that's going to be the outcome. And if that is what the outcome is, then perhaps there is another way of getting at this or perhaps it should be dropped entirely. But what we did, what we call -- we called it a placeholder, section 13. We asked for a report back, and that's basically so we don't forget it, and we hear what happened in New Hampshire. We hear if it is -- if it is approved by the courts and it goes into effect, that we hear what's happened as a result of it.

So we felt it wasn't -- it wasn't worth jumping right into this, that we wanted more information. We wanted to see what the results of the action in New Hampshire was before we said this is the right thing to do.

Again, going to my earlier concern about saving -- saving money for Vermonters, this could actually -- could actually cost Vermonters money if we are prosecuted. That's not -- if we are taking a case, that's going to cost money by the Attorney General's office in the federal courts.

It wasn't a clear call by the committee. It was debated by the committee. That's the conclusion that we came to. Obviously the day before we were at the other conclusion, so...

The other section was section 17, and this one -- the unconscionable pricing, and this one had an interesting evolution.

What we heard was that this was tried in the District of Columbia, and that it had been ruled unconstitutional. And what we heard is that your committee decided to rewrite this, and with what would appear in an emergency --

Robin Lunge helping you with the language, to try to create a compelling state interest as -- as a way to answer the concerns that the court had when in D.C. they ruled it unconstitutional.

MS. CUMMINGS: We also -- it was an outside phone conference.

SPEAKER 1: So we went through that process, and we looked at this. And the way we read your language was that it was various -- it was very broadly written, that it was about public health concerns, serious public health concerns. But the way we were reading it, and I think people in the room, including Dr. Schwartz from the Health Department, saying you could read this to mean -- include diabetes, high cholesterol, high blood pressure, obesity and a whole lot of other things, and our concern was that that was so broad as to not be able to create that compelling state interest.

So we were actually trying to type it up and what we created here was more of a public health emergency, and what we have got here is more of a price gouging bill, which is different. It is a different policy than what you were trying to get at. It is price gouging along the lines of...
which clause, the commerce clause, and that we are on very thin ice no matter how we wrote it. And then there was some discussion, well, maybe we should just go back to the finance committee language, because it is not going to make any difference. I don't know how to do I don't know how to resolve that one. But again, I don't feel that the state will be benefiting from a court action that's going to cost us money if the outcome is fairly predictable. The flip side of that argument, and I have heard this, and it is, again, it is debatable, it is not what our committee decided, but I can understand why others might think this way, is that we are pushing the envelope, and Vermont over recent years has really been trying to push the art of the possible and see where the openings are with the pharmaceutical industry to get us lower-cost drugs. And that's the goal. And that by continuing to push, even in these instances where we think we might be on shaky ground, certainly sends -- first, we don't know what other court might rule if our language is different, but secondly, it keeps putting the pharmaceutical industry on notice that we are going to continue to be aggressive in the state of Vermont. That wasn't as compelling an argument to me as trying to do something that was effective, and frankly, trying to get this bill through, I think those provisions became the most controversial. But the rest of this bill, more or less, is what's passed the Senate twice in recent years and passed the House in one year, and ended up being part of the bigger bill that was vetoed by the governor. And my goal here is to get something through that will have an impact on prices, and will also get a signature or at least enough votes that we can still pass this bill without a signature. MS. CUMMINGS: Any questions from the committee? SPEAKER 2: So it came down in which language form? SPEAKER 1: We came down in a language trying to -- to create a very compelling state interest that on the unconscionable pricing, yes, that we would pretty much be defined as a healthcare crisis rather than a serious public health problem, because we thought the serious public health problem was so broad, that it didn't create a compelling state interest. What I said after that, I just want to be clear, was after we went through that whole discussion, then we heard very clearly from a lot of people in the room that that's not going to make any difference anyway. And I don't know how to evaluate that. That's for the lawyers. MS. CUMMINGS: We were looking as, I think, part of the whole chronic care initiative, that -- at that kind of a public health crisis. So yes, you have tied it more up to the shortage of flu vaccine when the prices started to spike a couple years ago. SPEAKER 1: That's right. MS. CUMMINGS: There was limited amounts, so the price started to go up, until there was little action taken, but -- that kind of thing. SPEAKER 3: Did you have legal -- I used the term -- in discussions of this bill several weeks ago, I used the term compelling state interest, and was corrected by counsel for the Attorney General that we were talking about the state interest as opposed to compelling, saying that those were different levels of compulsion.
SPEAKER 1: Well, there was a concern that if we are encouraging Vermonters, we are encouraging them to leave their primary-care physician and go to FQHC, and you know, (inaudible), that was a great idea, because our FQHC is in Franklin County and (inaudible) she didn't like the idea of urging people to leave their primary-care physician.

MS. CUMMINGS: FQHC we have got around here, their lookalikes are doubling in size.

SPEAKER 1: So there are issues like that that I could discuss the policy.

MS. CUMMINGS: Okay.

SPEAKER 1: Some of them I think are more technical in nature. We listen to a lot of witnesses. We change language. Generally, I don't think there was much -- the PBM language was somewhat controversial, but I think it stayed more or less the way you --

MS. CUMMINGS: The fiduciary stated --

SPEAKER 1: -- discussed that.

MS. CUMMINGS: Well, the description of the standard, the fiduciary standard as opposed to contract standard. Okay. We will have --

SPEAKER 1: Basically that one is intact.

MS. CUMMINGS: Okay.

SPEAKER 1: To me that --

MS. CUMMINGS: That's what we have been trying for about four or five years already maybe.

SPEAKER 1: Right. Right. So --

MS. CUMMINGS: The other ones were --

SPEAKER 1: -- part of one of the big ones was not to create a bill that won't get through.

MS. CUMMINGS: Well, okay.

SPEAKER 1: In its stead to craft a bill that might and put -- and could actually reduce cost, and that's the goal and there is a lot of good things in the bill.

MS. CUMMINGS: Okay. Any questions at this point?

Thank you. When we get --

SPEAKER 1: Thank you.

MS. CUMMINGS: When we get our technical staff back, we will walk through it, and we will have a chance to read it. Okay. Thank you.

SPEAKER 1: Thank you very much.

(Thereupon the proceedings ended.)

CERTIFICATE

STATE OF FLORIDA
COUNTY OF BROWARD

I, Sara Glazer, Notary Public, do hereby certify that I was authorized to and listen to CD 2007-83, the Senate Committee on Finance, Tuesday, March 20, 2007 proceedings and stenographically transcribed from said CD the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 8th day of April 2008.

Sara Glazer
Esquire Job #928014
STATE OF VERMONT

SENATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: Friday, March 23, 2007

Type of Committee Meeting: Standard

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

CD Nos.: 07-87/T1, 2, 3
07-88/T1
07-89/T1
PROCEEDINGS

CD 87/TRACK 1

MS. CUMMINGS: Senate Committee on Finance, March 23rd, 2007. So, the first thing we've done is, we've asked Robin to come and walk us through the proposed amendments to the bills which are in your folder and in the white bag and just let us know -- we had Senator Sine in, and he explained the two big changes and said the rest were somewhat technical, and Robin tell us what they are and how technical they are.

MS. LUNGE: Good afternoon. I'm Robin Lunge, Legislative Counsel. Probably the easiest thing to do is to work off the section by section summary which shows a comparison of the bill as introduced as it came out of this committee with the Senate Health and Welfare amendments. If you'd like me to go through the language more specifically at any particular section, I'm happy to do that.

So, the first instance of amendment amends Section 1 of the bill, and the -- that section where it talks about the FQHCs. And what you'll remember is that the FQHC language said that there would be a plan created for increasing the usage of FQHCs, and two things happened in that language in Senate Health and Welfare. First of all, there was some concern about Vermonters moving from their primary care physicians to FQHCs, so they changed it from a plan to encourage folks to move to a plan to informed Vermonters about the availability of FQHCs and why the prescription drug pricing is cheaper there than elsewhere.

And also, the last -- a phrase was struck at the end of that subdivision which had talked about creating patients of record, and that's no longer allowed under the definition of patients that's required under federal law. So, the second part was truly required by federal law.

The second instance of amendment amends the part of the bill that talked about the joint drug purchasing consortium. And it merely added the V Farm Program to the list of programs that would be included, and the V Farm Program is our wrap-around program for Medicare Part D, so that's really a technical change, also. And also, OVA asked to add language that if it was necessary, that they seek authorization from CMS, to approve that if it was necessary. So, it's -- it's -- the language is put in the conditional, so if it's not necessary, they don't have to do that. Just it makes it clear that if they had to do that, we were expecting that.

There is also -- the third instance of amendment changes a reference -- a cross reference that was incorrect, so that is technical. The fourth instance of amendment is in Section 2 of the bill, and would strike -- this is the section where we were directing OVA to seek independent research from independent sources. And Senate Health and Welfare just took out the example of organ health and science university.

MS. CUMMINGS: Right. We'd already taken it out, seek them, and you said seek such as them and now it's just saying seek.

MS. LUNGE: Exactly.

MS. CUMMINGS: Okay.

MS. LUNGE: The fifth instance of amendment adds -- this is in the pharmaceutical marketer disclosure part of the law. What you had done is add the Department of Health as one entity that the AG could share information that they received, some of the disclosures, Department of Health still has to keep it confidential. Senate Health and Welfare also added OVA, so the AG and would be able to share with both OVA and DOH. Again, OVA and DOH keeps things confidential.

MS. CUMMINGS: Right.

MS. LUNGE: In the sixth instance of amendment, Senate Health and Welfare, this is the section that would require drug manufacturers to disclose to OVA certain prices for drugs. This was the part of the bill where you added from Texas law a third pricing indicator, and it was an average manufacturer price, etcetera. There is -- in -- in one part of that law, it said that OVA would use a federal standard of methodology or adopt its own standards by rule, and Senate Health and Welfare thought it made more sense to use just the federal standards so that there was -- the people who were reporting all knew that they were use one each the same standard that they would use for the Feds.

In the 7th instance of amendment, this is really a technical change because when you added that third pricing indicator, there was one place where two of the prices were described, and I neglected to change that reference, so the 7th instance changes refer to the subsection in lieu of those two particular prices. So, that's also technical.

In the 8th instance of amendment, it -- it's addressing the Healthy Vermonters Plus Program. This is the pharmacy discount card that we offer in Vermont, and currently the law says that OVA will seek permission from CMS to get a waiver to extend the discount card to additional populations. And what you had done was strike the requirement to get the waiver, so because we -- that had been clarified that that was no longer necessary. So that would have just had the program be implemented. OVA came in to Senate Health and Welfare and said, well, actually, in the current law it says that we would increase this to 300 and 350, but also to families whose prescription expenses...
including premiums equal five percent or more of their household incomes or whose total medical expenses equal 15 percent or more of household income and that's going to be really, really complicated to administer. Then the healthcare ombudsman came in and said, I can see how that would be really, really complicated to administer, so why don't you just leave it to increasing it to 350. So, that's what Senate Health and Welfare did, was make that change. So, you'll see in the 8th instance of amendment it adds new language from current line, just strikes the language about percentage of income stuff.

