2009 HOUSE HUMAN SERVICES

HB 1385

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1385

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 20, 2009

Recorder Job Number: 7276 18 min. 59 sec.

Committee Clerk Signature Vicky Crabtree

Minutes:

Vice-Chair Pietsch called the hearing to order on HB 1385.

Representative Weisz: spoke in favor of bill and also sponsor of bill.

Carlotta McCleary, Executive Director of ND Federation of Families for Children's Mental Health: testified in support of bill. **See attached #1.**

Corinne Hofmann, Director of Policy and Operations for the Protection Advocacy Project: testified in support of bill. **See attachment #2.**

Bruce Levi, representing the ND Psychiatric Society: had testimony passed out by Corinne Hofmann. **See attachment #3.**

Ken Tupa from the American Cancer Society passed out testimony from Deborah Knuth, Director of Government Relations of the ND American Cancer Society and from Dr. F. Addo. See attachments #4 and #5.

James Moench, Executive Director of ND Disabilities Advocacy Consortium read his testimony and passed out testimony for Patsy Garland from Fargo, ND and Susan Rae Helgeland, Executive Director of Mental Health America of ND. See attached #6,7 and 8.

Dr. Brendan Joyce, Administrator of Pharmacy Services for the Dept. of Human Services handed in written testimony. See attached #9.

No opposition to bill and hearing closed.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1385

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 20, 2009

Recorder Job Number: 7370 3 min. 32 sec.

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Any questions on HB 1385?

Representative Porter: We've gathered enough info and can remove any future expiration date and make it part of the Medicaid law.

Representative Porter made a motion of a DO PASS.

Representative Uglem seconded.

Roll Call Vote was taken: 13 yea, 0 nays, and 0 absent.

Bill Carrier: Representative Porter.

Date: 1-20-09

Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1385

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. Porter Seconded By Rep. Uglem

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	✓		REP. TOM CONKLIN	✓	
VICE-CHAIR VONNIE PIETSCH	✓		REP. KARI L CONRAD	✓	
REP. CHUCK DAMSCHEN	✓		REP. RICHARD HOLMAN	✓	
REP. ROBERT FRANTSVOG	✓		REP. ROBERT KILICHOWSKI	✓	
REP. CURT HOFSTAD	✓		REP. LOUISE POTTER	✓	
REP. MICHAEL R. NATHE	✓				
REP. TODD PORTER	✓				
REP. GERRY UGLEM	✓				

Total (Yes) 13 No 0

Absent 0

Bill Carrier Rep. Porter

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

REPORT OF STANDING COMMITTEE

HB 1385: Human Services Committee (Rep. Weisz, Chairman) recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1385 was placed on the Eleventh order on the calendar.

2009 SENATE HUMAN SERVICES

HB 1385

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1385

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 3/10/09

Recorder Job Number: 10587

Committee Clerk Signature Mary K Monson

Minutes:

Vice Chair Senator Erbele opened the hearing on HB 1385 relating to the prior authorization program.

Rep. Robin Weisz (District 14) introduced HB 1385. This is the carve out for the prior authorization on the mental health drugs and cancer drugs. It is important to have this because, from his perspective, the sensitivity of changing from name brand to generic and how it affects individual people can cause severe problems.

Dr. Kathleen Nordstrom (Bismarck Cancer Center) testified in support of HB 1385. See attachment #1. She introduced Jill Goetz an employee of the Bismarck Cancer Center and a cancer survivor who was available to answer questions.

Senator Erbele asked if this bill is passed if it makes the prior authorization procedures simple and clear.

Dr. Nordstrom said it does.

Deb Knuth (American Cancer Society Cancer Action Network) provided supportive testimony from **Dr. Terry Johnson** (Psychiatrist from St. Alexius Medical Center) who was unable to be present. Attachment #2

James Moench (ND Disabilities Advocacy Consortium) provided testimony in support of HB 1385 . Attachment #3

Susan Rae Helgeland (Executive Director, Mental Health America of North Dakota) testimony in support of HB 1385 was read by James Moench in her absence. Attachment #4

Todd Christlieb (Fargo) testimony in support of HB 1385 was presented for the record. Attachment #5

Senator J. Lee explained that physicians are able to prescribe the medications they feel their patients need.

Carlotta McCleary (ND Federation of Families for Children's Mental Health) testified in support of HB 1385. Attachment #6

Senator J. Lee pointed out that there are psychiatrists on the Drug Utilization Review Board who are part of the decision making process for that organization. There has been no effort to impede psychiatrists' ability to prescribe these medications.

Randy Solem (ND mental Health Planning Council) testimony in support of HB 1385 was presented for the record. Attachment #7

Janet Sabol (National Alliance on Mental Illness) testimony in favor of HB 1385 was presented for the record. Attachment #8

Dr. Brendan Joyce (Administrator of Pharmacy Services, Dept. of Human Services) provided neutral testimony. Attachment #9

Senator J. Lee asked Dr. Joyce to go through the bill and explain what it does.

(Meter 30:45) **Dr. Joyce** went through the bill explaining it and said it would also get rid of the sunset clause.

Senator J. Lee asked what changes would be made if all the crossed off language is deleted.

Dr. Joyce replied that the carve out would be removed. All the requirements would remain in effect, just the exclusions would go away.

Senator J. Lee asked if PERS and private insurance have carved out drugs. Is there some kind of formulary or prior authorization process?

Dr. Joyce explained that he couldn't speak specifically to any policies they have but he did know there are insurances where there are formulary. The coverage will be more generous for formulary medications than non formulary medications.

Senator J. Lee pointed out that what they are talking about here are Medicaid patients. She struggled with the idea that they would be looking at significantly different treatment for the medications prescribed for them as compared to everyone else.

The makeup of the DUR Board was discussed.

The medications now covered by the Medicaid program are about 68% generic.

Senator J. Lee asked for information on what the general impact has been of having prior authorization such as the impact on cost and utilization of drugs, number of patients that have been served, the number of drugs prescribed and the cost. Has it been effective in trying to control some of the health care costs?

Dr. Joyce said he would get her some information.

Senator J. Lee asked if he had any comments or observations about the carve out and the attitude of the DUR Board.

Dr. Joyce pointed out that he is a nonvoting member of the DUR Board and that he could only speak to the recommendations given by the Board which are in attachment 1 of his testimony.

The hearing on HB 1385 was closed.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1385

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 3/24/09

Recorder Job Number: 11469, 11505

Committee Clerk Signature Mary K Monson

Minutes:

Senator J. Lee opened committee work on HB 1385 – prior authorization. She pointed out that they have had this in front of them for the last several sessions and it has been moved forward every session because of the cost savings to Medicaid. Attachment #10 is information she had requested from Dr. Joyce to help the committee understand how the prior authorization works.

Dr. Brendan Joyce appeared at the request of **Senator J. Lee** to explain this information he prepared for the committee – ND Medicaid Prior Authorization Fact Sheet. (Meter 03:50)
He pointed out they would still like to make sure there is some clarity in the bill as to exactly which categories of medications are affected. Right now it's fairly nebulous. They would like to have some direction as to whether ADHD is one of the categories.
The differences between generic and brand name prescriptions were explained by Dr. Joyce.

Senator J. Lee asked if (1) some of the generic drugs are being produced by the same companies that manufactured them as brand name drugs but now are off patent and are generic and (2) some of the brand name manufacturers purchased generic manufacturing firms so they are now part of that distribution network.

Dr. Joyce said she was correct on both counts.

Prior authorization in other states was discussed.

Senator J. Lee asked if all insurance programs other than Medicaid would have some sort of formulary or preferred drug list to abide by.

Dr. Joyce said the only insurance coverage he was aware of that doesn't have anything is the federal employees program. Prior authorization is a tool that is used by at least 90% of insurances.

Senator Dever referred to item 2. How many of those were prior authorizations granted and of those that weren't did the medical providers challenge.

