MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

4027

2001 SENATE HUMAN SERVICES

SCR 4027

2001 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SCR 4027

Senate Human Services Committee

☐ Conference Committee

Hearing Date February 13, 2001

Tape Number	Side A	Side B	Meter #
2	X		
Committee Clerk Signature	Carol Kolodjeski		

Minutes:

The committee was called to order.

The hearing on SCR 4027 was opened.

SENATOR RUSSEL THANE introduced the resolution. (Written material)

MR. JORDON supports resolution.

DAVE ZENTNER, Dept of Human Services supports resolution. (Written testimony)

SENATOR LEE: Do you think there is any reason to amend in Medicaid? MR. ZENTNER: No

HOWARD ANDERSON, JR., Pharmacy, supports resolution. This would be a provision of prescription drugs to those that can't afford it. SENATOR KILZER: The use of generic prescriptions - are they widely used now? MR. ANDERSON: Generic utilization is good. It is generally used. 2 or 3% advise brand name necessary.

ROD ST. AUBYN, BCBS, supports the resolution.

NORM STUMILLER, AARP, supports resolution.

CAL ROLFSON, Pharmaceutical representative (Pharna) supports resolution and offered to provide technical help, support and date to the study.

The hearing was closed on SCR 4027.

Discussion was held.

SENATOR MATHERN moved an amendment. Another Whereas, beginning line 18 , "Whereas, Medicaid drug expenditures for the 1997-99 biennium totaled $47.1 million were from the general fund; for the 1999-2001 biennium, the department of human services budgeted $50.4 million, of which $15 million are state funds; and the latest estimates indicate that the department of human services will expend $63.5 million, of which $18.9 million are state funds while the department of human services is anticipating expenditures in the next biennium to exceed $80 million; and" . SENATOR LEE suggested on line 15, Consumers add" and the state" and after line 15 and whether ND should establish a program to assist in the purchase of prescription drugs based on income. SENATOR MATHERN moved the amendments. SENATOR FISCHER seconded the motion. Voice vote carried. SENATOR FISCHER moved a DO PASS AS AMENDED. SENATOR POLOVITZ seconded the motion. Roll call vote carried 6-0. SENATOR MATHERN will carry the bill.

Date: 2/13/01

Roll Call Vote #: 1

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 4027

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do pass as amended

Motion Made By Sen Fischer Seconded By Sen Polovitz

Senators	Yes	No	Senators	Yes	No
Senator Lee, Chairperson	✓		Senator Polovitz	✓	
Senator Kilzer, Vice-Chairperson	✓		Senator Mathern	✓	
Senator Erbele	✓				
Senator Fischer	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen Mathern

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SCR 4027: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SCR 4027 was placed on the Sixth order on the calendar.

Page 1, line 2, after "consumers" insert "and the state, and whether the state should establish a program to assist in the purchase of prescription drugs based upon income"

Page 1, after line 4, insert:

"**WHEREAS**, Medicaid drug expenditures for the 1997-99 biennium totaled $47.1 million, of which $12.3 million were from the general fund; for the 1999-2001 biennium, the department of human services budgeted $50.4 million, of which $15 million are state funds; and the latest estimates indicate that the department of human services will expend $63.5 million, of which $18.9 million are state funds while the department of human services is anticipating expenditures in the next biennium to exceed $80 million; and"

Page 1, line 21, after "consumers" insert "and the state, and whether the state should establish a program to assist in the purchase of prescription drugs based upon income"

Renumber accordingly

2001 HOUSE HUMAN SERVICES

SCR 4027

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SCR 4027

House Human Services Committee

☐ Conference Committee

Hearing Date March 21, 2001

Tape Number	Side A	Side B	Meter #
1		x	2382 to 4839
Committee Clerk Signature	Connie Easton		

Minutes:

Chairman Price: We will open the hearing on SCR 4027. Clerk will read the title.

Sen. Thane - District 25: Introduced resolution. The resolution you see before us is better than the original one I introduced. I think every one of us in this room has heard from our Congressional delegation either through the media or otherwise, about how they go across the border into Mexico and buy blood pressure medication at half the price. They do it on a regular basis and bring it back not only for themselves, but their friends and neighbors. There is something wrong when there is that much discrepancy. This happens in Canada also. I think rather than read a bunch of Whereas's I will close my testimony and urge you to pass this resolution.

Galen Jordre, R.Ph. - Executive Vice President: We support this study. (See written testimony).

Rep. Weisz: In one of the Whereas's it talks about cost of the competition drugs...increasing at a rate outpacing inflation 2 to 1. Is that because of the increase usage, the price of the drug itself, increased dosage rates. Can you comment on that a little bit.

Jordre: I think when we would talk about the top fifty drugs. If the top fifty drugs were the same top fifty drugs we had five years ago, the price would be within the rate of inflation. The reason that figure looks large is because probably of the top fifty drugs maybe half of them might be new entities introduced at a higher cost than some of the things they replaced. Or actually are entirely new entities for which there was no treatment before.

Rep. Niemeier: In your third paragraph, just as a point of clarification, are you relating those numbers of deaths to improper drug use?

Jordre: That is what the study had shown. That study was based on an earlier study released in 1996, that was published in a number of AMA publications, so it has been well scrutinized and they just re-projected the numbers.

David Zentner - Director of Medical Services for the Department of Human Services: I appear today in support of this resolution. (See written testimony).

Rep. Devlin: Does the department have any costs to show us on what less hospitalization, substituting expense surgery by substituting drug treatment that type of thing. We always just look at the cost of drugs, and I understand there are better and better drugs coming out on the market all the time, but we never seem to look at what the savings are also to the budget because we are spending all those dollars in those areas?

Zentner: There certainly is a benefit to drug therapy. It is difficult to quantify what the amount is, but I can give you an example of what happened to hospital costs in the Medicaid program. I can't say that all of it relates to drug therapy because of the things that have happened with in

patient. But the bottom line is we are spending less money on hospitals than we did three biennium's ago. That is even taking into consideration inflation. The bottom line is the cost for inpatient hospital has dropped and I think part of that is certainly due to better drug regimen. How much, I couldn't quantify. I think it is true, there are benefits to new drug therapy.

Rep. Devlin: When we looked at prior authorization, one of the things that was baffling to the committee is the DUR board had not been in operation and had not met yet, but I understand that they are talking about meeting again?

Zentner: Yes, they had a preliminary meeting this week to look at the new system we have to review for drugs. We anticipate getting that rolling again as soon as the session is over with.

Rep. Galvin: The disparity between the Canadian and the Mexican drugs. Are those drugs of the same quality, and have they undergone the same research?

Zentner: I don't know if I am in a position to answer that.

Jordre: I don't know if I am in a position to answer, but a lot of them are the same, many are produced in the United States and exported out. However there are manufacturing facilities in Mexico that are out side the realm of Food and Drug Administration. I think the other thing is within in Canada there is a rigid system of price controls. So the pharmaceuticals there are not freely priced. But I would say in Canada there is a much higher incidence of those products that would meet the US standards. But there is no guarantee that all of them would.

