STATE OF VERMONT
HOUSE COMMITTEE ON HEALTH CARE
PART 2

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

Committee Members:

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

CD No: 07-131/T1

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PROCEEDINGS

CD131/TRACK 1

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

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

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

But this actually teaches does how to learn how the drug salespeople actually approach them and also just kind of how to work with a drug salesperson, how the information is used, et cetera.

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

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

The other thing, and I apologize I don't have it right in my hands, we had actually provided a letter to the Senate in terms of the area of the budgets that were similar, very similar to what you have from Josh here. We can make sure that you also have that for your records and all. Again, I believe everything we recommended in that actually followed the bill and is in the bill as we recommended.

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

And I will tell you, just an aside from the health department's experiences, many of our serious substance abuse related mortalities in the state are not from diverted -- are not from drugs that are considered street drugs but are actually diverted prescriptions. We're seeing more and more of that in the investigations at our chief medical examiner's office. So again, a bill like this I think helps significantly to work towards supporting our providers and our citizens of Vermont in terms of protecting their health in the best way possible.

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

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

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

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

MS. MOFFATT: At least I've not started talking poultry to you yet.

ATTENDEE: Is that inspected or uninspected?

MS. MOFFATT: Hopefully not. Anyway, I'm sorry to divert the discussion there.

ATTENDEE: As a follow-up to that, you indicated that there was a second team would be needed. I would assume that there's a lot of demand for this kind of thing.

MS. MOFFATT: Well, and that's actually, I think, what AHEC suggested as we were working with them on the language in the bill. There was originally some appropriation to fund that.

What I had informed the Senate committee, that there was already a model in place. It wasn't that we had to go out and find a new model to actually create. We had one in our own state. So as one raising the level of awareness in that. But if appropriation was made in that area, that is how the money would be spent, to have a double -- you know, so you'd have essentially two teams, and you'd have better coverage around the state.

ATTENDEE: One other question (inaudible). We heard testimony a short while ago about the commissioner of health may issue a declaration of the health condition or diseases prevalent in Vermont. We heard some -- a recommendation that this is a highly subjective issue for the commissioner of health to make this determination. And the recommendation was to look at a list of diseases, if you will, from the CDC.

Would you -- have you thought about that?

MS. MOFFATT: Yes, actually myself and -- our medical director, Don Swartz, and I have already talked in that regard. What a model we would see very similar to is actually how we determine some of the formularies for HIV/AIDS treatment. Essentially, there's -- recommendations are made anytime a new drug comes on the market specific to the prevention of HIV/AIDS. For example, we go through and determine with a panel how to make that determination. We see the similar model but using (inaudible) a diseases based place.

Also, I think you're perhaps aware of how we set the communicable diseases that are reportable in our state, which is also by statute.

Actually, if you go on our website you'll see that every year we actually go in and look at what are the reportable diseases that are communicable. Rather than the health commissioner just making those choices we actually pull a team, an advisory team together that includes, in this particular situation, the infectious disease docs around the state, Kemper Alston of UVM and actually a court law (sic) come together. They look at the recommendations of what the diseases are, any new emerging, any hot spot areas, like is the east versus the west coast having more of an incidence around a particular disease. And then we put it on a reportable list.

So that's essentially very similar to the model that we would see moving out here, using existing data but also using state experts to advise the commissioner on what those reportable diseases would be.

ATTENDEE: Okay. So what I'm hearing is this language is okay with you?

MS. MOFFATT: That language works given the model of how we would apply. We're comfortable with that.

ATTENDEE: I'm just sort of having trouble. I'm hearing what you're saying, but it's not connecting yet in my brain, sort of how this would work. And Patty and I or a couple of us had had questions earlier on of -- because at one point or another this section of the bill was really -- was more confined to Katrina type situations. And now it seems, the way it's been presented to us, less confined to catastrophe sort of situations and more opened up, at least in theory.

And I guess my question to you is what types of situations, conditions, diseases do you contemplate that you would more forward with under this language, and how are you -- how are you connecting a particular condition or disease with the pricing of a pharmaceutical associated with the treatment of disease?

MS. MOFFATT: Let me -- let me --

ATTENDEE: I mean, where is the data connection there, is the second part of my question.

MS. MOFFATT: Okay. Let me see if I can
answer all those different kind of intersecting points, because your questions are (inaudible) around.

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

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

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

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

And then the data point to the formal --

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

MS. MOFFATT: Um-hmm.

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

MS. MOFFATT: Related drugs. That would be one -- that's an interesting example that we would certainly consider. I think what we would want to do is -- let me say stay open to rather than mandate, but actually do the research of what that actually determines.

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

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

ATTENDEE: I'm not trying to give you a particular signal on whether I think it's too open or too closed. And I think, actually,
your -- any advisory group that would -- this
is so -- in my view, so open-ended that it's
no, really, (inaudible) protection for gross
use of power, if you will. That's not the
right word, but you know what I'm saying.

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

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

ATTENDEE: Maybe you couldn't.

ATTENDEE: So to speak.

ATTENDEE: Maybe you couldn't.

MS. MOFFATT: Well, depending if you
had -- how much you were paying for stomach
stapling. But we won't go there today either,
will we?

ATTENDEE: Did you want to --

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

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

MS. MOFFATT: We've been supportive of the
position that the medical society has taken in
this area. I thinks it's an area that we do
have to be mindful of in terms of the full
ramifications of that. I -- mostly I think
some of the other work that we have going on in
the state with our prescription drug monitoring
program that's getting up and going, that
aspect of it, and also the chronic information
system that we have going up, which will
actually work with the -- some of the work that
Vital is doing in terms of bringing in that
prescription information more at the provider
level point of decision making, I think we've
got some important tools already in place in
Vermont that would prevent more that -- the
downside of what you're suggesting there. But
certainly we want to stay open to considering
that for a while.

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

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

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

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

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

That's the kind of thing -- I mean, it
happened through one particular event. They
found their way to the health department and we
resolved it. With more of the formal education
by AHEC, you could get at that. I mean, that
happened because we had a provider, uncomfortable, approached us. What we don't know happens out there is how many providers are uncomfortable, wouldn't necessarily come forward to us or the medical practice board or other venues, but would be comfortable in a smaller setting, in an anti-detailing class to actually talk that through. So that's one type of example where I see the benefits of this going beyond just the pure, are we -- the pure purposes of or the immediate purposes, I should say, of the bill as it's written.

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

I mean, that's all in -- in the computer software that we've developed and put in place to catch these patients going -- and the insurance companies have done the same thing, you know, to catch these patients going from doctor to doctor to doctor for OxyContin. What you're not going to affect are the robberies for OxyContin, and there's no bill that's going to affect that.

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

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

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

COUNTY OF SEMINOLE.

I, Christina Gerola, Notary Public in and for the State of Florida at Large, do hereby certify that I was authorized to and did listen to CD 07-131/T1, the House Committee on Health Care, Wednesday, April 11, 2007, proceedings and stenographically transcribed from said CD the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 20th day of August, 2007.

Christina Gerola
Notary Public - State of Florida
My Commission No.: DD617707
My Commission Expires: 12/10/10
STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: Friday, April 13, 2007

Type of Committee Meeting: Standard

Committee Members:

Rep. Steven Maier, Chair
Rep. Francis McFaun
Rep. William Keogh
Rep. Virginia Milkey
Rep. Hilde Ojibway
Rep. John Zenie

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

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

MS. TREAT: Okay.

MS. TREAT: Okay.

P R O C E E D I N G S

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CD 132/TRACK I

REPRESENTATIVE MAIER: Hi, Sharon.

ATTENDEE 1: Good morning. This is very low.

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

ATTENDEE 1: There we go.

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

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

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

MS. TREAT: Well, I wear many hats.

REPRESENTATIVE MAIER: Are you feeling better?

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

REPRESENTATIVE MAIER: Great.

MS. TREAT: -- might as well.

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

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

REPRESENTATIVE MAIER: Okay.

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

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

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

REPRESENTATIVE MAIER: Okay.

MS. TREAT: Okay.

REPRESENTATIVE MAIER: Thank you.

MS. TREAT: Just starting on the Consumer Fraud sections, you know, at the very end of the Senate Bill, one comment is that the provision in there that actually mirrors the language in Maine that focuses on misleading direct consumer advertising, since then we have gotten some comments from people who are really experts in the field saying, you know, why is this limited to DCT advertising. There's no reason why you shouldn't also be taking a look at or preventing misleading statements from being made in the advertising that goes to doctors and other health professionals.

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

REPRESENTATIVE MAIER: What's --

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

So that's one thing in that section.

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

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

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

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

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

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

REPRESENTATIVE MAIER: Do we have that report, Robin?

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

REPRESENTATIVE MAIER: Oh, okay.

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

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

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

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


MS. TREAT: In my prior life some years ago we passed this. It was the first in the country to do this, and it came from really conversations with our AG's office. I just want to stress again how important this is.

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

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

So can I leap to the data mining issue?

REPRESENTATIVE MAIER: Okay.

MS. TREAT: I don't know, you know, what's been said to your Committee but I've been going through this pretty -- in a great deal of detail with the Maine legislature that's working on this right now. We had actually three -- four different bills to regulate data mining and, you know, I just thought there might be -- I don't know what questions you might have but --

REPRESENTATIVE MAIER: I have a question for you.

MS. TREAT: Yeah.

REPRESENTATIVE MAIER: One of the -- one of the big arguments by the data mining companies is that if we cut off their ability to sell this information for commercial purposes, that they'll then just stop doing it and that data won't be available for other purposes that we might all agree are important, and my concern about that argument at least in Vermont's case and I think also in Maine's case is that we're actually already well under way in creating databases that produce that same information. And we had testimony from our own insurance department about our multipayer database and their work in collaborating with what's been going on in Maine for several years related to that. So I guess I would just invite you to comment about what has been going on in Maine and whether it's your experience there in Maine that you are actually able to provide the data for research and for oversight and some of those other purposes that are important.

MS. TREAT: Yeah. Well, that's actually quite an interesting question because the Maine Health Data Organization, which I think is what you're referring to, came and testified about this bill. They were very comfortable with it. If it goes forward, they're -- they're supportive of it. They just wanted to make sure that they still had access to the information that they're getting now, and they do. There would be no change in it. And so we -- in a way we already have that function going on quite apart from the data mining companies and what they do.

And there's actually efforts to make this go online and do a lot of really neat -- neat things with it. Yeah. I would just say about that particular statement from the companies that they would no longer collect information, period, that I think that falls into the category of a threat and I don't think it's borne out by the evidence elsewhere.

You may not be aware of it but there are a number of Canadian provinces that do not allow prescribers' specific information to be -- you know, it shields that information just like this legislation does and, you know, I doubt very much there's been a problem. There's been no evidence of that in any of the research.

And, you know, I would further say that the argument they made in Maine -- and I don't know if they made it in your state -- was that safety would be compromised by them not being able to get the specific data because they couldn't get out safety recall.

ATTENDEE: 1: Yes.

MS. TREAT: And I would like to draw your attention to a letter that was sent to the Maine legislature by Dr. Benjamin Shaeffer (phonetic). And he's a cardiologist in Maine. And he specifically addressed that point with a letter that came to the Committee after the testimony at the hearing and said that there's a lot of channels for safety data to be provided to prescribers and they include but are not limited to the FDA, Center for Drug Evaluation and Research, mass media, pharmacies, PDM as, you know -- and he also -- and AMA and other places. But he said specifically that he thought that, you know, this whole point didn't really make a lot of sense anyway because the -- you know, if a doctor is going to do that -- first of all, well, let me just read you what he says as opposed to paraphrasing it. He says, "Furthermore, the reasoning behind the pharmaceutical industry's suggested restriction of targeted safety warnings only to physicians that prescribe a drug is flawed."

They were basically saying, you know, we can't get the warnings out to the doctors who prescribe it most and therefore there's a flaw. Dr. Shaeffer continues,
"If this was truly physicians' choice of information source, he who prescribes the medication for the first time or not that often would put his patients at risk. We are not alone when we say that our primary information on any given drug comes from less biased data, medical journals and FDA warning. "In addition, this type of prescribing data is rarely used for purposes that benefit the public due to proprietary nature of this data and the high prices charged."

And I sent that letter to your staff. The other point I'd like to make is that in terms of reasons to pass this legislation and sticking with the kind of health and safety thought here -- we had quite detailed testimony from Drs. Jerry Ahorn (phonetic) and Erin Casselheim (phonetic). And I don't know if you have a copy of that, if they submitted testimony in Vermont, but it went into lot of detail about this issue and the fact that from a public health standpoint limiting the amount of information about specific prescriber pattern was a positive thing for promoting better medical prescribing and public health issues. And they submitted testimony -- again, I can get that to you if you don't have it -- which says that essentially it has encouraged the prescribing of drugs that may not be as safe and it -- they gave some very specific examples of that, including you know, the well-known example of Vioxx. But they've actually done some pretty serious academic studies on this issue. And I'll just read a little bit about one of them they've done. They said, "We have recently published an analysis of the adverse effect of marketing for the cardiac medication Nesaride or NATRECOR. It was approved for treatment of acute exacerbations of congestive heart failure in 2001 despite the fact that the manufacturer had not adequately studied its side effect profile. The product was immediately promoted through a cadre of detailers in individual meetings with cardiologists. Sales of the drug reached 400 million in 2004 but its use decreased dramatically in 2005 when it was found to be associated with (inaudible), kidney disease and death. The study showed these adverse effects were largely based on data available to the manufacturer when the drug was first approved but were not featured prominently in the marketing campaign."

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

And I also want to make one further point about this that we have been really getting into in Maine, which is the fact that, you know, if the people are saying to you that the AMA opt-out really works, at least in our state -- and I don't know if this is the case in Vermont -- but I think it's somewhat the case.

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

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

So that's about what I have to say on data mining. And, you know, I guess I'll open up to
questions before I turn to any other issue.

No questions?

REPRESENTATIVE MAIER: We got one.

ATTENDEE 2: In terms of this opt-out
process, even if the people don't belong to
the -- the AMA, they can still opt out. Right?

MS. TREAT: Well, I don't know what
they're opting out of. The AMA system is about
its own data which then gets -- about the
specific doctors, which then gets linked up to
the data coming from pharmacies and other
sources of information about the actual
prescription. And there's no -- I mean, if you
want to rely on that, you're going to -- you
know, if you're interested in opt-in or opt-out
that -- instead of like a straight-out ban on
this, what you really have to do is create a
little mini bureaucracy. And this is something
that one of the Senators on the Committee in
Maine is looking at very seriously. But you
have to create an independent place for that to
work.

She's looking at doing it through the
licensing of prescribers and the various
licensing boards, of which there are four or

know, get information out to all these people
about the availability of this law.

I don't think you really want to be
relying on people that have a vested, you know,
stance in -- in something not happening to be
getting that information out. So, you know, if
you're going to do that, then you've got to
come up with a funding source which you can
certainly, you know, put a fee on the drug
industry or the data mining industry to fund
it. But if you're going to do that, you know,
do it effectively. I mean, relying on the AMA
system is -- is not doing it and it's -- it's
allowing for this private entity to be its own
mechanism and it doesn't work now and it
doesn't cover, you know, a lot of the people
who are involved in this.

ATTENDEE 2: Okay. I've got a follow-up
question now. We're talking about the
violations and the Consumer Fraud Act and so on
and having somebody with a -- with a designated
private interest in this trying to watch dog
them. I just want to -- for the record I want
in my own mind -- I think I know the answer but
I -- I would like to make sure it's for the

record. What do you do for a living?

MS. TREAT: What do I do for a living?

ATTENDEE 2: Right.

MS. TREAT: I'm an attorney and I'm
Executive Director of the National Legislative
Association of Prescription Drug Prices which
is why I think I'm testifying today because my
organization is made up of legislators. We're
funded by state legislatures including the
Vermont legislature who pays dues to us. And
I'm available to help legislators figure out
what our -- you know, what the issues are
around prescription drugs and help with
testimony and drafting bills.

ATTENDEE 2: Okay. Thank you.

REPRESENTATIVE MAIER: Pat.

REPRESENTATIVE O'DONNELL: How many states
are -- are part of your organization now?

MS. TREAT: Well, I mean, there's kind of
two ways to look at it. We have -- we have
about 10 states that sort of formally sign up
and where the Speaker of the House and the
Senate President appoints specific people to --
to be on our board.

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

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

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

REPRESENTATIVE O'DONNELL: Thank you.

MS. TREAT: You're welcome.

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

REPRESENTATIVE MAIER: We have another question from Harry Chen.

REPRESENTATIVE CHEN: Hi, Sharon.

MS. TREAT: Hi.

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

MS. TREAT: Yeah.

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

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

And, you know, I just -- in our state where we -- we had -- the Maine Health Data Organization, I mean, they -- they had kind of technical concerns about how the language was drafted in -- in the bill that was presented here but once they were assured it wasn't going to, you know, affect what they do and how they use the information, they were fine with it.

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

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

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

MS. TREAT: That's right. And -- and I think that the basic premise to that this data will no longer be available is flawed with to begin with, because the fact of the matter is these people use this data for writing purposes. Keep in mind that even under the straight-out ban in New Hampshire and it's proposed in the Vermont legislation and the Maine legislation and, by the way, also in Nevada and Texas where it's moving ahead and in New York where it's being readied to be kind of unveiled so we don't know how it will go there, but under all of those bills which are the most stringent that are out there, and the New Hampshire law, aggregate data is still -- you know, the data is still collected and aggregate data is still used for marking purposes. It just can't be used at this sort of micro level. So they will still be able to get a huge amount of information about what the prescribing patterns are, you know, in a given area, in a given state, in a given practice.

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

And, you know, another comment on the AMA program, it's kind of a joke because, you know, the industry and the AMA admit that that information still can be used by just one level up from that detailer. And I have all kinds of information, you know, establishing that point
because when I met last on -- I think it was Monday -- about this issue with all of the opponents and the head of our medical association who has not supported the bill unlike what's going on in Vermont and Maine and I don't really know why -- but he was completely unaware of the fact that the AMA opt-out still made the information available to the industry and to, you know, the data mining companies -- the pharmaceutical and data mining companies, he didn't realize that. And so, you know, we got him information on some of it from -- from people in your state.

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

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

But, you know, this is the latest argument. We hadn't really heard that argument before and this is like a new thing that has been raised by the opponents as why legislators should vote against it, and I don't think it has merit from everything I've seen.

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

REPRESENTATIVE CHEN: Thank you.

REPRESENTATIVE MAIER: Ginny. This is Ginny Milkey.

MS. TREAT: Hi.

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

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

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

MS. TREAT: I don't think so.

REPRESENTATIVE MILKEY: Okay.

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

REPRESENTATIVE MILKEY: Okay. Thanks.

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

REPRESENTATIVE MAIER: Okay.

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

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

I know that you've all been really (inaudible) around the country in terms of focusing on chronic illness and certainly there are areas there where the drugs are extremely expensive. And, for example, you know, diabetes where there's no alternative to brand named insulin, that would be an example. But I don't think that the -- the conditions that you might want to look at are limited to that because certainly some of the more blatant examples of overpricing haven't gone into the chronic disease category. So, for example, you know, A.I.D.S. drugs and -- and, you know, flu drugs are examples of that.

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

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

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

There may be some other states out there focusing on this. You know, I don't know. I have to do a little research and I could get back to you on that point and see where else it might be pending.

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

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

MS. TREAT: Uh-huh.

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

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

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

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

MS. TREAT: Uh-huh.

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

MS. TREAT: You know -- well, you know, I guess that remains to be seen and maybe you don't want to wait and find out.

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

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

And I guess the other thing I would suggest -- I mean, I put my head together with Shawn again who's really focused on this more from the legal perspective of whether that is more narrowly drafted than it needs to be legally. Again, because the case law on this is based on I think very poorly drafted legislation so, you know, that -- I think, you know, I'd be willing to have a conversation with Shawn and just see if he had any additional thoughts on that. But I -- I just -- I do think there's a lot of threatening that goes on, whether it's we won't collect any data under the data mining, you know, law, so the sky will fall, or we won't sell drugs to your state and -- and I'm not sure how much merit there is to that.

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

MS. TREAT: Yeah.

REPRESENTATIVE MAIER: Quick question from Harry.

REPRESENTATIVE CHEN: Sharon, given some of these concerns on how narrow we made this bill, if we were to broaden it in terms of its criteria for the public health threat, do you think there'd be any benefit in -- in doing it more rather than as a legal action then do it more as kind of shining light on it, so here are the drugs in Vermont that meet the criteria for unconscionable prices and publish it as a report every year?
MS. TREAT: Well, reports are fine but you know where they go; they go in a file cabinet somewhere with all those other reports.

I mean, you know, now that I'm back in the legislature, it's unbelievable the amount of paperwork I get and I guess, you know, it's not a bad thing to do but I'm not sure, you know -- I'm not sure it accomplishes very much unless you want to put some funding into really, you know, doing some kind of a campaign on it. I mean, what really gets people's attention is hitting them in their pocketbooks and, you know, I do think there's some -- there's stuff going on here that's really worth paying attention to.

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

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

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

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

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

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

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

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

REPRESENTATIVE MAIER: You said a little while ago that PBM said they would leave and
that was a lie, I think was your word.

MS. TREAT: Well, yeah, I mean, because I
think they're saying this in every state in the
country except Maine. Well, see, because
there's -- the pharmacists put in a PBM bill in
Maine, I think not realizing we already had
one, but it has some provisions that aren't in
the Maine law right now so we're going to have
a hearing on that. So that will be interesting
to see what they say at that hearing. But the
thing to remember is that these companies were
not -- by and large they were not doing
business in Maine before the law. Very few
people had -- you know, companies or plans had
PBM. And in this state the vast majority of
the market is controlled by one company, by one
company only, Anthem Blue Cross and Blue Shield
which has its own PBM. So -- and of course
that PBM is not, you know, going out of
business or leaving the state.

I checked into this with state employees
which went self-insured around the time of this
law passing and so I wanted to check with them,
you know, did they get bids under the law. And
they said they got multiple bids from various
PBM. They rejected most of them because they
wanted their pharmacy benefits bundled with the
rest of their health-care, which is what Anthem
offered.