Dr.Joyce said their approval rate was over 90%. They don't know how many prior authorizations were not requested. Pharmacists do the screening up front. .

Senator J. Lee asked for information on total dollar cost reductions that there has been in Medicaid drug spend since this program started.

Dr. Joyce said they have saved around $8 million – total federal and state.

Senator Dever wanted to know what the problems are and why they keep seeing this.

Dr. Joyce said there have been studies that show that poorly decided prior authorization programs in these realms are a bad idea. If done properly and with input from everyone it can be beneficial and there is still the ability for the doctor to say "no". If done improperly, it can harm patients.

Senator J. Lee wanted to know how many complaints they have had from patients or professionals about the decisions made because of prior authorization.

Dr. Joyce said they do have complaints and they all come through him. He gave examples. The importance of education was addressed. The majority of complaints probably have more to do with educating people about the process and medications used.

There was a discussion on communication breakdowns.

Senator J. Lee asked Dr. Joyce if he would provide some information on the updated information on the demographics of who are receiving and what the drug categories are. That information affects the classes talked about in this bill.

There was discussion that followed on communication breakdowns with examples given.

One of the most important things about prior authorization is the expertise that goes into the decision. Safety of the patient was addressed.

Job #11505

Senator Heckaman showed support especially for #3 on page 2. She said it is sort of a personal issue with some of the kids and their families she has worked with.

Senator J. Lee said they had not been denied any of those meds because there has been no prior authorization and there is no plan to do so in a restrictive fashion.

Senator Heckaman thinks this is an important part of this bill.

Senator J. Lee pointed out that this guts the efforts that have been made in the last eight years to get under control the cost of drugs under Medicaid. At this point no one has been denied anything and the plan from the DUR Board is to not mess that up. If over 90% of the insurances and Medicare Part D have prior authorization, why should Medicaid patients be the only ones who don't?

She proposed an amendment that would add a representative of the generic drug manufacturers as a nonvoting member of the DUR Board. Attachment #11

She also suggested committee members talk to their pharmacists to see what they think about prior authorization and bring that information back to the committee.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1385

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 3/25/09

Recorder Job Number: 11515

Committee Clerk Signature Mary K Monson

Minutes:

Senator J. Lee brought the committee to order to continue work on HB 1385 – prior authorization. She provided information in the form of e-mail messages for the committee. Attachment #12 She then asked for any comments or thoughts from the committee.

Senator Heckaman reported that she had tried to find information on the study done by the DUR Board and couldn't find anything. She was wondering how they conduct their study and what process they go through. She said she hadn't found any of that type of information in the meeting minutes. She posed her question to Dr. Joyce.

Dr. Brendan Joyce replied that they had started policy right after the last session. They suspended all new business coming in to the DUR Board and started tackling one therapeutic class at a time. He cited the website www.hidndmedicaid.com as a place to access minutes, agendas, handouts, etc.

Senator Heckaman said she liked the bill as it is but because of information in an e-mail message thought maybe they should consider putting a sunset back in.

She felt it was important to leave the carve out there for the population that she is familiar with.

Discussion followed on denial of drugs, use of recommended drugs that don't work, waiting periods, and problems involved with those people who don't keep up with their medication.

Dr. Joyce talked about dial in prescriptions, smart prior authorization, and restricted costs of drugs.

Drug samples are not for Medicaid. Only the newest drugs are sampled – the ones that are protected by patent. Sampling is a marketing tool.

Senator J. Lee asked if the drug companies still get records that tell what physicians are prescribing what drugs.

Dr. Joyce said they still get it from Medicaid.

The possibility of amending this back to a sunset was discussed. The DUR Board has reviewed these classes extensively in the last two years.

Dr. Joyce made a point that the DUR Board put aside other work to do that review and wouldn't want to see them repeat anything they've done. If there is some way to make legislative intent clear which specific drug classes it is referencing, his department would like to know if it is specific to classes or if it is broader.

Senator J. Lee – What is our role in trying to make sure that we continue to provide the best possible circumstances for the Medicaid patients who are served here without intruding into the doctor/patient relationship and without making it onerous for physicians and without making it impossible to consider what the cost is as part of the whole picture?

Senator Heckaman looked at the carve outs from other states and said they were listed differently.

The charts from the testimony provided by Dr.Joyce were discussed in relationship to the preferred drug list and prior authorization.

More discussion on HB 1385 was put on hold.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1385

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 3/30/09

Recorder Job Number: 11565

Committee Clerk Signature Mary K Monson

Minutes:

Senator J. Lee brought the committee to order to continue discussion on HB 1385.

Dr. Brendan Joyce provided information requested by **Senator J. Lee**. Attachment #13

He explained the charts which showed how the drug classes that would be affected by this bill are trending.

Carrie Sorenson, PharmD (President of the DUR Board) provided information to the committee of the Board's proposed recommendations as a result of their review. Attachment #14

Senator Dever stated that she had said the purpose is to guide practitioners to prescribe efficacious medication that is the most cost effective to the state. Do physicians have the final say in the program if they can justify it?

Ms. Sorenson said it was her understanding that as long as they submit some sort of a reason those prior authorizations will be accepted.

Senator J. Lee – Do you find as a practitioner of pharmacy that there is a fairly streamlined process?

Ms. Sorenson's impression is that the prior authorization process works smoothly.

Discussion followed on the length of time it takes sometimes to fill prescriptions.

Ms. Sorenson's observation is that working with insurance companies to get medications approved as a formulary is challenging. Medicaid services work more smoothly. (Meter 35:30) She explained the differences between prior authorization and a formulary system.

Senator J. Lee thanked Ms. Sorenson and the Board for their noble effort to do the work requested of them. It was appreciated. The committee will do their best to make sure they consider primarily the safety and efficacy of the drugs provided for Medicaid patients and secondarily some cost containment. The safety issue is a huge issue.

The proposed amendments .0102 dated March 27, 2009, were suggested by **Senator J. Lee** as a place to start. Attachment #15 She asked Dr. Joyce to explain the last part of the amendment starting with page 2, line 2. (Meter 40:30) He explained that portion and pointed out that it was a clarification of how the bill came to the Senate from the House.

Senator J. Lee – What we have in front of us is just restating with more clarity the bill that came to the Senate.

Senator Heckaman asked what they would call it if they wanted to put ADHD in.

Dr. Joyce replied that if they wanted to add ADHD the best way would be to say "medications for the treatment of ADD/ADHD".

Senator J. Lee said this is looking at patients that are new.

There was discussion that prior authorization reviews are done by drug class because there is no better way to do it. Drugs have lots of different uses.

Committee work was recessed.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1385

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 4/1/09

Recorder Job Number: 11588

Committee Clerk Signature Mary K Monson

Minutes:

Senator J. Lee opened HB 1385 for committee work. She reviewed her notes from the hearing and prior committee discussions.

Senator Heckaman posed a question relating to the amendment .0102 page 2, line 9, c. She asked if that means it can only be used for bipolar and; if there is an anticonvulsant for epilepsy it wouldn't be carved out.

Senator J. Lee responded that was right. Two years ago it was voted to not carve it out for epilepsy. (Meter 07:15) She pointed out that the reason for this amendment is the clarification of the way it was before. Some of the drugs are used for things that are not even related. (Meter 09:10) **Senator J. Lee** said this is a much gentler program than private insurance firms might have in which there is no negotiating about the drugs. All they are asking is that if a doctor wants a particular brand name drug they just have to submit information that substantiates the reason for it. The doctor will always have the final word. If someone is currently taking a drug it continues to be available to them. Everyone is grandfathered in. This only applies to a patient getting a new medication. It seems reasonable to her to have a comparable program for Medicaid patients to that of others who have other kinds of insurance coverage.

(Meter 12:00) PERS and Blue Cross have a formulary, a list of drugs that they will cover the cost of. Depending which program it is there might be a higher co-pay for other drugs. There is no preferred drug list in Medicaid.