Cal Rolfson - Legislative Council PHARMA: While we are neither for or against this bill, but we expect it to pass. I only testify to tell you that PHARMA will offer to be an active participant in any study conducted during the interim. We would be pleased to be a participant. There is a host of data that is nowhere better available than from PHARMA.

Chairman Price: Any questions? Anyone else in favor or neutral? Any opposition? I will close the hearing on SCR 4027. Do you want to take action on this?

(some discussion on preventable deaths)

Rep. Cleary: I move a do pass.

Rep. Weisz: I second.

Chairman Price: I have a do pass for the consent calendar and a second. All those in favor signify by saying Aye. Opposed?

COMMITTEE WORK

MOTION FOR A DO PASS

UNANIMOUS VOICE VOTE

CONSENT CALENDAR

CARRIED BY REP. SANDVIG

Date: 3-21-01
Roll Call Vote #: 1

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SCR 4027

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken DO PASS & placed on Consent Calendar

Motion Made By Rep. Cleary Seconded By Rep. Weisz

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairman	✓		Audrey Cleary	✓	
William Devlin - V. Chairman	✓		Ralph Metcalf	✓	
Mark Dosch	✓		Carol Niemeier	✓	
Pat Galvin	✓		Sally Sandvig	✓	
Frank Klein	✓				
Chet Pollert	✓				
Todd Porter	✓				
Wayne Tieman	✓				
Dave Weiler	✓				
Robin Weisz	✓				

Total (Yes) 14 No 0

Absent 0

Floor Assignment Rep. Sandvig

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
March 21, 2001 1:20 p.m.

Module No: HR-49-6287
Carrier: Sandvig
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

SCR 4027, as engrossed: Human Services Committee (Rep. Price, Chairman) recommends **DO PASS** and **BE PLACED ON THE CONSENT CALENDAR** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SCR 4027 was placed on the Tenth order on the calendar.

2001 TESTIMONY

SCR 4027

TESTIMONY BEFORE THE SENATE HUMAN SERVICES COMMITTEE
REGARDING SENATE CONCURRENT RESOLUTION 4027
FEBRUARY 13, 2001

Chairman Lee, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you to support this resolution.

The cost of prescription drugs in the Medicaid Program has increased dramatically over the past four years and are expected continue their upward spiral with no end in sight.

Drug expenditures for the 1997-99 biennium totaled $47.1 million, of which $12.3 million were general funds. This was 17.3% greater than the amount used to build the appropriation for that period. In the current biennium, the Department budgeted $50.4 million, of which $15 million are state funds. Our latest estimates indicate that we will actually expend $63.5 million, of which $18.9 million are state funds. This is 26% greater than the amount used to build the budget for this biennium.

We are anticipating expenditures in the next biennium to exceed $80 million.

The Department did attempt to institute a prior authorization process for certain drugs in the current legislative session. We introduced the bill to assist us in providing appropriate and cost effective medications to individuals enrolled in the North Dakota Medicaid Program. That bill was soundly defeated in the House. At this time the Department has few options available to counter the high cost of drugs.

We believe that a study of drug pricing including the impact on the Medicaid Program is appropriate at this time and the Department supports a do pass on this resolution.

I would be happy to answer any questions you may have.

Sen Shane

MAINE

Department of Human Services

Bureau of Elder and Adult Services

Return to BEAS

Prescription Drug Assistance

A Guide for Maine Elders and Adults with Disabilities

March 2000

Contents

Introduction

The high cost of prescription drugs is a fact of life for everyone. But elders and adults with disabilities are particularly affected. This booklet is intended to be a guide for Mainers who need help paying for their prescription drugs especially those on Medicare. It will not have all the answers for everyone. If you don't find what you need in this guide, call one of the organizations listed in the back of this booklet for assistance.

When a doctor prescribes a medication for you, be sure to let him or her know what other drugs you are taking, including over-the-counter drugs like aspirin. It may be that you don't need another medication. Also, some drugs when taken together cause undesirable side effects.

Generic medications are sometimes less expensive than brand name medications. You should check with your doctor and/or pharmacy to see if a generic medication can be substituted for a brand name

If you have questions about health insurance, you can get help from the State Health Insurance Assistance Program (SHIP). This statewide service provides information and assistance for people who have questions about their health insurance. Counselors can assist Medicare beneficiaries with Medicare, Medicaid, Medigap Supplemental Insurance, Long-term care insurance, the Explanation of Medicare Benefits statements and other kinds of health insurance issues.

You can talk to a counselor at the office, over the phone or in your own home. To get in touch with a counselor, please call: Bureau of Elder and Adult Services, your Local Area Agency on Aging or Legal Services for the Elderly Hotline

Medicare & Medicaid

DOES MEDICARE COVER ANY PRESCRIPTION DRUGS?

Medicare pays for prescription drugs while you are in the hospital. But Medicare *does not* otherwise cover prescription drugs, except for very limited medical conditions. Outside of a hospital Medicare only covers certain anti-cancer and immunosuppressive drugs needed after an organ transplant.

WHAT ABOUT MEDICARE SUPPLEMENTAL INSURANCE?

If you are on Medicare, you may be able to purchase a private Medicare supplemental (Medigap) insurance policy that covers some of the costs of prescription drugs. These policies are more expensive than Medigap policies that do not cover prescription drugs. Whether you should purchase one of the more expensive Medigap plans depends on your ability to pay the monthly premium and the co-payment and the annual costs of your prescription drugs.

Call your local Area Agency on Aging or Legal Services for the Elderly to discuss your Medigap options.

ARE THERE ANY MEDICARE+CHOICE HMO PLANS IN MAINE?

Maine has one Medicare HMO that serves York, Cumberland, Sagadahoc, Androscoggin, Franklin, Kennebec, Waldo, and southern Penobscot Counties. Medicare beneficiaries enrolled in this HMO have a prescription drug benefit. Starting in January 2000, the Medicare HMO will offer two plans with prescription drug benefits.

For more information about Medicare health insurance choices, contact your local Area Agency on Aging or Legal Services for the Elderly.

HOW DO I FIND OUT IF I AM ELIGIBLE FOR MEDICAID?

If you are eligible for Medicaid, your prescription drugs will be covered except for a small co-payment that you pay the pharmacy. In 2000, you may be eligible for Medicaid if you are:

- An individual with a gross monthly income under $771 and assets under $2,000, or
- A couple with a gross monthly income under $1,038 and assets under $4,000.

Call your localDepartment of Human Services Regional office and ask to have an application mailed to you or go your localArea Agency on Aging and fill out an application.

If your income is low and your assets fall within these limits, call your local Department of Human Services Regional Office and ask to have an application mailed to you or go to the office and fill out an application.

If your income and assets are slightly over the limits, it is still a good idea to fill out an application. Even if you are not eligible for full Medicaid benefits, you may be eligible for other types of assistance **that can help pay for your Medicare Part B premium and other health care costs**. The Eligibility Specialists at the Department of Human Services will help you get any assistance for which you are eligible. You can also call your local Area Agency on Aging or Legal Services for the Elderly to find out more about Medicaid eligibility.