In the 9th instance of amendment, we start to get into the PBM sections of the bill. There were two sections, Section 7 and 8. The 9th, 10th, 11th, and 12th all address PBM, the PBM sections. So, the first thing Senate Health and Welfare did in the PBM section was, you'll remember that that section says the PBM has to disclose -- notify the health plan if the following things are available: 1., a prudent PBM standard, 2., certain disclosures of information, etcetera. What Senate Health and Welfare did was modify the prudent PBM standard to the current standards under Vermont law that an insurance agent owes to a customer. So, this is a slightly lower standard than the prudent PBM standard. And you can see that language on Page 3 of your amendment at the top at A-1. It says that the PBM would discharge its duties with reasonable care and diligence and be fair and truthful under the circumstances then prevailing that a pharmacy benefit manager acting in the like capacity and familiar with such matters would use in the conduct of its enterprise of like aims. So, that language, reasonable care and diligence, be fair and truthful under the circumstances was language which I found in a case, a Vermont case dealing with that duty between the agent --

MS. CUMMINGS: So, this is something between contract law which is what has been wanted, and --

MS. LUNGE: And the original bill is Page 15.

MR. MAYNARD: Fiduciary.

MS. LUNGE: Yeah. So on Page 15 of your bill as introduced on Line 4, you can see your language which was, discharge its duty with care, skill, prudence, and diligence under the circumstances then prevailing that a prudence PBM, blah, blah, blah; the rest of that's the same.

MS. AYER: What does it mean be truthful under the circumstances? That just sounds so, like, I'll stick with you as long as I can.

MS. CUMMINGS: The truth is as how long as it's convenient.

MS. LUNGE: What I can tell you, that would be something a court would sort out. But in this particular case, it was a case where The Court looked at a circumstance under which the customer was saying that they didn't understand something that was in the contract, that was written in the contract, and so it was dealing with whether or not the insurance agent has to specifically explain each and every provision in the contract. And what The Court basically did was, say, well, we think an agent has to discharge their work with reasonable care, diligence, and be fair and truthful under the circumstances. So, that was kind of the standard they used to apply and -- but they also said in that case that, well, you, the customer have an obligation to read the contract, too, and if it's in plain -- if it's simply put in a contract and understandable, then that's your duty.

MR. MCCORMACK: So, it leaves it to The Judge.

MS. LUNGE: Well, with any sort of standard, that's -- I mean, this is a standard that any court --

MR. MCCORMACK: It's a different standard --

MS. LUNGE: Right. You --

MS. AYER: But under the circumstances means it would vary by case?

MS. LUNGE: It could. It would -- well, it would vary by the circumstances.

MR. MCCORMACK: Who wanted the information?

MS. LUNGE: Who was asking for the information, is an insurance agent talking to somebody who's an expert in insurance law and who probably knows the ins and outs, so they didn't explain every detail knowing in their mind they were talking to an expert. So, I think in this kind of a standard, it's often very fact based, so The Court is going to look at, well, who --

MS. AYER: That's generally what that means.

MS. CUMMINGS: You couldn't tell me you couldn't read.

MR. MCCORMACK: Except by the X on the bottom of the page.

MS. CUMMINGS: A lot of people can sign their names, but really don't speak English or don't read well, I mean, enough to comprehend it. But in ordinary conversation, you might not know that. Okay. So, you think that's -- that's a middle standard.

MS. LUNGE: Well, I think the discussion in Senate Health and Welfare was, they wanted to replicate what they thought was sort of the standard that probably would be used in the circumstances now without citing if this didn't exist.

MR. MCCORMACK: Piggybacking with the standard to what they thought was closer to the advocate.

MS. LUNGE: I think that was their intent. I'm a little bit fuzzy now, it was a while ago, but I think that's what I was trying to do.

MR. MAYNARD: Not to the level of fiduciary --
MS. LUNGE: Right. No. They clearly did not want to stick with the fiduciary.

MS. CUMMINGS: But it is above contractual.

MS. LUNGE: Yeah, I think so. I'm not an expert on all the different standards, but I think it's meant to be the standard that an agent -- I tried to find something that looked as close as possible to what this transaction kind of included.

MS. CUMMINGS: Yeah. That's probably the closest transaction you're going to get, okay.

MS. LUNGE: In Vermont law, I should say. So, in the tenth instance of amendment, we reworked Subsection C, which is on Page 18 of your original bill, and this is not -- this re-working of the language was not meant to change meaning, I think it's just a little clearer and readable, so this is not really a substantive change. In the 11th instance of amendment, you'll see --

MS. CUMMINGS: Oh, yeah. C was where we had pharmacy benefit manager as somebody who does pharmacy benefit managing? We had trouble with that.

MS. LUNGE: Right. So, I think this reads a little better and more clearly. 11th instance of amendment is the enforcement provision in the PBM section. You'll recall that Julie Brill from the AG's office and Herb Olsen from Bishca were going to talk about some new language, and this is the new language. What this basically does is separate out, you can see on Subsection D of the amendment which is on Page 4 near the top, that this gives Bishca the exclusive authority to investigate, examine, or otherwise enforce the provisions of this subchapter relating to a PBM in connection with the PBM's contractual relationship with a health insurer.

So, it separates out the traditional area of jurisdiction for Bishca and puts that separate from the general enforcement.

MS. CUMMINGS: Okay.

MS. LUNGE: In the 12th instance of amendment, we're now moving into Section 8 in the original bill. This is the part which set up the registration of PBMs and also has the language about the administrative services only contract. And Senate Health and Welfare inserted a new B and C. And what this language does is, it clarifies that while the PBM has a duty to notify when they respond to an RFP, that administrative services only contracts are available in the marketplace, that it doesn't require each PBM to offer that type of contract. So, the PBM could then, if they're quoting a different kind of contract to somebody, they might have a little notice that said, and by the way, there's also something called an administrative services only contract, we offer that, or we don't offer that, but it is available in the marketplace.

And then there's some technical amendments in Subsection C which were meant to just offer clarity. And I'm trying to remember exactly what they were. I think -- let me just look real quick. Oh, yes. What I did was, in your C, which is on Page 20, big A and big B on Lines 11 and 16, both have lead-in language, if applicable under administrative services only contract; we moved that language to C-1, the lead-in so that it was clear that this -- the audit provision only applies to an administrator services only contract.

MS. CUMMINGS: Because the other one has --

MS. LUNGE: The other ones have audits or -- I didn't hear what you said.

MS. CUMMINGS: My remembrance of the testimony was that the other contracts audits is part of -- the ability to audit is part of most of those or you have the ability to ask for that as --

MS. LUNGE: I think -- what I recall from Senate Health and Welfare is that there was testimony that you have the ability to in your contract specify that you want audit, but the testimony -- there was some disagreement in the testimony as to whether or not an audit was appropriate in a non -- in a contract for something other than administrative services only. So, this part of it could be a substantive change from your version in terms of the -- what the audit applies to, but what Senate Health and Welfare decided to do was to only require the audit in the administrative services contracts where you're getting full pass-throughs of discounted stuff. And I think what they heard that -- was that in the other type of contract which might, for instance, say, you're guaranteed a 10 percent or 20 percent or X percent discount, that an audit didn't necessarily help the consumer. But I don't know that --

MS. CUMMINGS: I thought that an administrative only contract was one where you said, we'll administer your pharmacy benefit plan and we will guarantee you a 10 percent discount over what you're paying now, average wholesale price, whatever the standard is, and that's what you get. And that's the one where we wanted people to know they had the ability to ask for an audit because that's the one where there was a question about -- you know, how much money are you making from the pharmaceutical companies in the way of market share, that that was the one; the other one's where you could negotiate for a percentage of the market share, rebates, where -- that they were much more complicated and that there was generally -- it's sophisticated, and that there was generally an ability to audit at least --

MS. LUNGE: I think you might want to ask people about that because I don't know the contract in enough detail to really -- I can't tell you what I think is most appropriate for an audit because I don't know the contracts.
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1 well enough. There was conflicting testimony in Senate
2 Health and Welfare about the range of contracts that an audit
3 might be helpful and appropriate in.
4 MS. CUMMINGS: So, that one, we may want to red
5 flag here for a few minutes.
6 MS. LUNGE: And I think arguably under your
7 language, it could -- it could -- it could have been more
8 broadly applied than to just the admin services only. So,
9 but what this section would now do is require the audit only
10 in the admin services only contracts.
11 MS. CUMMINGS: Okay.
12 MS. LUNGE: Okay. Sorry I don't have more
13 specifics on that.
14 MS. CUMMINGS: Okay.
15 MS. LUNGE: The next section or amendment is in
16 Section 12 of your bill, which is the evidence-based
17 education program which starts on Page 22 of your original
18 bill. And what this would do is add in a couple other folks
19 to -- who the Department of Health would collaborate with.
20 Currently they -- in your version, they were collaborating
21 with the AG, Senate Health and Welfare added in the
22 University of Vermont Area Health Center Program because they
23 currently have a grant to develop the evidence-based
24 education materials. So, it makes sense to involve them in
25 the development and the Office of Vermont Health Access

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1 because they have the drug utilization review board and they
2 get a lot of information about sort of effectiveness and that
3 kind of thing because they consider that --
4 MS. CUMMINGS: I'm not finding that in the side by
5 side.
6 MS. LUNGE: I might have -- I did the side by side
7 quickly on the airplane, so let me see. It's on Page 3, and
8 it looks like I left that out, so --
9 MS. CUMMINGS: Yeah, okay. That's where I thought
10 it would be, and I was finding a hole.
11 MS. LUNGE: You're right, sorry about that.
12 MS. CUMMINGS: Okay.
13 MS. LUNGE: I'll double-check this and clean it up.
14 In the 14th instance of amendment, again they struck that
15 same reference to Oregon. In the 15th instance of amendment,
16 they removed the prescription drug confidentiality program --
17 MS. CUMMINGS: Right.
18 MS. LUNGE: -- and inserted instead a report on
19 from leg. counsel to the committees on the status of the New
20 Hampshire litigation and any other information we might be
21 able to get from the State of New Hampshire about what was
22 going on there.
23 MS. CUMMINGS: And this was the data mining?
24 MS. LUNGE: Yes, this is the data mining section.
25 MR. MCCORMACK: So do we continue to data mine?