(Meter 16:00) The testimony from Carrie Sorenson was referred to by **Senator Dever**. He thought it was a good thing to have the conversation between the pharmacist and the physician as long as the provider/doctor has the final say. He has been told that it does happen and also that it doesn't happen so it seems to him it's a matter of trust between the DUR process and the provider and/or patient. It seems to him it makes sense to prior authorize.

The trust issue was discussed. Part of it is for the legislators to decide if they trust those people who have put a tremendous amount of effort into doing what the legislature told them to do in researching this. By adding to this list, is the legislature trying to do what the DUR Board should be doing and is this telling them they their report isn't trusted.

(Meter 20:00) Doctors don't think about the costs of medication as they are prescribing them and don't have the level of expertise in that area that the pharmacists have. Doctors and pharmacists work together because each of them has special areas of expertise in trying to figure out what is the most effective drug and whether it is cost effective.

Senator Dever said it appeared the amendments would improve the bill.

Senator J. Lee responded that it did offer the clarity the department asked for.

Senator Erbele moved to **accept the amendment .0102**. Second by **Senator Dever**.

Roll call vote 3-3-0. Amendment failed.

Senator J. Lee asked why those opposing the amendment liked the old bill better.

Senator Heckaman asked why they needed an amendment if it said the same thing.

Senator J. Lee replied that it was clearer and the department asked for clarity about the classes of drugs because the original one talked about conditions. They are not medical terms.

Senator Heckaman said it narrows some of those categories down.

Senator J. Lee said what they were talking about in the original bill was naming conditions for treatment instead of classes of drugs which creates a problem because they don't deal with medical issues at the DUR Board. They are supposed to be dealing with drug classes.

(Meter 25:00) Deleting the reference to bi-polar disorder, adding medications for the treatment of ADD/ADHD, and medications for ADD were discussed

Senator Heckaman said she would support the amendment if they would take out the reference to bipolar and add medications for the treatment of ADD/ADHD.

(Meter 34:00) The correct wording for medications for ADD was obtained from Dr. Joyce and if added should read "stimulant medications used for ADD/ADHD. According to him it wouldn't matter if the bi-polar reference was deleted. It was in there only because the code currently says that. A sunset was discussed but was not deemed necessary.

Senator Heckaman moved to **accept the amendment .0103** which would add "stimulant medications used for ADD/ADHD and would delete "for the treatment of bipolar disorder".

Second by **Senator Pomeroy. Roll call vote 5-1-0. Amendment adopted.**

Senator Heckaman made a motion for a **Do Pass as Amended on HB 1385**.

Second by **Senator Pomeroy**.

Senator Dever said he would like to see this work with prior authorization so he said he would vote against the motion.

Roll call vote 3-3-0. Motion failed.

Senator Dever moved for a **Do Not Pass as Amended on HB 1385**.

Second by **Senator Erbele**.

Roll call vote 3-3-0. Motion failed.

Senator Dever moved **without committee recommendation**.

Second by **Senator Erbele**.

Roll call vote 6-0-0. Motion carried. Carrier is **Senator J. Lee**.

Additional information – Attachment #16

#11

90710.0101
Title.

Prepared by the Legislative Council staff for
Senator J. Lee
February 2, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1385

Page 1, line 1, replace "section" with "sections 50-24.6-02 and"

Page 1, line 2, after "the" insert "drug use review board and the"

Page 1, after line 3, insert:

"**SECTION 1. AMENDMENT.** Section 50-24.6-02 of the North Dakota Century Code is amended and reenacted as follows:

50-24.6-02. Drug use review board.

1. The board is established within the department for the implementation of a drug use review program.

2. The board consists of ~~sixteen~~ seventeen members. The pharmacy administrator of the department and the medical consultant to the department are ex officio nonvoting board members who shall provide administrative services to the board. A majority of the appointed members must be physicians and pharmacists participating in the medical assistance program. Four or more of the appointed members must have experience with a drug use review process or have participated in programs in which prior authorization is used. The appointed members of the board must be:

   a. Four physicians licensed in this state and actively engaged in the practice of medicine, one of whom is a psychiatrist, appointed by the North Dakota medical association;

   b. Two physicians licensed in this state and actively engaged in the practice of medicine, appointed by the executive director of the department;

   c. Four pharmacists licensed in this state and actively engaged in the practice of pharmacy, appointed by the North Dakota pharmaceutical association;

   d. Two pharmacists licensed in this state and actively engaged in the practice of pharmacy, appointed by the executive director of the department;

   e. One individual who represents consumer interests, appointed by the governor; ~~and~~

   f. One pharmacist or physician representing the pharmaceutical industry appointed by the pharmaceutical research manufacturers of America; and

   g. One pharmacist or physician representing the generic pharmaceutical industry appointed by the generic pharmaceutical association.

3. Appointed board members shall serve staggered three-year terms. Two physicians and two pharmacists must be initially appointed for two-year terms, and two physicians and two pharmacists must be initially appointed

for one-year terms. An appointed member may be reappointed for a period not to exceed three 3-year terms. A vacancy on the board must be filled for the balance of the unexpired term from the appropriate board category as provided under subsection 2. The executive director of the department may replace an appointed member of the board who fails to attend three consecutive meetings of the board without advance excuse or who fails to perform the duties expected of a board member. The pharmaceutical industry ~~representative is a~~ representatives are nonvoting board ~~member~~ members.

4. Voting board members shall select a chairman and a vice chairman on an annual basis from the board's voting membership.

5. The board shall meet in person at least once every three months and may meet at other times by teleconference or electronically at the discretion of the chairman. A board member is entitled to receive from the department per diem compensation and reimbursement of expenses as determined by the department, except that no compensation under this section may be paid to any board member who receives compensation or salary as a state employee or official."

Renumber accordingly

#15

90710.0102
Title.

Prepared by the Legislative Council staff for
Senator J. Lee
March 27, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1385

Page 1, line 1, replace "section" with "sections 50-24.6-02 and"

Page 1, line 2, after "the" insert "drug use review board and"

Page 1, after line 3, insert:

"**SECTION 1. AMENDMENT.** Section 50-24.6-02 of the North Dakota Century Code is amended and reenacted as follows:

50-24.6-02. Drug use review board.

1. The board is established within the department for the implementation of a drug use review program.

2. The board consists of ~~sixteen~~ seventeen members. The pharmacy administrator of the department and the medical consultant to the department are ex officio nonvoting board members who shall provide administrative services to the board. A majority of the appointed members must be physicians and pharmacists participating in the medical assistance program. Four or more of the appointed members must have experience with a drug use review process or have participated in programs in which prior authorization is used. The appointed members of the board must be:

   a. Four physicians licensed in this state and actively engaged in the practice of medicine, one of whom is a psychiatrist, appointed by the North Dakota medical association;

   b. Two physicians licensed in this state and actively engaged in the practice of medicine, appointed by the executive director of the department;

   c. Four pharmacists licensed in this state and actively engaged in the practice of pharmacy, appointed by the North Dakota pharmaceutical association;

   d. Two pharmacists licensed in this state and actively engaged in the practice of pharmacy, appointed by the executive director of the department;

   e. One individual who represents consumer interests, appointed by the governor; ~~and~~

   f. One pharmacist or physician representing the brand pharmaceutical industry appointed by the pharmaceutical research and manufacturers of America; and

   g. One pharmacist or physician representing the generic pharmaceutical industry appointed by the generic pharmaceutical association.

3. Appointed board members shall serve staggered three-year terms. ~~Two physicians and two pharmacists must be initially appointed for two-year terms, and two physicians and two pharmacists must be initially appointed~~

~~for one year terms.~~ An appointed member may be reappointed for a period not to exceed three 3-year terms. A vacancy on the board must be filled for the balance of the unexpired term from the appropriate board category as provided under subsection 2. The executive director of the department may replace an appointed member of the board who fails to attend three consecutive meetings of the board without advance excuse or who fails to perform the duties expected of a board member. The pharmaceutical industry ~~representative is a~~ representatives are nonvoting board ~~member~~ members.