The Department of Human Services has a special program for those who have Medicare because of a disability. If you return to work, you may be able to enroll in Medicaid at no cost to you or for a very low premium. Medicare would continue to be your primary insurance. Medicaid would cover your deductibles and co-payments as well as your prescription drug costs. If you want more information about this program, call your local Department of Human Services office.

Maine Low Cost Drugs for the Elderly or Disabled Program

The Maine Low Cost Drugs for the Elderly or Disabled Program helps eligible citizens get certain prescription drugs at a low cost. If you are eligible, you will get a card (the "drug card") that you can show the pharmacist when you pick up your prescription. You must reapply every year for this program.

How do I qualify for the Low Cost Drug Program?

To qualify for the Low Cost Drug Program you must:

a. Be a Maine resident,
b. Be at least 62 years old, or 19 years old or older and disabled according to the standards of Social Security,
c. Have a household income of less than 185% of the federal poverty level for your household size ($1,279/month for one; $1,705/month for two in the year 2000).

If you spend 40% or more of your household income on prescription drugs, the income limits are 25% higher.

The household income limits will change every year. The application for the Low Cost Drug Program will list the household income limits for that year.

Who do I contact for more information?

Bureau of Elder and Adult Services can provide general information and send you an application.

Toll Free	1-800-262-2232
Local/Out-of-State	207-624-5335
TTY	207-624-5442 **or** 1-888-720-1925

Maine Low Cost Drug for the Elderly and Disabled

Toll Free 1-888-600-2466
TTY 207-622-3219

Maine Revenue Services process the applications and can answer eligibility and financial questions

207-626-8475
TTY 207-287-4477

Bureau of Medical Services can provide information about medications covered in the programs

207-287-1818
Toll Free 1-800-321-5557
TTY 1-800-423-4331 **OR** 207-287-1828

Where can I get help filling out the application?

Contact your local Area Agency on Aging, your local Community Action Program **or your town or city office.**

What prescription drugs are covered?

The program has two parts – the **Basic** Program and the **Supplemental** Program.

Under the **Basic** Program, the State pays 80% of the cost of the drug and you pay $2.00 or 20%, whichever is greater. Under the Basic Program, prescription drugs used to treat the following chronic conditions are covered:

- Diabetes
- Heart Disease
- High Blood Pressure
- Chronic Lung Disease (including Emphysema and Asthma)
- Arthritis
- Anticoagulation
- Hyperlipidemia (High Cholesterol)
- Incontinence
- Thyroid Disease
- Osteoporosis (Bone Density Loss)
- Parkinson's Disease
- Glaucoma
- Multiple Sclerosis
- ALS (Lou Gehrig's Disease)

There are two major changes to the program. The first one adds coverage of ALL generic prescription drugs. For generic prescription drugs the Department of Human Services will pay 80% of the cost and you will pay 20%, or a $2.00 minimum. This means the program will pay part of the cost for a generic prescription drug for any condition, not just conditions covered under the basic program. The State will use the definition of generic drug as defined by the Medi-Span™ drug database.

The second change adds catastrophic coverage to the DEL program. After you have spent $1000 for the year on prescription drugs, then all of your prescription drugs after that point will cost you only 20% or a $2.00 minimum. The Department of Human Services will pay 80% of the cost of those prescription drugs. You will not need to keep track of how much you spend on prescription drugs. The State computer system will know at any time how much you have spent for your prescription drugs and when you have met the $1000 cap. The year for tracking prescription drug expenditures will be from August 1, 2000-July 31, 2001 to coincide with the start date of the new DEL expansion. The computer starts tracking your prescription drug expenditures on August 1, 2000 for those already enrolled in the DEL Program. For new DEL Program enrollees, the computer will start tracking your prescription drug expenditures from the date your DEL card is issued.

If you do not have a DEL card and would like an application or if you would like more information about prescription drug coverage under the program, please check with your local pharmacy or the Department of Human Services. The toll free telephone number for the DEL Program is 1-888-600-2466. The TTY telephone number is (207) 622-3210. You may also write to:

Department of Human Services
DEL Program
Bureau of Medical Services
11 State House Station
Augusta, ME 04333-0011

Drug Company Patient Assistance Programs

Many drug companies have special programs to help people who cannot afford the cost of their brand name prescription drugs. Often your doctor will know about these programs. If it is hard for you to pay for your drugs, ask your doctor if he or she can help you get assistance from the drug companies.

These are not public benefit programs. Acceptance is entirely up to the drug company. Generic drugs are not covered by these programs.

I can't afford my prescription drugs, how can I get help?

Most drug companies have programs to give people drugs for free or for a very low cost. To get into one of these programs, you have to apply to the drug company and you have to meet the eligibility requirements.

Who is eligible?

Anyone can apply for this program, you do not have to be elderly or disabled. Each company sets its

own requirements. Most companies require that:

- You have no insurance that covers outpatient prescription drugs,
- You do not qualify for a government assistance program for prescription drugs, like Medicaid, and
- Your income must be within certain income limits.

How do I apply?

The application process for each company is different. Usually your doctor fills out and sends in the application form. The telephone numbers for the drug companies are listed below. You can call the company to find out more about the patient assistance program.

How do I know which company to call?

All you need to know is the name of the prescription drug. Your doctor or the pharmacist will be able to tell what company makes the drug.

How will I get my medications?

The drug company will send a supply of the medication to your doctor. Usually it will be a 90-day supply. You will have to pick up the medication at your doctor's office.

It could take 4 to 8 weeks to find out if your application has been approved. In the meantime ask your doctor to help by giving you samples.

How do I get refills?

Your physician will need to contact the drug company every time you need refills. To make sure that you do not run out of the medication, you will have to tell your doctor at least a month before you need a refill.

How long will I be able to get help?

Most companies do not have time limits and will continue to send you the medications as long as you are eligible for the program. You need to check with the companies to find out if they have time limits.

I need more information. Who can I call?

You can contact your local Area Agency on Aging or Legal Services for the Elderly

An information booklet, "Guide to Low Income Medication Assistance Programs" has been prepared by the Staff of the U.S. Senate Special Committee on Aging. The booklet describes the program and includes a letter that can be shared with your physician or health care provider explaining the program. To obtain a copy, contact your U.S. Senator.

If you or someone you know has Internet access, a helpful Web site is www.needymeds.com. This Web site has up-to-date information about patient assistance programs, a list of drugs that are

covered, and a list of the drug companies.

Other Resources

VETERANS BENEFITS

Outpatient pharmacy services are provided free to:

- veterans receiving medication for treatment of service-connected conditions; and
- veterans whose income does not exceed the maximum VA pension

Other veterans may be charged $2 for each 30-day supply. If you are a veteran, call the number for the Veterans Administration. You can also get more information from veterans groups such as the Amvets, VFW or the American Legion.