So, you know, Medco may not have business
in the state. I don't know that it ever did
and I'm not at all clear because, I mean, I
checked into this with Anthem to find out what
percentage of the market they control. I don't
have those figures with me but it's a huge
percentage. I mean, it's a problem we have
with our health-care market. It has nothing to
do with the PBM law. It's the subject of
another -- it's another issue that we're
dealing with but that's -- that's the reality.
I don't think it has anything to do with that
law.

REPRESENTATIVE MAIER: You have a
question.

ATTENDEE 4: Where's the law in your state
that you're trying to get through right now,
what's happening to it?

MS. TREAT: We have a work session today
and so I don't really know. As I said earlier,
there -- I know that one of the Senators on the
Committee is interested in passing something
but it would be more along the lines of an
opt-in or an opt-in that was independently run
through the Maine Health Safety -- the Health
Data Organization and the licensing board, and
I don't know where the rest of the Committee
is. So, you know, I'll find out. I'll know
more by the end of the day. And then we have a
week's vacation so, you know, they'll probably
resolve it today, I think in that Committee, so
I'll know better then. Okay?

So I have to actually leave but if you
have additional questions you want to e-mail to
me or any of the reports that I mentioned, I'd
be happy to get them back to you as soon as I
could.

REPRESENTATIVE MAIER: Are you around
next week or are you going away?

MS. TREAT: Well, I'm not going on
vacation but I'm not going to be in my office.
I set up all my business meetings for that week
so I'm traveling. However, I always have
e-mail and I have my own cell phone so if you
do want to get in touch with me, I'm sure I can
find some time to -- to, you know, talk.

REPRESENTATIVE MAIER: One last comment.

ATTENDEE 3: Thank you. Sharon, could you
do us a favor? When -- when you find out
whether Medco and Express Scripts actually did
business in Maine, would you send that
information to us because I'm going to ask the
same question of the people (static noise).

MS. TREAT: You mean did they do business
before we passed the PBM law, that question?

ATTENDEE 3: Yes.

MS. TREAT: Okay. I'll try to find out.
Finding out absent of information sometimes is
hard but, you know, well, I'll see what I can
find out, you know, because I mean, I've gotten
a lot of states calling us and saying this is
what's being said and it just doesn't ring
true.

ATTENDEE 3: That's -- that's exactly what
is bothering me. I heard one -- one side and
now the other side.

MS. TREAT: Yeah.

ATTENDEE 3: There's got to be a record
somewhere of business either being done or not
being done.

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

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

So, you know, I'll look into it as much as I can but I'm not sure that the answer is -- you know, we can find that answer out because we have no way of knowing. You know, these are private contracts.

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

MS. TREAT: Well, that's me.

ATTENDEE 3: Oh, that's only you?

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

ATTENDEE 3: Okay.

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

ATTENDEE 3: All right. Okay. Thank you.

MS. TREAT: Sure, okay.

REPRESENTATIVE MAIER: Thank you, Sharon.

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

CD 135/TRACK 1

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

REPRESENTATIVE MAIER: Okay. Well, I think what we just decided is on the bottom of page 16, the very bottom, the last two lines is to leave it in as written. So we have -- we have a "unless the contract provides otherwise" provision." We may move the sections around a little bit too just so that it's clear to the reader in the packet here that the first thing is there is a notice that happens.

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

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

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

ATTENDEE 1: Of a like character.

MS. LUNGE: And this was also -- one is the language in Maine except Maine also uses the actual term fiduciary which --

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

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

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

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

ATTENDEE 1: That you can waive --

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

REPRESENTATIVE MAIER: Well, understand what we're saying here. In A we sort of just decided -- I'm not -- I'm not holding anybody to anything here today because we're not voting today. But I mean what we just semi decided was to keep A, which means that everything that follows is waivable.

ATTENDEE 1: Right.

REPRESENTATIVE MAIER: So then the question is --

MS. LUNGE: My question is, can you legally waive a legal duty and if you can -- is it then even a duty if it's waivable?

ATTENDEE 1: Right, right.

MS. LUNGE: So I'm -- I'm posing a legal question to myself.

REPRESENTATIVE MAIER: And is that question -- is that question the same for you whether it's -- you understand the finance version or the current version?

MS. LUNGE: Yes, because I think one is substantively different than two through six, because two through six are terms that you -- about disclosure and notification as opposed to the duty of care that a court would impose on a party to a lawsuit when looking at their contract.

ATTENDEE 1: So, in other words, one should be statute -- I mean, it should be the standard that applies legally rather than the contracts can do it or not.

MS. LUNGE: I think that's my understanding of what a duty of care is but I just want to check, you know, with some of my colleagues.

ATTENDEE 5: Take one out and then have A applied to two through six. Is that --

MS. LUNGE: Or to decide you don't want to touch one or, you know -- I don't know.

ATTENDEE 1: If there is a standard already that covers these kinds of things, it might be one or the other and we might not need to (inaudible).

MS. LUNGE: I think -- go ahead. I'm sorry to muddy the waters but that -- I -- that just -- I hadn't really thought about that from a -- you know, that legal question before today.

REPRESENTATIVE MAIER: I think that's what uncomfortable to me is that we're saying that you should be a good guy but you can have a contract that says --

ATTENDEE 1: Yeah, that you don't have to be a good guy, yeah, that's a strange.

REPRESENTATIVE MAIER: And if we think you should be a good guy, not to be sexist or anything, or good woman, but you can have --

ATTENDEE 1: Yeah.

MS. LUNGE: The good company because there really is --

REPRESENTATIVE MAIER: And then part of the things they can waive is all the -- the rest of it if they wanted the rest of it, but we still believe that they should have a certain standard they should live up to. So I would say leave in -- I'd be happy with the lower standard and then have the contract apply to the specific notice.

ATTENDEE 5: Well, I would like to know what the standard is before I decide whether I want it to be lower or not.

MS. LUNGE: I think the current standard would be the contract standard.

ATTENDEE 4: Okay. I have a problem with the time here because, Chuck --

ATTENDEE 7: I don't know if this is very helpful but, you know, when we're talking about parties in a contract relationship, the way the courts are going to look at their rights and responsibilities first and primarily is they're going to look at the contract and see what that says.

Now, there's lots of times in the course of a performance of a contract where issues come up that aren't specifically addressed in the document itself. And in all contracts, the courts will imply a covenant of good faith and fair dealing. And that's basically what they say, you know. And then what that actually means depends on the given facts and circumstances of the case but there's an obligation in performing a contract to treat the other party in good faith and in a fair manner. That's a given.

And then there's also an obligation to perform the contract in a non-negligent way, it can't be negligent. So I just throw that out there as something that you can rest assured is always going to be the case in the context of
parties dealing with each other in contractual contracts.

REPRESENTATIVE MILKEY: And when it's the higher stand, is it written to statute that proclaims that it's a the higher standard --

REPRESENTATIVE MAIER: I'm sorry, you're just going to have to hold on to that question because I'm worried about the doctor we have at 1:30 and I won't want to lose her.

REPRESENTATIVE MILKEY: Oh, Okay. I'm sorry.

REPRESENTATIVE MAIER: Hold on to your thought.

DR. BOERNER: Hello.

REPRESENTATIVE LERICHE: Dr. Boerner?

DR. BOERNER: Yes.

REPRESENTATIVE LERICHE: Thank you. This is the House Health Care Committee. I will transfer it over to Chairman Steven Maier.

DR. BOERNER: Hello.

REPRESENTATIVE MAIER: Hello, Dr. Boerner, how are you today?

DR. BOERNER: Very well. Thank you.

REPRESENTATIVE MAIER: We're here talking about a -- a -- a bill that's in front of us,

S115, which is a bill that contains a number of different provisions related to transparency and privacy of certain pharmaceutical information and a few other things as well. One -- one of the provisions in front of us relates to what is at least euphemistically referred to as data mining. And I understand you have something -- an experience related to that that you could relate to us that we'd be interested in hearing.

If you could do that, that would be great.

Maybe you can just start and tell us a little bit about yourself and where you practice and that sort of thing.

DR. BOERNER: Okay. I am that dreaded thing, I'm a flatlander. I practiced in Boston for 20 years and then moved six years ago to my weekend Vermont house in Reading, Vermont, and took a job with Lane and Nice (phonetic) Associates in Springfield.

Dr. Lane expanded his practice into New Hampshire and he put a satellite in Claremont and I'm the doctor in Claremont. So although I feel like a Vermonter, I practice mostly in New Hampshire unless I'm covering the E.R. near Springfield Hospital. So that's my story, that's who I am.

And I was particularly delighted to be practicing in New Hampshire when the ability of pharmaceutical companies to harass me became terminated.

Basically, when a doctor prescribes for a patient, you would like to think that the doctor takes the best drug for you and hopefully that's what the doctor can do. But the first thing they have to look at is, oh, what's your insurance? So we have to look at a list of drugs that their insurance will allow them to have. So that's the first painful thing that a doctor has to do when they're making a drug -- a decision to put a patient on a drug.

And then you can -- if you check the list, you write the prescription. If it's a drug plan -- even if a patient is begging you, please don't make me -- put me in the third tier drugs, you know, that kind of stuff, so it's a pain in the derriere any way to do prescribing these days. It's no longer what's the best thing for the patient. It's what their health plan will let you do for them.

So on top of that comes the layer of insanity that the drug rep -- these are the people paid by the drug companies to detail the doctors. A good rep is absolutely invaluable because when you're in the hinterlands, where are you going to get your information about what's going on with drugs? It's the drug rep.

They'll come in and they say, we have a new drug, you know, X drug does this, our drug does X plus Y, so you can see why it's a good idea for your patients. You know, you can learn from them. And oftentimes -- and they'll help you out. They'll say, you've had trouble with this. Well, put a artificial tear in the eye before you use it and then they won't have stinging. Little things, they can help, and they're useful. And most hopefully for us they bring samples of their drugs so that when you want to put somebody on a medicine, you don't tell somebody, particularly if they have no insurance, here, go spend $100 for this bottle of drugs and oops, two drops of it, you're allergic to it, well, I'm sorry about that. We don't have to put patients in that bind. We
just give a sample drop. It works, it doesn't
work and no one can order it.

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

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

And -- and the health plan's paying for
the health, I can understand they can say all
right, we're paying for the drugs, we don't
want you to use XY and Z. I don't like it. I
can understand that.

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

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

Any questions?

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

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

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

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

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

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

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

DR. BOERNER: But, you know, you do want
their samples, you know, so it's a -- I do need
their samples. And I will tell you guys that
when this thing came out with New Hampshire,
the outcome, the largest ophthalmic
pharmaceutical company in the world withdrew
all their reps from New Hampshire. So I said,
kick yourself in the foot, how do they expect
me to ever use their drugs if they do that?

And so we have no samples for Norcom
(phonetic) anymore. I mean is that stupid?

How stupid is that? You know, they piss --
they can't follow up on whether their rep is
doing a good job because their rep is doing a
good job if I prescribe the expensive drug --
the new expensive drugs.

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

REPRESENTATIVE MAIER: Bill.

ATTENDEE GIBB: Bill Gibb from Burlington.

Doctor, if you -- probably two questions.

Because you're in a more remote area in New
Hampshire, is that one of the reasons you're
not being harassed by detailers?

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

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

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

ATTENDEE GIBB: So there was legislation
that curtailed --

DR. BOERNER: Well, what the legislation
did, now let me make this clear, is one of the
major companies said, if we can't keep track of
what you're doing, we won't give you any samples. So basically they're just going to hurt the patients by not giving out samples. I don't know how long that's going to last but that was their real tit for tat.

ATTENDEE GIBB: My other question -- it's my only question --
DR. BOERNER: May I finish with that?
There are other drugs to use, so they're just hurting themselves.

ATTENDEE GIBB: My other question is, if the detailers didn't show up in your office, how else would you find out similar or parallel information?

DR. BOERNER: At meetings.

ATTENDEE GIBB: At meetings and you would --

DR. BOERNER: Meetings, talking to colleagues. There's a lot of information that go on at meetings and stuff right now.

ATTENDEE GIBB: And you have the time to do that?

DR. BOERNER: I do. Now that I'm working up here, I'm not crazy.

ATTENDEE GIBB: Thank you.

DR. BOERNER: I mean, working up here is wonderful because you do have -- the way it's set up, I have more time to take more care of my patients.

The overhead for a practice in Boston, I mean, my front desk people made 18.50 an hour. My technician was $25 an hour. And I know it's nowhere near that up here. I mean, the rent for my office in Boston was close to $9,000 a month, you know, so everything is less expensive up here so I don't have to see quite as many patients to make overhead. But that's not what you're asking about. You're asking about the drugs.

ATTENDEE 3: If you didn't have the samples --

DR. BOERNER: What would I do? I'd used another company's drugs.

ATTENDEE 3: How hard would it be just to have a container of the different drugs there and use them, you know?

MS. LUNGE: You can't do that.

ATTENDEE 3: You can't do that?
DR. BOERNER: Yeah.

ATTENDEE 1: Not unless you're a pharmacy.

DR. BOERNER: Who pays for it?

ATTENDEE 6: I think you have to be licensed as a pharmacist to have a dispensary in your office.

DR. BOERNER: Yeah. You can't give out drugs as a doctor because you're not a pharmacy. At least you couldn't in Massachusetts.

REPRESENTATIVE MAIER: Learn something new every day.

Ginny.

REPRESENTATIVE MILKEY: No, he asked the question.

REPRESENTATIVE MAIER: All right. Other questions?

ATTENDEE GIBB: How do you feel about your prescription patterns being sold to -- to commercial outfits?

DR. BOERNER: It makes me very, very angry.

ATTENDEE GIBB: Like how?

DR. BOERNER: Like how angry?

ATTENDEE GIBB: Yeah.

DR. BOERNER: Get me a pharmaceutical. It's not -- it's another hassle of practicing medicine. It's bad enough that Medicare is following everything we do. The health plans are following and telling you what to do. And then the pharmaceutical companies are going to check up on what you're doing. Hello. It's -- it's very unpleasant. I don't like being watched like that.

REPRESENTATIVE MAIER: Topper.

REPRESENTATIVE McFAUN: Doctor, this is Topper McFaun.

What if the information that the -- the company had was being used for research, how would you feel about it then?

DR. BOERNER: What kind of research -- that's just only what they know. It's not research who's using what. That's -- that's -- that's business. You see it's -- at least in ophthalmology there are several different drugs in every class of drugs. So the fact that one -- one company doesn't want to come to New Hampshire just cuts off their nose to spite their face.

REPRESENTATIVE McFAUN: I'm not talking about a company coming or going. I'm talking about the information that they --
DR. BOERNER: But that information to me, who's using what, that's not research. That's research for their bottom line. That's not research to make patients' care better. Who's buying what does not make patients' care better. It's not research. They want to call it that because it sounds really good. Research is when you try a drug and you find out whether or not it works.

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

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

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

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

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

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

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

REPRESENTATIVE McFAUN: Why would you keep prescribing it then?

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

REPRESENTATIVE McFAUN: Right.

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

REPRESENTATIVE McFAUN: Or because you had samples.

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

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

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

REPRESENTATIVE McFAUN: Okay. Thank you.

REPRESENTATIVE MAIER: Yeah, Harry.

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

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

REPRESENTATIVE CHEN: So you don't think
that's a problem.

DR. BOERNER: The pharmacy -- the pharmacy catches that. You get -- the pharmacy will call you and say, your lady, she's already on X, you can't do Y. And I go thank you.

Did she tell you she's allergic to this?

I go, no.

REPRESENTATIVE MAUFA: But what about things that are you know, like FDA notices or things like that of drugs that are -- you know, that maybe indications have changed --

DR. BOERNER: Well, that comes out to me, I get those all the time. They're mailed to me by the companies even for drugs I don't particularly use. I get that. The government -- FDA is real good about sending letters out.

REPRESENTATIVE MAUFA: Okay.

ATTENDEE 5: So it isn't just limited to the ones you prescribe?

DR. BOERNER: No. I can get warning drugs about other things -- warnings letters about other drugs. Like when this -- there's a problem with Glimperid came out, that they -- they notified me and I don't ever prescribe.

Glimperid. That's -- an internist practice, prescribed for diabetes.

REPRESENTATIVE MAUFA: All right, Dr. Boerner. Thank you very much for your time and your information.

DR. BOERNER: Please, please, it's a wonderful, wonderful, wonderful idea to not be spying on doctors and having the reps come back and make you feel guilty for not doing what they want us to do.

Thank you for your attention. Thank you for taking this up. I really appreciate it.

Have a great weekend.

REPRESENTATIVE MAUFA: All right. Thank you.

DR. BOERNER: Bye-bye.

ATTENDEE 4: I'm glad she waffles.

REPRESENTATIVE CHEN: Again, I wish she weren't so shy.

ATTENDEE 7: Is this a common story that we would hear from a bunch of physicians?

REPRESENTATIVE MAUFA: That's what I was going -- I was going to ask Harry the same question.

REPRESENTATIVE CHEN: Well, obviously, you hear some. The -- the husband of the person introduced in New Hampshire was getting harassed by -- again, I don't because I don't talk to them.

ATTENDEE 1: I have --

MS. LUNGE: My physician has a sign on the door that says no detailers because she's told me she feels their information is inaccurate. She won't let them in the front door.

ATTENDEE 2: Well, that equates to what salespeople do. They give whatever information that will sell their product, not necessarily accurate information.

ATTENDEE 1: The tragedy about this is the withholding of samples. If I can't get your -- your good information, I'm not going to give you my samples, because I know our pediatrician uses samples a lot either to start somebody on a Saturday night when they need -- you know, they need to start and they can't get to the pharmacy until Monday or people who can't afford the medicine can get their whole course of it free because he's got enough samples.

ATTENDEE 4: The Vermont Medical Society, you know, has been pushing this provision because we heard from our -- from the (inaudible) in New Hampshire. None of the folks from New Hampshire have said they can't get the samples. My sense is from her testimony it was one company that just kind of abandoned the New Hampshire market. I think they're more the exception than the rule. But we've heard a lot of comments to support, from New Hampshire physicians, none of them have said the samples have dried up.

And, in fact, I'm -- I don't know if Madeline mentioned it in her testimony but two weeks from now I'm supposed to speak at a conference in Washington D.C. of pharmaceutical detailers who are trying to figure out how to have effective marketing absent this -- this physician specific information. So, you know, I -- it sounds like for her it was one company and presumably the other companies continued to visit her and provide the samples. And it's the first time that I've heard they are no longer getting samples from one company in New Hampshire.

REPRESENTATIVE MAUFA: Okay, Ginny.

REPRESENTATIVE MILKEY: It seems to me if
of it. We know from all of us being around this table for years -- and, remember, before I make these statements I'm not sticking up for anybody but there's two sides to this. We know that drug companies provide drugs to people at a very, very reduced cost and sometimes nothing for -- for people who need help. We also know that they go into physicians' offices and they give the drugs for nothing so they can start people on a drug. So it isn't -- I just want to -- let's -- let's keep the playing field.

There's some good things they do, too.

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

REPRESENTATIVE McFAUN: When I read those -- what I get with my pills, there's enough stuff in there --

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

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

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

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

REPRESENTATIVE MAIER: Sure.

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

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

REPRESENTATIVE MILKEY: Thank you.

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

Tuesday, just to remind the Committee, we're doing -- Tuesday we're doing naturopaths
in the morning and prescription drugs in the
afternoon.

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

we'll just keep working on -- on the language
of the Bill and see how far we can get.

MS. LUNGE: So when is your target -- do
you have a target date for when you will
(inaudible.)
REPRESENTATIVE MAIER: At the end of the
next week will be the timetable -- but when
it's ready.

MS. LUNGE: Right. Right.
REPRESENTATIVE MAIER: And then in the
afternoon Wednesday and Thursday we have other
testimony on -- I have to remember. Do you
have it?
ATTENDEE 1: Health insurance and
reimbursement --
REPRESENTATIVE McFAUN: What is that
naturopath?
REPRESENTATIVE MAIER: Okay. Have a good
week. Thank you.
STATE OF VERMONT

STANDARD COMMITTEE MEETING

RE: SENATE BILL 115, RX DRUGS

DATE: Friday, April 13, 2007

TYPE OF COMMITTEE MEETING: Standard

COMMITTEE MEMBERS:

Rep. Steven Maier, Chair Rep. Henry Chen, Vice-Chair

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

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PROCEEDINGS

CD 133/TRACK 1

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

CHAIRMAN MAIER: Let's wait.

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

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

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

CHAIRMAN MAIER: Kathy had to reschedule from some other day this week and

here she is.

MS. CALLAGHAN: Hi.

ATTENDEE 4: Oh, perfect.

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

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

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

ATTENDEE 5: Yes, that's it.

CHAIRMAN MAIER: Do we need to elevate it?

MS. CALLAGHAN: No, no. I was looking for [ ]

ATTENDEE 6: Is it on?

ATTENDEE 7: It's picking up fine now.

MS. CALLAGHAN: Oh, okay.

ATTENDEE 8: That one died.

MS. CALLAGHAN: Oh, I've got you. Okay. Great. For the record I'm Kathy

Page 4

Callaghan and I'm the director of the State Employee Health Fund. And I wanted to take the

opportunity today while you're still taking testimony on this bill, to offer some information

about our plan. And I thought this information would be helpful as you consider S

1115.

This is essentially the same testimony that I gave to a Senate Finance

Committee on February 6th. And I used the front and back of the paper.

ATTENDEE 9: Oh, you're good.

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

CHAIRMAN MAIER: Narrow margins and [ ].

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

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

MS. CALLAGHAN: All right. The Senate Finance Committee asked me to come

in earlier this year and their question was: How is it working? Can you quantify any

savings, anything else you think the committee should know about the prescription drug plan

and is there any other information you would like to share. So I prepared some

information. I will walk through it and I'm happy to take any questions.

Some facts about the State Employees Prescription Drug Plan. There are

currently approximately 22,400 members, and this includes the state employees and the retirees

and their covered dependents.

Our plan is a calendar year plan and in calendar year 2006 plan members

filled

333,457 prescriptions for a total cost of $211.1 million. And of this total,

140,225 were for

brand name drugs and that cohort cost $16 million. The remaining 193,232 were for

generic

drugs and those cost $5.1 million. Quite a difference.

Through our plan design we maximized generic utilization. We negotiated

with the union a long time ago a mandatory generic substitution provision so that

unless it

Page 3

is medically contraindicated a generic is dispensed. The plan currently uses a

Pharmacy Benefits Manager, or a PBM, called Express Scripts. Express Scripts is a commercial

PBM covering approximately 50 million lives nationwide. And through Express Scripts the

plan provides prescription drug coverage through both retail pharmacies and mail

mail order

delivery.