4. Voting board members shall select a chairman and a vice chairman on an annual basis from the board's voting membership.

5. The board shall meet in person at least once every three months and may meet at other times by teleconference or electronically at the discretion of the chairman. A board member is entitled to receive from the department per diem compensation and reimbursement of expenses as determined by the department, except that no compensation under this section may be paid to any board member who receives compensation or salary as a state employee or official."

Page 2, line 2, overstrike "or AB-rated" and insert immediately thereafter ", or brand name drugs with a"

Page 2, line 4, overstrike "or otherwise restrict single-source or brand"

Page 2, overstrike lines 5 through 8

Page 2, line 9, overstrike "b. Cancer" and insert immediately thereafter "the following medication classes:

a. Antipsychotics;

b. Antidepressants;

c. Anticonvulsants, for the treatment of bipolar disorder;

d. Antiretrovirals, for the treatment of human immunodeficiency virus; and

e. Antineoplastic agents, for the treatment of cancer"

Renumber accordingly

Date: 4/1/09

Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1385

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .0102

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Rerefer to Appropriations

☒ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Erbele Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman		✓
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais		✓
Senator Dick Dever	✓		Senator Jim Pomeroy		✓

Total (Yes) 3 No 3

Absent 0

Floor Assignment

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

failed

Adopted by the Human Services Committee
April 1, 2009

4-1-9
1 of 2

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1385

Page 1, line 1, replace "section" with "sections 50-24.6-02 and"

Page 1, line 2, after "the" insert "drug use review board and the"

Page 1, after line 3, insert:

"**SECTION 1. AMENDMENT.** Section 50-24.6-02 of the North Dakota Century Code is amended and reenacted as follows:

50-24.6-02. Drug use review board.

1. The board is established within the department for the implementation of a drug use review program.

2. The board consists of ~~sixteen~~ seventeen members. The pharmacy administrator of the department and the medical consultant to the department are ex officio nonvoting board members who shall provide administrative services to the board. A majority of the appointed members must be physicians and pharmacists participating in the medical assistance program. Four or more of the appointed members must have experience with a drug use review process or have participated in programs in which prior authorization is used. The appointed members of the board must be:

   a. Four physicians licensed in this state and actively engaged in the practice of medicine, one of whom is a psychiatrist, appointed by the North Dakota medical association;

   b. Two physicians licensed in this state and actively engaged in the practice of medicine, appointed by the executive director of the department;

   c. Four pharmacists licensed in this state and actively engaged in the practice of pharmacy, appointed by the North Dakota pharmaceutical association;

   d. Two pharmacists licensed in this state and actively engaged in the practice of pharmacy, appointed by the executive director of the department;

   e. One individual who represents consumer interests, appointed by the governor; ~~and~~

   f. One pharmacist or physician representing the brand pharmaceutical industry appointed by the pharmaceutical research and manufacturers of America; and

   g. One pharmacist or physician representing the generic pharmaceutical industry appointed by the generic pharmaceutical association.

3. Appointed board members shall serve staggered three-year terms. ~~Two physicians and two pharmacists must be initially appointed for two-year terms, and two physicians and two pharmacists must be initially appointed for one-year terms.~~ An appointed member may be reappointed for a period

not to exceed three 3-year terms. A vacancy on the board must be filled for the balance of the unexpired term from the appropriate board category as provided under subsection 2. The executive director of the department may replace an appointed member of the board who fails to attend three consecutive meetings of the board without advance excuse or who fails to perform the duties expected of a board member. The pharmaceutical industry ~~representative is a~~ representatives are nonvoting board ~~member~~ members.

4. Voting board members shall select a chairman and a vice chairman on an annual basis from the board's voting membership.

5. The board shall meet in person at least once every three months and may meet at other times by teleconference or electronically at the discretion of the chairman. A board member is entitled to receive from the department per diem compensation and reimbursement of expenses as determined by the department, except that no compensation under this section may be paid to any board member who receives compensation or salary as a state employee or official."

Page 2, line 2, overstrike "or AB-rated" and insert immediately thereafter ", or brand name drugs with a"

Page 2, line 4, overstrike "or otherwise restrict single-source or brand"

Page 2, overstrike lines 5 through 8

Page 2, line 9, overstrike "b. Cancer" and insert immediately thereafter "the following medication classes:

a. Antipsychotics;

b. Antidepressants;

c. Anticonvulsants;

d. Antiretrovirals, for the treatment of human immunodeficiency virus;

e. Antineoplastic agents, for the treatment of cancer; and

f. Stimulant medication used for the treatment of attention deficit disorder and attention deficit hyperactivity disorder"

Renumber accordingly

Date: 4/1/09

Roll Call Vote #: 2

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1385

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .0103

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Rerefer to Appropriations

☒ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Heckaman Seconded By Sen. Pomeroy

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman		✓	Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 5 No 1

Absent 0

Floor Assignment

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

Date: 4/1/09

Roll Call Vote #: 3

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1385

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Rerefer to Appropriations

☐ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Heckaman Seconded By Sen. Pomeroy

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman		✓	Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair		✓	Senator Richard Marcellais	✓	
Senator Dick Dever		✓	Senator Jim Pomeroy	✓	

Total (Yes) 3 No 3

Absent 0

Floor Assignment _____

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

Failed

Date: 4/1/09

Roll Call Vote #: 4

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1385

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☐ Do Pass ☒ Do Not Pass ☒ Amended ☐ Rerefer to Appropriations

☐ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Dever Seconded By Sen. Erbele

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman		✓
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais		✓
Senator Dick Dever	✓		Senator Jim Pomeroy		✓

Total (Yes) 3 No 3

Absent 0

Floor Assignment

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

failed

Date: 4/1/09

Roll Call Vote #: 5

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1385

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 90710.0103 Title .0200

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Rerefer to Appropriations

☐ Adopt Amendment ☐ Reconsider

W/O Recommendation

Motion Made By Sen. Dever Seconded By Sen. Erbele

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen J. Lee

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

REPORT OF STANDING COMMITTEE

HB 1385: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **BE PLACED ON THE CALENDAR WITHOUT RECOMMENDATION** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1385 was placed on the Sixth order on the calendar.

Page 1, line 1, replace "section" with "sections 50-24.6-02 and"

Page 1, line 2, after "the" insert "drug use review board and the"

Page 1, after line 3, insert:

"**SECTION 1. AMENDMENT.** Section 50-24.6-02 of the North Dakota Century Code is amended and reenacted as follows:

50-24.6-02. Drug use review board.

1. The board is established within the department for the implementation of a drug use review program.

2. The board consists of ~~sixteen~~ seventeen members. The pharmacy administrator of the department and the medical consultant to the department are ex officio nonvoting board members who shall provide administrative services to the board. A majority of the appointed members must be physicians and pharmacists participating in the medical assistance program. Four or more of the appointed members must have experience with a drug use review process or have participated in programs in which prior authorization is used. The appointed members of the board must be:

   a. Four physicians licensed in this state and actively engaged in the practice of medicine, one of whom is a psychiatrist, appointed by the North Dakota medical association;

   b. Two physicians licensed in this state and actively engaged in the practice of medicine, appointed by the executive director of the department;

   c. Four pharmacists licensed in this state and actively engaged in the practice of pharmacy, appointed by the North Dakota pharmaceutical association;

   d. Two pharmacists licensed in this state and actively engaged in the practice of pharmacy, appointed by the executive director of the department;

   e. One individual who represents consumer interests, appointed by the governor; ~~and~~

   f. One pharmacist or physician representing the brand pharmaceutical industry appointed by the pharmaceutical research and manufacturers of America; and

   g. One pharmacist or physician representing the generic pharmaceutical industry appointed by the generic pharmaceutical association.