HIV/AIDS DRUG ASSISTANCE PROGRAM (ADAP)

People with HIV/AIDS can get assistance from the State of Maine to get HIV-related medications free of charge. ADAP is a program of the Bureau of Health's HIV/STD Division. To be eligible a person must have a household income of 200% or less of the federal poverty level and meet certain medical requirements. Most anti-HIV medication will be available at no cost and without limitation.

A new program beginning in 2000 will give people with HIV greater access to health care, including medical treatment and prescription drugs. Call the Bureau of Health at DHS at (207)287-2093 or your local AIDS service organization for more information.

People with HIV/AIDS who are not able to get all their medications through ADAP should apply directly to the drug companies for their patient assistance programs.

If you are interested in ADAP contact the Maine Bureau of Health at (207) 287-3747. Or contact one of the HIV/AIDS organizations in the state or contact the AIDS Hotline at 1-800-851-2437.

FREE CLINICS

Free clinics offer free primary care services to people with low income or who have no insurance or are under-insured. Each clinic has its own eligibility guidelines. However, some clinics do not offer services to people who are on Medicare. You may even be able to get some of your prescription medications at the clinic. You should call the clinics to find out if you are eligible for services and what kind of services are available at the clinic. The three largest clinics are:

Ellsworth Free Clinic
P.O Box 5104
Ellsworth, Maine 04603 207-667-7953

Biddeford Free Clinic
189 Alfred Street
Biddeford, Maine 04005 207-282-1138

Portland Street Clinic
15 Portland Street
Portland, Maine 04101 207-874-8982

HOSPITAL PROGRAMS

Most hospitals have programs to give people free medical services either in the hospital or at a family practice clinic. Usually these programs are available to people who have very low income and no health insurance. If you need hospital services or out-patient care, ask if you can fill out an application. You may still have some expenses for which you will be responsible.

If medications are prescribed that you cannot afford, these programs will give you samples when available and will help you enroll in the patient assistance programs of the drug companies.

COMMUNITY HEALTH CENTERS

Community health centers provide medical services to people on a sliding fee scale. The locations and telephone numbers for these clinics are listed below. The clinics do not have their own prescription drug program, but they may be able to give you samples of the medication. Most clinics will help you enroll in the patient assistance programs of the drug companies.

MAIL ORDER COMPANIES

There are private companies that offer discounts on prescription drugs. Some companies have mail order services. Either you or your doctor sends them the prescription. The company will mail the drugs to you at home. You pay a discounted price for the drugs and the shipping charge.

Other companies have discount programs that give you a card to use at participating pharmacies. You have to pay a fee to enroll in these programs. You will get a discount on your prescription medications. For more information contact your local Area Agency on Aging.

INDIAN HEALTH SERVICES

A wide range of medical, dental, mental health and social services are available to the Penobscot, Passamaquoddy, Maliseet and Micmac peoples. Each group has a clinic where most primary health care services are available. Prescription drugs can also be covered under Indian Health Services programs. However, there are limits to both the medical services and prescription drug coverage. For more information about Indian Health Services in Maine, call the health center for the tribe to which you belong.

HIV/AIDS Service Organizations

Sen. Thane 40 27

TITLE 22: HEALTH AND WELFARE

- SUBTITLE 2: HEALTH
  - PART 1: ADMINISTRATION
    - CHAPTER 101: GENERAL PROVISIONS
      - § 254-B. Maine resident low-cost prescription drug program

PAGE < PAGE > DOWNLOAD TEXT

§ 254-B. Maine resident low-cost prescription drug program

The department shall conduct a program, referred to in this section as the "Maine resident low-cost prescription drug program" or the "program," to provide low-cost prescription drugs to qualifying residents of this State. [1999, c. 431, §1 (new).]

1. Agreement. A drug manufacturer that sells prescription drugs in this State may voluntarily elect to enter into a rebate agreement with the department. The agreement must be modeled after Section 1927 of the United States Social Security Act and must include the requirement that the manufacturer make rebate payments to the State each calendar quarter or according to a schedule established by the department.

[1999, c. 431, §1 (new).]

2. Rebate amount. The rebate amount required from a manufacturer to the State is equivalent to the rebate amount calculated under the Medicaid Rebate Program pursuant to 42 United States Code, Section 1396r-8.

[1999, c. 431, §1 (new).]

3. Discount to qualifying residents. Any participating retail pharmacy that sells drugs covered by an agreement pursuant to subsection 1 shall discount the retail price of those drugs sold to qualifying residents. The department shall adopt rules to establish discounts for covered drugs and rules that promote the use of efficacious and lower-cost drugs. The amount of the discount for covered drugs must be determined by considering an average of all rebates provided pursuant to subsection 2, weighted by sales of drugs subject to these rebates over the most recent 12-month period for which the information is available. The total aggregate discount amount for all covered drugs must be equivalent to the total aggregate rebate amount for all covered drugs sold, less the administrative costs of the program pursuant to subsection 6.

[1999, c. 431, §1 (new).]

4. Operation of program. Participating retail pharmacies shall submit claims to the department to verify the amount of discount due the resident. The department may not impose charges on retail pharmacies that submit claims or receive payments under the program. The retail pharmacies shall charge residents the current retail price charged by each retail pharmacy for that prescription drug to persons purchasing that drug who are not covered by insurance or 3rd-party payor plans, less the discount amount, pursuant to subsection 3.

The amount of the discount must be indicated on the resident's receipt. On a weekly or biweekly basis, the retail pharmacy must be reimbursed by the department for drug discounts provided to residents. The department shall collect the necessary utilization data from the retail pharmacies submitting claims in order to comply with 42 United States Code, Section 1396r-8. The department shall protect the confidentiality of all information subject to confidentiality protection under state and federal law, rule or regulation.

[1999, c. 431, §1 (new).]

5. Discrepancies in rebate amounts. Discrepancies in rebate amounts must be resolved using the process established in this subsection.

A. If there is a discrepancy in the manufacturer's favor between the amount claimed by a pharmacy and the amount rebated by the manufacturer, the department, at the department's expense, may hire a mutually agreed-upon independent auditor. Following the audit, if a discrepancy still exists, the manufacturer shall justify the reason for the discrepancy or make payment to the department for any additional amount due. [1999, c. 431, §1 (new).]

B. If there is a discrepancy against the interest of the manufacturer in the information provided by the department to the manufacturer regarding the manufacturer's rebate, the manufacturer, at the manufacturer's expense, may hire a mutually agreed-upon independent auditor to verify the accuracy of the data supplied to the department. Following the audit, if a discrepancy still exists, the department shall justify the reason for the discrepancy or refund to the manufacturer any excess payment made by the manufacturer. [1999, c. 431, §1 (new).]

C. Following the procedures established in paragraph A or B, either the department or the manufacturer may request a hearing before the Administrative Hearings Unit. Supporting documentation must accompany the request for a hearing. [1999, c. 431, §1 (new).]

[1999, c. 431, §1 (new).]

6. Administrative and associated computer costs for program. Administrative and computer costs for the program must be funded solely from the rebates received from the pharmaceutical manufacturers. The department may not spend more for the administrative costs and associated computer costs of this program than it spends on the elderly low-cost drug program.