Retail pharmacists in Vermont and nationally contract with Express Scripts

to provide retail drugs and then Express Scripts provides mail service

prescriptions

through its own mail service pharmacy. The mail service home delivery component is especially

appreciated in our case because we have over 3,000 retiree members, and this

allows them to get prescriptions in the mailbox rather than having to go out in the snow and what

not.

Express Scripts obtains and passes along to the state manufacturer

pharmaceutical discount based on a drug's Average Wholesale Price of AWP. The discounts vary

between Express Scripts retail network and their mail order pharmacy. Mail order discounts

are generally deeper discounts.

In our current contract with Express Scripts we negotiated the following

discount levels. At retail, for brand name drugs, we get average wholesale price,

minus 16

18 percent, plus $0.20 dispensing fee. For generics we get average wholesale price

minus 51.5

19 percent, plus the $0.20 dispensing fee. Through mail order home delivery you can see that the

discounts are deeper at minus 24 percent for brands and there are no dispensing fees,

and then generics are minus 54.5 percent with no dispensing fees.

ATTENDEE 11: May I ask a question?

CHAIRMAN MAIER: Yes.

ATTENDEE 12: Kathy, I remember from previous days in this building

AWP

stood for AIN'T What's Paid.

2 (Pages 2 to 5)
MS. CALLAGHAN: Well, not in this plan, I guess.

ATTENDEE 13: Well, I mean, you "%

ATTENDEE 14: Well, it is in this plan because it is a minus 24
percent, 54
24 percent, 16 percent.

ATTENDEE 15: It's a basic "% I just question the credibility of
Express
6 Scripts in the situation when they are using an artificial number so much to issue
you a
discount, issue the (inadvisable) discount. It's an artificial number.

MS. CALLAGHAN: Okay.

ATTENDEE 16: So when you may be getting a good deal, you may not be
getting. Maybe they are not "% Express Scripts is not passing along all of the
advantages of
bulk purchasing.

MS. CALLAGHAN: Okay.

ATTENDEE 17: That's all I'm saying and I just raise that issue.

MS. CALLAGHAN: Sure. No, I would like to address that. I have no
doubt
that they are not passing along all that they could be passing along because the very
nature of pharmaceutical pricing is a shell game at best.

ATTENDEE 18: Yes.

MS. CALLAGHAN: I don't know if you've heard testimony before I came in.
I'm sure you probably have.

The commercial PBMs all use this very same basis. It is average
wholesale price as determined by First Data Bank. There's been some recent
controversy about
First Data and it is possible there is a lawsuit pending. And what the suit
suggests is
that First Data was favoring a particular drug manufacturer over others. And as a result
of that, and in settlement of that it is our belief that AWP as we know it is no longer

going to be the standard by which pricing is set. And we think that the industry
is going
to move as a whole to another form of pricing.

That doesn't say that AWP isn't workable right now but it is on the
chopping block. Okay?

ATTENDEE 19: We will see what the substitute looks like, but go ahead.

I just have a problem with the credibility of that process. Go ahead.

ATTENDEE 20: And I'm surprised that you have a better, that you somehow
get a better deal than our Medicaid Program.

MS. CALLAGHAN: We do.

ATTENDEE 21: And does that include the other "% Medicaid gets like two
discounts.

ATTENDEE 22: Oh, that's right. The supplemental rebate.

ATTENDEE 23: They get the federal discount.

MS. CALLAGHAN: That's correct and we don't get a supplemental
discount. I
believe the Medicaid supplemental is only on certain drugs and in certain quantities.

I don't think it is a wholesale overall two-tiered system.

ATTENDEE 24: Right.

REPRESENTATIVE COPELAND CHANZAS: May I ask a question?

CHAIR MAIER: Sure, Sarah.

REPRESENTATIVE COPELAND CHANZAS: We've been told that Medicaid can't
be
used to leverage better prices for other Vermonters.

MS. CALLAGHAN: Uh huh.

REPRESENTATIVE COPELAND CHANZAS: But is there any reason that if this
something better than Medicaid, that Medicaid couldn't get prices through the
state
Employees?
I. ATTENDEE: I am interested. I just think that there are in place right now some barriers but who knows how that is all going to shake out. So do you think that a pharmaceutical company has an interest, a financial interest, in Express Scripts, to your knowledge?

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

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

MS. CALLAGHAN: Yes.

ATTENDEE: Thank you.

ATTENDEE: And they all swear that they don't.

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

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

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

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

ATTENDEE: They are not broken out.

Ms. Callaghan: They are not broken out. They are all built in.

ATTENDEE: (inaudible) charges.

Ms. Callaghan: And generally I think they make their money on the spread in the generic, the cost between the cost of what they purchase the generic for and what they sell it out for. But if you look at our pricing structure.

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

Ms. Callaghan: Correct.

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

Ms. Callaghan: We did. And when we went out to bid in 2005 we solicited bids from so we instructed our consultants to solicit bids from everybody. That included RIXAS (phonetic), it included NLRAX, and all the individual profits that they could find and the profit and the commercials they could find.

We got no bids back from any of the non-profits, including NLRAX. And that was a little disappointing because we had been sort of going back and forth with Senator Reed (phonetic) and Senator Rivers and as we were looking at this. And we did, but they declined to bid. And I, myself, gaining a better understanding of the difference between a...
1. bid again for this plan in 2008 we will solicit bids from anyone who is viable for
2. profit, not for profit, consortiums just to see what the marketplace looks like.
3. Our goal
4. is to save as much money as we can for the state and for the employees, so we will be
5. looking very closely at it. And that's all I have.
6. CHAIRMAN MAIER: I just want to O I don't know. Maybe Robin can O
7. she's walking in the door there. The committee has been asking questions about NLARX,
8. and what they are, and who they are. I don't think this is technically correct. NLARX is a
9. non-profit organization. I believe what they are trying to do a few years back was
10. set up, was spun off a different organization that would become a non-profit PBM.
11. And was
12. that O I don't think it was under the umbrella of NLARX as an organization.
13. ATTENDEE 62: No, it wasn't.
14. CHAIRMAN MAIER: So, it is not NLARX.
15. MS. CALLAGHAN: Okay.
16. CHAIRMAN MAIER: It's O and partly O it never got off the ground.
17. MS. CALLAGHAN: Never got off the ground. Okay. O I O
18. CHAIRMAN MAIER: So just because we've been hearing from NLARX in their
19. capacity as O in their staff capacity from that organization, they have no interest, never had
20. a specific interest officially and certainly at this point don't have any interest as a
21. PBM because it never O
22. MS. CALLAGHAN: It never got off the ground. Okay. Yes. Thank you
23. for that clarification. I think that in Q5 when we were looking at them O
24. CHAIRMAN MAIER: They had a different name. I don't know what the
25. that non-profit had a different name for a while.
26. ATTENDEE 63: NLARX had a different name?
27. CHAIRMAN MAIER: No.
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1 purchasing pool in West Virginia. But at that time they were taking no new states
so we weren't
2 able to.
3 That there are other purchasing pools we've learned across the country
4 that
5 charge you a fee to get in. So there's all kinds of interesting things going on.
6 But, I
7 mean, we keep our eye set on the service you have to have and the lowest possible
8 price for
9 the same thing in whatever way we can do it.
10 CHAIRMAN MAIER: Harry.
11 REPRESENTATIVE CHEN: I just have a general question. The dollar
12 amounts
13 you list like 140,000, 2.5 prescriptions cost $16 million. Is this total dollars
14 or does
15 it include the cost to the state holders?
16 MS. CALLAGHAN: No. It is total dollars.
17 REPRESENTATIVE CHEN: So is it member plus it is the cost sharing is
18 included in that?
19 MS. CALLAGHAN: Yes, it is.
20 REPRESENTATIVE CHEN: Okay. And let me just throw out to you. If
21 you do
22 the math, brand name prescriptions average out to costing $114 and the generic
23 prescription average out costing $26. And I'm just going to make a case that you
24 should be paying
25 people to do generics. You shouldn't it should be you would save money if
26 you paid
27 somebody ten bucks to have a generic prescription. I'm serious.
28 MS. CALLAGHAN: No. I get you.
29 REPRESENTATIVE CHEN: Right. Rather than the percentage. You know,
30 agree with the percentage (inaudible).
31 ATTENDEE 69: I don't have any co-pay with generics.
32 REPRESENTATIVE CHEN: I think that it should be zero or actually
33 paying
34 them.

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1 MS. CALLAGHAN: Well, we do have something in place that forces them.
2 ATTENDEE 70: Yeah, right.
3 MS. CALLAGHAN: At this point.
4 ATTENDEE 71: If there is a generic for the drug he has to take it.
5 REPRESENTATIVE CHEN: Oh, yes. No, no, I understand that. But it
6 ATTENDEE 72: (inaudible) drugs that don't have generic.
7 MS. CALLAGHAN: Well, there are. I think we're maxed out. I could also
8 give you this piece of information. I think we're maxed out at somewhere around

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9 which is all of the my understanding is, it is all of the drugs that have a
10 generic equivalent. We are very we are like 98, 99 percent maxed out to what we could be
11 because we checked that out, too.
12 REPRESENTATIVE CHEN: I would like to go off line and talk to you.
13 MS. CALLAGHAN: Sure.
14 REPRESENTATIVE CHEN: Because I don't think you are. I mean, I think the
15 mandatory is a good think but I think within a class. So, for instance, you have cholesterol
16 drugs, Lipitor, and Zocor. Zocor is now generic.
17 MS. CALLAGHAN: Right.
18 REPRESENTATIVE CHEN: So if you write Zocor you get a generic Zocor.
19 but if
20 you write Lipitor you won't get a generic Zocor. You could use, for many people, the
21 generic Zocor.
22 REPRESENTATIVE O'DONNELL: Is Zocor the only one that is generic?
23 REPRESENTATIVE CHEN: I think right now. There may be another one coming.
24 So that you know, that's so, again, I think you would save money by actually
25 paying people.

Page 21

1 MS. CALLAGHAN: I would love to talk with you off line. I just have one
2 other comment and then I'll finish.
3 CHAIRMAN MAIER: John had another comment.
4 MS. CALLAGHAN: Oh, I'm sorry.
5 REPRESENTATIVE ZENIE: That's okay. It actually kind of piggybacks on
6 this.
7 I was curious. Can you tell me what the criteria is as to how someone is placed on
8 the PDL, and specifically relative to preferred versus non-preferred? I mean, obviously
9 cost is one factor but is there other factors that
10 MS. CALLAGHAN: Yes, there are. That work is done by the PBM, generally
11 and they have a therapeutics and pricing in therapeutics committee that they use which
12 comprised of pharmacists, doctors, and folks who are not their employees. And they meet
13 quarterly and then establish new PDL drugs on an annual basis.
14 Now, the PBM's have either an open formulary, a middle of the road
15 formulary, or a very restricted formulary. So depending upon what drug you are talking about it
16 could land someplace else in a different formulary. But it is done by those
17 and my understanding is those experts are not employees of the PBM?
18 REPRESENTATIVE ZENIE: Okay. So it is not each PBM that is developing
19 their own formulary?
20 MS. CALLAGHAN: Yes, it is.
21 REPRESENTATIVE ZENIE: It is?
22 MS. CALLAGHAN: Yes. Within the PBM it is.
23 REPRESENTATIVE ZENIE: I don't understand that. Why would it be so
24 different between PBMs?
25 CHAIRMAN MAIER: Because that's how they are making their money.
26 MS. CALLAGHAN: That's how they make money.
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REPRESENTATIVE ZENIE: That's what I'm trying to get at.

MS. CALLAGHAN: The chair knows. He knows.

ATTENDEE 73: It has to do with making money, not with (inaudible).

REPRESENTATIVE ZENIE: I understand. I guess what I'm trying to get at is ______

5 CHAIRMAN MAIER: They are trying to set up some sort of firewall between their clinical group and the

6 money

7 making part.

8 MS. CALLAGHAN: Yes, yes.

9 CHAIRMAN MAIER: But [inaudible] and I don't have any reason to doubt that

10 there is

11 [inaudible] you know, that it is most [inaudible] at least mostly valid. I haven't heard any complaints

12 particularly about [inaudible] the complaints we hear about formularies are more like from

13 doctors and, you

14 know, they're considered a thousand of them.

15 MS. CALLAGHAN: Yes.

16 CHAIRMAN MAIER: You never know (inaudible). I don't know if you've seen Harry in

17 his [inaudible] he has a little [inaudible] he can show you. He has a little (inaudible). He can show you [inaudible]

18 I don't know how many different formularies are on it. He isn't strong enough to have

19 them all.

20 REPRESENTATIVE CHEN: No. I couldn't fit them.

21 CHAIRMAN MAIER: It isn't big enough.

22 MS. CALLAGHAN: I believe you.

23 CHAIRMAN MAIER: He needs to get a new one.

24 MS. CALLAGHAN: Yes.

25 CHAIRMAN MAIER: But that's the complaint more than I hear about that

26 there are inappropriate drugs, preferred drug things going on.

Page 23

MS. CALLAGHAN: Right.

CHAIRMAN MAIER: The state [inaudible] the Medicaid PDL is, like Kathy just

suggested, it is done [inaudible] it's stuff, or the appointees to the drug utilization

board are

physicians and pharmacists and [inaudible]

MS. CALLAGHAN: They develop it.

CHAIRMAN MAIER: And they make the decisions on therapeutic, on value

of a particular drug. But they do [inaudible] it is an odd collaboration of therapeutic science

and costs.

REPRESENTATIVE ZENIE: Well, that's what I'm trying to find out. Is

the overriding or the driving factor, the leveraging factor in terms of things are

placed?

ATTENDEE 74: I don't think it is.

CHAIRMAN MAIER: Well, I think [inaudible] and maybe Harry can help with it.

I think there are [inaudible] there are classes of drugs [inaudible] you know, there are a number of

many classes that are either completely equivalent or largely equivalent in their

therapeutic value. So I think you have to meet that standard first.

15 REPRESENTATIVE ZENIE: Okay.

16 CHAIRMAN MAIER: And then you move on to a class negotiation and [inaudible]

17 MS. CALLAGHAN: Yes.

18 REPRESENTATIVE ZENIE: Well, I'm glad to hear that anyway.

19 MS. CALLAGHAN: It starts with [inaudible] my understanding is it starts with a

therapeutic look, cost aside. Then when the decisions are made about the

therapeutic then it goes

21 to cost and then something may be thrown out or [inaudible]

ATTENDEE 75: And (inaudible) then the drug can (inaudible).

22 CHAIRMAN MAIER: But what she was (inaudible) at in terms of open or

23 closed, [inaudible]

24 the Medicaid formulary is an open one in the sense that yes, there is

25 you go through the process of they are preferred things. But if [inaudible] but there is an out.
<table>
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<th>Page 26</th>
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<tbody>
<tr>
<td>1. MS. LUNGE: You know what, though? If you have ideas on that then we should get that addressed to Medicaid because that saves a lot of money in Medicaid.</td>
</tr>
<tr>
<td>2. ATTENDEE 81: Well, I'll tell you, Consumer Reports does do their own evaluation on drugs. It's not as clinically sound, probably. I mean, they look at cost, but also at side effects and other things relative to blood pressure medications and so on.</td>
</tr>
<tr>
<td>3. MS. CALLAGHAN: Yes.</td>
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<td>4. ATTENDEE 82: I have two questions. When do I think I have apparently answered my first one.</td>
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<tr>
<td>5. When those people on the other side of the firewall who decide, you know, which things work, are doing their work, do they have access to all of the studies or only the studies that each pharmaceutical company makes public that favors their drugs?</td>
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<tr>
<td>6. MS. CALLAGHAN: Well, I don't know what studies there would be.</td>
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<td>7. ATTENDEE 83: (Inaudible) share their problems.</td>
</tr>
<tr>
<td>8. MS. CALLAGHAN: Well, let me back up. Let me back up a bit. Let me back up a bit. Because they are independent individuals, it is my understanding that it is their duty to look at all the studies.</td>
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<td>9. ATTENDEE 84: But can they get them, I guess is my question.</td>
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<td>10. MS. CALLAGHAN: Well, from leading medical schools and other NIH and so forth.</td>
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<td>11. ATTENDEE 85: I think that the answer is no because do not.</td>
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<td>12. MS. CALLAGHAN: Why wouldn't they be able to?</td>
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<td>13. CHAIRMAN MAIER: Most of them get.</td>
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<td>15. ATTENDEE 86: There are ones that are done when they contract, for instance, with the universities to do research and it comes out unfavorable and they put the gag order on it.</td>
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<td>16. MS. CALLAGHAN: Well, I guess my answer would be that I think they can get what they can get.</td>
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<td>17. ATTENDEE 87: They can get what they can get.</td>
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<td>18. MS. CALLAGHAN: Right.</td>
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<td>19. ATTENDEE 88: So they are basically working with the same information that anybody else could get, which isn't necessarily all the information. Okay.</td>
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<td>20. And my second question is: Going back to do I think do.</td>
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<td>21. ATTENDEE 89: I love the conclusions that are drawn.</td>
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<td>22. ATTENDEE 90: I know.</td>
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<td>23. ATTENDEE 91: Going back to do I think I earlier in the session we were talking about some other aspect of health care and the State employees plan is going to be tracking cat. amount as it unfolds. And I think that was in the context of the, you know, the language that talks about health care professionals that opens it up to other providers.</td>
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<tr>
<td>24. But my question on this is that is do will the plans for State employees in terms of chronic illnesses track cat. amount when it starts in the fall with the no co</td>
</tr>
<tr>
<td>25. PAY for visits related to the chronic illness and no co-pay for the medications needed, you know, for the diabetes and do.</td>
</tr>
<tr>
<td>26. MS. CALLAGHAN: We're working on it.</td>
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<tr>
<td>27. ATTENDEE 92: So you are. You're aiming to (inaudible).</td>
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<td>28. MS. CALLAGHAN: It's our intent because we are required under do the way I read do the way I read the legislation. We've had some meetings on that and some discussions. It's our intent to fully comply unless we are do.</td>
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<td>29. CHAIRMAN MAIER: It's not the cat. amount; it's the blueprint.</td>
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<td>Page 28</td>
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<tr>
<td>1. MS. CALLAGHAN: Yeah.</td>
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<td>2. ATTENDEE 93: I'm sorry.</td>
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<td>3. MS. CALLAGHAN: It's not cat. amount; it's the blueprint.</td>
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<td>4. ATTENDEE 94: The blueprint.</td>
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<td>5. MS. CALLAGHAN: Yeah, you're right. Yeah, I was thinking blueprint.</td>
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<td>6. REPRESENTATIVE O'DONNELL: I may need help for this because I'm not sure I'm phrasing this right. But we heard testimony from the Attorney General's Office that they felt this language was needed because do.</td>
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<td>7. CHAIRMAN MAIER: Which language?</td>
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<td>8. MS. CALLAGHAN: Which language?</td>
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<td>9. REPRESENTATIVE O'DONNELL: The PBM language. Because the insurance companies may be big enough to negotiate for themselves but there were do there were entities within the state of Vermont that they felt needed that protection and staff employees were one of the ones.</td>
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<tr>
<td>10. Do you feel you need the AG's protection or do you feel that you are doing a good enough job do obviously by our Medicaid, the difference in Medicaid prices. But do you feel that you're doing a good enough job negotiating that you don't need anybody else's protection?</td>
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<td>11. MS. CALLAGHAN: Well, I think it would depend on do.</td>
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<td>12. REPRESENTATIVE O'DONNELL: Did I phrase that right?</td>
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<td>13. MS. CALLAGHAN: Part of the bill you're referring to. If do. Yeah.</td>
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<td>14. I'm not sure how to answer that.</td>
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<td>15. We hire experts in the field to do our negotiating for us and these consulting firms that have ex-PBM's working for them. These are the do. I swear. I can't help.</td>
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<td>Page 29</td>
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<td>1. instance, with the universities to do research and it comes out unfavorable and they put the gag order on it.</td>
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<tr>
<td>2. ATTENDEE 95: And if you didn't have an &quot;in&quot; or didn't have the budget to do, to hire somebody to negotiate for you, would you feel you were at a disadvantage?</td>
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<td>4. ATTENDEE 96: So this is kind of a necessary part of dealing with PBM's that you have to have an insider to do.</td>
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<td>5. MS. CALLAGHAN: Yes, it is. And we save much more money than we otherwise could because it requires people who know what the do. Well, you know the story.</td>
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<td>6. (inaudible) people know. This all may change as we go forward.</td>
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<td>7. CHAIRMAN MAIER: Well, we were, I think, sort of do the committee has been excited this morning and I think we've hit you with questions that we have more generally than you do you just happen to receive because you were the one sitting in this chair.</td>
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<td>8. MS. CALLAGHAN: You know, that's happened to me in Senate Health and Welfare, too.</td>
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<td>9. CHAIRMAN MAIER: I'm not sure Kathy is the expert on PBMs or other things but it interesting to hear what do.</td>
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<td>10. REPRESENTATIVE O'DONNELL: I think she's done a very good job answering the questions. You know, how many private employers do.</td>
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<td>11. MS. CALLAGHAN: Thank you.</td>
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<td>12. ATTENDEE 97: (Inaudible) interesting (inaudible).</td>
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<td>13. ATTENDEE 98: And hire a consultant (inaudible).</td>
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<tr>
<td>14. ATTENDEE 99: Well, another thing I like about the labor relations is what you have for (inaudible), too, for the employees, and how that works.</td>
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</table>
| 15. Well, that's shifted recently but, you know, that's a nice way to, I don't know, crowd control the prices on an individual. And that's, of course, a nice
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1. ATTENDEE 100: Tell me □ □ I mean, do you have any idea roughly how
2. much money you spend on these consultants to negotiate with the PBMs? I just (inaudible).
3. MS. CALLAGHAN: I want to say $60,000.
4. ATTENDEE 101: That's $60,000 in administrative costs just kind of tacked onto the
5. system?
6. MS. CALLAGHAN: Yeah, yeah.
7. REPRESENTATIVE O'DONNELL: But it saves a lot of money.
8. MS. CALLAGHAN: It saves a tremendous amount of money.
9. ATTENDEE 102: I understand that.
10. REPRESENTATIVE O'DONNELL: It's worth it.
11. ATTENDEE 103: Yeah, yeah. Millions.
12. MS. CALLAGHAN: I mean, under today □ □ in today's □ □ it pays for itself
13. many, many, many times over.
14. ATTENDEE 104: But just thinking about access, about you, know, if we can
15. afford $60,000 to negotiate □ □ you know, to hire somebody to □ □
16. MS. CALLAGHAN: Well, that's true.
17. ATTENDEE 105: I mean, you have to be pretty large entity.
18. MS. CALLAGHAN: That's true. But, you know, I don't think that there are
19. many employers in Vermont who use PBMs either. What they do is they will get their drug
20. coverage through CIGNA who negotiates with its PBMs, and Blue Cross who negotiate with
21. RECP (phonetic).