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1 MS. CUMMINGS: Yeah.
2 MS. LUNGE: So, they struck 13, and related to 13
3 was 14, so 14 also got struck as a result. They also took
4 out 15 and 16 which were the provisions about a person
5 paying --
6 MS. CUMMINGS: What -- on 14 --
7 MS. LUNGE: This was --
8 MS. CUMMINGS: That if you go to Wal Mart in the
9 normal, it's $4 and your co-pay is 10, they want you to pay
10 the 10?
11 MS. LUNGE: That's 15 and 16.
12 MS. CUMMINGS: Oh, what's 14?
13 MS. LUNGE: 14 is related to the data mining
14 section.
15 MS. CUMMINGS: Okay.
16 MS. LUNGE: That was Bishca's confidentially
17 provision related to that, so that doesn't make sense to
18 leave in if you take out 13. So 13 and 14 are together, 15
19 and 16 are together. They did take out 15 and 16. They
20 heard from a couple of different witnesses that this was --
21 they didn't think that these provisions were necessary, that
22 they thought the current electronic system currently does
23 this anyway and that it's in -- it's a requirement that's in
24 the contract between the insurer, the health insurance
25 companies, and the pharmacists. And there's an example of a

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1 contract that had language that included that. So, they took
2 it out because they thought it was happening anyway.
3 Section 17 is the unconscionable pricing section.
4 And Section 17 is reproduced in its entirety in the
5 amendment. And I'll go through --
6 MS. AYER: In which amendment?
7 MS. LUNGE: -- what the changes are.
8 MS. CUMMINGS: Their amendment.
9 MS. LUNGE: Their amendment. So, the first change
10 in that section is on Page 6 of their amendment in Section
11 4653. And what this section now -- the one change is that
12 the previous language had read, serious public health
13 problem, I believe, and that -- they changed that to threat.
14 We also added the reference to Section 4654 to be a little
15 bit clearer that the requirements of 4654 were something that
16 had to be looked at. In 4654, there are several changes to
17 the criteria. These are the criteria that the commissioner
18 of health would look at when declaring that there's a public
19 health threat. So, most of the changes they made are in
20 Subsection B.
21 So you'll notice B-1 is significantly changed. You
22 had that the commissioner would consider how many Vermonters
23 suffer from a health condition. Senate Health and Welfare --
24 I guess the overall point of these changes in their mind was
25 to -- they wanted to exclude chronic illness from -- as a
possible target of a serious public health threat. They were thinking more along the lines of, like, a flu epidemic as opposed to obesity or chronic heart disease or something that -- widespread like that. So, that's kind of what was behind the changes in the section. So, one, you can see now reads, if a large number of Vermonters suffer from a health condition and the condition in life threatening in the short term -- so that would exclude a chronic illness that's life threatening in the long, in 20 years -- or has severe consequences to health in the short testimony or if the condition is highly contagious and threatens a large number of Vermonters, to, if the cost to the state employer sponsored insurance and private insurers of the treating health condition with prescription drugs would be expensive without intervention allowed for under this chapter.

So, that's also a little bit more narrowly tailored than your two. Three, if the cost of prescription drug -- a drug or a class of drugs used to treat the health condition is prohibitively expensive to the extent that the information is available. So again, that's also a narrower spectrum of situations. Four, I believe is the same, five is the same, and six is the same. In 4655, we added a reference to 4653 because there was some confusion as to how these sections all fit together. So, we tried to clarify that by adding cross references. But otherwise, this section is the same, I believe. Then I'm pretty sure that's it in terms of modifications to this section; the rest is just reproduced because it was easier to reproduce the whole section than just make those particular changes.

So, the next instance of amendment is in Section 19. Because Senate Health and Welfare took out the prescription drug confidentiality section, I removed the cross reference to that that was in 2466-A, Subsection A. So, that's a technical amendment that goes with removing that section. Then in the C of that section, this is the -- the advertising provision that says -- that references the federal standards for false advertising. And Senate Health and Welfare added a sentence at the end to clarify how the letters issued by the FDA would be used. So, they added a warning or entitled letter which is the names that they use on the FDA website issued by the US Food and Drug Administration shall be prima facie evidence of a violation of federal law and regulation. So, that's the change there.

And I believe -- oh, in D, we also made a change. This is in the electronic prescribing software section which prohibited advertising in that type of product. Senate Health and Welfare added the clarification that this subsection wouldn't -- shall not apply to information provided to the health care professional about pharmacy reimbursement, drug formulary compliance, and patient care management. So that in the prescribing software, it would still be allowable for the software to say, hey, that drug's not on this insured's preferred drug list or something like that.

MS. AYER: Robin, I've lost track of where we are on both sheets.

MS. LUNGE: We're at the end of the amendment.

MS. AYER: Technical provisions?

MS. LUNGE: There were no changes in the technical provisions.

MS. AYER: So, what we're looking at was not even in the end of the this original bill; is that right?

MS. LUNGE: Which --

MS. AYER: I'm looking for the paragraph that has the sentence to it trying to follow along.

MS. LUNGE: In yours?

MS. AYER: Yeah.

MS. LUNGE: Okay. So, In yours, it was on page 35, D. Has a sentence added to the end. And also the previous one I was talking about about the advertising is on Page 34, C. It would be added on Line 13.


MS. BRILL: Good afternoon. I'm going to mention something that I hadn't mentioned to Robin earlier, but I think a pretty important provision was dropped out by Senate Health and Welfare perhaps by mistake. It's important to OVA, they asked for -- well, let me start over. I'm Julie Brill from the attorney general's office, and we're here to talk particularly about the unconscionable pricing provision. We think that Senate Health and Welfare was trying to address a constitutional problem that actually does not exist, and failed to address the constitutional problem that arguably does exist. So, we have language which we're hoping will address the constitutional problem that at least was found by the District of Columbia Court and not unduly narrow the bill in that provision in other ways. That's the primary reason I'm here, the first one.

The second primary reason I'm here is, the Medical Society has prepared amendments to the data mining section, and we very much would like to see the data mining section either as enacted by this committee or as being proposed by the Medical Society. Probably since I actually don't have their draft with me, they've shown it to me, and I've seen it. But probably it would make sense for them to testify about that and then maybe I can come back and answer any further questions you might have on that one. But I will say with respect to that, if you're going to go with their -- not with your original language, which is our preferred
provision, but instead you're going to go with the Medical Society's alternate, they're proposing either an opt in on opt out for doctors, that they can opt in or opt out to the database -- to the prescription disclosure of their prescription information, we very much would urge you to make it an opt in, we do not believe in opt outs in our office.

And in Vermont, we have a very strong history of enacting opt ins, not opt outs. In the credit reporting issue, financial privacy, there are a number of others areas where we have urged this legislature and you have always agreed with us thus far to do opt ins, not opt outs. And I can get into all the reasons why and all the consumer data that's out there regarding computer inertia, etcetera. But leave that aside, so that's the other primary reason I'm here.

But I just noticed in talking with -- in looking at what Robin went through that there was an -- a third provision that OVA wanted, and it is related to prescription privacy issue, and that is -- and I -- did they -- did Ann Rubb come in here to testify to you all when you heard this bill? She might have only made it over there.

MS. CUMMINGS: She may have, but -- MS. BRILL: I was not here when she was here. Bottom line is -- did she come -- anyway, bottom line is, OVA has a real concern that their information will start to be mined, that is, the information that Medicaid has with respect to prescription practices. And they have a very rich database. And they have asked the legislature to have their information made confidential, but there would be an exception for the attorney general's office and others. And that language appears to have dropped out of the bill.

Whether or not you do anything -- MS. CUMMINGS: I thought we'd done that, so -- MS. BRILL: That was supposed to be in here. MS. CUMMINGS: Yeah.

MS. LUNGE: It came up after you voted the bill out, so the language actually got developed after Senate Health and Welfare started on the bill, but they never got to that point of discussing it because they took that section out. So, they never heard Ann on this.

MS. BRILL: The bottom line is, whatever you do on the Medical Society and the attorney general's joint proposal on data mining, this proposal that OVA has is a separate proposal and should -- we would urge you to insert it, whatever you do with respect to our proposal on data mining. And what it does is, it would ensure that the Medicaid which is very rich also on prescription practices couldn't be used for the same purposes. So, if you don't have that language, we can get it to you real quickly. I think it was just one of those loose ends that we weren't -- and I actually thought it was in the bill. And it was clearly not in the bill now.

MS. CUMMINGS: I remember the discussion, and I thought it was in the bill. But we may have lost it. MR. MAYNARD: I think it may have been one those things, fix it on your way over.

MR. MCCORMACK: Could you give me an update on opt in terms of how many states -- I don't need to know exactly, but a feeling for how opt in is faring, because I thought we were kind of in the small end of the minority.

MS. BRILL: We are. I mean there are many, many ways in which Vermont, the Vermont legislative and Vermont laws are more protective of privacy than lots of other states, and you can start with criminal searches and go all the way down. But with respect to the kind of consumer issues that I focus on, I think we're the only state, or there may be one or two others that now require permission before a consumer report can be reviewed, so we're on the minority there. In terms of financial privacy, there's probably about five states that have some form of opt in as opposed to opt out. So we are in the minority, there's no question. But it is a strong tradition that we have here in terms of protecting privacy. And the reason is because, of course, opt outs, the reason why companies who want to use this kind of data, they want an opt out because consumers don't respond to it. And the reason we want an opt in is if they really want to use the data, they should do a good job selling to consumers or doctors or whomever you're talking about the need for that data. They do a real good job in selling lot of other things, they should be able to sell the need to use the data.

So, that -- and I could talk to you much more about that.

MR. MAYNARD: I just wanted to know, how many times do we really realize we're signing an opt in?

MS. BRILL: Exactly, exactly. I mean, most consumers have no idea what they're reading. And companies have the ability to communicate clearly with consumers; you look at the on television, they really have the ability to do it if they want to. So leaving that aside for a moment, what I'd like to do is, again, I'll let the Medical Society present its proposal on data mining. Our first choice is, go with your language. We understand that it's being litigated in New Hampshire; we are concerned about waiting for the end of that litigation because it's not just going to be a trial court decision, there will be appeals, it will go on for years. And as my Senator from Orange County just said, you know, the data mining will go on in the meantime unless we do something about it. So, it's important I think to act now on this issue rather than wait four or five years waiting down the road for the litigation to end.
And so our first choice is your language, our
second choice would be the Medical Society's proposal with an
op in, not an opt out. And I'll answer any questions after
you see that language. I do have language on unconscionable
pricing, if I can say that word, unconscionable pricing.
MR. MCCORMACK: I didn't know you moved to Orange
County.
MS. BRILL: It's probably about ten years ago. I
do have copies for other people. Some people who are sitting
around here have seen this because they asked me for it
because I know you wanted to act fairly quickly. I wanted to
make sure people who are interested had a chance to see some
of the language. But before we look at specific language
that I'm proposing, maybe I can take a step
back -- I think I should take a step back and describe what
is really at issue with respect to the constitutionality of
unconscionable pricing. And if -- if I didn't bring enough
copies -- actually, I have one more. I kept -- there's one
more.
MR. MCCORMACK: There's one here.
MS. BRILL: And I can get more -- if someone
doesn't get it out here, I can email it to them. The
District of Columbia court struck down --
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CD 07-88/Tracks 1, 2, and 3