[1999, c. 431, §1 (new).]

7. Obligation of retail pharmacies in State. The obligation of retail pharmacies to discount drugs to qualifying residents begins 3 months after the drug manufacturer begins to pay the rebate to the department.

[1999, c. 431, §1 (new).]

8. Dedicated fund. There is established the Prescription Drug Dedicated Fund, referred to in this section as the "fund," to receive revenue from manufacturers who pay rebates as provided in subsection 1, to reimburse retail pharmacies for discounts provided to residents pursuant to subsections 3 and 4, to reimburse the department for administrative and associated computer costs and to pay other reasonable program costs. The fund is a nonlapsing dedicated fund. Interest on fund balances accrues to the fund. Surplus funds in the fund must be used to increase the amount of discounts given to residents under the program.

[1999, c. 431, §1 (new).]

9. Annual summary report. The department shall report the status of the program to the Legislature on an annual basis. The report must include information on changes in 3rd-party prescription drug coverage and the financial status of the program.

[1999, c. 431, §1 (new).]

10. Qualifying resident. Qualifying resident, also referred to in this section as a "resident," means a legal resident of this State who does not have 3rd-party prescription drug coverage.

[1999, c. 431, §1 (new).]

11. Participating retail pharmacy. Participating retail pharmacy, also referred to in this section as a "retail pharmacy," means a retail pharmacy located in this State, or another business licensed to dispense prescription drugs in this State, that voluntarily elects to participate in the program and that provides discounts to residents as provided in subsection 3.

[1999, c. 431, §1 (new).]

12. Rulemaking. The department shall adopt rules to implement the provisions of this section. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter II-A.

[1999, c. 431, §1 (new).]

Section History:

1999, c. 431, § 1 (NEW).

PAGE < PAGE > TOP ^

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REGULATION

Rx Relief

With prescription drug costs soaring, states are taking bold steps to bring them down.

BY JOHN BUNTIN

Many residents of Maine, especially senior citizens struggling to get by on a fixed income, are fed up with the high prices of prescription drugs. "They're saying, 'This is wrong. This is unfair,'" says ator Judy Paradis, chairman of the alth and Human Services Committee. "They had a job. They worked. They had a fairly good retirement. Then illness hits and it breaks them completely."

So last fall, Paradis sponsored—and the legislature passed—the Maine Resident Low-Cost Drug Program, which requires pharmaceutical manufacturers that do business in the state to provide consumers with a Medicaid-level rebate on all drug purchases.

That was just the beginning, however, as Maine lawmakers soon came to realize that the state budget wasn't immune from the problem, either. "We had a $60 million Medicaid shortfall this year, and most of it was due to the rising cost of prescription drugs," says Chellie Pingree, the Senate majority leader.

In May, Governor Angus King signed into law the nation's first pharmaceutical price control legislation. The goal of the Maine Rx program is ambitious: It aims to reduce the cost of all prescription drugs sold in the state by approximately 40 percent by July 2003.

Indeed, the appearance of a new generation of very effective, very expensive prescription drugs is squeezing the pocketbooks of both seniors and state Medicaid programs throughout the country. And with proposals for a new Medicare prescription drug benefit bogged down in Congress, states are starting to respond with an array of innovative—and untested—programs.

According to the National Conference of State Legislatures, more than 20 states debated legislation this year that would in some way help low-income seniors purchase prescription drugs. Most are considering fairly traditional proposals, such as creating senior pharmacy-assistance programs, which pick up part of the costs of seniors' drug purchases, or expanding eligibility for state Medicaid programs. But a handful of states have, like Maine, grown impatient with simply picking up the tab and are pressing ahead with more radical approaches.

In the past year, legislators in the New England states, as well as in California and in Florida, have passed legislation intended to lower the prices of prescription drugs. Massachusetts is seeking to create a statewide bulk-purchasing pool that would use the state's purchasing power to negotiate discounts on prescription drugs for seniors, state employees, and the uninsured. California and Florida are attempting to extend the discounts Medicaid recipients receive on prescription drugs to Medicare beneficiaries. And a growing number of policy makers view price-control measures such as Maine's as their best hope for holding down prescription drug costs. The pharmaceutical industry, however, sees them as a potential disaster in the making.

Most Americans buy prescription drugs at discounted prices through their managed-care plans. Low-income people enrolled in state Medicaid programs get deep discounts, too. Federal law requires that drug manufacturers offer Medicaid programs their "best available prices" for most products. In addition, drug companies generally give state Medicaid programs a rebate on drugs sold to Medicaid recipients.

Medicare, the federal health insurance program for older Americans, is different. Although it covers most medical procedures, it doesn't cover the costs of prescription drugs. Still, many seniors manage to secure prescription drug coverage anyway. Some have access to discounted prescription drugs through the health insurance plans of their former employers. Others buy supplemental "Medigap" insurance. Seniors with incomes below 150 percent of the poverty line often qualify for Medicaid.

But approximately one-third of all Medicare recipients—about 13 million people—don't have access to discounted prescription drugs. These seniors earn too much to qualify for Medicaid and too little to afford supplemental insurance. As a result, when they need to buy a prescription drug, they have no choice but to go to a pharmacy and pay the full retail price. At more than $3 per pill, the retail price for a year's supply of Prilosec, a frequently prescribed ulcer medication, can top $1,400. For people of modest means, that can be financially ruinous.

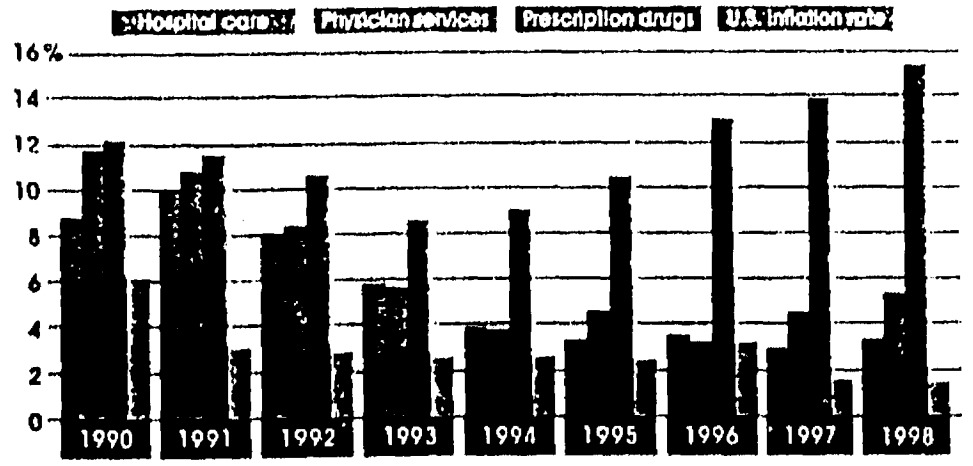
The problem isn't exactly new. "In some sense, it's an age-old issue," says Richard Cauchi, a senior policy specialist at the National Conference of State Legislatures. "There are some people who cannot afford the prescription drugs they need or their doctors say they need, so there's always an urgent or even desperate medical situation for some individuals." Indeed, many states have long sought to help this population. At least a dozen states have had senior pharmacy-assistance programs since the mid-1980s. This year, four more states—Florida, Indiana, Kansas and South Carolina—created such a program for the first time.