3. Appointed board members shall serve staggered three-year terms. ~~Two physicians and two pharmacists must be initially appointed for two-year terms, and two physicians and two pharmacists must be initially appointed for one-year terms.~~ An appointed member may be reappointed for a period not to exceed three 3-year terms. A vacancy on the board must be filled for the balance of the unexpired term from the appropriate board category as provided under subsection 2. The executive director of the department may replace an appointed member of the board who fails to attend three consecutive meetings of the board without advance excuse or who fails to perform the duties expected of a board member. The pharmaceutical industry ~~representative is a~~ representatives are nonvoting board ~~member~~ members.

4. Voting board members shall select a chairman and a vice chairman on an annual basis from the board's voting membership.

5. The board shall meet in person at least once every three months and may meet at other times by teleconference or electronically at the discretion of the chairman. A board member is entitled to receive from the department per diem compensation and reimbursement of expenses as determined by the department, except that no compensation under this section may be paid to any board member who receives compensation or salary as a state employee or official."

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Page 2, line 9, overstrike "b. Cancer" and insert immediately thereafter "the following medication classes:

a. Antipsychotics;

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c. Anticonvulsants;

d. Antiretrovirals, for the treatment of human immunodeficiency virus;

e. Antineoplastic agents, for the treatment of cancer; and

f. Stimulant medication used for the treatment of attention deficit disorder and attention deficit hyperactivity disorder"

Renumber accordingly

2009 TESTIMONY

HB 1385

#1

Same given to Senate

Testimony
House Bill 1385
House Human Services Committee
Representative Robin Weisz, Chairman
January 20, 2009

Chairman Weisz and members of the Committee: my name is Carlotta McCleary. I am the Executive Director of ND Federation of Families for Children's Mental Health (NDFFCMH). NDFFCMH is a parent run advocacy organization that focuses on the needs of children and youth with emotional, behavioral and mental disorders and their families, from birth through transition to adulthood.

House Bill 1385 will allow children and adults with mental health needs access to needed treatment by allowing access to the medications their doctor has prescribed. This bill prevents delays in treatment from a "you must fail this treatment first" theory to receiving the medications that the doctor feels would be the best course of treatment.

According to The President's New Freedom Commission on Mental Health, "For consumers of all ages, early detection, assessment, and linkage with treatment and supports can prevent mental health problems from compounding and poor life outcomes from accumulating. Early intervention can have a significant impact on the lives of children and adults who experience mental health problems.

Emerging research indicates that intervening early can interrupt the negative course of some mental illnesses and may, in some cases, lessen the long-term disability. New understanding of the brain indicates that early identification and intervention can sharply improve outcomes and that longer periods of abnormal thoughts and behavior have cumulative effects and can limit capacity for recovery."

There are other costs beside the cost of the medication that must be considered. According to a study in the May *American Journal of Psychiatry* (Vol. 165, No. 5), each year, serious mental illness costs Americans $193 billion in lost earnings. The lost earning potential is only one of the many indirect costs of mental illness in American society. Social Security payments, homelessness and incarceration add to that economic burden.

According to the American Psychiatric Association (APA), the direct cost of treating and supporting mental illness is approximately $55 billion a year. But there are indirect costs to society as well, including the cost of lost employment or decreased productivity, accidents, and social welfare programs, which have been estimated at $273 billion a year.

About $70 billion of that $273 billion is the estimated cost of untreated mental illness. That's actually more than the direct cost of treating mental illness.

Included in the $70 billion are:

- The added cost of emergency room care. Individuals with untreated mental illness tend to use emergency rooms on a regular basis to deal with medical crises.
- Added costs of care by private physicians. Because many symptoms of mental illness are physical, family doctors hear complaints from patients with untreated mental illness. The problem is, they often refer these patients for more tests, which are costly. In addition, untreated mental illness actually causes some medical conditions to worsen, such as asthma, arthritis, and diabetes, which require even more visits to private physicians.
- Absenteeism. Lost days from work create a financial drain on employers.
- "Presenteeism." This term has been used to refer to employees who show up for work but, because they're impaired with a mental illness such as depression, they cannot work up to their ability.

Medications have played a key role in mental health recovery. Allow children and adults with mental health needs access to needed treatment by allowing access to the medications their doctor has prescribed.

Thank you for your time.

Carlotta McCleary, Executive Director
ND Federation of Families for Children's Mental Health
PO Box 3061
Bismarck, ND 58502

Phone/fax: (701) 222-3310
Email: carlottamccleary@bis.midco.net

TESTIMONY – PROTECTION AND ADVOCACY PROJECT
HOUSE BILL 1385
HOUSE HUMAN SERVICES COMMITTEE
January 20, 2009

Chairman Weisz and Members of the Committee, my name is Corinne Hofmann. I am Director of Policy and Operations for the Protection and Advocacy Project [P&A]. P&A serves individuals who have disabilities.

P&A supports passage of House Bill 1385. We oppose implementation of prior authorization or restrictions on the use of medications currently "carved out" in N.D.C.C. 50-24.6-04.

Our work as advocates for people with disabilities has helped us understand that people's response to medications is individual and varied. We are concerned about delays that might arise because of a need for prior authorization and the potential requirement to use medications that may be ineffective or cause significant side effects for an individual. This could have a very negative effect on the individual's health and well-being.

Our agency believes that the best decisions regarding appropriate medication are made when the individual requiring them is involved in an ongoing discourse with their doctor and together they are free to decide what works best for the person.

We recommend passage of House Bill 1385. Thank you.

#2

Testimony in Support of HB 1385
North Dakota Psychiatric Society
House Human Services Committee
January 20, 2009

Chairman Weisz and members of the Committee. I'm Bruce Levi and I represent the North Dakota Psychiatric Society – North Dakota's psychiatrists.

The North Dakota Psychiatric Society supports HB 1385, which removes the sunset on subsection 3 of section 50-24.6-04, which essentially retains the following statutory language relating to the Medicaid Drug Utilization Review Board:

> 3. Except for quantity limits that may be no less than the pharmaceutical manufacturer's package insert or AB-rated generic equivalent drug for which the cost to the state post rebate is less than the brand name drugs, in the aggregate, the department may not prior authorize or otherwise restrict single-source or brand name antipsychotic, antidepressant, or other medications used to treat mental illnesses, such as schizophrenia, depression, or bipolar disorder, and drugs prescribed for the treatment of:
> a. Acquired immune deficiency syndrome or human immunodeficiency virus; and
> b. Cancer.

This issue has been presented to the Legislative Assembly on more than one occasion, and there remains considerable discomfort in the medical community over elimination of the prohibition on the Department prior authorizing mental health drugs that are so critical to the well-being of psychiatric patients.

Psychiatrists are particularly concerned that roadblocks are not put in place that prevent them from determining the best treatment for each individual patient in treating mental illness. Treating psychiatric patients is very complex. Physicians and other practitioners have many tools to use in treating these patients. The current array of medications are some of their most powerful tools. The best results are attained when an experienced physician can take into account the multiple variables and wisely combine that with the treatments available and then determine the best treatment for that patient at that time. Some of the variables include:

- the diagnosis (not usually black and white – there are many variations, shades and blending of diagnoses that can make a difference in what treatment is chosen.
- comorbid conditions
- family history
- the patients preconceived ideas about their illness or certain treatments
- compliance issues
- the psychological dynamics going on between patient, treater, family and others
- many more

The key is therapeutic equivalency. What is often found is a specific formulation is helpful for a patient (such as an extended release medication) and if there is a generic short acting release medication it might get switched. Or, if a person has done very well on a "prior auth medication," can they continued to be grandfathered in? Often, psychiatrists have to "rescue" people who've been switched from Lexapro to Celexa because prescribers/dispensers are not aware of the dosing equivalent ranges, or people with poor medication compliance get switched to a twice a day vs. once a day version and become non-compliant.