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1. REPRESENTATIVE O'DONNELL: (Inaudible) self- □ □ □ □ (Inaudible)
2. MS. CALLAGHAN: So, we're large enough to be able to command market
3. share and do our own deal. And, by the way, both CIGNA and Blue Cross bid for our drug
4. plan and they were both significantly higher than Express Scripts. So when you take
5. Express Scripts and add $60,000 you're still doing a whole lot better than we would get through
6. a commercial.
7. ATTENDEE 106: And Express Scripts is a significantly bigger company, I
8. would guess?
9. MS. CALLAGHAN: They cover 50 million lives.
10. ATTENDEE 107: As compared to the other ones?
11. MS. CALLAGHAN: I think the others are smaller.
12. ATTENDEE 108: (Inaudible) Vermont.
15. ATTENDEE 111: (Inaudible) CIGNA.
16. MS. CALLAGHAN: Well, they use a RETSTAT who probably is bigger than that
17. but I don't think they are as big as □ □ there are only two or three big ones in the
18. commercial marketplace. Caremark just merged with CVS, Express Scripts, and I think it is Medco.
19. ATTENDEE 112: Yeah. That's what we're talking about.
20. MS. CALLAGHAN: Yeah.
21. ATTENDEE 113: So we will see who becomes WalMart in the long run.
22. CHAIRMAN MAIER: Any other questions?
23. ATTENDEE 114: Yeah, right after here.
24. CHAIRMAN MAIER: We have a technical problem with WalMart. Here it comes, baby.
25. MS. CALLAGHAN: Save the best for last.

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1. ATTENDEE 115: Representative Leriche talked to you about is there any part
2. of this bill that concerns you. And you talked specifically about joining forces with
3. the other identities, to purchase to get a lower price.
4. MS. CALLAGHAN: Uh-huh.
5. ATTENDEE 116: Now, in that discussion the words "may" were used and the
6. words "shall" was not used.
7. MS. CALLAGHAN: That's right.
8. ATTENDEE 117: Except that it is "may" and not "shall." My reading of it
9. is, it is "shall" not "may." Now, if I'm wrong, correct me.
10. MS. CALLAGHAN: Okay.
11. REPRESENTATIVE O'DONNELL: What page are you on, Topper?
12. ATTENDEE 118: I'm on page six and seven.
13. ATTENDEE 119: That's the one where it says (inaudible).
14. ATTENDEE 120: Shall is (inaudible).
15. ATTENDEE 121: That's the "may." This is □ □ yeah.
16. MS. CALLAGHAN: Yes.
17. ATTENDEE 122: Practicable is "may" with a good reason. Shall try.
18. MS. CALLAGHAN: Shall. You're correct. It says shall. And shall do it to
19. the extent practicable and consistent with the purpose of the chapter.
20. CHAIRMAN MAIER: It also says shall on a voluntary basis.
21. MS. CALLAGHAN: Yes. We are going out to bid next year.
22. CHAIRMAN MAIER: But if you look at the language □ □
23. ATTENDEE 123: This is coming from the Senate, right?
24. ATTENDEE 124: Why would we expect any (inaudible).
1 identify which areas of the bill we are either more or less comfortable with, needing more or less work from our standpoint. I'm quite sure that that will (inaudible) quick page, but, yeah, I think we're going to get into some discussion about it. I'm not sure that we can do ___ we will even be able to do that in the hour that we have here before lunch.

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

8 ATTENDEE 132: Maria.

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

10 MS. MITIGUY.BURNS: Mitiguy.

11 ATTENDEE 133: Maria.

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

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

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

16 MS. MITIGUY.BURNS: Okay.

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

20 MS. MITIGUY.BURNS: Oh, I'm pretty open, I think, now, and I can ___

21 whatever works for you folks.

22 CHAIRMAN MAIER: That ___ are you ___

23 MS. LUNGE: I'm free all day except ___

24 CHAIRMAN MAIER: ___ flexible?

25 MS. LUNGE: Of course.

11 CHAIRMAN MAIER: Let's do it that way.

2 CD 133/Track 3

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

4 MS. MITIGUY.BURNS: Everyone has one.

5 CHAIRMAN MAIER: Okay. Burlington Drug is the most ___ only drug wholesaler.

6 Maybe you could spend a minute or two explaining what that means ___

7 MS. MITIGUY.BURNS: Sure.

8 CHAIRMAN MAIER: ___ to be a drug wholesaler.

9 MS. MITIGUY.BURNS: Yes.

10 CHAIRMAN MAIER: And maybe you will come to the point in this letter and I think your primary interest in what's before us is with this section of (inaudible) ___

11 being referred to as un competitive pricing exception.

13 MS. MITIGUY.BURNS: Yes. Chapter 5, I believe it is. Well, good morning.

14 My name is Maria Mitiguy Burns and I work for Burlington Drug Company. We're a wholesale distributor that services Maine, Vermont, New Hampshire, New York, Massachusetts.

16 Connecticut. We've been in business for 116 years. We're a family-owned business. We have about 150 employees and roughly 500 dependents. And we are a full line wholesaler. We are considered regional and we distribute in the area I expressed. And we do everything from pharmaceuticals to health and beauty aids, the whole gamut.

20 And specifically I think ___ well, also as an aside, we also provide, being the only interstate wholesaler, a service to the state of Vermont. We do things such as stock excessive amount of Tamafii for in case there is a pandemic. So having an interstate wholesaler is also a plus for anything that happens and also for distribution. We wouldn't be around as long as we had if we weren't one of the finest in the business. So, that aside.
Representative O'Donnell: I'm Patty O'Donnell. I actually talked to Michael.

Representative O'Donnell: I'm sorry, Patty. I just talked to my constituent. And I don't want to make any assumption.

Representative O'Donnell: I just want to talk to you about this contract with the wholesalers. And I have a clause that they can break that contract within thirty days.

Representative O'Donnell: Uh-huh.

Representative O'Donnell: And what would that do? If you could explain that to the committee.

Representative O'Donnell: Yes. We enter into a partnership contract where they will basically stop doing business with us at any point in time.

Representative O'Donnell: Who is "they"?

Representative O'Donnell: I'm sorry. Manufacturers.

Representative O'Donnell: That we purchase from.

Representative O'Donnell: Pharmaceutical manufacturers. I'm sorry. So they can be out at any given moment at any time. And I don't even know that it would take thirty days. But I think that there is a thirty-day clause.

Representative O'Donnell: We have had two manufacturers phone us. I just don't think that they are going to you, be hindered or hurt by selling to Burlington Drug and they could just be you, "Sorry, we're going to sell to Cardinal in Massachusetts and they will ship into Vermont." And they will get around the law that way.

So is it if that answers your question?

Representative O'Donnell: I'm trying to get at it, they wouldn't the manufacturers wouldn't lose a speck of Vermont business, but Burlington Drug Company wouldn't lose it all?

MS. MITIGUY-BURNS: Yeah. But then there's also the potential, I believe, that they could be Vermont is like one-tenth of one percent of the entire national pharmaceutical business. So they're said before, you know, it's not like Vermont is going to deter them in their bottom line or whatever they make for profit. If they have trouble they may not sell into Vermont. They may say, "If we're going to get lawsuits or we're going to do," but I can't speak for them. I can't make assumptions. But yes.

CHAIRMAI: I'm sorry. But I need to be somebody who knows. And Robin can actually correct this. That this law in is the one I see when she says this law will only affect one transaction between Burlington Drugs and that MS. LUNGE: I don't know because it's a factual question. And I don't know the supply distribution (inaudible) change in enough factual detail that I feel like I could answer that question.

Representative O'Donnell: Okay. Because obviously that's an important question.

MS. LUNGE: Yes. But, I mean unless I think you would really need to find out the factual situation in order for that question to be answered. And then with commerce (inaudible) and talking to Sam Berg, who I think is our technical expert on it, they are very factually specific. But it is hard for us to give you an answer because it's going to be your question, it is not the kind of legal area that is clear and easy to predict.

So I'm not going to give you something other than a wishy-washy answer. That's my answer.

You know, I can't.

Representative O'Donnell: And therefore you won't be able to give us a different answer when I...

MS. LUNGE: Well, I don't think there are likely to be other markets that are analogous to this market. So in order to give you an answer I would need to find another case somewhere that has an analogous market and say: Well, this case found in this market which looks like it is the same X, Y, and Z. And I just don't know that it is going to exist out there.

MS. MITIGUY-BURNS: I do have it. I do have a 2005 Washington D.C. case.

Representative O'Donnell: I'm sorry. The same thirty percent, the same must meet.

MS. LUNGE: I've read that case and actually I addressed some of the issues of that case in rewriting the legislation. So that I mean, that is rough if it is the same subject matter but it is not the same market and it is not the same words.

So it is just it is a hard area to legally predict.

CHAIRMAI: Sarah?

Representative COPELAND-HANZAS: The contracts that Patty was referring to that you said are severable within thirty days notice.


Representative COPELAND-HANZAS: Does that include prices? When you sign that contract with the manufacturer that does set a price for a particular period of time on a particular drug?

MS. MITIGUY-BURNS: No. They set the prices. We don't have any we can't say, you know, if they go up or down. I don't even to be honest with you, I don't.
even think price is written in there. It is more: You will hold it at certain
temperatures;
you will pay within thirty days; you might get two percent; there might be a
rebate on
this item that, you know, you pass on this item to your customer; you know, drop
shipments, things of that nature.
It's not: We're going to sell you at this price, you know, for
Lipton.
It doesn't really □□ it's more of a distribution agreement. If you □□ you know:
You will
have temperature monitoring for this particular product in your warehouse; you will
meet DEA guidelines. Things of that nature.
REPRESENTATIVE COPERLAND-CHANZAS: So there wouldn't be any reason for
a manufacturer to even weigh in on this section of the bill since their contract
with you has nothing
11 to do with price, and this is about unconscious pricing.
MS. MITIGUY-BURNS: Well, what they will do is they wouldn't sell to us
if
they had to if the state of Vermont compiled with that piece of the bill.
REPRESENTATIVE COPERLAND-CHANZAS: Okay.
ATTENDEE 138: Sell it to somebody else in other states?
MS. MITIGUY-BURNS: Right.
REPRESENTATIVE O'DONNELL: And ship it in.
MS. MITIGUY-BURNS: And ship it in.
ATTENDEE 139: And ship it in.
20
ATTENDEE 140: So the way this is written, my □□ tell me if I'm correct.
That this only governs the transaction between the pharmaceutical industry and the
wholesaler? Or pharmaceutical industry and it is the sale from a pharmaceutical company
to
whoever buys it from them, whether □□ generally a wholesaler, or □□
25 MS. LUNGE: The □□
example, from pharmaceutical companies trying to sell to them at an unconscionable
price as Maria is saying they could just sell to another distributor and get the
market through another distributor and be able to get their unconscionable price
from somebody else. I mean, is that the issue?

Ms. Lungo: I think that’s the issue that ☐ ☐

Attendee 152: Yeah.

Ms. Lungo: I mean, I think ☐ ☐ I don’t know if you ☐ no, really. I
don’t seem to me like you’re asking me a legal question.

Attendee 153: Yeah, I guess not.

Ms. Lungo: You’re asking me a factual question that I don’t know.

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

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

you know, get their drugs directly from the manufacturer.

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

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

Ms. Mitiguy Burns: Canada.

Attendee 156: Yes.

Ms. Mitiguy Burns: We’ve done that.

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

Ms. Mitiguy Burns: Just kind of touching what ☐ ☐ is it Robin?

Ms. Lungo: Yes.

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

But the big issue, the $6 million question is that can you regulate
interstate trade coming from, if you sell to Cardinal en masse and they ship into Vermont. And
the belief and the legal belief is that not. And I don’t know that the Attorney General’s
Office, to be frank with you, is being completely up front with that. And I feel that
that particular case what the loss would be unless ☐ unless the state of Vermont
said, "
2 Now we're going to purchase it from you for thirty percent less," then we would be
like, "
3 Well, we already bought it for . . ."
4 ATTENDEE 165: So you ☐
5 MS. MITIGUY/BURNS: Months ago. Yeah, we keep it on hand.
6 ATTENDEE 166: Your price is set at that non-crisis price ☐
7 MS. MITIGUY/BURNS: Right.
8 ATTENDEE 166: If you think it would get more expensive than that if we
9 have an epidemic.
10 MS. MITIGUY/BURNS: Yeah. But, I mean ☐
11 ATTENDEE 167: I'm saying, if you had to buy more.
12 MS. MITIGUY/BURNS: Two issues, I think. Are you saying that if the state
13 said, "All right. Now sell it to us at thirty percent less," or are you just
14 saying,
15 you know what I mean?

CHAIRMAN MAIER: She is saying the market is going to go up.
ATTENDEE 171: What I'm saying is the market is going to go up, you
know, the same way that heating fuel does in a very cold winter season. You know, the
market is going to go up because of demand. And so you are already going to be in a good
situation in Vermont because you have a stockpile of this that you can sell in a very
tight market.
7 MS. MITIGUY/BURNS: I don't think we would ☐ no, because we wouldn't
sell it. We actually sell most of our product at costs minus, believe it or not. So we wouldn't
say, "All right, state of Vermont, we're going to sell it to you for
$4,000 more than
we paid for it." That would be unconceivable.
15 ATTENDEE 174: I am just saying that compared to distributors outside of
Vermont, nobody would be able to tap into that market in a serious public health
threat.
17 MS. MITIGUY/BURNS: Yeah.
18 ATTENDEE 175: You've got ☐ you're holding the oil reserves so you're
doing a wonderful thing.
20 MS. MITIGUY/BURNS: Yeah. Okay. I see where you are ☐ I was
confused, I
guest.
22 ATTENDEE 176: You said something that I didn't understand and I guess
I'll come back to it unless I can ☐
24 MS. MITIGUY/BURNS: Okay.
25 ATTENDEE 177: Rubaia, the very first paragraph on page thirty-nine,
could
You could have a drug that costs $1,000 and on the FSS it could be
that's always been an issue. And we actually have to maintain that pricing
when we
sell to our customers. It's called a chargéback. And then we get reimbursed for the
amount in between. We pay at full price.
So to answer your question, it's all over the board. There is a
multiplier price system in the country which yes, so yes, it could be many you know, any
item,
especially if you are comparing it to the FSS because, as I said, that's about the
lowest,
Federal Supply Schedule.

ATTENDEE 182: Maria, what percent of your business is in Vermont, roughly?

MS. MITIGUY-BURNS: At this point in time it varies, you know. It
depends it's probably anywhere from 20 to 30 percent, yeah.

ATTENDEE 183: Thank you.

CD 134/TRACK 1

ATTENDEE 184: (Inaudible) disease is prevalent. We've already done that
with diabetes, high blood pressure, obesity. So, you know, these are diseases
that the
Commissioner of Health has already has already said, you know, are at dangerous
levels. So all
of the drugs for all of these diseases could be part of this, not just vaccines
that are
coming in for the pandemic flu.

MS. MITIGUY-BURNS: Right.

ATTENDEE 185: So you're talking probably the basis of their supply to
their customers.

MS. LUNGE: It's definitely broader than a pandemic flu. But I think because the Commissioner is in Vermont and they are looking at conditions in Vermont, I was
just trying my point was only that I don't see how these drugs to New York, for instance,

would be affected, because that's not connected to the conditions in Vermont.

But

that was my only

ATTENDEE 186: Clarification. In that case then, in this example they were
using of the drugs going into Burlington Drugs and going out to New York. If say

or whatever was determined to be unconscionable, then who is on the who is actually

who would the state be going after? The manufacturer or Burlington Drug, or both?

MS. LUNGE: The manufacturer because it says the manufacturer shall not
sell at (inaudible).

ATTENDEE 187: So it really wouldn't even affect Burlington Drug, then.

MS. MITIGUY-BURNS: No, it would.

MS. LUNGE: I think the issue is the effect on Burlington Drug's supply.

MS. MITIGUY-BURNS: They wouldn't sell to us. They wouldn't want to be
putting themselves in that situation.

ATTENDEE 188: Or they would say: We're only going to sell to you for
distribution in the other 60 to 70, 70 to 80 percent of your market you may not distribute in
Vermont. Then how could they do that?

MS. MITIGUY-BURNS: No, they wouldn't sell to us at all. And that's what
I was going to touch on is our the percentage of our business may be 20 to 25
percent in Vermont but they simply won't sell to us so we won't have supply. So even though
we're only selling 20 percent of our business to Vermont we won't have supply to even be in
business.

ATTENDEE 189: How do you know they won't?

MS. MITIGUY-BURNS: We've had two phone calls already.

ATTENDEE 190: Threats?
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1 MS. MITIGUY-BURNS: No, not threats. We are trading partners and they want to know if they called about what is going on in Vermont. They are not threats at all.
2 I've made that very clear already. They are not threats at all and I'm not defending a manufacturer, but that is part of the issue that we have in this letter that I think describes it very well.
3 We've always been very open and communicative with the state. We've come up many, many times over the years and we've informed on how the pricing works and all the multi levels. We've been more than willing to discuss and communicate. We are not threatened by manufacturers. It's simply that they wouldn't sell to us. So.
4 ATTENDEE 191: It's Economics 101. They are not going to sell where they may end up with a lawsuit.
5 MS. MITIGUY-BURNS: Right.
6 ATTENDEE 192: Even with this (inaudible) are we on thin ice, Robin?
7 Even with this, even if we pass this we would be on legal thin ice?
8 MS. LUNGE: It's not a legally-identified area. So, I mean, it.
9 ATTENDEE 193: That's not what she means.
10 ATTENDEE 194: That's what I thought. That could clear the (inaudible).
11 ATTENDEE 195: You know, this reminds me (inaudible) talking about.
12 CHAIRMAN MAIER: She tried to blow as much.
13 MS. LUNGE: If it was an easy answer I would give it to you.
14 CHAIRMAN MAIER: She tried to blow some cold air on it so the ice might be a little thicker. She doesn't know how much.
15 MS. LUNGE: Exactly.
16 ATTENDEE 196: It just reminds me of my days in Commerce when we were discussing whether or not we were going to get rid of the usury laws for credit cards because they only applied to cards issued in Vermont. And anybody who wanted to could go get a card any place else and we had no jurisdiction. And it's not exactly the same thing but it just, you know, it brings back for me the frustration we had in dealing with banking issues around how little control we had because of interstate commerce. We just could never win those.
17 CHAIRMAN MAIER: John.
18 MR. ZENNE: Just a comment. This whole topic seems to reek of the same issue that you hear in public when we talk about price gas gouging and how do you protect against that.
19 It's very similar.
20 MS. LUNGE: Yes.
21 MR. ZENNE: But the whole issue is very complex and it's not like you can say: No, you can't do that any more. It is (inaudible) who are you pointing to.
22 CHAIRMAN MAIER: Scott and then (inaudible).
23 REPRESENTATIVE WHEELER: I don't know if I'm on the same vein as you but I think we're trying to tackle a nationwide issue on a statewide basis. And I'm sitting here and I'm thinking that we might just make things worse before we make it better.
24 Well, not before.
25 The one question that comes to my mind is I've been talking to (inaudible) I'm already prescription drug.
26CONFUSED HERE NOW.
27 MS. MITIGUY-BURNS: There are drugs that will take care of that.
28 REPRESENTATIVE WHEELER: And, by the way, the (inaudible)
29 ATTENDEE 197: There are pharmaceutical labs that can help you with that.
30 REPRESENTATIVE WHEELER: My wife works in a pharmacy in the hospital.

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1 CHAIRMAN MAIER: Is your question specifically related to the section that we're talking about or are you talking about the whole bill?
2 REPRESENTATIVE WHEELER: Well, just about (inaudible) well, this particular section.
3 CHAIRMAN MAIER: This is (inaudible) you know, this is the first I've been through the conversation about unconscionable pricing. It's a relatively newer attempt on the (inaudible) you know, (inaudible)
4 MS. LUNGE: Well, yes and no because in SD 288, which was a prescription drug bill, there was a prescription drug fair pricing board that actually looked directly setting prices in a more aggressive way than what this section would do. So it is related in the sense that the state, for a number of years, has looked at different creative or legally unsettled ways to directly attack the prices of prescription drugs because it is a high cost area. And so in my mind, I sort of see it as starting in previously with this idea of having a pricing board. And it has kind of evolved over time where different states have done things and gotten sued to a more narrow approach. So that's kind of my historical knowledge, is that there have been other bills that have looked at the issue of drug pricing and tried to look at direct ways of addressing that. Not in this form but in a bigger.
5 REPRESENTATIVE WHEELER: I guess my concern was just on a state level whether it can be done on a state level versus a national level.
6 ATTENDEE 204: Well, some things can. I mean, the generic issue we've dealt with a lot on the state level but, you know, when.
7 REPRESENTATIVE WHEELER: Generic drugs?
8 ATTENDEE 205: Yes. The.
9 MR. WHEELER: I'm on the generic of Zocor and it cleansed out my arteries.