However, what was once a problem has turned into a crisis. In recent years, drug costs have shot through the roof. In 1998, spending on prescription drugs increased 18.4 percent from the previous year, bringing national spending on prescription drugs to almost $80 billion. In 1999, it increased another 18.8 percent.

The primary force behind fast-rising prices is the appearance of a new generation of wonderdrugs. Seniors with arthritis don't want Advil (5 cents a pill) when they can take Celebrex ($2.20 a pill). As drug manufacturers have brought more and more innovative but expensive prescription drugs to market, seniors have devoted even more of their limited resources to buying these products.

Bitter Pills

Since 1990, the annual percentage change in prescription drug costs has outpaced all other areas of health care spending—and the overall rate of inflation—in the United States.



Sources: Henry J. Kaiser Family Foundation and U.S. Bureau of Labor Statistics

Legislators in states with big surpluses might have been content to continue to pick up seniors' drug tabs if they thought drug prices were reasonable. But increasingly, they don't. A series of studies and media stories about how prices for prescription drugs in Canada are often much lower than the prices of the very same drug in the United States have convinced many lawmakers that consumers are getting a bum deal. "The price difference is so dramatic, it just strikes people as something that's unfair," says Maine's Pingree, who was the primary sponsor of the state's prescription drug price-control legislation.

Some state officials suspect they're not getting the best deal, either. Despite being legally entitled to receive the "best available price" (plus a manufacturer's rebate), in practice, state Medicaid programs often don't. While drug pricing is a notoriously murky matter, it's clear that other institutional customers are getting bigger discounts than state Medicaid programs. A recent study by the Lewin Group estimated that big health maintenance organizations buy drugs for 30 to 39 percent less than the retail price. That's at least twice as big as the discounts state Medicaid programs are receiving.

The U.S. Department of Veterans Affairs is also getting much bigger discounts than state governments. By limiting veterans' drug choices to a relatively small number of medicines, and thus assuring drug companies who bid for its business a large market, health policy experts estimate the Veterans Administration's price breaks at between 35 and 40 percent.

After years of basically paying what they were told to pay, states are now starting to question these pricing arrangements. "We have a veterans' hospital right down the road, and the price the federal government has negotiated for veterans' drugs is about as low as the Canadian prices," says Pingree. "So we're saying, how come the feds just down the road from us can purchase drugs for their clients at these much lower prices but we can't?"

In the past year, states' tactics to reduce the cost of prescription drugs have varied widely—from the price-control regime of Maine to the free-market approach of Massachusetts.

The Bay State is attempting to lower Rx prices the same way that HMOs do: by bu

buying in bulk. Last fall, Mark Montigny, chairman of the Senate Ways and Means Committee, inserted language into the commonwealth's fiscal year 2000 budget that directed the executive branch to draft a plan to aggregate state employees, Medicaid enrollees, all of the participants in the state's senior pharmacy-assistance program and the uninsured into a single purchasing pool. Montigny's hope was that this pool, which could potentially amount to more than a million people—roughly the same size as the state's largest private-sector health plan—would be able to negotiate the kinds of deep discounts on prescription drugs that many HMOs had.

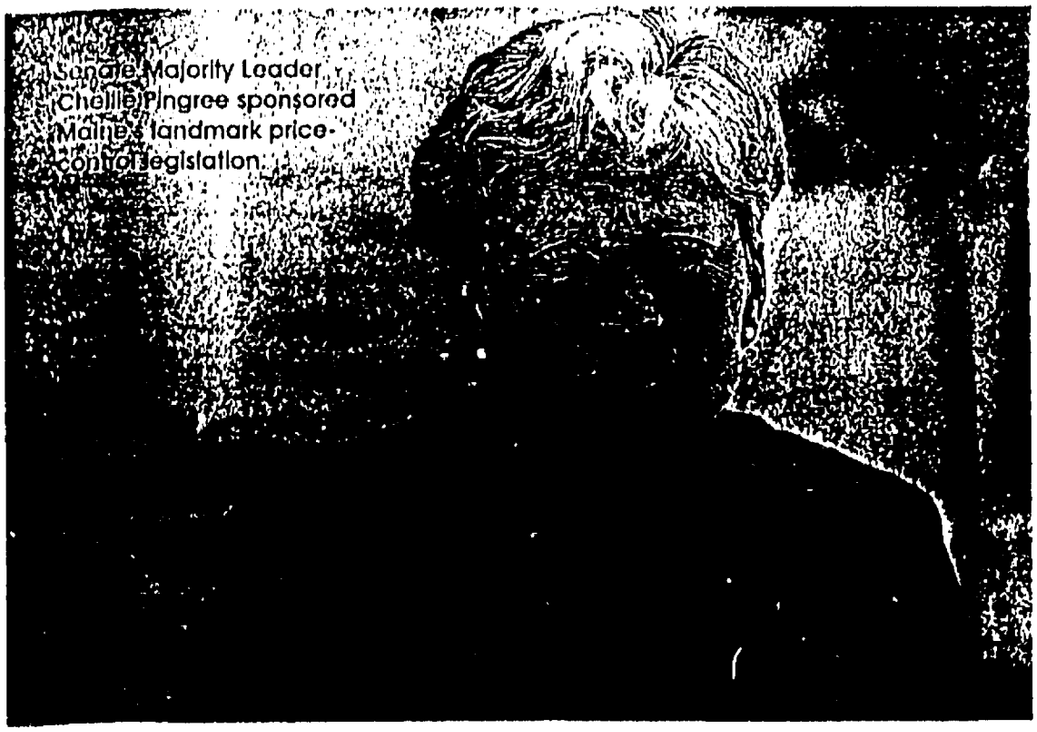
Montigny and other backers of the measure, who included former Republican Governor William Weld and former Democratic Congressman Joseph Kennedy, claimed that they were simply trying to harness the state's market power to lower costs for some of the state's neediest citizens. "[N]egotiating volume discounts from drug companies and securing price reductions from pharmacies have become standard practice in the health care industry," wrote Weld and Kennedy in a *Boston Globe* op-ed supporting the proposal. "The only people who don't benefit from these market mechanisms are those who most need a break—the 70 million poor and elderly Americans without prescription drug coverage of any kind."

"We view this as a no-brainer," says Doug Brown, chief counsel to the Massachusetts Senate Ways and Means Committee. Pharmaceutical firms and the state's dynamic biotech industry saw the measure differently. "It's not marketplace competition," says Jeffrey Trewhitt, spokesperson for the Pharmaceutical Research and Manufacturers Association (PhRMA).