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MS. BRILL: -- that it was happening in the
District of Columbia.
MR. MCCORMACK: It was the results --
MS. BRILL: Right. It was the results in the
language. If you look at my draft, let's see if it's clear
here. If you go to the second page. You're going to be
looking at some of the language I'm striking out. But it
was -- in particular what they were concerned about was, the
language that said, supply for sale or impose minimal resale
requirements for a drug that results in the prescription drug
being sold in DC for an unconscionable price; in other words,
a lot of those activities were happening outside of the
District of Columbia. That was the primary reason why the
law was struck down. As I said, there were also some
supremacy clause issues, which I also think do not apply
given how we've changed our draft from the District of
Columbia's bill or law.
So, what I tried to do, and actually I will tell
you that I have consulted now with people, law professors and
Washington, DC attorneys at very large firms who argued both
sides of the District of Columbia case. So, I have consulted
with everybody that was involved in developing those
arguments down in Washington. What I have done is revised
the language in the District of Columbia law so that we will
be focusing on commerce in Vermont. We will not be focusing
on commerce outside of Vermont. I think that takes care of
the constitutional infirmity. I don't think you need to make
more narrow or -- make more narrow this business about what's
a serious public health threat. You don't need to only focus
on short-term conditions and not-long-term chronic
conditions. That doesn't help the constitutional argument.
And all you're doing is narrowing the provisions and focus of
the law without addressing the real issue which is, is this
thing going to be struck down or want to be struck down.
MR. MCCORMACK: Narrowing, I'm not sure I -- the
narrowing is not only focused on -- (inaudible).
MS. BRILL: That's a way to put it, yes. That is
what I think needs to happen. And instead, Senate Health and
Welfare -- and part of this, frankly, it's not their fault;
they looked to Robin and I and said, what should we do here.
And I hadn't yet had all these discussions with all the
people about what was really going on in the District of
Columbia case. So they're looking to us, and we're saying,
you know, yeah, make it more compelling, and really that
wasn't what the issue was. So, you know, they were looking
to us for guidance. So, I want to make that really clear.
But so what, though, at the end when they came up with this
language, I said to them, what you're doing is, you're
focusing on narrowing the conditions that are covered, but
you're not narrowing, as Senator McCormick just said, you're
not narrowing the location of the activities, and that's what
we need to do. We don't need to narrow the conditions
covered, we do need to narrow the commerce effected, that's
exactly right.
So, going through the draft, you'll see that what
I've done is, in terms of affected parties, the people who
can bring a lawsuit, it has to be someone in Vermont who's
directly affected by the unconscionable pricing. That's the
only change on -- and what I did is, I took this draft that
you have in the front of you is Senate Health and Welfare's
language with my modifications to it, okay. So going to the
second page, this is probably the most important change to
Section 4653 that the prohibition is that a manufacture of
prescription drug or its licensees shall not sell in Vermont
a prescription drug necessary to treat a serious public
health threat provided for in 4654 in this state for an
unconscionable price. So, it's, the manufacturer shall not
sell in Vermont the product for an unconscionable price.
This business about supply for sale or impose minimal resale
requirements or that the action can result in a public -- in
a prescription drug being sold in Vermont, that is stricken
but that all activities that could occur outside, okay?
MR. MAYNARD: Was does define unconscionable price
or else --
MS. BRILL: Yes, that comes up. You defined it, and it was also in Senate Health and Welfare's. I'm actually not changing that, but doesn't come up. But we're not there yet in the bill.

MR. MCCORMACK: Is there case law on the right of the state to regulate an activity with the state that by so doing regulating --

MS. BRILL: There's tons of case law on this issue, and it's all very fact determinative. And what we're really trying to do here, to be honest with you, is, we're trying to avoid a facial attack on this law that would not be based upon a prosecution that we might bring. We think that it would be much better for a judge to understand what we're going to do with this law in light of an actual prosecution.

What happened in the District of Columbia was, it was a facial attack, there was no prosecution that was actually pending. They just said, look at the words of this statute, Your Honor, and it's way too broad. And what we're trying to say is, no, it's not going to be broad, it's going to be in Vermont, and let's look at the actual prosecutions that we bring before we say, yeah, it may affect a little bit too much commerce outside the state.

But yes -- so, the short answer to your question is yes, there's tons of case law.

MR. MCCORMACK: But it doesn't have bold principles in this --

MS. BRILL: No, no. This is the grayest of the gray areas in constitutional law, in my view; I always found it that way. I'm sorry, but Senator Maynard, to go to your specific question, the definition of unconscionable pricing is in 4655. I didn't mean to not respond to you. It's a page later at the bottom. But before you get to that, 4654 is actually something that we created. It is not in the District of Columbia's law. And I have meant to talk about Robin about where it came from. I don't actually remember, she may remember --

MS. LUNGE: I'm sorry, what --

MS. BRILL: 4654, this whole business about going to the health commissioner for a finding.

MS. LUNGE: It's not based on another state's law.

It's based on concepts as best --

MS. BRILL: Okay. This is actually another requirement that we're imposing that is in addition to a requirement of the District of Columbia's law. And what we're imposing is a requirement that before our office, the attorney general's office, or a private person can ever go to court, you have to have a finding by the commissioner of health. That's a very unusual process. And, you know, we're giving a lot of -- we're giving the manufacturers or any licensee or whoever else might be subject to this law an additional opportunity to argue that there is no unconscionable pricing here. This process of allowing them a kind of a first shot at the commissioner before we could ever get to court is unusual. So, I just wanted to outline that we're not --

MR. MCCORMACK: Serious public threat out as a criteria?

MS. BRILL: You could take this entire provision out, and I do not believe you would have any constitutional difficulty if you do that. I do not think that this is necessary in light of the District of Columbia's case. But given this bill it at this point, and in fact, it was in your draft, if you don't want to take it out, we certainly understand that. I just wanted to highlight for you and for Senate Health and Welfare that this is an additional protection, if you will, for potential defendants that you will have added to this bill. I just wanted to highlight that.

But we do think the changes that I'm proposing to this -- assuming you want to keep it in -- actually, I didn't remember that Senate Health and Welfare changed the word, "problem" to threat. I actually like the word, "problem" better than threat, and even though it's not in my draft, I would propose you go back to the word, "problem." But in any event, what we have proposed here is that you go back to your language, the Senate Finance language with respect to B-1, 2, and 3, and the reason is, again -- do you see where I am, Senator Ayer?

MS. AYER: Uh-huh.

MS. BRILL: I'm sorry. So, you've got -- what your language required was that the commissioner of health may issue a declaration that a health condition is prevalent in Vermont to such an extent as to constitute a serious public health threat, and then we can request -- that's A-1, A-2 is that our office can request that they have a hearing.

Now in B, it lists the factors that need to be considered when declaring that a health condition or disease is a serious public health threat. And what you see in originally what Health and Welfare -- what Health and Welfare did which is the language I've proposed to be stricken, is that they have really narrowed 1, 2, and 3, as Robin said, so that chronic conditions wouldn't be considered, you'd have to have a large number of Vermonters affected. They really narrowed it in ways that I didn't -- No. 1, are certainly not necessary to fix the constitutional infirmity, and also, would really narrow it so that you're not even necessarily talking about all the public health threats that are out there. I mean, chronic diseases kill people just as well and easily, although over a longer period of time, as do short-term epidemics. And the idea that you would only be
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focused on short-term epidemics that are potentially
affecting a large number of people didn't make rational sense
to me. It just doesn't make sense. And I felt like they
were trying to make it more compelling because they thought
that would address the constitution problem. I don't even
think it makes it more compelling, but it doesn't address the
constitutional problem anyway.

MR. MACDONALD: But if -- unconscionable pricing,
it doesn't matter you do it.

MS. AYER: Well, it doesn't even matter what it's
prescribe for.

MS. BRILL: It would need to be a serious public
health threat, as you've created this additional layer. It
would have to be prescribed for something that would fit the
factors. My point is that they've so narrowed some of the
factors that you would have very few conditions that would
ever meet this test.

MS. CUMMINGS: You would be looking at a pandemic.

MS. BRILL: Flu vaccine, and we did have a problem
with flu vaccine a couple years ago. But that's what they're
talking about here. And I thought that that -- our office, I
don't want you to think this was just me -- our office felt
this was too narrow here. I'm sorry, Mark?

MR. MACDONALD: The real opportunity to get a lot
of money in unconscionable pricing is on the chronic stuff

where you've got a lot of sales.

MS. BRILL: That's exactly right.

MR. MACDONALD: Ebola, you get one shot.

MS. CUMMINGS: Some of the highest prices are on
the things used most often.

MS. BRILL: Yes. That's absolutely true. There's
also a real problem with some miracle drugs, there's no
question, that are for very rare diseases that are keeping
people alive, but they're costing 30, 40 $50,000 a year for
consumers. And, you know, question whether those ought to be
examined in a health commissioner's hearing as to whether or not
those prices are unconscionably high. There were some
recent articles in the Wall Street Journal about some of
these conditions and how consumers are completely unable to
afford the payments and what some of the manufacturers are
doing to try to help them afford it. There's a lot of
discussion and debate around this.

So, that's another reason why I think 1, 2, and 3
need to be changed because as you all passed it, you didn't
say it had to be a large number of Vermonters, for instance,
in V-1, you just said, the number of Vermonters is to be
considered. Whether it -- it might be that it's a small
number of Vermonters, but if the other factors are that the
costs are extremely high, and there are many who can't afford
it, then the fact that it's a small number of Vermonters

affected wouldn't kick you out, you would still be able to
meet this test.

MS. CUMMINGS: And it still has the 30 percent
higher than the government standard, so you have that, they
do have to meet their cost and research costs for --

MS. BRILL: Yes, exactly. And they always have
that defense. It's just a prima facia case. And that goes
to Senator Maynard's question of, well, what's the test of
whether it's an unconscionable price. We haven't even gotten
there yet, but yes, all that would still need to be met. So,
we would your urge you again now having fully considered the
constitutional issues -- and in fairness to Senator Health and
Welfare, they didn't have the benefit of this discussion that
I'm now giving you because I haven't yet been able to
communicate with all the people that were involved in the
District of Columbia case. But in light of now what is
clearly -- what clearly went on there, the amendments that
we're proposing we think address the problem but don't unduly
narrow the bill.

So we're saying with respect to B-1, get rid of the
language about, if a large number of Vermonters suffer from
the health condition, and the condition is life threatening
in the short-term or has severe consequences, etcetera,
etcetera.

MS. AYER: I thought this was the definition of a

health threat.

MS. BRILL: Correct. No, it's the factors that
shall be considered when you decide if something is a health
threat. It's kind of like the definition, but it's more like
factors that will be considered in a hearing, that's really
what it is.

MS. CUMMINGS: Because if the definition would say,
you know, more than 200 Vermonters are affected by this and
it would be more narrow. This is --

MS. BRILL: We're saying it's -- this is your
language, we're proposing going back to your original
language. So, if you look at the top of --

MS. AYER: I guess I'm getting confused between
unconscionable pricing and public health threat, which we're
defining and for what purpose.

MS. BRILL: So taking a step back, and I apologize
for maybe going a little too quickly.

MS. AYER: Well, I might be going a little too
slowly.