While it is important that all be aware of the cost differences between drugs, it is also important to be aware of other indirect costs that could occur, including additional staff time, hospitalization costs, etc. In fact, the following are some of the benefits of and cost savings associated with having available the needed treatments for patients:

-decreased use of other medical services
-decreased emergency room visits
-often decreases the severity or even existence of comorbid illnesses and physical pain
-decreased death through suicide or inadvertent death through associated problems
-decreased hospitalization
-increased productivity

There are many other considerations, but the bottom line is that medical/psychiatric treatment is a complex process, and to get the best results the physician needs the ability to choose the best treatment for the patient.

On behalf of the North Dakota Psychiatric Society, I urge a "Do Pass" on SB 1385. Thank you.

#4

Testimony

House Bill 1385
House Human Services Committee
Tuesday, January 20, 2009

Deborah Knuth
Government Relations Director, North Dakota
American Cancer Society Cancer Action Network

Good morning, Chairman Weisz, and members of the House Human Services Committee. I am here representing the American Cancer Society Cancer Action Network. ACS CAN is the nonprofit, nonpartisan advocacy partner of the American Cancer Society that supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem.

We support the ability of doctors to make the best medical decision for their patients in consultation with their patients. Prior authorization programs limit the ability of patients and doctors to make medical decisions in an unimpeded manner. While generic alternatives are not currently widely available for cancer patients, we are concerned that future cancer patients have timely access to the complete continuum of treatment, regardless of generic status.

Prior authorizations and procedural barriers may not result in costs savings. There are significant administrative costs associated with setting up and maintaining a prior authorization system. We encourage the state to gather all of the relevant figures before embarking on a prior authorization program

The legislature should insist on evidence of any potential cost-savings. Not all proposed cuts save dollars. The cost in both administration and decreased health of the population served has the potential to be significant and ought to be considered before the adoption of any prior authorization plan or process.

We would advocate for a carve out for cancer prescriptions now and in the future. Prior authorization creates an additional administrative barrier, can discourage physicians from prescribing prior authorization drugs, even if they're the most appropriate option for the patient, and can deter beneficiaries from seeking the recommended care. Prior authorization in some cases, can take up to 72 hours. For cancer patients undergoing chemotherapy, such delays could be detrimental to their treatment success and quality of life.

If a prior authorization process were to be implemented, the procedures need to be simple and clear. If all of the other figures are gathered and the system seems to be one that

would benefit the patients, allow for the appropriate doctor/patient relationships and not impede patient quality of life and timeliness of care, it is still the case that the system needs to be simple for providers and patients.

In closing, the American Cancer Society and ACS CAN strongly support the right of cancer patients and their doctors to decide what is best for the patient, based on the patient's medical and emotional needs. ACS CAN believes that Medicaid coverage should allow for timely access and coverage of the complete continuum of quality, evidence-based healthcare services. Prior authorization programs can detrimentally impact a patient's timely access to healthcare services. We encourage the state to consider all of the real costs of implementing any program and ask you to consider the total impact on patients' quality of life during a significant illness such as cancer.

Thank you for the opportunity to speak with you today.

Talking points in opposition to prior authorization:

Hello, my name is Dr. F. Addo. I am here representing FEKA Ovrw and on behalf of the American Cancer Society Cancer Action Network. ACS CAN is the nonprofit, nonpartisan advocacy partner of the American Cancer Society that supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem.

We support the ability of doctors to make the best medical decision for their patients in consultation with their patients. Prior authorization programs limit the ability of patients and doctors to make medical decisions in an unimpeded manner. While generic alternatives are not currently widely available for cancer patients, we are concerned that future cancer patients have timely access to the complete continuum of treatment, regardless of generic status.

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If a prior authorization process were to be implemented, the procedures need to be simple and clear. If all of the other figures are gathered and the system seems to be one that would benefit the patients, allow for the appropriate doctor/patient relationships and not impede patient quality of life and timeliness of care, it is still the case that the system needs to be simple for providers and patients.

In closing, the American Cancer Society and ACS CAN strongly support the right of cancer patients and their doctors to decide what is best for the patient, based on the patient's medical and emotional needs. ACS CAN believes that Medicaid coverage should allow for timely access and coverage of the complete continuum of quality, evidence-based healthcare services. Prior authorization programs can detrimentally impact a patient's timely access to healthcare services. We encourage the state to consider all of the real costs

of implementing any program and ask you to consider the total impact on patients' quality of life during a significant illness such as cancer.

Thank you for the opportunity to speak with you today.

#17

TESTIMONY

House Human Services Committee
HB 1385
Representative Weisz, Chairman
January 20, 2009

Chairman Weisz and members of the House Human Services Committee,

My name is Patsy F Garland, from Fargo, North Dakota. I would like to support HB 1385

I am undergoing treatment for bipolar disorder. I have been taking brand name drug called Abilify. It has been working great!

This bill allows people like me to receive the medications they need to stay healthy. Please keep legislation in mind that supports people with mental health issues.

I like feeling better and I am able to work on a daily basis when take this medication.

Thanks for your support.

#8

Testimony
House Human Services Committee
HB 1385
Representative Weisz, Chairman
January 20, 2009

Chairman Weisz and members of the House Human Services Committee, I am Susan Rae Helgeland, Executive Director, Mental Health America of North Dakota (MHAND). MHAND is a 57-year-old non-profit organization. Our mission is: To promote mental health through education, advocacy, understanding and access to quality care for all individuals. MHAND supports the continuation of a carve-out for psychotropic drugs.

Scientific research has led to the development of a number of medications that have transformed the practice of medicine, reduced the need for costly and invasive medical procedures and improved the quality of life for millions of people. Efforts to restrict access to these newer medications threaten the financial, physical and mental health of all North Dakotans.

The following statements are taken from the national organization, Mental Health America, *Issue Brief #1 on The Case for Open Access to Medications*:

"Restrictive policies fail to take into account the fact that physicians and consumers should make treatment decisions and that the lack of access to medications has both human and fiscal consequences...The need for individualized treatment is particularly acute among people who have mental health disorders. Researchers are still not sure why many mental health medications are effective, or why there effectiveness can vary so widely from one

person to another...Research shows that different antipsychotic medications affect different portions of the brain."

The I*ssue Brief* states that many states have instituted a variety of cost-containment strategies to reduce pharmaceutical costs as a way of reducing general Medicaid spending. "Such strategies tend to reduce pharmaceutical budgets but states have not analyzed the impacts of cost-containment strategies on other portions of their Medicaid budgets or other state agencies. It is important to consider the trade-offs involved. Providing consumers with increased access to medications can shorten hospital stays, prevent the need for crisis care and enable them to live more productive lives."

The *Issue Brief* goes on to state that "Medication therapy for any disorder is fairly complex and its management requires a thorough understanding of the person's mental condition, the medication's side effects, other medications he or she may be taking, the person's history of medication use and any co-morbid illnesses the person may have. The confluence of these factors makes it essential for treatment decisions to remain with the health provider and the consumer. Policies that restrict the access of medications may jeopardize opportunities for recovery."

Sound policy requires that all antipsychotic medications be carved out from the prior authorization requirement.

Testimony
House Bill 1385 – Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
January 20, 2009

Chairman Weisz, members of the committee, I am Dr. Brendan Joyce, Administrator of Pharmacy Services for the Department of Human Services, providing testimony regarding House Bill 1385.

The 2007 Legislature, through House Bill No. 1422, asked the Drug Use Review (DUR) Board to review the utilization, cost, and effectiveness of the drugs identified in subsection 3 of section 50-24.6-04, and make recommendations for managing the utilization of the identified drugs or any other drugs for the conditions identified in that subsection. Their recommendations were provided to the Legislative Council in October 2008. See Attachment 1.