"When you give a discount to a private-sector health plan, there is still a discussion with the company," he notes. "The company can still sit down with the pharmacy and therapeutics committee of an HMO and make a case that maybe the discount should not be as great as you'd like for it to be and here's why. There's still a back-and-forth discussion, whereas with a government-mandated program, there is no discussion. It's mandated." And with government mandates, Trewhitt adds, "goes the power to put in place price controls or threaten price controls."

Governor Paul Cellucci ultimately signed the legislation that included Montigny's bulk-purchasing plan. However, his administration has yet to implement the program. While the department charged with drafting the plan has cited problems with the legislative language and asked for more time, many legislators see this as an effort to sabotage a piece of legislation that Cellucci signed only reluctantly.

Last fall, at the same time Massachusetts' legislature was attempting to create the country's first statewide bulk purchasing program, lawmakers from four states—Maine, Massachusetts, New Hampshire and Vermont—were meeting to discuss an even more ambitious idea: the creation of a regional, New England-wide bulk-purchasing pool. Since then, the group has expanded to include representatives from all the New England states, as well as New York and Pennsylvania. In June, the group formally organized itself as the Northeast Legislation Association on Prescription Drug Prices and constituted itself as a 501(c)3.



Senate Majority Leader Chellie Pingree sponsored Maine's landmark price-control legislation.

Many state and federal officials are enthusiastic about the idea of a regional bulk-purchasing pool. "I think it's a great idea, and we've been very supportive of the regional approach," says Judith Kurland, the New England regional director for the U.S. Department of Health and Human Services. "When I look at the data, and I look at the purchasing prices of countries throughout Europe"—where brand-name prescription drug prices are often much lower than in the United States—"and I look at populations, I say, 'Well, New England is 13.5 million people. That's a nice-sized population, a little smaller than the Netherlands, but if you add New York or Pennsylvania, you're starting to talk about a major country in Europe. If purchasing for such large numbers of people wouldn't achieve substantial reductions, I can't imagine what would."

Still, no one predicts any dramatic movement towards a regional purchasing pool in the near future. "They do have to figure out what they can do with or without common legislation, what they can do with Medicaid, what they could do with Medicare, if there was a prescription drug benefit," Kurland notes. As a result, she and most New England state legislators believe the short-term focus will remain on the individual states or on more modest efforts, such as that made by the governors of Maine, New Hampshire and Vermont to create a joint bulk-purchasing pool for their states.

Others are taking a different tack. In

October 1999, California passed legislation authored by state Senator Jackie Speier that aims to extend the discounted Medicaid price to all Medicare recipients. Under the provisions of SB 393, pharmacies that want to continue to participate in Medi-Cal, California's Medicaid program, are required to offer all Medicare beneficiaries the same discounted rates that Medicaid recipients receive. Unlike most state legislation, Speier's legislation targeted pharmacies, not drug manufacturers, and thus avoided the ire of PhRMA.

Several states have passed similar legislation. Florida Governor Jeb Bush signed legislation in February that created a discount prescription drug pricing program based on the Medicaid rates for Medicare enrollees. And this summer, Rhode Island passed legislation sponsored by Lieutenant Governor Charles Fogarty that expanded the state's existing senior pharmacy-assistance program, which includes a mandatory price-rebate provision.

And beginning in November, under its low-cost drug program, Maine will issue Rx cards to any resident who applies for them. Even people who don't currently have some form of drug benefit will realize the lower costs, Pingree says.

Meanwhile, the state will seek to negotiate steep rebate agreements with the various drug companies. In January 2001, Mainers with Rx cards will be eligible to receive a 6 percent discount on all prescription drug purchases at participating pharmacies. (To encourage pharmacies to participate in the program, Maine allows them to charge a $6.50 processing fee for each drug order.) As the rebates from drug manufacturers flood into the state coffers, the discount will gradually increase — and retail prices for prescription drugs will fall. At least, that is the theory.

In practice, Maine officials don't expect that drug companies will be queuing up to offer the state big rebates. "So we structured some 'reality' into the bill," says Kevin Concannon, Maine's health and human services commissioner. If a drug company refuses to offer "voluntary" rebates, Maine will retaliate by "prior authorizing" that company's sales to Medicaid. In other words, doctors will have to get approval from the state Medicaid program to prescribe drugs to Medicaid patients. As a result, physicians who dislike the hassles associated with "prior approval" would probably switch to other drugs.

That's not the only "reality" in the Maine Rx program. If the state attorney general determines that prescription drug prices are "unconscionable," the attorney general now has the authority to prosecute drug companies under an old anti-profiteering law. And if that fails, the legislation provides one final remedy: If prescription drug prices at pharmacies are not comparable to the lowest price available anywhere in the state by July 2003, the state commissioner of health and human services may impose a maximum price schedule.

The pharmaceutical industry has threatened to challenge the Maine legislation in court. Even Pingree concedes that the Maine law is unusually ambitious. Nevertheless, similar price-control legislation was introduced in seven other state legislatures last year, including Arizona, California, New York and Pennsylvania. In Vermont, a price-control bill fell through only at the very last minute, when the House rejected the measure that had been approved by the Senate.

The flurry of state efforts to reduce drug prices has alarmed the pharmaceutical industry. "There are no state bills we support," says Jeffrey Trewhitt of PhRMA. "It goes back to the proposition that we don't want a patchwork of 50 state laws that may conflict with one another. So there are no bills that are solutions to the problem because what we need is a uniform national solution to that problem."

To PhRMA, the problem—and the solution—are simple. "The problem is that Medicare, which is supposed to be seniors' comprehensive health care program, has fallen short," says Trewhitt. "It has fallen short because it does not cover medicines outside of the hospital and it should."

Most state legislators agree with this sentiment, but they aren't holding their breath waiting for the federal government to take action. "The pharmaceutical companies say, 'You can't do this. Let Washington do it,' " says Maine's Paradis. "It was insulting to me when I'd hear that because we know what happened to the Clinton health insurance plan, and we know who opposed it."

Even if Congress does create a Medicare prescription drug benefit or restructure the program in a way that encourages more health plans to offer a drug benefit, many officials believe the need for state involvement isn't going away anytime soon.

"Whatever Congress does next year is probably going to be rather modest, when all is said and done," predicts Maine's HHS commissioner Concannon. "They're only talking about some benefits for Medicare recipients. They're not taking about all the people who are 50 years old or in their early 60s who don't qualify for Medicare. I think whatever is done nationally, I applaud it, but I think it's going to be additive to what the states are going to have to do."

North Dakota Pharmaceutical Association

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Testimony on SCR 4027
House Human Services Committee
March 21, 2001
Galen Jordre, R.Ph. – Executive Vice President

Chairperson Price, members of the committee – I am Galen Jordre, Executive Vice President of the North Dakota Pharmaceutical Association and a registered lobbyist for that organization.

The North Dakota Pharmaceutical Association supports a study as proposed by SCR 4027 because our members daily see the impact that rising costs have on the patients they serve. We will be ready to provide information about how pharmacists purchase drugs, the economics of providing service, and barriers to obtaining best prices.