MS. BRILL: No, no, you're not. What you all
added, you in and this committee added the unconscionable
pricing section is before you get to unconscionable pricing,
the commissioner has to find that the indication that the
drug is used for the condition, the health condition, is a
serious public health threat. So, there's this additional
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1 step. So, before you get to unconscionable pricing at all,
2 and this business about is it above 30 over the federal
3 supply schedule, all that, first we have to go to the
4 commissioner and the commissioner has to find that there's a
5 serious public health threat.
6
7 MS. AYER: So this isn't going to affect the four
8 Vermonters with some rare disease, to start with, that's a
9 different --
10
11 MS. BRILL: We still can bring a case to the
12 commissioner saying, we've got a serious public health
13 threat, it only affects a small number of Vermonters, but
14 because it's a rare disease, but the price of this product to
15 treat them is unconscionably high. Now, the commissioner
16 wouldn't decide that final issue of, is it unconscionable
17 high. The commissioner would look at these five factors to
18 decide whether there is a serious public health threat. Then
19 our office would go to court and say, is this price
20 unconscionably high for this serious public health threat.
21
22 MR. MAYNARD: But you're basically, if I understand
23 correctly, suggesting we take any reference out to public
24 health threat.
25
26 MS. BRILL: I like the word, "problem" better than
27 threat.
28
29 MR. MAYNARD: Well, what about serious public
30 health problem? I mean, or do you have to have a standard to
31 make it unconscionable?
32
33 MS. BRILL: You do not. 4654 could be deleted in
34 its entirety.
35
36 MS. AYER: That sort of answers my question.
37
38 MS. BRILL: It could be deleted earlier. And
39 again, apologies because I'm going kind of fast because
40 there are other people that want to speak this afternoon.
41
42 MR. McCORMACK: But if it's deleted entirely, just
43 take it out the section?
44
45 MS. BRILL: Yes. You would just say -- in 4653
46 you'd say, a manufacturer of prescription drugs or its
47 licensee see shall not sell in Vermont a prescription drug
48 for an unconscionable price, is what you would say.
49
50 MR. McCORMACK: And that does not have a
51 constitutional problem?
52
53 MS. BRILL: Correct. It would not have a
54 constitutional problem. But given the fact that that was in
55 the bill as you guys introduced it, "you guys" meaning you,
56 the members of Senate Finance, you know, you already
57 determined that you thought that that was an appropriate step
58 to take, we can live with keeping that in. We're not
59 suggesting that you have to take it out. I'm telling you you
60 can take it out if you choose to; but if you leave it in, do
61 not make it so that it's so narrow that very few conditions
62 will come under the definition.

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1 MR. MAYNARD: I think I can -- I opened a can of
2 worms when I said taking out threat. We were talking about
3 two things. Just not defining threat and going back to the
4 old language or going back to the old --
5
6 MS. BRILL: Well, it's defining it, you're giving
7 it factors, you're basically defining it. But I think
8 Senator Cummings said it best. It really doesn't matter if
9 you call it threat or problem, leave that aside. What's
10 important is, what are the factors that you're going to
11 require the health commissioner to look at. And what I'm
12 suggesting is, the language I put in here is exactly the
13 language you all had enacted or proposed, it's going back to
14 those factors that you all had suggested rather than the
15 narrowed factors that Health and Welfare has proposed.
16 That's what I am suggesting you go back to.
17
18 MS. AYER: Can you give me an example of how this
19 would narrow -- give me a hypothetical --
20
21 MS. BRILL: How Health and Welfare would narrow --
22
23 MS. AYER: What you could do with the original
24 version versus what you can do with current version of Health
25 and Welfare, just something really brief?
26
27 MS. BRILL: Sure. I think Tamoxifen is the example
28 I would give.
29
30 MS. AYER: All right.
31
32 MS. BRILL: So, Tamoxifen is a hormone drug that is

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1 MS. CUMMINGS: So what you're doing is, as I'm
2 reading is, you're deleting the word, "threat."
3
4 MS. BRILL: I would actually suggest you change it
5 to problem.
6
7 MS. CUMMINGS: I like threat because it's -- sorry.
8 But we're then defining that word the way we did more as just
9 not as a pandemic, but that a chronic condition, if suddenly,
10 because we seem to have a lot of MS in this state, MS drugs
11 went over the 30 percent above what the feds could get it
12 for, that standard, then we could take action or ask for a
13 hearing. So, there's a floor on this. You can't just say,
14 you know, we want you to sell it for the Wal-Mart four bucks.
15
16 MS. BRILL: Exactly. And Tamoxifen is another
17 example. I'm sorry, Tamoxifen. We brought an anti trust
18 case on that issue because there was lot of manipulation of
19 the market price of Tamoxifen; it's something that's needed
20 by women who have breast cancer, and it probably is used for
21 other conditions, as well. You know, it is not a short-term
22 condition. People who take Tamoxifen take it for potentially
23 years. And, you know, I -- at the very end of the debate in
24 Senate Health and Welfare said, are you trying to exclude
25 these, and they said, yes, because we're trying to address
26 this constitutional concern. And again, you know, people
27 dying from breast cancer have the same health outcome as
28 people who are dying from the flu.

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1 MR. MAYNARD: I think I can -- I opened a can of
2 worms when I said taking out threat. We were talking about
3 two things. Just not defining threat and going back to the
4 old language or going back to the old --
5
6 MS. BRILL: Well, it's defining it, you're giving
7 it factors, you're basically defining it. But I think
8 Senator Cummings said it best. It really doesn't matter if
9 you call it threat or problem, leave that aside. What's
10 important is, what are the factors that you're going to
11 require the health commissioner to look at. And what I'm
12 suggesting is, the language I put in here is exactly the
13 language you all had enacted or proposed, it's going back to
14 those factors that you all had suggested rather than the
15 narrowed factors that Health and Welfare has proposed.
16 That's what I am suggesting you go back to.
17
18 MS. AYER: Can you give me an example of how this
19 would narrow -- give me a hypothetical --
20
21 MS. BRILL: How Health and Welfare would narrow --
22
23 MS. AYER: What you could do with the original
24 version versus what you can do with current version of Health
25 and Welfare, just something really brief?
26
27 MS. BRILL: Sure. I think Tamoxifen is the example
28 I would give.
29
30 MS. AYER: All right.
31
32 MS. BRILL: So, Tamoxifen is a hormone drug that is
designed to attack or to keep breast tumors from coming back
that are hormone receptive, okay. And women who are required
to take it have to take it for years. Well, it is life
threatening, it is not life threatening in the short term,
okay, it is life threatening in the long term. It does have
severe consequences to health, but not in the short term.
So -- and it is not a condition that is highly contagious.
So, that one would be taken out automatically. I could give
you --

MS. AYER: That's good enough. I just wanted to
make sure I had a --

MR. MAYNARD: Might bankrupt you in the short term,
but it may --

MS. BRILL: Right, right, right. But it is a
long-term condition. It is, in essence, a life -- a
maintenance drug that is required to maintain life for women
who need it.

MS. AYER: Thank you. Good example.

MS. BRILL: Okay. So, going on to the changes.

So, we suggest you go back to your factors, we think that's
very important. Going to 4655, we've taken out --

MS. CUMMINGS: Wholesale.

MS. BRILL: Right. I think the reason we're
suggesting taking out the word, "wholesale," and I will
propose this here -- I need to think about this a little bit

more -- is because the wholesale price is often established
outside of the state. But that's one of the things Robin and
I were having a late night conversation with a professor
yesterday about exactly the contours of all this. But for
right now, I will propose you take out the word, "wholesale,"
you insert in Vermont a couple of times in this
unconscionable pricing provision. And then the rest of it I
believe stays the same.

So, that would be our proposal, to address the real
constitutional issue and not a different constitutional issue
that doesn't exist.

MS. AYER: Madam Chair, I could be mixing up the
bills at this point -- imagine that -- but did we have a
discussion about the idea that most of the big transactions
for drugs aren't actually -- don't take place necessarily
inside the state, that we're looking at a very small pond?

MS. BRILL: Well, we are narrowing the pond. I'm
not sure that it's all that narrowed. You know, we -- we are
not -- we would not be going after wholesaler here, as you
see it requires us to go after the manufacturer, the
manufacturer's licensee, but the manufacturers do sell to a
wholesaler here, so there is a lot of commerce that is taking
place in Vermont.

MS. AYER: So, who can you get for this --

MS. BRILL: The manufacturers.

MS. AYER: You're not going to get my guy Frank at
the pharmacy; right?

MS. BRILL: No. It's not -- we're not focused on
retailers here. We had a long discussion about that last
night.

MS. AYER: We haven't changed this, we're just
going back to where we were before which is --

MS. BRILL: That's the intent, but saying it's got
to be commerce in Vermont, that's exactly right. We're not
expanding it to focus on wholesalers or to focus on
wholesalers in terms of them being a defendant or to focus on
retailers. It's really designed to target the issue that
was raised at trial, that's the changes that we're proposing.

So in addition, I just want to underscore again the
need to get that OVA language in which appeared to have just
dropped out, dealing with privacy of their data, the
confidentiality of their data. So I'm available to come back
after you hear the Medical Society's proposals.

MS. CUMMINGS: I think what I said to Chairman
Racine is that I would like to give their committee a chance
to look at this. If they agree it's a reasonable compromise,
then we're all set, and the same with the other proposals,
and then they can come in Monday and tell us if they like it,
don't like it. We can decide if we like it or don't like it
today, and now we can see where we go, okay?
about it that I didn't know the answer to when I was in here
before. And it describes their sales force effectiveness
product, and on the second page which is what this is all
about and there's several components of that. And then on
the last page you can see that the revenue that this company
has from their sales force effectiveness product is 847
million dollars in 2005, and that it's been quite an
expansive growth in the two years before that. So, that's
all I wanted to bring that to you.

And then I have two other things that are sort
of -- give you an idea of how businesses are looking at the
New Hampshire law. And the first is -- I'll give you the
shortest one first. This is a short article from Forbes
Magazine that they're looking at the New Hampshire law and
the trial that's pending now and trying to figure out what
happens. And in the last sentence of this, you can see that
an analyst from Bear Stearns is reported in Forbes as saying
that he -- that this analyst thinks that The Judge is not
going to buy the free speech claim and that New Hampshire
will prevail in the lawsuit. But that's again just
background information.

And the other piece of information about the
business community's response, really, the pharmaceutical
manufacturing companies response to the prescription price
bill is this -- is this agenda for conference that Paul is
going to be speaking at in a couple of weeks, which -- which
I'm not going to go into in detail at all, but it shows how
the pharmaceutical manufacturing companies are already
adapting their business practices to the prospect that they
might not have this information available. They're already
figuring out what to do about that and how to address it.

So, that's the information that I was just going to
bring to you today. So, Paul. I have what I have our
compromises are. Paul's going to come up and talk to you
about.

MS. AYRE: Who is CBI?

MS. MONGAN: It's on the form here. But the --
(inaudible) but it is the --

MR. HARRINGTON: Good afternoon. I'm Paul
Harrington, the executive vice president of Vermont Medical
Society. And as Madeleine and Julie Brill from the AG's
office has indicated, the Medical Society is here to
encourage you to retain in the S115 Section 13 that would
have Vermont follow New Hampshire's lead, and in order to
help control the costs of drugs here in Vermont, prevent
pharmaceutical company marketers from having detailed
information about -- of other physicians' prescribing history
when they go to that physician's office and try to basically
encourage that physician to stop prescribing generic drugs or
their competitor's drugs and prescribe their company's
pharmaceutical product.