The classes of medications account for 46% of total drug spend. Please see the chart below for August through October 2008 expenditures.

Drug Class	Amount Spent	% of Total Drug Spend
Antipsychotics	$1,294,263	16.4%
Mood Stabilizers	$912,278	11.6%
ADHD	$766,556	9.9%
Antidepressants	$478,762	6.1%
Oncology	$114,706	1.5%
HIV/AIDS	$32,959	0.4%
Total		45.9%

I would be happy to answer any questions.

Attachment 1

North Dakota Department of Human Services
Summary of Drug Utilization Review Board Recommendations
On Managing Utilization of Identified Drug Classes Currently Restricted
2007 House Bill 1422 Report

Same handout given to Senate.

The 2007 Legislature, through House Bill No. 1422, asked the Drug Use Review (DUR) Board to review the utilization, cost, and effectiveness of the drugs identified in subsection 3 of section 50-24.6-04 and make recommendations for managing the utilization of the identified drugs or any other drugs for the conditions identified in that subsection.

The classes of medications reviewed include Oncology, HIV/AIDS, Attention Deficit/Hyperactivity Disorder (ADHD), Antidepressants, Antipsychotics, and Mood Stabilizers/Anticonvulsants. Antipsychotics, Mood Stabilizers/Anticonvulsants, Antidepressants and ADHD medications are the top four classes of medications (by cost) paid by ND Medicaid.

1. HIV/AIDS-DUR Board consulted with an Infectious Disease Specialist. His opinion was that ND Medicaid should not prior authorize any HIV/AIDS medication, but he did not believe that a law should exist to prohibit action in the future-specifically if a physician prescribed outside of the AIDS Drug Assistance Program (ADAP) guidelines. The DUR Board concurred with the Infectious Disease Specialist's opinion.

2. Oncology-DUR Board consulted with an Oncologist. Specialist stated that no law was needed to prevent antineoplastics from being placed on prior authorization as long as recommendations for PA come from the DUR Board and that the turnaround time for PA's also remained the same (98% reviewed in 8 hours or less and 100% in 24 hours). The DUR Board recommended that antineoplastics no longer be exempt from prior authorization and that the DUR Board be involved in the PA of certain agents using private insurance as a guideline.

3. Attention Deficit/Hyperactivity Disorder (ADHD)-DUR Board recommended removing the exemption for this class, prior authorizing Vyvanse after Adderall XR trial, and prior authorizing Daytrana.

4. Antidepressants-DUR Board recommended placing certain SSRI medications on prior authorization and therefore removing the exemption for the antidepressant class of medications.

5. Antipsychotics-DUR Board recommended prior authorizing alternate dosage forms and Invega if the exemption was removed from this class of medications.

6. Anticonvulsants-DUR Board made no recommendation on the Anticonvulsant class of medications.

#1

Testimony
HB No. 1385
Senate Human Services Committee
March 10, 2009, 9:00 a.m.

Good morning Chairman Lee and members of the Senate Human Services Committee. My name is Dr. Kathleen Nordstrom, and I am here today speaking as an oncologist from the Bismarck Cancer Center, and also as a volunteer of the American Cancer Society Cancer Action Network.

I support the ability of doctors to make the best medical decision for their patients in consultation with their patients. Prior authorization programs limit the ability of patients and doctors to make medical decisions in an unimpeded manner. While generic alternatives are not currently widely available for cancer patients, I am concerned that future cancer patients have timely access to the complete continuum of treatment, regardless of generic status.

I would advocate for a carve out for cancer prescriptions now and in the future. Prior authorization creates an additional administrative barrier, can discourage physicians from prescribing prior authorization drugs, even if they're the most appropriate option for the patient, and can deter beneficiaries from seeking the recommended care. Prior authorization in some cases, can take up to 72 hours. For cancer patients undergoing chemotherapy, such delays could be detrimental to their treatment success and quality of life.

If a prior authorization process were to be implemented, the procedures need to be simple and clear. If all of the other figures are gathered and the system seems to be one that would benefit the patients, allow for the appropriate doctor/patient relationships and not

impede patient life and timeliness of care, it is still the case that the system needs to be simple for providers and patients.

In closing, I and ACS CAN, strongly support the right of cancer patients and their doctors to decide what is best for the patient, based on the patient's medical and emotional needs. We believe that Medicaid coverage should allow for timely access and coverage of the complete continuum of quality, evidence-based healthcare services. Prior authorization programs can detrimentally impact a patient's timely access to healthcare services. We encourage the state to consider all of the real costs of implementing any program and ask you to consider the total impact on patients' life during a significant illness such as cancer. Please vote yes on HB 1385. Thank you for the opportunity to speak with you today.

ACS CAN is the nonprofit, nonpartisan advocacy partner of the American Cancer Society that supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem.

#2

March 10, 2009

Testimony of Terry M. Johnson, M.D.
For the
Senate Human Services Committee
Re: HB 1385
Rational for unrestricted use of psychotropic medications
from the perspective of a busy practitioner.

I am sorry that I cannot be there in person this morning. I am speaking for myself as a psychiatrist practicing at St. Alexius Medical Center in Bismarck, who sees hundreds of psychiatric patients per month and who treats many of the treatment resistant mood disorders in the area as well as many other severe psychiatric problems in the adult population. The practice of psychiatry is both very challenging and exciting. We are able to successfully treat people with severe disorders such as schizophrenia and the most severe depression and bipolar disorders as well as many other psychiatric illnesses. The use of medications for these disorders has advanced greatly in the past 40 or 50 years since we started using chlorpromazine (Thorazine) and imipramine (Tofranil) to even more dramatic results as we moved into the newer generation of anti psychotics and antidepressants and antiepileptics (used as mood stabilizers). People who used to be warehoused in the State Hospital with no hope of improvement, suddenly were given hope. Schizophrenic patients on Clozapine and some of the other novel antipsychotics (Zyprexa, Risperdal, Geodon and others) are now sometimes able to go to college and/or get full time jobs with benefits. Not all of the seriously mentally ill are that fortunate, but many more than before are. For some a more realistic goal is for them to have a better life with their family and to stay out of the hospital and to be less tormented with voices, delusions and mood swings.

Following are some of the benefits and cost savings of having available the needed treatments for our patients:

- decreased utilization of other medical services
- decreased Emergency Room visits
- often decreases the severity or even existence of comorbid illnesses and physical pain
- decreased death through suicide or inadvertent death through associated problems
- decreased hospitalization
- increased productivity

Other issues to consider:

- Treating into remission and preventing relapse -- We have learned that our patients do the best, if their mood disorder is treated into full remission. With less than that they are more prone to relapse. We have also learned that the more they relapse the more treatment resistant they become and the more likely they are to keep relapsing. The more they relapse the more likely they are to relapse, and the longer they stay healthy or are in remission the longer tend to stay that way. If we are required to go through a progression, starting with the cheaper medications and then have them relapse to go to the next level of meds, we may be causing increased illness

and morbidity and much more suffering and expense in the long run. If I can do what I determine to be the best treatment for the patient at the start, I have an increased likelihood of success and decreased likelihood of making their illness worse.

- Some patients need multiple medications to get the best results. I have patients I have worked with over months and years to find the right combination to keep them out of the hospital and decrease their suffering, and in some cases get them back to work. This is often with multiple medications, carefully combined, often along with some psychotherapy, and always taking into account their other comorbid illnesses and medications.

Treating psychiatric patients is very complex. Physicians and other practitioners have many tools to use in treating these patients. The current array of medications are some of our most powerful tools. The best results, I believe, are attained when an experienced physician can take into account the multiple variables and wisely combine that with the treatments available and then determining the best treatment for that patient at that time. Some of the variables include

- the diagnosis (recognize that this is not usually black and white -- there are many variations, shades and blending of diagnoses that can make a difference in what treatment is chosen)
- comorbid conditions
- family history
- the patient's preconceived ideas about their illness or certain treatments
- compliance issues
- the psychological dynamics going on between patient, treater, family and others
- many more.