The study as proposed may be a little narrow and does not look at the entire cost of prescription drugs. A study recently released in the American Pharmaceutical Association's (APhA) March/April *Journal of the American Pharmaceutical Association (JAPhA)* has updated an analysis of prescription drug use problems in the United States. It estimates that drug misuse costs the economy more than $177 billion each year. The estimated number of patient deaths has increased from 198,000 in 1995 to 218,000 in 2000.

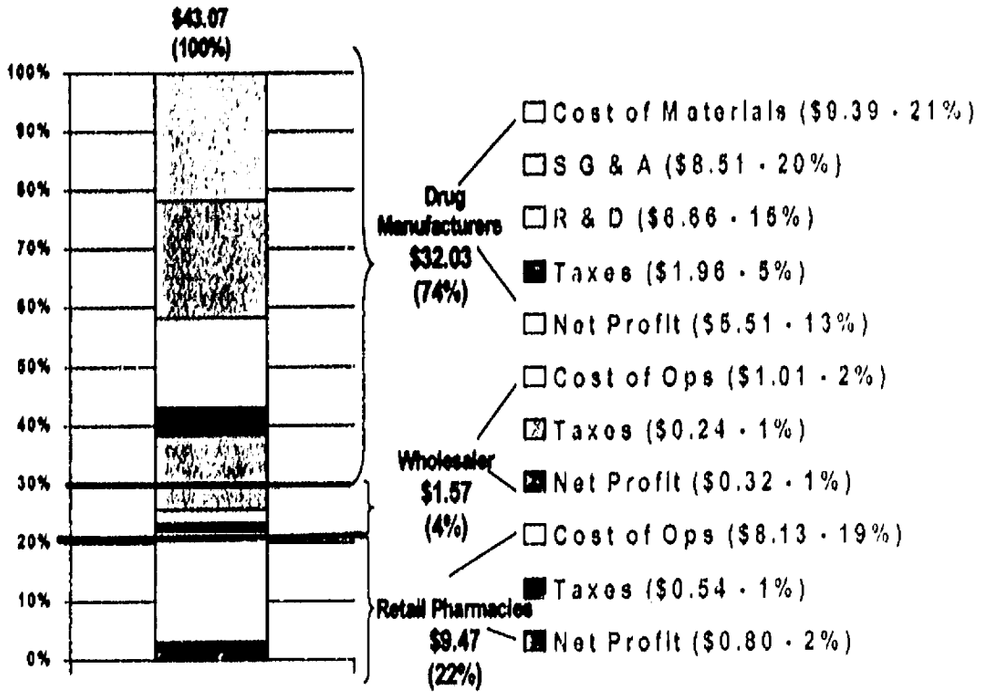
According to the authors, "Researchers have shown that costs associated with drug-related problems exceed the expenditures for initial drug therapy; that is, the total cost of drug-related morbidity and mortality exceeds the cost of medications themselves. Drug-related problems are increasingly recognized as a serious and urgent—but largely preventable—medical problem."

Among the most significant drug-related problems identified in the *JAPhA* study are untreated indication, improper drug selection, subtherapeutic dosage, and failure to receive drugs, overdosage, adverse drug reactions, drug interactions, and drug use without indication.

Of the $177.4 billion costs in the new study, hospital admissions accounted for $121.5 billion (69%) per year, and long-term care admissions represented $32.8 billion (18%). Physician visits accounted for another $13.8 billion (8%), and emergency department visits and additional treatment cost more than $5.8 billion (3%) and $3.5 billion (2%), respectively.

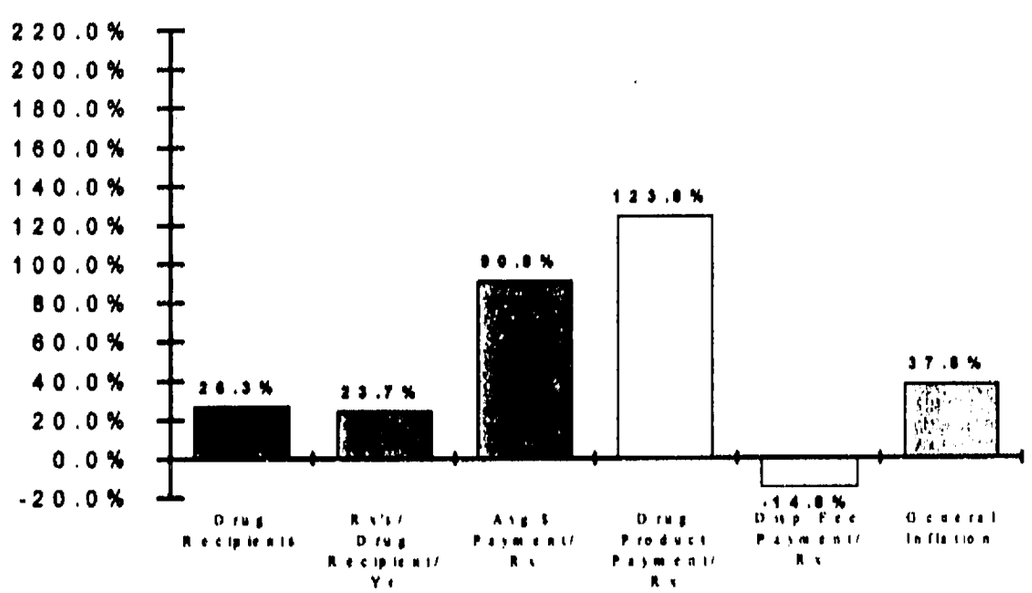
We would like to see the proposed study examine some of these issues as well as the savings that proper use of prescription drugs provide to other components of the health care system. By focusing alone on the price, we will not effectively come to a satisfactory ending with this study.

Prescription Cost Components



Source: IMS HEALTH, Hoover's Company Information, PhRMA, Retail Census, U.S. Bureau of the Census; average prescription price $43.06, 3rd quarter 1999.

U.S. Medicaid Drug Expenditures
Percent Change in Major Components:
1988 to 1998 in Inflation Adjusted $



TESTIMONY BEFORE THE HOUSE HUMAN SERVICES COMMITTEE
REGARDING SENATE CONCURRENT RESOLUTION 4027
MARCH 21, 2001

Chairman Price, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you to support this resolution.

The cost of prescription drugs in the Medicaid Program has increased dramatically over the past four years and are expected continue their upward spiral with no end in sight.

Lines 7 through 12 of this resolution outline the dramatic increases in drug costs that the Medicaid Program has experienced since 1997. Drug costs for the 1997-99 biennium were 17.3% greater than the amount used to build the appropriation for that period. Drug costs for the current biennium are likely to be 26% greater than the amount used to build the budget for this biennium.

The Department did attempt to institute a prior authorization process for certain drugs in the current legislative session. We introduced the bill to assist us in providing appropriate and cost effective medications to individuals enrolled in the North Dakota Medicaid Program. As you are aware, that bill was defeated in the House. At this time the Department has few other options available to counter the high cost of drugs.

We believe that a study of drug pricing including the impact on the Medicaid Program is appropriate at this time and the Department supports a do pass on this resolution.

I would be happy to answer any questions you may have.