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1 how did we get here? I can't even (inaudible) I can't remember anymore how did we even get
2 why?
3 is this discussion going on? What happened
4 CHAIRMAN MAIER: (inaudible) is a bill in front of us that has (inaudible).
5 REPRESENTATIVE WHEELER: All right. But where did the bill pop up out of and why? I'm just (inaudible) being a history person I like to know history.
6 ATTENDEE 198: You don't have enough time, Scott.
7 REPRESENTATIVE WHEELER: Because I'm sitting here and I'm trying to
8 and I'm going back to my memory banks. Did I miss something? Did I not understand something?
9 So how did we, in a minute or two thing, can somebody explain the need for this
10 it all popped up? Did we have a crisis in the pharmaceuticals?
11 ATTENDEE 199: I was going to ask the same question.
12 ATTENDEE 200: Do we (inaudible) money.
13 CHAIRMAN MAIER: I don't have an answer for that.
14 MS. LUNGE: And you haven't heard from the sponsors yet, so that's part of why you haven't, I think.
15 ATTENDEE 201: I don't think this just popped up. This has been ongoing for years as the costs of health care have gone up and as the percentage of health care costs related to pharmaceuticals has gone up. And as that cost increases and at a huge rate.
16 CHAIRMAN MAIER: Was your question?
17 REPRESENTATIVE WHEELER: I'm talking about on a state level
18 ATTENDEE 202: He is wondering if there is some
19 ATTENDEE 203: A reaction to a (inaudible).

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16 (Pages 55 to 58)
1. **CHAIRMA An: Prima facie case, that definition?**
2. **ATTENDEE 208: Yeah.**
3. **MS. MITI GUY/ BURNS: Page 317?**
4. **REPRESENTATIVE CHEN: Is that the definition?**
5. **ATTENDEE 209: Section 15.**
6. **MS. MITIGUY/BURNS: I must have a ☐ ☐ can I read yours.**
7. **ATTENDEE 210: It's on page ☐ ☐**
8. **ATTENDEE 211: She's got it.**
9. **MS. MITIGUY/BURNS: I have a different ☐ ☐ well, I think what you are asking**
10. **me is do I think that that is unconscionable to have a 30 percent. Is that what you**
11. **are saying?**
12. **REPRESENTATIVE CHEN: More than (inaudible).**
13. **MS. MITIGUY/BURNS: I mean, I guess where I'm coming from is whether I**
14. **agree with it, whether Burlington Drug or not does, there's not anything we can do**
15. **about it.**
16. **I mean, as I said before, there's plenty of times when it can be 30 percent**
17. **because FSS**
18. **is the lowest.**
19. **REPRESENTATIVE CHEN: Right.**
20. **MS. MITIGUY/BURNS: So I'm not saying that ☐ ☐**
21. **ATTENDEE 212: What does FSS mean?**
22. **MS. MITIGUY/BURNS: I'm sorry. Federal Supply Schedule.**
23. **ATTENDEE 213: So that's not the manufacturer's price or is it? I**
24. **still**
25. **haven't gotten that straight.**
26. **ATTENDEE 214: That's Federal Government (inaudible).**
27. **MS. MITIGUY/BURNS: That's what the (inaudible) negotiated.

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**original text continues...**
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1 regulated utility where they get guaranteed a profit that is a little bit above, you know, (inaudible).
2 REPRESENTATIVE O'DONNELL: And then let's have them work on health care
3 when they're done.
4 ATTENDEE 217: They get a defined profit and that's it.
5 CHAIRMAN MAIER: Scott?
6 MR. WHEELER: When I hear about unconscionable pricing, the (inaudible)
7 also (inaudible) because I know what the mark-up is in the hospital, which I find totally
8 unconscionable. The mark-up is just extreme. My wife has gone over some of that
9 with me and just
10 said no. So what are we doing to address that unconscionable mark pricing because it can
11 get there as low as you want.
12 ATTENDEE 218: But you're paying for (inaudible) you're paying for all the security
13 systems and procedures of everybody that handles that aspirin.
14 REPRESENTATIVE WHEELER: No.
15 ATTENDEE 219: (Inaudible) answer to (inaudible)
16 ATTENDEE 220: (Inaudible) the cost shift.
17 ATTENDEE 221: Well, yes, but the (inaudible)
18 ATTENDEE 222: And the cost shift.
19 ATTENDEE 223: Before you get to the cost shift the answer that you get is:
20 Well, it doesn't matter because the insurance company is just going to pay it.
21 ATTENDEE 224: Yeah, that's right.
22 ATTENDEE 225: Then you get to the cost shift.
23 ATTENDEE 226: Yeah. (Inaudible).
24 REPRESENTATIVE WHEELER: (Inaudible) has anything to do with the cost
25 of

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1 hospital care.
2 MS. MITIGUY-BURNS: The hospital pricing is one of the lowest when
3 you're looking at the mishmash system.
4 ATTENDEE 227: (Inaudible).
5 REPRESENTATIVE WHEELER: For the drugs.
6 ATTENDEE 228: (Inaudible) the insurance company (static).
7 MS. MITIGUY-BURNS: Like we pay at full price and if we were to sell
8 it to,
9 say, Fletcher Allen, and we paid $100 for a drug and they get it for $19, we bill
10 them
11 $19 and then we bill the difference back to the manufacturer and get reimbursed like
12 thirty days later. So it is (inaudible) that's a whole other piece. We've been up here
13 discussing
14 that before, just people trying to understand the different price levels.
15 ATTENDEE 229: The hospital charges the hundred bucks (inaudible).
16 ATTENDEE 230: So you have money coming in and out and back and forth, and
17 through all sorts of sources to you.
18 MS. MITIGUY-BURNS: We do wait. We do wait for (inaudible) that's why we sell
19 at
20 such volume, to give you an idea. That's why we are (inaudible) we've expanded a little
21 bit over
22 the year. We just expanded over into Connecticut and that's why it's in (inaudible) that's why we
23 do try (inaudible)
24 REPRESENTATIVE O'DONNELL: You have to do a lot of volume to keep your
25 bottom line.
26 MS. MITIGUY-BURNS: Yes.
27 ATTENDEE 231: Lots of wheeling and dealing going on.
28 REPRESENTATIVE O'DONNELL: But any distribution is different
29 because
30 it's the middleman. So they are always paying out, waiting for their money to
31 come in. So
32 a distribution is a different (inaudible)

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1 ATTENDEE 232: They are waiting for their money to come forward and
2 backwards.
3 ATTENDEE 233: Right.
4 REPRESENTATIVE O'DONNELL: And so when a drug distributorship that's (inaudible)
5 who
6 has more levels of pricing and craziness has got to be too (inaudible).
7 MS. MITIGUY-BURNS: We maintain a lot of contracts, you know, whether
8 it is
9 PHS, Public Health Service, or FSS, o, you know, Ameriprin, or whatever the hospital
10 contracts are, what have you. So you are right. Hospitals are one of the lowest
11 in the price
12 tier.
13 REPRESENTATIVE O'DONNELL: Highest charge and lowest paid.
14 MS. MITIGUY-BURNS: And I don't know that they pass it on. Some
groups
15 pass it on, like FSS. And PHS passes along because they are garnering it because they are
16 health centers in rural areas, public health centers. So they are getting the price because
17 they're in rural areas. So they usually pass it on.
18 REPRESENTATIVE O'DONNELL: That's another (inaudible) Topper. I'm just
19 getting (inaudible) I'm just getting you going. (Inaudible). It's lunch time.
20 ATTENDEE 234: That's not nice to do right before lunch.
21 REPRESENTATIVE O'DONNELL: And now I'm sitting here with my stomach
22 growing. (Inaudible).
23 CHAIRMAN MAIER: What I would like to do is first thank you for (inaudible).
24 MS. MITIGUY-BURNS: Thank you very much. I appreciate it. I wasn't on
25 today so (inaudible)
26 CHAIRMAN MAIER: (Inaudible) notice.

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1 MS. MITIGUY-BURNS: Thanks a lot.
2 CHAIRMAN MAIER: (Inaudible) understand how this works.
3 MS. MITIGUY-BURNS: Feel free to call if you have any questions.
4 CHAIRMAN MAIER: So can we please come back at 1:00 and we will see
5 we can put a couple of hours in on this before we head out for the weekend. And we'll sit
6 down with Robin and we will try to figure out how we want to proceed with some of these
7 sections and we will (inaudible
8 CD 124/track 2
9 CHAIRMAN MAIER: Let's see if we can't start to get our way through the
10 bill as we talk about (inaudible) the goal is not perfection today. Our goal is (inaudible) in
11 terms of words or whatever. Our goal is how are we (inaudible) what are we thinking in a general
12 what
13 more information would we need about a section or if we don't like a section all
14 together
15 can we (inaudible) we can get rid of it. That's what I would like to see how far we
16 can get
17 with that sort of a conversation today.
18 And then particularly with those things where we need more
19 information,
20 and that will give both Lauren and Robin something to work with going into next week.
21 MS. LUNGE: Cool.
22 CHAIRMAN MAIER: Okay.
23 MS. LUNGE: Okay.
24 CHAIRMAN MAIER: So if you can sort of give us a brief summary of each
25 section again and then we can (inaudible
26 MS. LUNGE: Sure. Section 1, which actually starts on page two, is
27 the
28 Pharmacy Best Practices and Cost Control Program in OVA. So this is the section that has the
29 statewide PDI, language that's being struck. That starts page two to three and then moves to the
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1. Purchasing Pool concept. It also has the FQHC language in it and also strikes language about the counter detailing program which later in the bill is moved to the Department
2. 3. of Health.
3. 4. CHAIRMAN MAIER: Okay. So this was the section that took out the language
5. 6. on the statewide PDP?
6. 7. MS. LUNGE: Yes.
7. 8. CHAIRMAN MAIER: We broke that up on the board. We were ☐ ☐ ☐ ☐ ☐ we wanted to
8. 9. know why it didn't work. We had some testimony from OVA about why it didn't work.
10. 11. CHAIRMAN MAIER: And I guess maybe I suggest our general reaction is maybe
11. 12. naiveness but in a little ☐ ☐ to a sense ☐ ☐ you know, in some sense. I mean, it would be great
12. 13. if it could work but I'm not sure I disagree with them that it's hard to make it work.
13. 14. Are there other ☐ ☐ other talk about that part of it?
14. 15. What OVA said seemed reasonably persuasive to me is all I was saying.
15. 16. But I ☐ ☐
16. 17. ATTENDEE 235: I agree. That sounds like it would be much too large a problem. I mean, if our goal is to get this bill out and then, you know, fairly soon, I would
17. 18. think, you know, within (inaudible).
18. 19. ATTENDEE 236: Right. The (inaudible) is structural and (inaudible)
19. 20. permissible.
20. 21. ATTENDEE 237: So what are you saying? Take this out?
21. 22. CHAIRMAN MAIER: No, leave it in.
22. 23. ATTENDEE 238: It's okay (inaudible) because it says impracticable.
23. 24. CHAIRMAN MAIER: Because we can't ☐ ☐ yes, not practicable.
24. 25. ATTENDEE 239: Okay. I agree with that.

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1. MS. LUNGE: And OVA did have two suggested changes but both of them are in the senate version of the bill.
2. CHAIRMAN MAIER: Okay.
3. MS. LUNGE: So, I can clarify it. Maybe they just missed them, but (inaudible) was added ☐ ☐ that was one suggestion ☐ ☐ and then they suggested adding language about getting CMS approval, which I did add, although I didn't write it exactly the same way.
4. That they suggested. But it is in there so I think that was just an oversight.
5. CHAIRMAN MAIER: Okay. Can you tell me a little bit more about the ☐ ☐ on page five now, the change to the FQHC section?
6. MS. LUNGE: Yes.
7. CHAIRMAN MAIER: On ☐ ☐ and I'll just ☐ ☐ I note from past experience that this committee feels much smarter ☐ that has historically felt much more positively about FQHCs than the Senate Health and Welfare Committee. So with that background I just have a little red flag that went up that suggested I want to understand whether this is ☐ ☐ ☐ or not.
8. Indeed, something is that is taking something significant away from FQHCs or not? That's sort of where I'm probing here.
9. MS. LUNGE: Uh-huh. Well, I think that the language, the original language, the plan to encourage, was really sort of, I think, drafted with the concept that you wanted more people to be moving and you think FQHCs regardless of income level, et cetera. And because of the senate's discomfort with, I think for some people it was FQHCs, with other people it was just having ☐ encouraging people to move from a current doctor.
10. They modified that language so it would be more general information and not necessarily a plan to kind of think about how to move people there into those entities.
11. So I think ☐ ☐
12. ATTENDEE 240: is doing this again, (inaudible)?

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1. MS. LUNGE: It's OVA.
2. ATTENDEE 241: OVA is doing (inaudible)?
3. MS. LUNGE: Yes. Yes. And I think what OVA had ☐ ☐ OVA prefers to take it out, I thought. Take them out, themselves out, at which point I don't think that it makes sense to override it, but ☐ ☐
4. REPRESENTATIVE O'DONNELL: A note here that says (inaudible) sees better prices, better prices.
5. ATTENDEE 242: New pricing and the (inaudible) financing plan.
6. ATTENDEE 243: (Inaudible) supplemental.
7. ATTENDEE 244: Because of the supplemental rebates so they didn't want to be telling their Medicaid patients (inaudible) pharmacy benefits when they could get them cheaper.
8. MS. LUNGE: Right.
9. ATTENDEE 245: It's cheaper to (inaudible) the Health Department, if anything. Because they (inaudible) the ones that do all the (inaudible) grants.
10. ATTENDEE 246: Can I say something?
11. CHAIRMAN MAIER: Uh-huh.
12. ATTENDEE 247: I know that one of the reasons one person has given me about concerns about FQHCs is that the physicians at FQHCs (inaudible) get slightly higher reimbursement rate than Medicaid pays primary care physicians in other settings. And there's a question of whether that is being fair to other physicians who take a lot of Medicaid patients and don't get paid as much. So that's one reason I know that there is some concern about the FQHC.
13. All this makes sense when we are talking about pharmaceuticals.

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1. we're going to try to get more doctors moving their practices under the auspices of FQHCs, why would you want to be encouraging people to leave their primary care physician I mean, this is a question I have. ATTENDEE 248: Yes. That was a concern.
2. ATTENDEE 249: And I guess that ☐ ☐ I mean, that's kind of what I heard in the rationale for doing this. But it just doesn't ☐ ☐ in terms of the big picture of health care, unless our aim is to get all of those PCP's to move to the FQHC's where they have a 340B drug pricing, then why would you be doing this? I mean, it seems a little disjointed. And I (inaudible).
3. ATTENDEE 250: A suggestion that I might have is, because who are the people we want to go to (inaudible). You know, that's my question.
4. ATTENDEE 251: Maybe people that don't have a choice.
5. ATTENDEE 252: People who don't have a choice, or don't have prescription drug insurance. Those are the people that really, in my mind, we should target (inaudible).
6. That might be a way to modify this.
7. MS. LUNGE: Although if people who don't have prescription drug insurance are below 300 percent of poverty they can get the Healthy Vermonters card which gives you the Medicaid price which, if Joshua's figures are accurate, would be lower than the 340B price, at which point ☐ ☐
8. ATTENDEE 253: I thought they had to cancel that program.
9. ATTENDEE 254: The Medicaid card program.
10. MS. LUNGE: No.
11. ATTENDEE 255: I was confused with that (inaudible).
12. MS. LUNGE: Yes, they ☐ ☐ it was ☐ ☐
13. ATTENDEE 256: I was confused with that testimony, too. They said ☐ ☐

19 (Pages 67 to 70)
ATTENDEE 257: I thought they said  
ATTENDEE 258: It sounded like more  
ATTENDEE 259: got taken to court and told they couldn't do that  
because  
they were leveraging better prices for people who  
MS. LUNGE: Well, we were, but then Maine built on our experience and  
Maine  
passed a law which was upheld. And our changes were modeled on Maine. So (  

I was going to touch base with them about that to try to understand exactly what the  
issue was, which part of it.  
ATTENDEE 260: So we aren't doing it.  
MS. LUNGE: We are doing it up to 300 percent of Federal poverty right now,  
and 400 for  
ATTENDEE 261: There was a hassle factor with the waiver or something.  
Somehow to do with the waiver.  
MS. LUNGE: And that was a piece of the whole litigation back and forth  
between Maine and Vermont. When we we changed it to require a waiver before the  
litigation was finished because based on our court case it seemed like we needed a waiver. But  
then Maine was litigated and found favorably and they didn't need a waiver. So it's been  
kind of like court case language, court case language, court case language. So, it's a  
little confusing. But I will definitely touch base with them about that to try and clarify  
what that issue with Healthy Vermonters program exactly is.  
But on FOHC's they just back to that. I'm sorry. I sort of  
brought us  
on a tangent.  
MR. WHEELER: Where did this come from?  
MS. LUNGE: It was in it's been around for a long time. It was in  

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

language that said that instead, you know, that directs them to I don't know how it might be  
different but if or we can just accept her  
MS. LUNGE: But  
CHAIRMAN MAIER: It seems like a it seems like a good thing to do if  
there is benefit to be had, but if  
MS. LUNGE: The mandate is on OVA offering to be the person kind of  
administering the joint purchasing consortium. The voluntary basis is for the  
other people to  
So it tells OVA: You need to work on this joint purchasing consortium. It says to the  
state employees and Workers' Comp, et cetera, et cetera: This is voluntary for you until  
2010. And then to the extent that it is double, or practical, then you should do it;  
it is  
mandatory unless you have a really good reason not to.  
ATTENDEE 270: And does mandatory mean everybody mean everybody?  
MS. LUNGE: Mandatory for state or publicly funded purchasers,  
administered or subsidized purchasers. So not mandatory for private insurers.  
ATTENDEE 271: But they can join if they want?  
MS. LUNGE: They can join if they want.  
ATTENDEE 272: And the Workers' Comp? Whose Workers' Comp?  
Everybody's  
Workers' Comp has to do this?  
MS. LUNGE: I think I guess my question is, is Workers' Comp I don't  
know that much about Workers' Comp. Is it publicly funded, administered or  
subsidized?  
6305: Well, I think it's written in the state Workers' Comp program  

it would be in (the inaudible) cities and towns is a self insured Workers' Comp  
program. And so I would imagine that they are outside of that that would be at the  
employer's  
offered benefit, so it would be ERISA.
MS. LUNGE: Uh...huh.
ATTENDEE 273: But it is just it says Workers' Comp and it is not for me if it is saying that it is going to be Workers' Comp for state employees, or Workers' Comp for (inaudible).

MS. LUNGE: So that could (inaudible).
ATTENDEE 274: Yes. It says... (inaudible)
ATTENDEE 275: Well, it could be counties and cities, too. It says publically funded.
ATTENDEE 276: Any other state or publically funded purchaser of prescription drugs.
MS. LUNGE: So that's something that needs to be (inaudible) out, is who. It needs work.
ATTENDEE 277: So I guess what it is trying to say is for any Workers' Comp thing in this list of things, that they have to (inaudible) for the health insurance part of it.

MS. LUNGE: For the drug purchasing part of it?
ATTENDEE 278: Yes. But I don't know if the League of Cities and Towns, it's (inaudible) I don't know how that counts because it's all those employers who happen to be towns self insuring together.

MS. LUNGE: I mean, I think you could decide, you know. I don't know. I mean, it is not something (inaudible).
ATTENDEE 279: I don't know if I have the ability to regulate that.
ATTENDEE 280: (Inaudible) Workers' Comp is not subject to ERISA.
ATTENDEE 281: No, it is not.
ATTENDEE 282: It's not. It is state regulated.