I'm just going to give you a little bit of
background. The Vermont Medical Society learned about this
proposal a year ago. Each year, the Medical Societies of New
England get together. Last spring we met in New Hampshire.
And our then president, Dr. Peter Dale, a physician here in
Central Vermont, learned from his counterpart in New
Hampshire that they passed this legislation preventing drug
marketers from having information about physicians'
refilling. And the first question out of Dr. Dale's mouth
was: I had no idea they had this information. And that's
basically the common reaction from physicians, certainly in
Vermont and in New Hampshire.

This is something that physicians are unaware of,
that the drug marketers going to their office trying to talk
to them about the -- their company's products, has detailed
information about what their prescriptions were as early as
last week. And having that information are able to track the
effectiveness of the market. They can basically go in and
say, well, gee, if we say these kinds of things, that seems
to have an impact or a change in the prescribing patterns or
what have you. So, it's a terrific tool for the
pharmaceutical companies. And as Madeleine said, they pay
this data mining company, IMS, 447 million dollars a year in
order to get this information. And organized medicine's not
completely absent from this.

The American Medical Association provides
information to IMS that connects the physician with this
prescription information, and the American Medical
Association gives about 40 million dollars per year for
selling the information to IMS, the data miner, and another
compny called Verispan. And in this article from Forbes
that Madeleine gave you, you can see the sums involved where
it cites the American Medical Association gives 40 million
dollars a year for the sales of their physician directory.

And then this article which probably is only US sales, it
talks about IMS and Verispan making 400 million dollars a
year to help support a 270 billion dollar pharmaceutical
industry here. So, you can understand the financial stakes
involved in this discussion.

So when the Vermont Medical Society learned that
New Hampshire had passed this law, the clear direction was,
we need to follow suit. We had a panel discussion at our
annual meeting last fall that Senator Ayre attended, it was
at the Basin Harbor Club, heard from Attorney General Sorrel,
representative from the AMA, and then state legislatures and
the president of the New Hampshire Medical Associates
describing why they did this. And we operate a little bit
like a legislative, we have an annual meeting, bring up
resolutions which were now get the bills, had a debate on
that resolution passed unanimously that the Vermont Medical
Society take this marketing tool out of the hands of drug
marketers in order to help control commercial costs here
in Vermont and also protect the confidentiality of physicians
prescribing -- that is, from drug companies. We're not
trying to curtail the information for research purposes,
certainly insurance companies have that information through
claims. But we are trying to take this away for commercial
purposes.

The conference that Madeline indicated, and I'm
going to be joined by representatives from New Hampshire and
then West Virginia and -- yeah, West Virginia talks about
legislative efforts. And if you just open this brochure up
to the first inside page where it starts talking about some
of the topics under consideration before they hear about the
legislative activities. And I think in you're on Day 1, main
conference on the left-hand side; and just read the subject
matter for the first session at 8:45. Strategies for
preparing your sales force for targeting and selling to
physicians without prescription level data, and it goes on to
say, the absence of prescription level data should not be
seen as a bad thing. Pharmaceutical companies can put the
spin to work in and turn this into an opportunity to develop
smarter sales representatives.

And then perhaps even more telling in the session
that begins at 9:30 in the morning, tap into current systems
and optimize data availability through closed loop marketing,
and then go on to talk about how much pharmaceutical companies have
invested in this. And then as you go to the last several
lines, the next generation solution can predict which
physicians should be visited and with what information in
order to better inform physicians about products resulting in
increased prescription rates.

So, I mean, this is a -- frankly, a Washington
based two-day conference, the attendees are paying $2,000 to
take this conference, and it's all about how can we
basically, you know, encourage physicians to prescribe more
of the pharmaceutical company product. And they anticipate
that legislatures such as Vermont are going to put
restrictions on this kind of marketing tool, and they're
trying to figure out, okay, what do we do absent that
information that we relied on for so long and we pay close to
a billion dollars in order to obtain, so we've got to find
some other techniques here.

And just as Attorney General Brill and Madeline
indicated, we strongly support the Section 13 and the related
Section 14 as the bill came out of this committee; however,
we recognize that Senate Health and Welfare has taken a
different approach on this and feel that because the -- as
this Forbes article indicates IMS and Verispan, the data
mining companies, have sued in federal and district court in
Concord, New Hampshire to try to prevent the New Hampshire
law from going into effect. And you can -- given the amount
of money involved, you can understand why they would try to
prevent New Hampshire's law from going into effect and slow
down this from become a snowball effect here. We don't think
that that is reason to not move ahead here. I had a chat yet
afternoon with a physician from Windsor county, Dr. John
Ledman, and he basically said every physician he's talked to
supports Vermont going ahead here.

If you decide to find some common ground with
the Senate Health and Welfare Committee, we have developed
alternative language that certainly is not our preference,
but we think could be in place in order to get the
information about the New Hampshire lawsuit and then
presumably move ahead with Section 13, if you so desire. And
this language would show -- Madeline has passed it out, would
basically require the marketer to at least know -- let the
physician know that that marketer has this information about
this prescribing history. And so there would be a
requirement that the marketer disclose to the physician or
other prescriber any identifiable prescription information
that they have available. It would also -- and this is the
first paragraph, Paragraph A, provide the prescriber with the
information sheet about any programs that the manufacturing
company or participants then collects and reviews
identifiable prescription information for commercial
purposes.

We kept going back to this commercial practice. We
in no way, shape, or form want to stifle the information for
research and for legitimate claims review, but commercial
activities -- to put and end to here in Vermont. And in the
third piece of this legislation would be to require the
marketer to basically -- if the physician feels given this
information that heretofore they have not been aware of the
detailed records that the marketers are keeping about the
physicians' prescribing pattern, and presumably the marketer
is going to try and make a good case as to why they should
have that information, if they make a compelling case, allow
the physician to opt in so that that could continue.

An alternative that we also discussed with Senator
Race is an opt out; that would not be our preference, you
know, I think Julie Brill talked about consumer inertia. I
would not subscribe inertia to physicians, but they are busy
people, and they're not going to -- they want to treat
patients, they don't want to fill out forms. So, I think
having the opt in is a strong preference. And then finally
in Paragraph C, the attorney general would be given the
authority to develop these forms and the opt in or opt out,
if that's your desire to do so, and hopefully do this in an
of you know, part of the attractiveness of drug marketing are
the free samples. And for a lot of physicians, those free
samples are what they give to their low income patients. So,
there's a, you know, sometimes some physicians, I think, take
advantage of the marketers to get the free samples to help
their low income patients. And certainly marketers can
provide important information about their particular product,
but we do not feel they should be able to provide that
information with the full knowledge of what drugs the
physician prescribed the week before.

So with that, I'd be happy to answer any questions.
MS. CUMMINGS: Any questions from the committee?
MS. AYER: Can you just -- could you just tell me
again in a couple of sentences what is the program -- which
is the trojan horse that's really not related?
MR. HARRINGTON: This is another AMA sponsored
program called Therapeutic Insights. It's funded by IMS, the
data mining company. And basically, they initiated the
program looking at particular conditions and then the drugs
that are appropriate for that condition. This issue I have
deals with the management of migraine in adults, and it
presumably would be tailored to a physician's prescribing
patterns so that physician, again, what they've been
prescribing, but prescription rates are in Vermont and
nationally and then try to educate the physician on what the

best drugs are for that particular condition.
Certainly, physicians have that information readily
available from other sources. Again, when I was talking to a
physician yesterday and I told him about this, he says,
there's no way I want to spend more time with a drug marketer
going over my prescription patterns. So, we think this may
be worthwhile for some physicians, and we'll certainly
discuss it with our governing council, we're meeting next
month, but it should in no way be seen as an alternative to
what we're trying to achieve here.

MR. MAYNARD: That's an individualized report.
MR. HARRINGTON: It -- it certainly compares the
drugs prescribed in Vermont and nationally and then, you
know, absent the passage of Section 13, the marketer would
also have the drugs that the physician prescribed, as well.
So whether that would be in the report or in the marketer's
hands as he or she went through the information from Vermont
and nationally, I'm not a hundred percent sure.

MS. AYER: I feel compelled to say just for the
record that the Basin Harbor Club is in my district, and I
bought my own dinner. I didn't want you to think I was there
as a guest of the Medical Society.

MR. HARRINGTON: We were happy to have you there.
MS. AYER: Thank you.

MR. HARRINGTON: It was a great venue, and we'll go
study concludes that access to provider identifiable data by pharmaceutical companies actually serves as a price constraint, and he explains why. They also conclude that banning commercial use of provider identifiable data will not lower drug prices. They also conclude that the use of provider identifiable data helps extend life expectancy; that is, it saves lives because it gets drugs to the market quicker and in the hands of the right physicians. And provider identifiable data enables reductions in size of pharmaceutical sales forces and prevents mismatches in marketing.

So, I will leave that executive summary -- the entire study is 60 or 70 pages and long, and I regret that it hasn't been published yet, but I am grateful that I was at least able to give you the executive summary. And once again, this is a place called political and economic research council PERC, P-e-r-c is there website. I went through it, they've got a board of directors, and they are, apparently, a thing tank. You can research them because obviously they --

16 Economic Research Council.

17 MR. KIMBELL: You know, their website doesn't say.

18 I read it this morning, but, Senator Ayer, PERC, if you Google that, you can find it. And you're right, you know, you're right to ask the question. I don't know where -- so, let me hand out some of these and -- so now I think we do have some evidence on the question, would banning the use of this data will do, and you can judge the quality of the evidence, but I don't think there's any evidence from the other side or the question.

19 Secondly, I did want to talk about the program that Paul Harrington discussed that the AMA is sponsoring along with my client, and that's called Therapeutic Insights. And -- well, let's back up before I drag you through it. I'd just like to point out a couple things about this document --

20 MS. AYER: Is this the one we were just talking about?

21 MR. KIMBELL: Yeah. I just wanted to point a couple things about this. This is the third page in the packet that Paul had. And if you'll note up at the top about the third line down it says, in cooperation with the Connecticut State Medical Society. So, this is an example of this program as it's being done in Connecticut on a pilot basis, and going to be rolled out rest of the country. And
by the way, notwithstanding the fact Vermont Medical Society has a very low membership in the AMA of its members, this would still be available to Vermont physicians; it doesn't depend on AMA membership, is what I'm saying.

And the key point about this, and I just vigorously disagree with Paul that this isn't related to their compromise proposal what their compromise proposal is basically to have the pharmaceutical marketer give the physician the data they've got on them before they talk to them or when they talk to them. And that data is, of course, for use by a marketer, not for clinical use by a physician. So, it really would add to the amount of paper coming into a physician's office and not be particularly useful. The same proposal was made in California by physicians there saying, we were surprised, we didn't know you had this information, we want to see it ourselves. And the AMA and my client, IMS, and the California physicians agreed on a protocol to figure out how to get this information to physicians in a useful way. They did a focus group with a bunch of docs, they said, how would it be helpful for you to get your personal prescribing information. And this program, Therapeutic Insights, is the result. It started in January with, as Paul said, migraine which is a disease, chronic disease for which a lot of pharmaceuticals are prescribed, and it affects an alarming number, percentage of the population. I think this piece says 25 percent, which was a little stunning to me, but a chronic disease.