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

ATTENDEE 287: So the insurance companies providing the Workers' Comp... (inaudible) coverage can do whatever they want. That's all they are going to get paid.
ATTENDEE 288: No. It's the pharmacies who have (inaudible) basically pharmacies can only get a certain amount for the drugs. It is a (inaudible) price plus a dispensing fee. The insurance companies can negotiate a lower fee but there is a v. (inaudible)
ATTENDEE 289: But they have to use that formula?
ATTENDEE 290: There is not a formula but there is a ceiling on what the insurance company has to pay.
ATTENDEE 291: (Inaudible) make sense to keep them in here if they can achieve some (inaudible) from purchasing (inaudible).
ATTENDEE 292: I don't see why not.
ATTENDEE 293: Didn't she say (Inaudible) same price as the Medicaid, (inaudible) though?
ATTENDEE 294: I don't know.
ATTENDEE 295: She did but I don't know if she was including the (inaudible)
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<tbody>
<tr>
<td>4 Before ☐ it should say &quot;subdivision.&quot;</td>
<td>1 MS. LUNGE: Not ☐ information that's not public, you mean? Is this</td>
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<td>5 CHAIRMAN MAIER: I don't know about that.</td>
<td>2 related to your ☐</td>
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<tr>
<td>6 MS. LUNGE: We can do it now or we will do it later, but we're going</td>
<td>3 ATTENDEE 326: The studies. Is there something we need to add to this</td>
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<tr>
<td>7 to do</td>
<td>4 bill to get at the studies that have ☐ that are gagged by the ☐</td>
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<td>8 it.</td>
<td>5 MS. LUNGE: I don't think we can do that.</td>
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<td>8 ATTENDEE 306: Which one are you on?</td>
<td>6 ATTENDEE 323: We can't. I thought the Attorney General's Office said we</td>
</tr>
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<td>10 section, in F01 it talks about evidence based refers to the definition in Title 18, adds a</td>
<td>8 MS. LUNGE: If they ☐ if two parties have a contract saying that one party</td>
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<td>11 a couple of other criteria. And then there was discussion of ☐ then there is ☐ directing over the (inaudible) additional information from entities doing clinical comparisons.</td>
<td>9 won't talk about something. I'm not sure how we can countermand unless it's in Vermont.</td>
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<td>12 ATTENDEE 307: Robin go back to the previous page. Did you want to ☐ on page nineteen, at page seven, the reference is to the OVA director. Did we feel one that needed clarification of who that was?</td>
<td>11 REPRESENTATIVE O'DONNELL: It's not my state. It's not our state.</td>
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<td>15 MS. LUNGE: No. Because in that whole section director is defined as the director of OVA so you don't need to repeat it.</td>
<td>12 ATTENDEE 324: But it's illegal (inaudible) contract.</td>
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<td>17 ATTENDEE 308: Okay. I had that note and (inaudible).</td>
<td>14 CHAIRMAN MAIER: They said that we could do it potentially. I'm not sure if (inaudible).</td>
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<td>19 ATTENDEE 309: So you are on F01 on page seven, did you say?</td>
<td>16 MS. LUNGE: Okay. I didn't hear that testimony.</td>
</tr>
<tr>
<td>21 MS. LUNGE: F06, I think, on page seven, nineteen ☐</td>
<td>17 CHAIRMAN MAIER: Having a clinical study registered.</td>
</tr>
<tr>
<td>22 line nineteen. We define director ☐</td>
<td>18 MS. LUNGE: Oh. All right. This isn't ☐</td>
</tr>
<tr>
<td>23 ATTENDEE 310: No, no.</td>
<td>19 CHAIRMAN MAIER: This doesn't address that?</td>
</tr>
<tr>
<td>25 MS. LUNGE: I'm sorry.</td>
<td>20 MS. LUNGE: Doesn't address a clinical trial's registry. We did have a clinical trials bill, I thought.</td>
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<tr>
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<tbody>
<tr>
<td>1 ATTENDEE 311: Before that question was asked were you talking about ☐ ☐</td>
<td>1 MS. LUNGE: Yeah, Maine. Maine has those. Yes, that legislation isn't in this bill.</td>
</tr>
<tr>
<td>2 you were talking about F01?</td>
<td>3 ATTENDEE 326: Oh, it's up on the board. Clinical trial registry.</td>
</tr>
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<td>3 MS. LUNGE: The subdivision addition?</td>
<td>4 CHAIRMAN MAIER: Is that something you want to come back to?</td>
</tr>
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<td>4 ATTENDEE 312: Before you said that you said something about the evidence space.</td>
<td>5 ATTENDEE 327: Yeah, absolutely.</td>
</tr>
<tr>
<td>5 MS. LUNGE: Yes, F01.</td>
<td>6 CHAIRMAN MAIER: Or we could just find the main bill and (inaudible) easy to (inaudible).</td>
</tr>
<tr>
<td>7 ATTENDEE 313: Okay. Well I didn't ☐ I wanted to say something before we moved on to something else.</td>
<td>8 ATTENDEE 328: I think the more light we shine on what is going on in this industry the safer and more effective drugs people will have. And that's what my goal is. (Inaudible) safe (inaudible).</td>
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<tr>
<td>8 MS. LUNGE: Okay.</td>
<td>9 CHAIRMAN MAIER: Are you okay with moving on to the next question?</td>
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<td>10 ATTENDEE 314: And it's just that if this does what it think it does, this seems to me to be one of the most important pieces of this bill. Because ☐ ☐</td>
<td>11 ATTENDEE 329: Yes.</td>
</tr>
<tr>
<td>12 ATTENDEE 315: (Inaudible) chocolate?</td>
<td>12 CHAIRMAN MAIER: On this section two. Is that where we are at.</td>
</tr>
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<td>13 ATTENDEE 316: Here, take the big one.</td>
<td>13 MS. LUNGE: Yes.</td>
</tr>
<tr>
<td>14 CHAIRMAN MAIER: Where did this come from?</td>
<td>15 CHAIRMAN MAIER: So you've stricken this Oregon language?</td>
</tr>
<tr>
<td>15 ATTENDEE 317: (Inaudible)</td>
<td>16 MS. LUNGE: Yes.</td>
</tr>
<tr>
<td>16 MS. LUNGE: This came from me.</td>
<td>17 CHAIRMAN MAIER: Regardless of whether or not that language is in there, do we ☐ what do we mean when we say shall seek assistance from? Does that mean we are going to ☐ we're going to ☐ what does that mean? How does the Oregon health thing work?</td>
</tr>
<tr>
<td>17 ATTENDEE 318: A little devil. The one in red.</td>
<td>20 Does it ☐ do you pay something to become a member of it?</td>
</tr>
<tr>
<td>18 ATTENDEE 319: My biggest concern in this whole ☐ one of my biggest concerns in this whole thing is the misinformation that gets given to prescribers and the public about safety and efficacy of pharmaceuticals. And the studies that are published or the misleading comparisons that are done, is this going to address that?</td>
<td>21 MS. LUNGE: There are ☐ it has two different stages. You can pay to become a member of it, which allows you to get earlier access to the research and information, or if you don't ☐ you can still get access to the information without paying. It's just there is a time lag. And I don't know how long a lag but there is testimony in the senate that it ☐ I think the Department of Health looked into it and there was something</td>
</tr>
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1. That on this statewide preferred drug list, did we actually agree that that was something
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3. CHAIRMAN MAIER: No. We agreed to leave it the way it was in the bill
4. which was they were striking the language that had not been implemented for several years
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16. education program (inaudible). (inaudible)
17. MS. LUNGE: The preferred drug list referenced there is the OVA preferred
18. drug list or the Medicaid preferred drug list.
19. ATTENDEE 339: This is a new section.
20. MS. LUNGE: So earlier in that section we modified the statewide PDL
21. language to be just an OVA Medicaid PDL.
22. ATTENDEE 340: That answers my question. Thank you.
23. MS. LUNGE: You're welcome. Okay. Three, section three is the

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8. add OVA as well as Department of Health there.
9. CHAIRMAN MAIER: Okay. Are we or what are we or any comments?
10. about this section, concerns, praise?
11. ATTENDEE 341: All set.
12. ATTENDEE 342: Does this sequence stuff, by the Attorney General, does that
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16. CHAIRMAN MAIER: Yeah.
17. ATTENDEE 343: Serious public health. That had to do with that
18. unconscionable (inaudible).
19. MS. LUNGE: The information referred to in Section Three is the marketing
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22. doctors. You know, basically the kinds of things that the详细 would bring to the office.
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27. ATTENDEE 345: Why different standard.
MS. LUNGE: But I don't know. I meant to actually ask the judiciary about that but I don't know without (inaudible).

ATTENDEE 350: But it's covered somewhere.

MS. LUNGE: I don't know if it is covered because I don't know what our crime if that's a crime in Vermont or not. So I'll try to find out but it's not my area of expertise.

ATTENDEE 351: Thank you.

MS. LUNGE: Certainly it sounded like it is in Maine from what Sharon said this morning about the main AG liking that provision.

CHAIRMAN MAIER: Harry?

REPRESENTATIVE CHEN: We heard something about trying to put in some flexibility.

MS. LUNGE: Yes.

REPRESENTATIVE CHEN: You heard that?

MS. LUNGE: Yes. I heard Sharon's testimony that it would be good to put in some flexibility in case the federal law.

REPRESENTATIVE CHEN: Changes in terms of the nomenclature (inaudible).

MS. LUNGE: So I can work on that.

REPRESENTATIVE CHEN: Okay.

ATTENDEE 352: Roy, (inaudible) in that. Must've been doing something else.

CHAIRMAN MAIER: Okay. Any other questions or comments on this section?

ATTENDEE 353: I guess I don't understand what if we were you just talking about (F) when you said you weren't sure if it was illegal or.

MS. LUNGE: No. I was talking about (D).
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MS. LUNGE: And you've heard lots of testimony on this section, mostly
2 think in terms of in or out more than specific language (inaudible), I think.
3
ATTENDEE 365: And all these, the unless contract provides applies to
4 all of them?
5 MS. LUNGE: Yes. Because it is in subdivision (A) on line ☐ page
6 sixteen, line twenty-one. It's a number (inaudible).
8 ATTENDEE 366: And this is so ☐ Sharon Treat this morning said ☐
9 it's
10 kind of like she felt pretty strongly that she should not be (inaudible) the duty
11 of care (inaudible) of that.
12 CHAIRMAN MAIER: And the standard again is of an insurance agent and
13 customer?
14 MS. LUNGE: Yes.
15 CHAIRMAN MAIER: And what is the fiduciary? What is the example of a
16 fiduciary standard?
17 MS. LUNGE: It is a higher standard ☐ I'm trying to think of a good
18 example.
19 CHAIRMAN MAIER: Is it like a bank?
20 MS. LUNGE: Yeah, like a bank. That's a good example. A bank is a
20 fiduciary for your money so it means that they have a high level of responsibility,
sort of, in
21 terms of their dealings with you.
22 ATTENDEE 367: Mr. Chairman (inaudible) with Express Scripts. Usually
23 a fiduciary duty applies in a situation where somebody has given somebody else some
24 money.
25 For instance, like the State Employees Retirement Board. They have a
fiduciary duty to manage the assets for the benefit of the members so they should
make prudent
development decisions and things like that. And we would argue that fiduciary duty
really isn't
3 applicable to the relationship, or shouldn't be applicable to the relationship
between a PB
5 and one of its customers because that's a different type of transaction. That's a
transaction
4 for services, or a middle man (inaudible).
5 CHAIRMAN MAIER: And can you distinguish for us then, this was
considered
6 to be a step less fiduciary, or something. A lower standard.
7 MS. LUNGE: Yes. Then this is considered to be a lower standard than a
8 fiduciary (inaudible).
9 CHAIRMAN MAIER: What is a regular contract? Whatever is there.
10 MS. LUNGE: I don't remember the magic words but it is basically to ☐ you
11 would assume both parties are knowing and have their own interest at heart. So
it's a
12 lesser standard than this. So there's no duty owed from one contracting party to the
other.
13 You assume two willing parties going at it to come to the best terms that they can
come
14 to.
15 ATTENDEE 368: From their own interest?
16 MS. LUNGE: From their own interest, yes.
17 CHAIRMAN MAIER: John and ☐
18 MR. ZENIE: Correct me if I'm mistaken. I interpret this (inaudible)
19 materials more like you promise to do, have good behavior.
20 MS. LUNGE: Uh huh.
21 MR. ZENIE: And what Sharon was saying, we should make it a little bit
22 stronger and have maybe some financial motivation for good behavior. Is that what
she was
23 saying?
24 MS. LUNGE: I didn't hear all of her testimony this morning, unfortunately.
25
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1 MR. ZENIE: Okay. Well, I just wrote down, you know, waiving a duty
of due
care that's bad, and that there should be fiduciary language to require the
behavior.
2 That was my notes.
3 CHAIRMAN MAIER: And that really comes out to this, the (A), which is the
4 unless the contract provides.
5 MS. LUNGE: Yeah.
6 CHAIRMAN MAIER: I mean, that's something that we need to have a
discussion
7 about.
8 ATTENDEE 369: And basically everything after this is moot. They
don't
9 have to put it in our contract.
10 ATTENDEE 370: Right.
11 MS. LUNGE: And one thing that Paul remind me of is that ERISA also
12 has a
13 fiduciary duty.
14 ATTENDEE 371: So the whole linchpin of the ERISA framework which
deals with all employee (inaudible) benefit plans is the employer is the fiduciary to the
employee.
15 And, you know, it's a different kind of model but that's the real core.
16 CHAIRMAN MAIER: How does that play out in the context of a health
insurance plan?
17 ATTENDEE 372: Well, the employer in an ERISA situation, in all employer-
18 sponsored health benefits, including health insurance, the employer is
contracting with the
19 insurance company. Most of your work deals with the regulation of the insurance
company but the
20 employer, under federal law, is never relieved of his or her fiduciary
responsibility
21 to the employees. And if there were (inaudible) if a grievance was brought under ERISA
22 employer would be subject to that fiduciary standard.

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1 ATTENDEE 373: Just humor me for a minute. So is the leap that I
would
2 make there correct that under ERISA then the contributions that my employer make on
my
3 behalf for health insurance coverage would be considered my money in essence? Do
you see
4 where I'm going with that?
5 ATTENDEE 374: And this is why I brought it up (inaudible)
6 ATTENDEE 375: What is the fiduciary, where does it come from?
7 ATTENDEE 376: Well, it's basically that the employer is making
decisions
8 in the best interest of the employee. So that the monetary exchange may be coming up
in
9 some instances, but not in all instances. And I think the core concept of
10 fiduciary
11 responsibility, as Robin articulated, that you're acting in the best interest of
12 the other party.
13 ATTENDEE 377: So the difference here would be if it's the fiduciary
12 responsibility then the PB would be required to act in the best interest of the
employer or health
13 plan whereas this standard would be that they act in their own best interest. Did
I get
14 that right?
15 MS. LUNGE: Well, under this standard they would ☐
16 ATTENDEE 378: They've made agreements.
17 MS. LUNGE: They would still have a higher, a slightly higher duty
18 than in a contract situation where they were only acting in their best interest. With
19 this
20 standard it is higher than that. They would have to ☐ I think that it could be interpreted
21 that they would have to disclose enough information that something wouldn't be
misleading.
22 For example. That they ☐ it's not entirely relying that the other side completely
23 all the information they might need.
24 So it's ☐ it's not ☐ I would say it's a little bit higher than what
25 you
described. So it's not entirely their own self-interest. They have to sort of judge if how
Page 94

1. they're acting, is that also going to meet the reasonable care and diligence and be fair and truthful under the circumstances. So if this were a fiduciary standard how much farther beyond that.
2. ATTENDEE 379: If so if this were a fiduciary standard how much farther beyond that.
3. MS. LUNGE: Well, you know, it's ☐ ☐
4. ATTENDEE 380: ☐ ☐ would you go?
5. MS. LUNGE: Well, it's not sort of a linear measure so it's ☐ ☐ I mean, I think as Paul said ☐ ☐
6. ATTENDEE 381: Yeah. I was trying to (inaudible).
7. MS. LUNGE: I know. It's hard to kind of ☐ ☐
8. ATTENDEE 382: I understand it under that circumstances because you know, we've all read about the employers that took ☐ ☐ the occasional employer that took ☐ ☐ big companies that took employee money that was paid in and matched by the employer, whatever person, for health insurance benefits and used it for some other purpose so people were left without insurance.
10. ATTENDEE 383: So I understand through this example. But I'm just trying to put this in the perspective of what we've heard in terms of these are now entities and then, you know, the head of the State Employee Benefits Plans was here today and they really don't know that much about how all of this stuff works. And I think once the program is set up do they keep the consultants, or are they on their own? And a large employer would be in the same position, I would think. So I don't know. I'm trying to get a grasp of it so it really does make sense.
11. MS. LUNGE: Yes. And there's not really a clear ☐ ☐ I mean, I ☐ ☐ the fiduciary language is the language that's in the Maine and the D.C. laws. And Maine really just got up and running because it was in litigation.
12. ATTENDEE 384: Uh-oh.
13. MS. LUNGE: And so it's not like I can give you an example, really, that v ☐ ☐
14. CHAIRMAN MAIER: So let me ☐ ☐
15. ATTENDEE 385: Inaudible (inaudible) these out (inaudible).
16. CHAIRMAN MAIER: Yes. I would like to take our temperature here but I think ☐ ☐ I think we need to have a conversation about (A) before we do that. So what ☐ ☐
17. MS. CONNELL: Only the people whose paid consultants have told them that they must.
18. ATTENDEE 389: Well, they would insist on those things in their contract.
19. ATTENDEE 390: I mean, we've clearly gotten the message from the PBM's that they don't like this so they don't have to agree with it. That's the ☐ ☐
20. CHAIRMAN MAIER: Bill first and then ☐ ☐
21. ATTENDEE 391: Mr. Chairman, when it is appropriate I would like to talk about the in inner-play between Section 7 and 8 and how it looks at the agreement between the PBM and the health insurance. I think it might answer a lot of these questions or maybe allay some of the uncertainties about who is, you know, gaining or losing a perceived advantage based on the (inaudible) part of Section 7.
22. If I may, for example, in subsection (B) at the bottom of page 19 it talks about ☐ ☐ It talks about that it shall provide notice to the health insurer that the terms in (A) may be included in the contract.
23. So it presupposes, we're precourse contract at this point. And the first thing that happens when ☐ ☐ and as we heard from, I think, Mr. Hardy at Medco, the insurer said about the RFP thing, "Here's what I want for my beneficiaries." The PBM's then would have to come back and say, "Okay. Don't forget, you have a right to (A) if you want it. And if you want these things we're going to respond ☐ ☐ you know, we're going to respond to your RFP with perhaps a different model of pricing and pass reducing, all those other things that Mr. Hardy talked about. But if you ☐ ☐ we don't have to do that. So you health insurer decide if you want these in your initial RFP or not."
24. ATTENDEE 392: Only in the state of Vermont?
25. ATTENDEE 393: Right. And so we have to, first of all, give them notice that these are out here. This was more to allay the concerns about the little employer out there who may not know that they could get (A) one through six. So we had to say to them, "Don't forget, you get (A) one through six in this contract if you want it."
26. CHAIRMAN MAIER: So, this isn't nothing, this whole section, so that we're here. You're trying to show us that there is a notice requirement here.
27. ATTENDEE 394: We're talking them, if you want to put it in your RFP and you want us to bid on this business, you know, you can do that. We can also choose not to contract with you at that precourse stage. Okay?
28. CHAIRMAN MAIER: Uh-oh.

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1. ATTENDEE 395: And then under Section 8 it talks about audit requirements.
2. This gets at Representative Milkey's concern, I think, about, how do we follow up on it if you're doing this stuff or not. And that's fine. You know, Section 8, starting on page 23 is how the senate addressed at least administrative service only contracts in auditing those. Because many of the RFP's that are out there in the (inaudible) agreements with (inaudible) have audit rights. That ☐ ☐ they're out there in the RFP's though so that the PBM ☐ ☐
3. CHAIRMAN MAIER: I hate this jargon. I'm so sorry.
4. ATTENDEE 396: The (inaudible). The next thing it will be (inaudible).
5. ATTENDEE 397: We're with you so far.
6. ATTENDEE 398: A total of maximum daily (inaudible). No, that's across the hall. So I might be exceeding my twelve maximum daily (inaudible) that chocolate.
7. So what was crafted in the senate was an attempt to have the transparency that someone would want in an administrative services contract if ☐ ☐ and have all the parties to a potential contract with the PBM aware of that up front and say ☐ ☐ so that my client can knowingly bid on it and price their product accordingly, and so that the smaller employer ☐ ☐ (inaudible) what's a small employer these days, it's really not (inaudible) Smith World Headquarters in Northdale with three employees.
8. But in any event, the PBM has to give notice that you could get (A) one through six. And at that point if you want to go then to your RFP and get a bid on it, put it in there. If you don't, you're bound by regular contract law and whatever audit and penalty provision you might put in to your RFP. So it is driven by the health insurer and not by the PBM. But we have an affirmative obligation to say, "Have you thought about (A) one through six?" We've got to do that no matter what.
ATTENDEE 399: And it was possible that those consultants would also
ATTENDEE 400: Yes. They probably wouldn't earn their $60,000 if
ATTENDEE 401: (inaudible) picture.
ATTENDEE 402: It helps.
CHAIRMAN MAIER: Thank you.
ATTENDEE 403: Did I answer the process with ☐ ☐
ATTENDEE 404: Bill hit it right on the head as far as what I was
going to
tell. The only thing I would say additionally is that I think (A) is important
because
without it, it's a one-size-fits-all contract. And I think the parties that Ms.
Callaghan said
the representatives from the PBMs have described a situation where everybody
doesn't
necessarily want a one-size-fits-all.
ATTENDEE 405: Well, given that this is optional, is there any reason
why
we couldn't have (inaudible) standards as an option, the fiduciary and (inaudible)?
MS. LUNGE: The only complication with that is that it does say unless
the
contract provides otherwise. So it sort of sets up the standard if the contract
is silent. So
if you had two ☐ ☐
ATTENDEE 406: Two standards which would ☐ ☐
ATTENDEE 407: Yes.
MS. LUNGE: It would be confusing as to which would control if the
contract
was silent.
ATTENDEE 408: Since it's optional I would think that we would want
people
to know that they could have a stronger one because the PBMs would be letting
them know
that there is a less strong and they could have it like (inaudible).

ATTENDEE 409: But the consultant would be letting them know that the
ATTENDEE 410: Well, the consultant would let them know that.
ATTENDEE 411: Right. And I think the Attorney General's Office
testified
that they are concerned about small groups but the state employees testified the (inaudible)
whatever they are, testified that they hired consultants who were former PBMs
employees that know all the ins and outs and they don't feel they need this
protection. And
there aren't many ☐ ☐ I mean, there's no small shops like mine that are getting
their
prescription drugs from PBMs. We're getting our prescriptions through MBP.
ATTENDEE 412: No. But there are employers who have 400, 500, 600
that are
doing self-insured. And they may be mostly doing them through the insurance
company
contracting with an administrator. But ☐ ☐
ATTENDEE 413: I don't think there's anybody that's just (inaudible).
CHAIRMAN MAIER: I would like to ask ☐ ☐ did you have ☐ ☐
ATTENDEE 414: No.
CHAIRMAN MAIER: Okay. What I think I would like to ask the committee
☐ ☐
John, did you want to (inaudible).
MR. HOLLAND (phonetic): Well, I don't ☐ I do, just a ☐ ☐ on behalf
of MBP,
John Holland. In our view we do obtain the transparency that we need through the
negotiating process with these PBMs. So this language that is in the bill as
passed by the House
was sufficient for us in terms of obtaining that information.
These are generally transactions between very large sophisticated
entities
so we're able to waive that and we certainly are comfortable with that language.
CHAIRMAN MAIER: The way it is now? 😊
MR. HOLLAND: The way it is now. We don't think ☐ ☐ I mean, we are
able to
obtain these things currently just through the negotiating process.
CHAIRMAN MAIER: Well, let me first ask the committee, we could just
go
around, or ☐ ☐ about the (inaudible) in (A). How do you feel about the (inaudible)
(End of CD transcription.)
STATE OF VERMONT
HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: April 17, 2007

Type of Committee Meeting: Standard

Committee Members:

Rep. Steven Maier, Chair
Rep. Francis McFaun
Rep. William Keogh
Rep. Virginia Milkey
Rep. Hilde Ojibway
Rep. John Zenie

Rep. Harry Chen, Vice-Chair
Rep. Sarah Copeland-Hanzas
Rep. Lucy Leriche, Clerk
Rep. Pat O'Donnell
Rep. Scott Wheeler

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

(Start of Track 1 from CD labeled 4/17/07 #1c, made from CDs 136, 137, and 138.)
ATTENDEE: Prescription drugs.
MS. LUNGE: That's what we're doing.
ATTENDEE: You didn't happen to mark where we ended, did you?
MS. LUNGE: Well, I think what we did was talk about PBMs and then skip ahead to the data mining stuff and then skip ahead again to the unconscionable pricing, so there -- I think we could go back to page 25 and talk a little bit about evidence based and then move forward and sort of skip over the two big chunks we already did.
Does that make sense?
I think we were -- we kind of ended in the -- let me see. Where are my notes?
FEMALE ATTENDEE: What's the last graph? (inaudible).
MS. LUNGE: It's the Bill as passed.
FEMALE ATTENDEE: (Inaudible).
ATTENDEE: It doesn't actually say that, or does it?
FEMALE ATTENDEE: On the front.
ATTENDEE: Oh, yeah, it does.
ATTENDEE: But in the middle of it, it said Bill introduced (inaudible).
FEMALE ATTENDEE: Mine said Bill is introduced on the whole thing.
ATTENDEE: Go to the very front.
FEMALE ATTENDEE: Oh, (inaudible).
FEMALE ATTENDEE: Page 25.
MS. LUNGE: Yeah. I have a star there, and that says "come back," so I think it means we skipped it.
ATTENDEE: And just to remind the committee, what we're trying to do is take a temperature here. This is your last chance to raise a question or concern on that section, but what I'm trying to get to is if no one has a particular question on this section, I'm going to assume that we're more generally okay with it than if you were raising questions or more serious concerns at this point. I'm trying to narrow the field here.
MS. LUNGE: So I think we did finish the PBM section, so unless anybody else remembers differently, I think that's right.
ATTENDEE: We had questions to come back to it though, right?
MS. LUNGE: Yeah.
ATTENDEE: We were going to talk about the standard, right?
MS. LUNGE: Right.
ATTENDEE: And whether -- MS. LUNGE: We were going to come back to that issue later and then -- ATTENDEE: Which one now?
MS. LUNGE: That was on page 17, the standard. We had -- I think that was our last discussion maybe.
ATTENDEE: Oh yeah, right.
MS. LUNGE: We were in the middle of addition we finished kind of --
ATTENDEE: Fiduciary versus --
FEMALE ATTENDEE: Are we back to drugs?
ATTENDEE: Where does that --
FEMALE ATTENDEE: Contracts.
ATTENDEE: Contract versus -- what's the other one?
FEMALE ATTENDEE: Private contracts.
MS. LUNGE: Fiduciary versus the contract versus the in between that's set in case law.
ATTENDEE: The one we're at now.
MS. LUNGE: Right.
ATTENDEE: Insurance agent.
MS. LUNGE: Right, exactly so -- and I think we had kind of gone over these six duties already that are listed on Pages 18 and 19 and the notice provision.
What I don't remember is if we did talk very much about the enforcement provision starting on page 21.
FEMALE ATTENDEE: I don't have any notes on that.
MS. LUNGE: So maybe that's where we kind of left off.
So just a little summary, this section is the enforcement provision for the PBM section and the part -- there are two different PBM sections.
This is enforcement for the requirement that the PBMs give notice that those six duties could be contained in a contract, but they didn't have to be -- they can be contracted around, so this would be enforcement if the PBM didn't give that notice that that was possible.
And so the enforcement section is split between BISHCA and the AG's office and provides
basically that the two agencies, BISHCA and the AG's, would share enforcement, that there would be a right of action that the AG could bring under the Consumer Fraud Act, and -- but, excuse me, that the Commissioner of BISHCA would have the same exclusive authority to investigate, examine or otherwise enforce this chapter when it's a PBM connect -- who has a contractual relationship with a traditional health insurer.