And if you just look on the left-hand corner of this document where it's in gray, it's a nice summary of how this program is going to work. It's a quarterly continuing medical education newsletter, so if you looked at the whole document, physicians are going to be able to read the 10 or 12 pages, fill out a multiple choice quiz, and send in a certification that he did it, and he's going to -- he or she will get an hour of counting medical education for doing that.

MR. MAYNARD: Now, is this an individualized?

MR. KIMBELL: I'm going to get to that. And it's intended to provide primary care physician with evidence based guidelines for selected medical conditions, so we're going to go disease by disease. Migraine is the first one, Type II Diabetes is the second; they're going to roll out one disease per quarter. Will serve -- this CME activity will serve as a clinical context for your review of personalized physician prescribing reports that you can request after each issue. So, each doc is going to be able to ask on-line for their personalized date.

MR. MAYNARD: Like a stock report.
MR. KIMBELL: But related to this disease. And show -- these reports are for your use only and are intended to improve clinical practice, which was the goal of this, not just provide useless information. Improve clinical practice and prescribing habits, it's as a function of self assessment. And here's the key, Senator Ayer, to review your confidential, personalized prescribing data, go to, and then it gives an AMA website. So, instead of just dumping up a bunch of new data on physicians as the Vermont Medical Society proposal would have you do, this program will give physicians clinically relevant information comparing their prescribing patterns with those in their state and nationally. So, it's really a constructive way to go about this. It was constructed by physicians, not by my clients, IMS, Paul is correct that IMS is paying for it, because they would like the data that they produced to be useful as well as to make money off of.

I must say I think that the shallowness of the Medical Society's position is emphasized by their use of the large numbers that are involved in the pharmaceutical industry today. I'm not sure how that's relevant. I'm on a drug now that I wouldn't have been on a year ago because the medical standards changed for cholesterol. You know, it used to be where I was was okay, and now it isn't. So, I'm taking some drug my doc told me to take. It's increasing. If that saves my life, maybe the increased usage keeps me out the hospital, is actually saving money. But I'm not sure what those red herrings about 400 million or billion dollars have to do with this issue. I think the question here is: Will banning commercial use of this data lower prescription drug costs. The only evidence you've got before you, in my opinion, is that it will not; in fact, it will have the opposite effect. And furthermore, Vermont physicians, if they want to participate actively in this AMA program, will have their clinically relevant personalized prescribing data disease by disease as this program rolls out.

So, those are the points I wanted to make. I think the Health and Welfare Committee took a lot more -- had time to take a lot more testimony than your committee did, Madam Chair, on this question, and reached the conclusion that they did, at least to wait, see if we can get some data from New Hampshire about the impact that this has.

MS. CUMMINGS: Okay. Questions?

MS. AYER: So, I don't care about this program one way or the other. Physicians choose to do it. But why would I go on-line to find out what I do?

MR. KIMBELL: Because you probably don't now.

MS. AYER: Well, it's true that the practice I work in has a very limited set of things that they do.

MR. KIMBELL: I mean, over time, Senator --

MS. AYER: You don't think people know what their
MR. KIMBELL: Well, I think physicians I talked
with my doc, Randolph, he's a primary care doctor. He
doesn't know what he does. He's got so many -- I mean, on an
organized, statistical --
MS. AYER: He doesn't know that he usually
prescribes --
MR. KIMBELL: -- how much I did this year, last
year, what are the trends going forward, what should I be
doing.
MR. MCCORMACK: It would be like when you go on the
Internet and looking at your stock portfolio and see how
you've done and what you've bought and what you've sold it.
MR. KIMBELL: Well, yeah. Or did I prescribe a lot
more drugs last year than this year with the same number of
patients; if so, why; what am I doing, how do compare with my
peers in the state, how do a compare with my peers national.
I don't know, if I was a physician, I would think that
would be useful, tool. And it's not something that the
pharmaceutical marketer is going to bring into their office,
as Paul suggested. It's an on-line tool for physicians to
use when they want to use it.
MS. AYER: Well, for the sake of argument, it
doesn't really matter if they take it in the office or not,
it's that Steve, the detailer who always comes into our
office with -- to sell us birth control pills knows that even

though we receive him with open arms and always listen to
what he says, we don't prescribe Oxycontin for most of our
patients, we prescribe some other drug.
MR. KIMBELL: Probably a generic that's less
expensive. In fact, Senator, I'm glad you made that point
because --
MS. AYER: But we listen to Steve because we
understand that he occasionally and maybe even often brings
us other new information.
MR. KIMBELL: I mean, that's a judgment. Somebody
said earlier --
MS. AYER: It's like listening to lobbyists, some
of them are good, and some of them you don't trust.
MR. KIMBELL: Well, and you've made that comparison
before. Physicians don't have to let in pharmaceutical
marketers who behavior badly into their offices. Some of
them, as you say, must be constructive because your employer
sees them.
MS. AYER: Some we spend time with, some we don't.
MR. KIMBELL: I'm glad you raised that because one
of the points is, these marketers are poudning on physicians
to prescribe brand name drugs instead of generics. Well, one
of the nice things about working, for a data company is that
they actually have some data. And I didn't make copies of
this, but I'll leave this one with the committee. This

compares Vermont and the United States. Where there's a
generic alternative, the red is generics, the blue is brand
name.
MS. AYER: Don't they have to do that by law now,
that's the law.
MR. KIMBELL: Well, none the less, I'm just saying,
what you've got in place is working. If we're using this
data to force doctors or convince doctors to prescribe brand name
drugs in private plans where they can do what they want, you
know, it may be the law in government programs, but in
private plans, you pay Price A for a brand name, Price B for
a generic, and Price C for a preferred brand name. Well, the
marketing, if it's being used for what the proponents of this
provision claim, it's not working. And I'll just leave one
of those with the committee. I'm sorry I didn't bring
multiple copies, but that --

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MS. GRETKOWSKI: -- hopefully on two issues, the
prescription data piece as well as the unconscionable pricing
parts of the bill. On the prescription data piece,
specifically on the Medical Society's proposed compromise or
alternative, I would submit to the committee that we are far
too far along in the process at this stage of the game to be

entertaining a new idea and a new concept.
You know, this bill has already been through this
committee, Senate Health and Welfare, it's been noticed on
the floor for a second reading, and now it's back here again;
some of us aren't sure exactly why. But there has not been
time to fully vet it. And just as an example of one problem
that exists and the way that they have drafted it, in terms
of the disclosure that the pharmaceutical sales rep would
have to make to the physicians when he or she goes into that
physician's office, it said, it shall include the name of the
prescriber, name of the patient, if available, name of the
drug, date of the prescription, and amount of the drug
prescribed.

Well, according to our clients, that information is
not made available from IMS to the pharmaceutical company.
What it actually made available is the name of the prescriber
and the drug that is prescribed. All of these other things
are not made available. So, that's just one example of
potential problems with adopting without really a full
vetting of all of the issues that are in here would lead is
to if you were just to take this and insert this in the bill
as is as it. And again, I go back to this name of the
patient. I think there has been testimony throughout this
process that this information that goes from -- actually from
the pharmacy to IMS to then the pharmaceutical companies, is

18 (Pages 66 to 69)
patient de-identified, there is not an issue there. And I
just found it surprising that our Medical Society would
actually be saying that they thought it would be okay if
patient names were actually available, that that's going to
be more information that is going to be replayed throughout
this process. There are serious HIPAA problems here, federal
law, confidentiality of medical information.

The other point I would like to make in connection
with the Medical Society's proposal is, you folks several
years ago passed a Price Disclosure Law which basically says
that when a pharmaceutical rep goes into an office, they have
to give the doctor the relative prices of the other drugs in
that therapeutic class. And so, that's been in effect, that
has been happening, the attorney general's office developed
the guidelines around exactly what has to be included in
that. The attorney general's office actually approached us
before the section started because they were starting to get
complaints from physicians from nurses and physicians'
offices that this is too much paper. You know, they're
coming in with reams of paper, and I think AG even testified
to that here, and we're working with them to try to
streamline that. What would this do on top of that, you
know, if they're going to be coming in piling on more
information on top of that, is that going to just sort of
compound the problem.

So those are really my two points specifically with
respect to their proposal. And again, I would just really
echo Senator Racine's comments to this committee, you know,
In terms of there has been no data that this will actually
lower the cost of prescription drugs and just all the other
points that he made.

So, secondly, on the unconscionable pricing. It is
true that you do not have an interstate commerce problem if
you have a transaction that is between, say, a manufacturer
outside the state and a wholesaler or perhaps an independent
pharmacy inside the state. There you have, you know, the
transaction occurs in the state of Vermont. However, that's
as far as it goes. If you have a transaction between an out
of state manufacturer and an out of state wholesaler who then
may be sells to a chain, pharmaceutical or chain pharmacy,
that then makes drugs available in Vermont, that is not a
transaction in the state. And actually this goes back to
Senate Ayer's question of, exactly what would this as
proposed by the attorney general now, what would this affect.
So, there are no pharmaceutical manufacturers in Vermont;
there is one wholesaler in Vermont, and that's Burlington
Drug, and they account for about 20 percent of the drugs that
come into Vermont. The other 80 percent of the drugs that
come into Vermont go from a wholesaler out of state to a wholesaler out of state to a chain out of state

and then coming into -- you know, the distribution channel
into Vermont. That would not be touched by this. That would
-- if we tried to touch that transaction between the
manufacturer and the wholesaler out of state, that would be a
violation of the interstate commerce clause. So, I guess
practically speaking, you know, what are you really
accomplishing by doing this. Apparently back in -- I think
it was 2000 when you folks were doing S300, there were
discussions about doing price controls in that bill, and
apparently Burlington Drug did testify at that time. They
have not weighed in on this at this time.

So, the question is, what would happen to them,
would they stay in Vermont if -- and again, the attorney
general is right, she has not aimed this at the wholesaler.
But again, if the manufacturer is going to be subject to this
with interstate wholesaler, will they continue to sell to
that interstate wholesaler. No. 2, there were multiple
constitutional issues involved in the DC litigation, it
wasn't just the interstate commerce clause. The other one
was the supremacy clause, and this -- I'm not going to get
into a whole lot of detail here, but basically, patent law is
federal law on the federal level. And the claim was that by
trying to go after drugs that were patented drugs, that would
have been a violation of the supremacy clause, that federal
laws have supremacy over state laws. What the attorney
genral has done in this particular case is to try to get
around that constitutional challenge by saying, this not only
applies to patented drugs, which is what the DC law did, but
it also applies to unpatented drugs, which are basically
generic drugs. So, the DC case found that there was a
violation of the supremacy clause with respect to patented
drugs. So if that's going to continue to be upheld, the only
thing that would be affected by this would be the cost of
generic drugs.