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

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

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

Section 8 is this --

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

MS. LUNGE: Right.

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

FEMALE ATTENDEE: That's right.

MS. LUNGE: Uh-huh.

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

Isn't that the same?

MS. LUNGE: Where on page 19?

ATTENDEE: Page 20.

MS. LUNGE: Oh, I'm sorry.

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

MS. LUNGE: I think you mean --

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

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

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

ATTENDEE: The process, right, okay.

ATTENDEE: On page 21.

MS. LUNGE: Yes.

ATTENDEE: That enforcement section.

MS. LUNGE: Yes.

ATTENDEE: Is my memory right on this one?

BISHCA is okay with all of this?

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

ATTENDEE: This italicized language?

MS. LUNGE: Yep.

ATTENDEE: Thank you.

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

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

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

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

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

ATTENDEE: Is the other thing she's going to
check on or someone's going to check on, is the AG involvement necessary? There are other laws that might be in effect right now that cover this?

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

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

MS. LUNGE: You get different remedies than under Consumer Fraud Act.
FEMALE ATTENDEE: Right. Yeah, I was just -- but I remembered that. I had written that down as what somebody said.
MS. LUNGE: I see. Thank you.
FEMALE ATTENDEE: Not something I'm saying I know.
MS. LUNGE: Section 8, 9421-A directs the Commissioner of BISHCA to register PBMs. On page 23, subsection B --
ATTENDEE: Didn't we hear that that's not necessary?
MS. LUNGE: There is currently a pilot project under the multi-payer database, and so for the purposes of the multi-payer database, registration is happening.
If for some reason, I think you decide to change what's going on with the multi-payer database and registration was not involved in that, then this would give you a stand-alone provision, so I think it's cleaner if you want to register for the purposes of registering to have that separate from the multi-payer database statute because right now, it's specifically linked for that purpose. And we could probably take it out of the multi-payer database, this section of the statute if you wanted.
ATTENDEE: Is this authoritatively different about the registration that we're following if it were to happen here, and what's happening in -- already happening?
MS. LUNGE: I don't think so because it's not very specific here so I think they're doing now would be fine.
ATTENDEE: Okay.
MS. LUNGE: And I don't think it was very specific in the multi-payer database section either, but I will also double check that in case my memory is faulty.
It's more just legally speaking, I think there's an argument that registering -- if the language is in the multi-payer database statute, if for some reason, you decided not to do the multi-payer database, the registration would also go away because it's linked specifically to that project, as opposed to general regulation.
ATTENDEE: And are there -- we've got to go through that, but presumably, there may be parts of this section that may ask for or at least imply
that we would use information associated with the registration for purposes other than just the multi-payer database, or is that not an issue?

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

ATTENDEE: Okay.

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

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

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

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

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

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

ATTENDEE: It's very similar.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTENDEE: Okay, thank you.

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

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

MS. LUNGE: Why?

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

MS. LUNGE: Right. Well, the testimony in -- it was less clear. In fact, the way it was written as they came out of Senate Health and Welfare, it could have been interpreted to apply more broadly.

It had some specific language about -- like A and B were specific, that they meant administrative services only contracts, but C was broader and could have been applied to other types of contracts, but the testimony -- there was competing testimony in Senate Health and Welfare about whether or not admin only contracts were the type of contracts that you really need to audit for, and I think Senate Health and Welfare decided that they were most concerned about making sure people could audit in that type of contract, so -- but there are some sort of pros and cons from different folks about -- about that.

ATTENDEE: (inaudible) by design, the other kinds of contracts, by design.

MS. LUNGE: That you get "X" amount regardless of what --

ATTENDEE: Right. They're keeping all that other stuff in themselves.

think 8 and 9 --

MS. LUNGE: Uh-huh.

FEMALE ATTENDEE: -- this is just kind of a catch-all for anything that might be required by the Commissioner?

MS. LUNGE: It has to be something that's relating to your specific contract, but it would give the Commissioner some other opportunities through rule to say okay, here's some other ways to audit these types of contracts.

If that specific thing wasn't in your contract, then obviously, you wouldn't audit for it but...

FEMALE ATTENDEE: Okay.

MS. LUNGE: But yes, it's kind of a catch-all.

FEMALE ATTENDEE: Okay.

MS. LUNGE: Should I try and just finish this section because we're almost done?

So D is the bill-back.

E is a general just rule-making provision for the Commissioner.

And then F has some definitions. It uses our standard -- one of our standard definitions for insurer, one of our standard definitions for health plan. PBM was defined in the previous section and Pharmacy Benefit Manager, management and manager as defined in the previous section of the Bill.

And then Section 9 is a technical provision which would state when the PBM provisions would apply to contracts in existence and as they come into creation, so that just clarifies for folks when they have to start complying with it.

ATTENDEE: Okay. You can stay there if you want.

MS. LUNGE: Sure.

ATTENDEE: Just as Lauren is getting this set up, just to orient the Committee again, this is Elliot Fisher.

He's a researcher at Dartmouth, has done work with Dr. Jack Wenberg (phonetic) there, as much as his own work, and this Committee has heard from him-- it's hard for me to remember how many times he's been in the Committee room here and some other places I've seen him, and he's a pretty well-known health policy researcher, and he wrote a letter that's copied in the materials that Steve Kimball (phonetic) gave us, expressing some concern against, against the data mining sections,
concern about losing access to the data producers, but I'm sure he'll tell us.

FEMALE ATTENDEE: What section is that in?

I'm sorry.

ATTENDEE: Section 3.

FEMALE ATTENDEE: Thank you.

FEMALE ATTENDEE: Thank you very much.

(Speaker phone call placed.)

DR. FISHER: Hi, it's Elliott Fisher.

MS. STAR: Dr. Fisher, hello. This is Lauren Star of the House Health Care Committee.

DR. FISHER: Hi.

MS. STAR: Thank you, and I will pass you over to Representative Steve Maier, the Committee Chair.

REPRESENTATIVE MAIER: Hi, Elliot, how are you?

DR. FISHER: I'm well, Representative Maier, how are you?

REPRESENTATIVE MAIER: We're doing well here today.

Thank you for joining us, taking time out of your schedule.

DR. FISHER: I'm happy to do it. Wish I could be there. It's more fun to look at you all and be able to say "hi" and have a chat, but I couldn't get up there.

REPRESENTATIVE MAIER: We have all of our Committee members here. Maybe I'll ask them to introduce themselves, and we also have a pretty cool Committee room of other interested folks.

But I understand you would like to talk with us about the data mining sections of the Bill.

DR. FISHER: I'm happy to try to answer questions or give you a little bit of my own opinion about my concerns about that section.

REPRESENTATIVE MAIER: Let me have the Committee just introduce themselves.

REPRESENTATIVE CHEN: Hi, Elliot, Harry Chen here.

REPRESENTATIVE LERICHE: Lucy Leriche.

REPRESENTATIVE COPELAND-HANZAS: Sarah Copeland-Hanzas.

REPRESENTATIVE OJIBWAY: Hilda Ojibway.

REPRESENTATIVE ZENIE: John Zenie.

REPRESENTATIVE WHEELER: Scott Wheeler.

REPRESENTATIVE O'DONNELL: Patty O'Donnell.

REPRESENTATIVE KEOUGH: Bill Keough from Burlington.

REPRESENTATIVE MILKEY: Ginny Milkey

REPRESENTATIVE McFAUN: Robert McFaun.

REPRESENTATIVE MAIER: All right, so we have a copy in front of us of the letter that you wrote, I guess it's to me, but I think at Steve Kimball's request or something along that line, and then you also had either testified or submitted testimony on the Senate side.

So maybe if you could just summarize what you said there or more generally what your concerns are about this.

DR. FISHER: Yeah. Let me start by being very clear so that you're aware of any -- any potential conflicts of interest that you may -- or perceived conflicts of interest.

First, I have spoken with folks from IMS at various points over the last several years when I learned of a Canadian atlas of prescribing that was prepared by researchers at the University of British Columbia with whom I've done work in the past, and more recently, on a project that is not related to prescribing, but is related to understanding physician groups throughout the United States.

We are using some data that we obtained from an IMS subsidiary that tries to figure out which physicians are members of which groups.

We're doing some research for the Common Law Fund that has us trying to look at the quality and costs of care within the United States and how -- whether physicians are in one-person, two-person or a hundred-person, multi-specialty group practices, whether that makes a difference in terms of the quality and costs of care.

So we are -- you should be aware that we are using some data that is owned by a subsidiary, that's from a company that's a subsidiary of IMS and that I have thought about in, you know, in the context of the Dartmouth atlas of health care, developing a Dartmouth atlas of prescription drugs within the United States which could be done with the kinds of data that is prepared by -- maintained by IMS, so that's the -- you should understand my comments in that context.

So my concern about the Bill that's before you all is that by precluding the commercial use of aggregated data, it will make it harder for us to understand trends and patterns of practice related to prescription drugs.

One of my earlier studies that reported on the overuse -- the potential overuse of drugs for
ADHD was based on prescription reporting
maintained by -- put together by a data aggregator
similar to IMS.

So that's -- the concern would be that by
restricting the commercial use, you would
eliminate the kinds of population-based research
that can be carried out doing that.

Now, it may be worth doing if the public
interest in preventing detailing, prescription
drug detailing to physicians is more important,
and that's a judgment that you all will have to
make.

My concern about this Bill is I'm not sure
that as I understand the Bill, it actually is
likely to reduce detailing of physicians or the
amount of time that the drug companies are trying
to get to physicians.

Rather, it will change the information that
they have to target physicians, but it won't
necessarily reduce the degree to which
pharmaceutical company representatives are in
physicians' offices, the use of gifts or other
inducements to prescribe inappropriately through
the use of samples.

So that's -- that's the question I would -- I
would ask you all to think about.

So that would be my initial statement,
Representative Maier, and I'm happy to answer
questions.

REPRESENTATIVE MAIER: All right. Thank you
very much.

Patty O'Donnell?

REPRESENTATIVE O'DONNELL: Yes, thank you for
making yourself available to us today.

We heard testimony that a lot of the
information that you receive -- that you receive
to calculate could be gotten from Medicare and
Medicaid.

Is there a difference in the quality of the
information that you receive from them and the
quality of the information you receive from like
an IMS?

DR. FISHER: Medicare right now does not
provide -- Medicare, which is the program for the
over 65, does not now make accessible the
prescription drug data that's under the Medicare
Part B program.

We are in discussions with Medicare, and
there's legislation pending in the Senate, I
believe, the U.S. Senate that would require CMS to
release that data, but under the original MMA
(phone name) date, we don't get it.

Private insurance companies do provide
detailed claim level prescription drug data that
can be used for many of the kinds of things, the
kinds of post-marketing surveillance or
epidemiologic studies that we have done.

But when the patients of the private data and
of the Medicaid data -- is that it has to be put
together from multiple different sources, so that
although -- for instance, Wellpoint I believe has
the largest population-based coverage in the
United States, it still covers, you know, a very
small fraction of the total population, so the
advantage of a -- you know, until we develop
comprehensive population-based claims data systems
for the under 65 that can be combined with the
over 65 and bring in the prescription drugs, the
IMS data provides the only sort of comprehensive
population-based window, I believe.

So within Vermont, you will have within, we
hope a couple of years when BISHCA gets contracts
set up for the all-payor database, you will have
for the under 65 population data on prescription
drugs, but that would -- if you stop the
commercial access to prescription drug data within
Vermont, it makes any national analyses likely to
have some holes, as we will now have in New
Hampshire. You know, it's not a huge hole, as you
know.

Does that answer your question?

REPRESENTATIVE O'DONNELL: Yes, thank you
REPRESENTATIVE MAIER: Yeah, John?

REPRESENTATIVE ZENIE: Elliot, this is John
Zenie.

I'm trying to get my arms around this idea of
the fact -- I have an IT background, and I
understand data very well, and I understand how
data can be collected, and then it can be
dispersed based upon a need to know; in other
words, that data is only as valuable as those that
want to use it and where it's going to go to.

And if this -- if this data is no longer used
for commercial use does this make this data
invaluable to the rest in the way of research,
even though the data would still be there, but
only for research purposes?

MR. FISHER: I think, you know, I think if
the data is still there, the likely -- it's not
clear to me, and I don't know the answer to this,
it's not clear to me that in the absence of the commercial uses that it's -- this is clearly very valuable information to phRMA, I believe, and it's probably not only about how they detail and try to change physicians' behavior, but overall understanding the impact of all of their activities.

So the concern would be that precluding any of its commercial uses would mean it basically doesn't get collected, and then we -- you might hope that someone else would set up a research database but, you know, we've got three states now that are trying to do this, and Maine is the farthest along of anyone in the country, and so it's going to be a while, I'm afraid, before we have comprehensive data sets for the rest of the country.

REPRESENTATIVE ZENIE: I'm a little confused by that. You make it sound like there is two different sets of data that's needed for research versus on commercial use, and I guess -- but then we say if we take away the commercial use, then there won't be any research data.

MR. FISHER: Well, I guess what I'm -- what I don't know, would IMS still collect the data from the PBM and try to put it together into a clean manageable database that's acceptable to researchers if they couldn't also market it to phRMA? And that, I don't know the answer to. That, they'll have to tell you.

REPRESENTATIVE ZENIE: Right. I don't think you would know the answer. I'm just saying I think there is a certain value left if there's no commercial value, that there is still value left, and I'm not sure where it would come from but --

MR. FISHER: Oh, I think there's tremendous value.

REPRESENTATIVE ZENIE: Right.

MR. FISHER: I mean, I think for -- I mean, I've been calling for comprehensive regional databases to allow us to monitor population health and health outcomes in health care for years, so yes, it would be tremendously valuable, but -- but it will require the public sector to come to support it if it's for research purposes because -- I mean, NIH funding is now flat.

We're only -- it's a very small percentage of grants that are being awarded, so there's great concern that the adequacy of funding research dollars to support the development of databases isn't there right now. Maybe it will be for health care performance measurement in the next few years, but it's not there yet.

REPRESENTATIVE ZENIE: Thank you.

ATTENDEE: Harry?

REPRESENTATIVE CHEN: Elliot, I guess I mean, sitting where we're sitting, I mean, we're really asking --

DR. FISHER: I'm sorry?

REPRESENTATIVE CHEN: This is Harry.

MR. FISHER: Yeah.

REPRESENTATIVE CHEN: We're asking the question, to what extent is this data causing some of the problems that you're seeing in terms of inappropriate prescribing and things of that sort?

And if that is the case, then, you know, is there -- can we make a more compelling case to you know, banning the use of this data for commercial purposes in -- in the hopes of trying to reduce the cost, in the hopes of trying to reduce the inappropriate prescribing?

MR. FISHER: Well, I -- I think that's exactly the right question.

I'm very concerned about the behavior of the pharmaceutical companies. If I could do away with direct consumer advertising, I would. If I could do away with physician detailing, I would.

I think the recent articles about the public release of the transparency of physician performance -- of payments by pharmaceutical companies to physicians which, you know, on which Vermont is one of the two states that tries to do this, but still protects the data much more so than Minnesota does, um, I -- I think we ought to do everything we can to reduce the influence of the pharmaceutical industry on physicians' prescribing practices.

What I don't know is whether -- and I'm actually concerned about whether this Bill is the correct vehicle to do -- the section on banning data mining essentially, is that the right approach to reducing the influence of the pharmaceutical industry on physician prescribing?

And I would bet that a more direct approach would be to say let's -- let's keep the pharmaceutical industry out of the physician's office as follows and, you know, the physicians could sign up for, you know, not to be contacted, and we could get rid of samples, and we could
get— I think there would be other approaches that might be more direct because I bet this will lead to — I would hypothesize that there will still be detailing, but it will be less accurate and more sort of shotgun.

And the detailing is the problem for me, not the, you know, not specifically how they're doing it, although maybe — Harry, you could be right. It could be that this'll make it so ineffective that they stop doing it, but I doubt it.

REPRESENTATIVE CHEN: Thanks.

ATTENDEE: I have the most --

MR. FISHER: Recent calculation on how much they're spending on every one of us?

ATTENDEE: No.

MR. FISHER: It's relatively high.

FEMALE ATTENDEE: (inaudible) $13,000.

REPRESENTATIVE MAIER: Elliot, this is Steve I think we've heard -- I forget where I've heard, but somebody I think suggested that the price tag to get access to the data from companies like IMS is pretty high.

Can you -- is that -- I'm not sure, from what you said before, whether you've actually used data from them or not, and can you comment about how accessible it is from the standpoint of cost or price for researchers?

I mean, what sort of a budget do you have there?

MR. FISHER: Well, I have not tried to purchase the pharmaceutical -- the data on the pharmaceutical stuff, so -- so that, I can't, I can't speak to, and because this IMS subsidiary has an interest in having this physician data used for performance measurement by others, they have been giving us this data to use for this particular research project with Common Law.

So I think the question, the question that really needs to be posed back to IMS -- I actually will say that I do know that the prices charged to a -- I think they were Rand investigators for IMS data were rather high, were steep, and they were being charged I think the same price as the pharmaceutical firms would have been paying.

So I think it would be a fair question to— I mean, I think IMS is vulnerable on this one to the extent that they -- that they do not have a sort of public, you know, a public sector price where, you know, BISHCA could buy the -- could get access to it for feedback as well, and I think that they should be pressured to do that, in fact, that if this is felt to have public value, that there should be some -- some -- I mean, I would be worried myself if the data became inaccessible to researchers because of its high cost, and then I'd be happy to shut it down.

But I don't -- my sense is that they're -- in my conversations with them about the potential of the atlas, they were talking about setting a price that would be affordable for us and not, you know, not in the kinds of realms that we would not have been able to do with our -- with our grant funding.

REPRESENTATIVE MAIER: Is $50,000 a lot or a little in your world?

MR. FISHER: $50,000? That's a lot. So that— I mean, we pay -- the purchase of Medicare data, well, it's a lot or a little. It depends, it depends whether our grants are going well or not going well.

I don't know whether that's a fair answer, but we get Medicare, who normally charges most research organizations, you know, $50,000 to $100,000 a year for the data that we've been getting, gives it to us because of our population-based public reporting.

So we do not pay CMS for their data, although most others do.

We would expect -- for some data, we pay up to 10,000. We purchase the AMA data, and that's in the sort of $5,000 per year to $10,000 for sort of copyrighted material to a more commercial organization, and that is what I would hope to be paying for IMS data. 10 to 20 or something per year would seem more -- depending on if it's readily available, and I mean, we'd have -- we would pay -- for special production runs, we still have to pay -- we still pay Medicare. It depends if it's a routine data request. But 50 seems like a lot.

REPRESENTATIVE MAIER: Bill Keough?

REPRESENTATIVE KEOUGH: Yes. How well known in the medical profession is this opt out capability for doctors to opt out of this program?

MR. FISHER: I really can't speak to that.

I-- I had heard of it. I think when there was -- I believe there -- and Harry may remember this better than I, there was an article I think in the New England Journal about California's physicians working in this area, you know, on this concern.
I think the opt out -- I mean, I would like all physicians to opt out of their detailing.

We finally managed I think Dartmouth Hitchcock to stop letting the prescription drug folks in to deal with the -- to be with the residents, to bring lunch, but it's only recently.

REPRESENTATIVE KEOUGH: Thank you.

REPRESENTATIVE MAIER: Hilda?

REPRESENTATIVE OJIBWAY: Dr. Fisher, you said again it sounds like, you know, you want to reduce influence, and you said consider alternatives, but let's say that some of these alternatives you talked about were all implemented.