And I think you've had testimony in this committee
that the cost of generic drugs in the United States tends to
be lowest, at least vis-a-vis Canada and lower than a number
of other countries. So, would anything actually, practically
speaking, be affected by this according to the DC litigation.
So -- and again, there were a couple other constitutional
issues with this, as well. So, it's not 100 percent fixed if
you figure the interstate commerce clause issue. So, that's
my testimony.

MS. AYER: Going back to the first part of your
testimony, the proposed defendant. We're reading it
differently, and I guess I just want to make sure I have that
right. What I read in A is that marketer -- and that would
be the drug detailer case I go back to every time -- tells
the physician any identifiable prescription information
relating to the physician, so his or her drug practices, and
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<td>1 accessible to the pharmaceutical marketer, so the physician</td>
<td>1 have to have the chain headquartered in Vermont and then --</td>
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<tr>
<td>2 would know the name of his own patient or her patients. I</td>
<td>2 for that transaction to actually occur in Vermont. Just</td>
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<td>3 think that's not giving the physician any new information.</td>
<td>3 because a manufacturer sells to a chain and that chain</td>
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<td>4 MS. GRETKOWSKI: Well, why is it in here, is my</td>
<td>4 happens to have stores in Vermont, and that drugs sold in</td>
</tr>
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<td>5 point. I mean, if all the pharmaceutical marketer has is,</td>
<td>5 those stores in Vermont, that is not enough to get you to</td>
</tr>
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<td>6 Dr. Ayer, and you prescribe, you know, Lipitor and whatever</td>
<td>6 have the transaction actually occurring in the state of</td>
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<tr>
<td>7 it is you're prescribing --</td>
<td>7 Vermont.</td>
</tr>
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<td>8 MS. AYER: And the market doesn't have it, then</td>
<td>8 So, now, if there is a direct sale -- Robin, just</td>
</tr>
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<td>9 the market doesn't need to give it to the physician, but</td>
<td>9 to go further with your question, if there is a direct sale from</td>
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<td>10 even if the market did, it's information that was the</td>
<td>10 the manufacturer to an entity in Vermont, you know, if,</td>
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<td>11 physician's anyway.</td>
<td>11 they're selling directly to a hospital, something like that,</td>
</tr>
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<td>12 MS. GRETKOWSKI: Well again, I think there's</td>
<td>12 then you -- you don't have an interstate commerce clause.</td>
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<td>13 significant HIPAA issues involved if that were to be the</td>
<td>14 MS. CUMMINGS: Or directly to the consumer.</td>
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<td>14 case, there's no question about that.</td>
<td>15 MS. AYER: Prescription assistance programs?</td>
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<td>15 MS. AYER: I agree with that. I didn't see this as</td>
<td>16 MS. CUMMINGS: No. I'm just saying or drugs are</td>
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<td>16 permissive is that a -- whatever --</td>
<td>17 sold directly to the consumer, there's a transaction</td>
</tr>
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<td>17 MR. MAYNARD: I'm not sure I follow the</td>
<td>18 somewhere in that chain.</td>
</tr>
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<td>18 unconscionable pricing chain. As far as out of state</td>
<td>19 MS. GRETKOWSKI: Right. But again, they're not</td>
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<td>19 wholesalers.</td>
<td>20 sold from the manufacturer directly to the consumer; again,</td>
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<td>20 MS. GRETKOWSKI: Okay. To not be in violation of</td>
<td>21 you go through that whole --</td>
</tr>
<tr>
<td>21 the interstate commerce clause, the transaction has to occur</td>
<td>22 MS. CUMMINGS: You go through the chain.</td>
</tr>
<tr>
<td>22 within the state. So, when you have -- and all</td>
<td>23 MS. GRETKOWSKI: Right.</td>
</tr>
<tr>
<td>23 pharmaceutical manufacturers are out of the state, there's</td>
<td>24 MR. McCORMACK: So, we're busting all the points.</td>
</tr>
<tr>
<td>24 none in Vermont. So you have an out of state manufacturer</td>
<td>25 MS. GRETKOWSKI: You know, I guess my question</td>
</tr>
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<td>25 selling to an in-state wholesaler. That is the transaction</td>
<td>26 would be Rich Harvey who has opened up an independent</td>
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<td>1 that occurs within the state. And that is the transaction</td>
<td>1 pharmacy here in Montpelier, if he is buying directly from</td>
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<td>2 that again, does not violate the interstate commerce clause.</td>
<td>2 the pharmaceutical manufacturers, that would be covered under</td>
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<td>3 In Vermont there is one wholesaler in Vermont which accounts</td>
<td>3 this. If he isn't, then it's not.</td>
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<td>4 for about 20 percent of the drugs. Everything else comes</td>
<td>4 MS. CUMMINGS: Well, we'll leave that to legal</td>
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<td>5 through out of state wholesalers, so the out of state</td>
<td>5 research. This sounds like one that we have a multiplicity</td>
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<td>6 manufacturer sells to an out of state wholesaler. That would</td>
<td>6 of legal opinion.</td>
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<td>7 be the transaction that this is trying to get at. And it</td>
<td>7 MS. AYER: But this is all going to unconscionable</td>
</tr>
<tr>
<td>8 can't get at that because that transaction occurs outside</td>
<td>8 pricing, is that correct, it's not just --</td>
</tr>
<tr>
<td>9 Vermont, okay? So, you have to be outside, you know, it just</td>
<td>9 MS. CUMMINGS: So, we will have -- let our legal</td>
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<td>10 -- that's an interstate commerce clause problem, so --</td>
<td>10 folks research it and give us an opinion. Any other</td>
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<td>11 MS. LUNGE: And I don't know the answer, that's why</td>
<td>11 questions?</td>
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<td>12 I'm asking. Do you know -- I think there are also</td>
<td>12 MR. MAYNARD: Do you want to hear again from the</td>
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<td>13 manufacturers who sell directly to hospitals or to chain</td>
<td>13 AG's office?</td>
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<td>14 pharmacies or to chain -- you know, big chain stores like Wal</td>
<td>14 MS. CUMMINGS: Yes. And I'll give her time to do</td>
</tr>
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<td>15 Mart or grocery stores with pharmacies. So, I would assume</td>
<td>15 some work on that. I also want to give time for the other</td>
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<td>16 that those transactions also happen in Vermont but not</td>
<td>16 committee to take a look at all of this and tell us their</td>
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<td>17 absolutely everything goes through a wholesaler; for</td>
<td>17 thoughts on it.</td>
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<td>18 instance, things that go through a PBM wouldn't go through a</td>
<td>18 MS. AYER: Susan, could you just go through really</td>
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<td>19 wholesaler. So, I just don't if you know anything about the</td>
<td>19 quickly again why the DC case will affect generic -- price of</td>
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<td>20 prevalence of that.</td>
<td>20 generics more than -- I just didn't get it.</td>
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<td>21 MS. GRETKOWSKI: I don't know anything about the</td>
<td>21 MS. GRETKOWSKI: Okay. Patents are controlled by</td>
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<td>22 prevalence of it, but again, if a manufacturer is selling to</td>
<td>22 federal law. It's sort of a creation of federal law. And</td>
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<td>23 a chain, it's where that transaction occurs. So if Brooks is</td>
<td>23 so, and there's all kinds of public policy reasons built in</td>
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<td>24 headquartered out of New York or Connecticut or whatever,</td>
<td>24 behind the federal patent law basically saying that if an</td>
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<td>25 that is where the transaction occurs. You know, you would</td>
<td>25 entity, you know, whether it's the -- you know, invention of</td>
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20 (Pages 74 to 77)
1 this or that or the next -- or a drug, you know, all of the
2 time and effort that goes into getting a product that you can
3 actually take to market that is effective, be it a light bulb
4 or a prescription drug, that needs to be recognized and
5 protected and then also encouraging the development of new
6 technologies or whatever it is. So, that is protected by
7 federal law. So in the DC case, what they looked at is
8 saying that the DC law, by controlling or being able to
9 control the prices pegging them to other countries, DC pegged
10 it other countries not the way we did it in this particular
11 bill --
12 MS. AYER: Countries, you said?
13 MS. GRETOWSKI: Countries. It was the four
14 highest income countries, so that's what they're 30 percent
15 was pegged to. Ours is pegged to, you know, the federal
16 supply schedule, Medicare, things like that. So what they
17 said was, that is infringing on the productions afforded to
18 the inventor under the Federal Patent Act, and therefore that
19 violates the supremacy clause of the constitution. Because
20 there's a number of clauses in the constitution and what the
21 supremacy clause says is --
22 MS. AYER: Right now we're talking about patented
23 drugs?
24 MS. GRETOWSKI: Yeah, just patented drugs. So
25 what the supremacy clause says is, there are certain things

1 apply to generic.
2 MS. GRETOWSKI: That would be my reading of it.
3 MS. CUMMINGS: Okay. We'll let legal counsel shed
4 light on that one. Any other questions, committee? Okay,
5 not. Thank you. I'll let you mull on this through the
6 weekend. Give me a deliberational call if you want to
7 hear --
8 (CD ended.)
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1 that are -- that Congress has reserved to regulate itself,
2 that the states really do not have the ability to regulate.
3 So, if there's a violation of -- if a state tries to encroach
4 on something that is controlled by federal law, that's a
5 violation of the supremacy clause, okay. Now, the DC case or
6 the DC law was only vis-a-vis patent drug. What is in here
7 is patented and non-patented drugs.
8 So, assuming that the DC law will be upheld on
9 appeal, the supreme clause will preempt the ability to apply
10 this to patented drugs, okay? Because that's what was found
11 on the trial court -- or the district court level. However,
12 generics -- well, it's -- first of all, it's unclear exactly
13 what's going to happen with generics. But if it is upheld,
14 the generics can be covered by this. You know, my question
15 is, generics are the -- most of the time the most inexpensive
16 drugs. I think there's been testimony throughout this whole
17 process that they are cheaper in Vermont than they are in
18 countries -- or they're cheaper in the United States than in
19 other countries. So, practically speaking, will this really
20 have any effect, you know, if you're going to be limited to
21 generics and if they're basically, you know, very low cost at
22 this point.
23 MS. AYER: So just to make sure I got it. So, the
24 DC case only addresses medicines under patent, and if it's
25 upheld, as you believe it will be, then our law will only

CERTIFICATE

1 STATE OF FLORIDA )
2 COUNTY OF POLK )
3
4 I, Evelyn M. Adrean, Notary Public, Registered
5 Professional Reporter, Florida Professional Reporter, do
6 hereby certify that I was authorized to and did listen to CD
7 07-87/T1, 2, and 3, 07-88/T1, and 07-89/T1, The House
8 Committee on Finance, Friday, March 23, 2007 proceedings and
9 stenographically transcribed the foregoing proceedings and
10 that the transcript is a true and accurate record to the best
11 of my ability.
12 Dated this 21st of August 2007.
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Evelyn M. Adrean, RPR, FPR
My Commission #DD360489
Expires October 5th, 2008