Then why would they continue to do the research? Because it's like you're closing the door one way or the other.

I don't know if I'm being clear about this, but --

MR. FISHER: Yeah. No, I could --

REPRESENTATIVE OJIBWAY: So I don't -- I understand, you know, the idea that just be direct about it, but it seems like if -- if I don't see how the other one would work.

MR. FISHER: Uh-huh.

REPRESENTATIVE OJIBWAY: How it would -- would it would really stop -- would -- would decrease the amount of influence.

I mean, maybe you have a -- maybe I just didn't kind of get what you were talking at. I didn't see how -- how it would work.

MR. FISHER: Well, I mean some of this is -- gosh, I don't know.

I mean, I've only -- you know, it's only when this, when lightning struck the second time in a state that I actually lived in, you know, New Hampshire, that I started worrying about this, and I think one of the questions we should all ask ourselves is, you know, what's the best way forward, and how should we put something together, and can we do it in the next week or two? Because I think you're asking a very good question.

How can we have this -- is the data resource that IMS has put together valuable?

If you block the commercial use for -- and will this -- would it have an adverse -- would they stop collecting it?

If it's all commercial uses, I worry they might. If it's -- if it could be so narrowly framed so that they can't use it for detailing, maybe less, maybe less so. So I guess I'm not answering your question very clearly but...

REPRESENTATIVE OJIBWAY: Well, it's sort of the same thing Harry was saying. I guess it's just -- and you laughed when you started. You said, you know, that's for us to figure out, but it's -- it's looking at, well, the costs of having this influence or increased cost of insurance and inappropriate prescribing, so that's a bad public health issue, and then on the other hand, we're hearing that well, but if you don't have that ability to have the detailers go out, then there's no incentive to collect the data, and that's a -- that will have a bad impact on public health, so either way, we're hearing it.

MR. FISHER: Although I, you know -- if you guys could shut down the detailing, I'd give up the IMS data.

You know, I guess, I guess some of this is I think we're -- we're in a period in health care where we're trying to improve our data systems, and Vermont is at the forefront of that with your -- with the efforts you made to support BISHCA's creation of an all-payor database.

We're not there yet in terms of the kinds of performance measures that we'd like to be able to put in place.

I -- I think it's possible that the data collected by IMS could be used as a, you know, for public reporting on rates of generic prescription, rates of high-cost drug use, overuse of, you know, the latest anti-psychotic medications for patients with schizophrenia.

You know, there's a lot of those -- I believe that the data they put together, and I haven't -- you know, we've talked about doing an atlas.

I believe that that could be used to improve health care until we get the kinds of measures that we really need, which are from all-payor databases and the Medicare data with prescription drug data, but I don't see the public sector in the next year or two nationwide stepping forward.

So I'm -- this is where I really -- you know, on the question, Should we stop it now, and if you decide to, I don't think it'll -- I don't -- I think it will make it harder to do, you know, an atlas of prescription drugs.

I can't promise you we'd do it even if, you know, in the -- in the very near term, but I worry that would it be in the public interest to try to come up with a direct -- what you're -- I guess
what you're asking is if we stop detailing, would they stop, would the pharmaceutical industry stop paying to collect the IMS data? Is that correct?

REPRESENTATIVE OJIIBWAY: So if every doctor-- yeah, because I mean, one of the arguments is well, the doctors can just turn away the reps now. There's no need for a law like this.

MR. FISHER: Right. Well, and I wish they would, and I'm not sure that this law is going to reduce the numbers of detailers visiting physicians. That's my -- one of my fears about this, so that -- because I think what we're doing-- what it seems to me is we're -- we're guessing that this might change their practice somehow, but I'm not -- with known -- and -- and we're guessing that then it would make it no longer useful for IMS.

I wonder if we're ready to act at this point.

I mean, if I had access to the Medicare Part D data, if we had -- or if IMS decided in its wisdom to produce, you know, state-level reports to help states understand prescribing in their local communities, would we be in a different place?

It's something that you should -- that's -- I'm -- my concern about the Bill is that you're moving into something where I really don't know what the -- what the impact will be, so I'm not sure I can be helpful.

REPRESENTATIVE MAIER: John?

MR. FISHER: Or have been helpful.

REPRESENTATIVE ZENIE: Actually, this is John Zenie again, Dr. Fisher. You're being very helpful to me anyway. I know that. I think to others too, as I see heads nod, and you're helping me to brainstorm some different ideas than what's in this Bill, so I find it very useful.

And my latest brainstorm is if this was feasible, whether or not the research community could basically hire IMS to maintain a database for which the research community controls access to the database; in other words, basically, pay IMS to continue doing what they're doing and that the research community maintain control over access and the use of the database.

I don't know whether that's even a plausible thing. How much money would IMS want for that kind of service? I don't know.

MR. FISHER: I think, I mean the little I know about -- the little I know about how IMS assembles the data and their sources, my guess is the research community couldn't afford to -- to pay for it.

REPRESENTATIVE ZENIE: Well, we're paying for it one way or the other, right? I mean, that's just a matter of how you want to pay for it I guess.

MR. FISHER: Yeah, that's certainly true, but I -- you know, as I look at -- as we try to figure out how Congress is going to fix this physician payment schedule for next year, you know, and -- pay for S chips, (phonetic), I don't see increased funding for -- for the maintenance of a federal database, you know, federal support for a database of prescription drugs. I don't think that's very high on their list.

REPRESENTATIVE ZENIE: Could I take your answer as saying if we could find the money, yes, that might be a good idea?

MR. FISHER: I mean, I think if -- if -- I guess I wouldn't if we could find the money, I wouldn't put it only into the pharmaceutical stuff.

I would put it into the kinds -- I'd have every state doing the kinds of population-based data systems that you're talking about here or that BISHCA's already starting to move forward on contracting, putting implementation on for the all-payer database in Vermont, which will include prescription drugs for as many -- you know, for those who are enrolled and have it, as I understand it, have drug coverage.

So I think the question -- a question would be whether that's in the short term something that you can expect and whether -- you know, and that, I can't predict.

REPRESENTATIVE ZENIE: Okay.

MR. FISHER: Because I don't think -- I don't see a lot of excellent resources floating around to pay IMS to maintain this database without some support from the pharmaceutical industry which needs to understand trends in -- you know, which, you know, trends in overall drug use, sales of drugs, you know, where they're going as much as it does to understand individual physician prescribing, I believe.

I think there are a lot of other uses besides individual prescribing which would not be of great use to the research community. But that's
something you'll have to ask IMS, you know, that
IMS would have to testify to.

REPRESENTATIVE ZENIE: Sure, and also to the
pharmaceuticals to find out, you know, in our own
minds, is there an aggregate-type thing that we
could still provide to the pharmaceuticals that
they would still find of some value, not to
necessarily help detailers as much as just seeing
trends and analysis in a global way, rather than a
doctor-by-doctor basis?

MR. FISHER: Right. I bet there are -- I
mean, I hear you -- I hear the Committee trying to
do some creative work around how can we meet the
public interest in maintaining access to important
and valuable data that can be used to understand
the performance of a delivery system and reduce
the impact of the pharmaceutical -- adverse impact
of the pharmaceutical industry on physician
prescribing.

REPRESENTATIVE ZENIE: Correct.

MR. FISHER: And I think those are -- I agree
with both of those goals. I don't -- I worry that
I can't come up with the right answer to that, or
we may have a hard time as a community coming up
with that in the next month or two.

REPRESENTATIVE ZENIE: All right.

MR. FISHER: Or whatever your time frame is
for this Bill, so the question -- you know, a
question then is is this something you should, you
know, we should all think about further? And
that's -- I think that's really where my testimony
to the Senate Committee was.

You know, it seems like we're rushing
something here, so I think there's some -- some
challenges that we should work through.

REPRESENTATIVE MAIER: Okay. I think -- I
think -- well, I don't see any more questions, so
thank you very much, and I'm sure we'll cross
dates sometime.

MR. FISHER: Yeah, I'm happy to help you.
Good luck with your deliberations. I -- you know,
you're doing God's work.

REPRESENTATIVE MAIER: Really?

MR. FISHER: I remember being on the School
Board. You guys have the hard job. All right.

Thanks a lot.

REPRESENTATIVE MAIER: It could be worse. We
could be on a School Board.

ATTENDEE: Thank you.

(Start of Track 2 from CD labeled 4/17/07 #1c,
and cost-effective utilization of drugs to
physicians, pharmacists and other professionals
who prescribe drugs, prescribe and dispense drugs.

"The Department may collaborate with other
states in establishing this program."

And that was specifically included because
there was some testimony that prescription policy
choices, which is a policy organization affiliated
with NLRAX (phonetic) may be working with Maine,
Vermont and New Hampshire to do a regional program
which would save a little money because all the
programs could use the same materials and develop
common things like that.

Also, Pennsylvania, does have an
evidence-based education program, which I think is
affiliated with their Medicaid, so they've been
developing some materials as well.

"The Department of Health shall request
information and collaboration from physicians,
pharmacists, private insurers, hospitals, PBMs,
the Drug Utilization Review Board, medical
schools, the AG, and any other programs providing
an evidence-based education program to prescribers
on on prescription drugs and developing and
maintaining the program.

"The Department may contract for technical
and clinical support in the development and
administration of the program by entities
conducting independent research into
effectiveness."

And you can see this reference to the Oregon
program was struck by the committees as well so
that there was no specific program mentioned.

"D. The Department of Health and AG shall
collaborate in reviewing the marketing activities
of the pharmaceutical manufacturing companies in
Vermont in determining appropriate funding sources
for the program, including awards from suits
brought by the AG against the manufacturers,"
which is the current funding for the AHEC program
I think.

FEMALE ATTENDEE: You've said this already,
but could you just please remind me of the amount
of money that you just mentioned that funds this
program? Do you remember?

MS. LUNGE: I actually don't know that I know
that.

FEMALE ATTENDEE: I thought somebody told us.

MS. LUNGE: I don't think I know --

FEMALE ATTENDEE: Okay.

MS. LUNGE: -- how much AHEC is currently
operating on. It could be the Department of
Health mentioned that, but I don't recall off the
top of my head.

FEMALE ATTENDEE: Okay. I'll look at my
notes.

ATTENDEE: The money was going to come from
the settlement.

MS. LUNGE: I think it currently -- AHEC is
currently getting some money.

ATTENDEE: Some money.

MS. LUNGE: From a settlement through a grant
by the AG's Office, but I don't know the amount.
Okay?

ATTENDEE: A hundred thousand pops into my
head. I have no reason to think that that's
actually true, other than I just -- I shouldn't
have said it out loud, but that's the number that
popped into my head.

FEMALE ATTENDEE: The part that I asked --
you know, I'm just trying to get a sense of say
the state of Vermont spends a hundred thousand and
has four employees working on this, and then if
you could quantify how much is on the detailing,
so there's -- it's kind of so lopsided, it's
ridiculous, isn't it? Well, I mean just within
the state. I was just trying to get a sense for--

FEMALE ATTENDEE: David and Goliath kind of?

FEMALE ATTENDEE: Yeah, but I just -- that's
my impression, but I don't have anything
quantified. I just (inaudible).

FEMALE ATTENDEE: Never mind.

MS. LUNGE: I can't recall if AHEC is coming
later this week, but I can certainly e-mail
someone there and try and find out the specifics
of the amount of money.

ATTENDEE: I think that would (inaudible).

FEMALE ATTENDEE: It's me against the NFL
defensive line, isn't it?

FEMALE ATTENDEE: It is.

FEMALE ATTENDEE: That's what I thought.

FEMALE ATTENDEE: I hope you've been pumping
iron, honey.

MS. LUNGE: So the next section is
Section 13, which was the data mining section you
were just hearing about, and -- so should I go
through this again?

It seemed like we kind of went through it, so
I don't know.

ATTENDEE: Yeah.
ATTENDEE: Not line by line.

MS. LUNGE: Okay.

ATTENDEE: I think we need -- I need to be clear exactly what this does.

MS. LUNGE: Okay.

ATTENDEE: And I'm not (inaudible).

MS. LUNGE: Well, you did ask me at one point for the language from the other versions, and I do have that with me as well. I don't know if it makes sense to do that now or wait until we get through the rest of the Bill and then come back to that or what, but I do have it when you're ready for it.

So -- well, so this Section 4631, A is basically just a finding intent section.

B. I think the two most important definitions in this section, one is commercial purpose, which shall include advertising, marketing, promotion or any activity that is intended to be used or is used to influence sales or the market share of a pharmaceutical product, influence or evaluate the prescribing behavior of an individual health care professional market prescription drugs to patients or evaluate the effectiveness of a professional detailing force.

So that's, that's how we define commercial use.

ATTENDEE: So -- so it's to evaluate the prescribing behavior of an individual health care provider, so in that just, you know, just taking what Eliott Fisher does, that would include that?

MS. LUNGE: It potentially could, although we also -- there's some clarifying language in D, which excludes certain things, including research purposes, so I think you have to read this section in conjunction with the rest of the text too to kind of get the full picture, but I think you're right, that just those words taken alone potentially could.

ATTENDEE: Right, okay.

MS. LUNGE: Although you could -- I think you could if you wanted to say something like evaluate the prescribing behavior for the purpose of influencing, and that would narrow that down too because I think the intent was certainly not to sort of affect the research evaluation part.

So the other important definition is on page 32, line 5, and that is regulated records, which means information or documentation from a prescription written by a prescriber doing business in Vermont or a prescription dispensed in Vermont, and so that's the definition where we narrow the information that we're talking about to just Vermont-based information.

ATTENDEE: Where are we again?

MS. LUNGE: This is on page 32, lines 5 through 7.

ATTENDEE: Okay.

FEMALE ATTENDEE: And one of the reasons you did that was in response to the lawsuit which was an interstate commerce?

MS. LUNGE: Yes, because my understanding -- the New Hampshire law didn't specify that, you know, what records they were talking about very clearly, so it didn't have a definition like this which tried to be very specific, that we were just looking at Vermont-based data.

FEMALE ATTENDEE: Doing business in Vermont just refresh my memory on mail order pharmacies, do they have to be registered or something? Are they considered doing business in Vermont, or is it?

MS. LUNGE: That's a good question. They are -- I don't know if it's registered or licensed.

I think it might be registered, and let me just double check on that. I would think that would be since we're regulating them, I think they're considered to be doing business in Vermont, but I'll just double check with the Commerce people to make sure that --

FEMALE ATTENDEE: Okay.

MS. LUNGE: -- that that is accurate.

ATTENDEE: Could I -- could I go up a few levels, and could you help us -- help me review what -- I got confused about where the firewall gets put up if we pass language such as this, and there was this conversation going on. I forget whether you were in the room about, you know, does the information from -- from an IMS have any -- does it still go to the pharmaceutical company and then the firewall is set up, you know, somewhere between, you know, pharmaceutical companies and --

FEMALE ATTENDEE: Detailers.

ATTENDEE: And somewhere down and then the detailer?

MS. LUNGE: The firewall for this program, the way it's written in this version is between the pharmacy or the entity or the doctor, whoever has the records in Vermont and IMS.

FEMALE ATTENDEE: You're thinking about the
<table>
<thead>
<tr>
<th>Page 58</th>
<th>Page 60</th>
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<tbody>
<tr>
<td>AMA firewall.</td>
<td>MS. LUNGE: If they intend to sell the data for advertising, marketing --</td>
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<tr>
<td>MS. LUNGE: The AMA firewall is within the pharmaceutical manufacturers.</td>
<td>FEMALE ATTENDEE: Okay.</td>
</tr>
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<td>ATTENDEE: Oh, that's under the opt out.</td>
<td>MS. LUNGE: -- promotion or any activity that is intended to be used or is used to influence sales or market share, but they can still sell it for other reasons.</td>
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<td>ATTENDEE: Yeah, that's the opt out.</td>
<td>FEMALE ATTENDEE: Okay.</td>
</tr>
<tr>
<td>MS. LUNGE: That's under the opt out.</td>
<td>MS. LUNGE: So -- and then D is supposed to clarify again specific situations that have come up where people were worried about it.</td>
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<tr>
<td>ATTENDEE: Okay. Thank you.</td>
<td>So it doesn't apply to the license, transfer, use or sale of regulated records for the purposes of pharmacy reimbursement, formulary compliance, patient care management, utilization review or health care research.</td>
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<td>ATTENDEE: What if we took out collection on all these, you know, 5 and 6 and 7? Well, how would that change it?</td>
<td>It doesn't apply to dispensing prescription drugs to the patient.</td>
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<td>MS. LUNGE: 5 and 6 and 7 on page --</td>
<td>It doesn't apply to transmission of the information between a prescriber and the pharmacy or between pharmacies that may occur in the event a pharmacy's ownership is changed or transferred.</td>
</tr>
<tr>
<td>ATTENDEE: 32.</td>
<td>It doesn't apply to care management, educational communications provided to a patient -- and then there's a list of those kinds</td>
</tr>
<tr>
<td>MS. LUNGE: 32.</td>
<td>of things, or to, you know, recall or patient safety notices or to clinical trials.</td>
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<td>ATTENDEE: Because it's that collection which is what's --</td>
<td>It doesn't apply to using the data for the multi-payer database, the -- what's the name of that program? It was S-90 last year, but it's the program, the electronic prescription drug monitoring program by the Department of Health where they're looking for misuse of regulated drugs, and Chapter 84 is our other regulation of prescription drugs that we have in terms of collecting information in Vermont. It's about regulated records, so I think it's like the narcotics and stuff, so it doesn't apply to those things.</td>
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<tr>
<td>ATTENDEE: 28.</td>
<td>It doesn't apply to collection or transmission of prescription information to a Vermont or federal law enforcement officer engaged in his official duties as otherwise provided for by law.</td>
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<td>ATTENDEE: -- creating the firewall at the pharmacy level.</td>
<td>It also doesn't apply to the commercial use of the data if the data does not identify a person and there's no reasonable basis to believe that the data provided could be used to identify a person. And person in that sense means health care professional as well as, you know, a patient.</td>
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<td>If we changed anything, it would be in C.</td>
<td>of things, or to, you know, recall or patient safety notices or to clinical trials.</td>
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<td>ATTENDEE: C, yes.</td>
<td>It doesn't apply to using the data for the multi-payer database, the -- what's the name of that program? It was S-90 last year, but it's the program, the electronic prescription drug monitoring program by the Department of Health where they're looking for misuse of regulated drugs, and Chapter 84 is our other regulation of prescription drugs that we have in terms of collecting information in Vermont. It's about regulated records, so I think it's like the narcotics and stuff, so it doesn't apply to those things.</td>
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<td>MS. LUNGE: On lines 8 through 12 because there is the prohibition.</td>
<td>It doesn't apply to collection or transmission of prescription information to a Vermont or federal law enforcement officer engaged in his official duties as otherwise provided for by law.</td>
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<td>ATTENDEE: Okay.</td>
<td>It also doesn't apply to the commercial use of the data if the data does not identify a person and there's no reasonable basis to believe that the data provided could be used to identify a person. And person in that sense means health care professional as well as, you know, a patient.</td>
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<td>MS. LUNGE: This says, &quot;The insurer, a self-insured employer, an electronic transmission intermediary,&quot; which would be someone like IMS, a pharmacy or other similar entity, &quot;shall not license, transfer, use or sell regulated records which include prescription information containing patient identifiable or prescriber identifiable data for any commercial purpose.&quot;</td>
<td>of things, or to, you know, recall or patient safety notices or to clinical trials.</td>
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<td>So it's saying that the health insurer or the pharmacy or IMS, it doesn't prohibit them from licensing, transferring, using or selling the regulated records for a different purpose, but it would prohibit it from the commercial purpose, which refers back to our definition.</td>
<td>It doesn't apply to using the data for the multi-payer database, the -- what's the name of that program? It was S-90 last year, but it's the program, the electronic prescription drug monitoring program by the Department of Health where they're looking for misuse of regulated drugs, and Chapter 84 is our other regulation of prescription drugs that we have in terms of collecting information in Vermont. It's about regulated records, so I think it's like the narcotics and stuff, so it doesn't apply to those things.</td>
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<td>FEMALE ATTENDEE: Your definition of commercial purpose.</td>
<td>It doesn't apply to collection or transmission of prescription information to a Vermont or federal law enforcement officer engaged in his official duties as otherwise provided for by law.</td>
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<td>ATTENDEE: Okay.</td>
<td>It also doesn't apply to the commercial use of the data if the data does not identify a person and there's no reasonable basis to believe that the data provided could be used to identify a person. And person in that sense means health care professional as well as, you know, a patient.</td>
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<td>FEMALE ATTENDEE: Does it become a commercial purpose because IMS intends to sell the data?</td>
<td>of things, or to, you know, recall or patient safety notices or to clinical trials.</td>
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So that means IMS could still sell the data to a phRMA if it didn't identify the prescriber. So for instance, they could say here's statewide data on your sales of this particular product.

FEMALE ATTENDEE: Or data for all prescribers in zip code 05401.

MS. LUNGE: Unless there was only one prescriber in that zip code, and then I think that could be used to identify the prescriber, but if there were -- let's say it was a primary care doc, and there were a bunch of them, then yes.

FEMALE ATTENDEE: Uh-huh.

FEMALE ATTENDEE: So they couldn't include -- if they do transmit this -- this data, these data, they couldn't include the prescriber numbers with it?

MS. LUNGE: Correct.

FEMALE ATTENDEE: Because that could be used.

MS. LUNGE: Right.

FEMALE ATTENDEE: In conjunction with the AMA to identify it.

MS. LUNGE: Right.

ATTENDEE: But it seems to me they can -- well, they -- let's just say on this company, I'm a data mining company, and I go to CVS Pharmacy, and I say I want your Vermont data. If you have a contract with this CVS pharmacy, not to -- not to uses it for commercial purposes, then you could collect it.

MS. LUNGE: Yes. Yes.

ATTENDEE: So it can be collected, it's just that the supposition is that it wouldn't be collected because it's not financially --

FEMALE ATTENDEE: Right.

FEMALE ATTENDEE: Who's going to pay for it?

ATTENDEE: -- profitable.

FEMALE ATTENDEE: Right.

MS. LUNGE: Right, correct.

ATTENDEE: Or...

MS. LUNGE: Yes, that's correct.

FEMALE ATTENDEE: They're all still going to be there. They're just not going to get it nicely arranged, potentially.

(Track 2 ended there.)