The bottom line is that medical/psychiatric treatment is a complex process, and to get the best results the practioner needs the ability to choose the best treatment for the situation, and not have roadblocks preventing that.

Thank you for your attention.

Terry M. Johnson, M.D.

#3

North Dakota Disabilities Advocacy Consortium
Testimony
Senate Human Services Committee
HB 1385
Senator Judy Lee, Chairman
March 10, 2009

Same to given House.

Chairman Lee and members of the Senate Human Services Committee, I am James M. Moench, Executive Director of the North Dakota Disabilities Advocacy Consortium (NDDAC). The Consortium is made up of 24 organizations concerned with addressing the issues that affect people with disabilities. Our mission is: To advocate for public policy to ensure that people with disabilities have the supports and services they need to be as productive and independent as possible. NDDAC supports the continuation of a carve-out for psychotropic drugs found in HB 1385.

NDDAC member organizations feel that retaining the carve-out is essential to fast quality care providing the needed flexibility to the doctor and the requisite safety to the patient. The concept has proven itself during the biennium trial period and the sunset can be safely removed.

Thank you for the opportunity to testify and we urge your support for HB 1385.

NORTH DAKOTA DISABILITIES ADVOCACY CONSORTIUM

2008-09 Membership

1. AARP
2. American People Self Advocacy Association
3. Autism Society of North Dakota
4. Experience Works, Inc.
5. Fair Housing of the Dakotas
6. Family Voices of North Dakota
7. Independence, Inc.
8. Mental Health America of North Dakota
9. Metro Area Transit – Fargo, ND
10. ND APSE: The Network on Employment
11. ND Association for the Disabled
12. ND Association of Community Facilities
13. ND Association of the Blind
14. ND Association of the Deaf
15. ND Center for Persons with Disabilities
16. ND Children's Caucus
17. ND Consumer & Family Network
18. ND Federation of Families for Children's Mental Health
19. ND IPAT Consumer Advisory Committee
20. Protection & Advocacy Project
21. Senior Health Insurance Counseling/Prescription Connection
22. The Arc of Bismarck
23. The Arc of Cass County
24. The Arc of North Dakota

3-02-09

#4

Testimony
Senate Human Services Committee
HB 1385
Senator Lee, Chair

March 10, 2009

Madam Chair and members of the House Human Services Committee, I am Susan Rae Helgeland, Executive Director, Mental Health America of North Dakota (MHAND). MHAND's mission is: *To promote mental health through education, advocacy, understanding and access to quality care for all individuals.* MHAND supports the continuation of a carve-out for psychotropic drugs.

Scientific research has led to the development of a number of medications that have transformed the practice of medicine, reduced the need for costly and invasive medical procedures and improved the quality of life for millions of people. Efforts to restrict access to these newer medications threaten the financial, physical and mental health of all North Dakotans.

The following statements are taken from the national organization, Mental Health America, *Issue Brief #1 on The Case for Open Access to Medications*:

"Restrictive policies fail to take into account the fact that physicians and consumers should make treatment decisions and that the lack of access to medications has both human and fiscal consequences...The need for individualized treatment is particularly acute among people who have mental health disorders. Researchers are still not sure why many mental health medications are effective, or why there effectiveness can vary so widely from one

person to another...Research shows that different antipsychotic medications affect different portions of the brain."

The I*ssue Brief* states that many states have instituted a variety of cost-containment strategies to reduce pharmaceutical costs as a way of reducing general Medicaid spending. "Such strategies tend to reduce pharmaceutical budgets but states have not analyzed the impacts of cost-containment strategies on other portions of their Medicaid budgets or other state agencies. It is important to consider the trade-offs involved. Providing consumers with increased access to medications can shorten hospital stays, prevent the need for crisis care and enable them to live more productive lives."

Brenda Weisz, CFO, Fiscal Administration of the ND Department of Human Services reported to me that there will be unexpended General Funds from the Medicaid drug grant budget that total $6.8 million. Medicare Part D (Federal drug coverage) and a higher use of generic drugs are two of the reasons for the lower than anticipated costs of the Medicaid drug budget this biennium. The current Medicaid budget is more than adequate to meet the needs of consumers. There is no justification for implementation of a sunset on HB 1385 at this time.

Sound policy requires that all antipsychotic medications be carved out from the prior authorization requirement.

Thank you for your time and attention on this matter.

#5

Testimony
Senate Human Services Committee
HB 1385
Senator Lee, Chair

March 10, 2009

Madam Chair and members of the Senate Human Services Committee, I am Todd Christlieb and I live in Fargo. My testimony is written in support of HB 1385.

I have been on the same two medications, Zyprexa and Depakote, for twelve years. Other comparable medications have been introduced a couple of times as an alternative, but have been proven ineffective. The first time was in the late fall of 2005 when I was hospitalized for depression. The attending psychiatrist replaced Depakote with Topamax, and Zyprexa with Seroquel on account of my weight; a side effect of both Depakote and Zyprexa. However, three months later, and fifty pounds lighter, I was hospitalized with chronic mania and psychosis. After two weeks, I was admitted to the North Dakota State Hospital. It was there that I was introduced to a medication called Geodon which is not only an anti-psychotic medication, but also a mood stabilizer. Eventually, Depakote was reintroduced to my medication regimen. However, I remained manic and psychotic for several months getting no more than four hours of sleep a night. Finally, I went for three days without sleep and found myself very exhausted.

On the third day, I personally requested to be reintroduced to Zyprexa, an anti-psychotic and mood stabilizer for mania. My request was honored and I got eight hours of sleep that very night. Shortly thereafter, I was discharged after being in treatment for eight and a half months. I gained my weight back, but I accept it as

a good trade off for good mental health. My psychiatrist, whom I have been working with for several years, has mentioned to me several times that I am very sensitive to medication changes, and is reluctant to adjust them. When he does, he only does so in small amounts with my existing medications.

I feel that if for some reason, my attending psychiatrist and I were limited to certain medications; it would be a disservice to my health and overall quality of life. I would like to mention that the cost of my Zyprexa alone without insurance is approximately $800 per month. Yet, if one would consider the amount of time and money that was spent while I was in the state hospital, and any future stays due to medication restrictions, I would have to say $800 per month is a good investment.

I would like to again ask your support for HB 1385. Thank you for your time.

#7

Testimony
House Bill 1385
Senate Human Services Committee
Senator Judy Lee, Chairman
March 10, 2009

Chairman Lee and members of the Committee: my name is Randy Solem. I am the Chair of the North Dakota Mental Health Planning Council (NDMHPC). NDMHPC members are appointed by the Governor of North Dakota. Council's Objective is to receive federal funds designated for mental health services and to monitor, review, and evaluate the allocation and adequacy of mental health services in the state. The NDMHPC has a focus and vision on mental health wellness and recovery that is consumer and family driven.

The mental health system is often times driven by the funding available rather than by need. In a consumer and family driven system, individuals' and families' needs drive the policies and service delivery system. Choice leads to greater participation and higher consumer satisfaction with services.

Therefore the NDMHPC supports carving out mental health medication from the prior authorization process. The NDMHPC urges you to support House Bill 1385.

The NDMHPC authored three White Papers, as well as related Talking Points, to share their position and philosophy regarding three of the New Freedom Commission Goals. These are statements from NDMHPC white papers. Here is the link to the MHPC White Papers:
http://www.nd.gov/dhs/services/mentalhealth/ndmhpc/papers.html

Thank you.

#8

Testimony
House Bill 1385—Prior Authorization Program
Senate Human Services Committee
Senator Judy Lee, Chairman
March 10, 2009

Chairman Lee and members of the Senate Human Services Committee, I am Janet Sabol from Minot. I have volunteered for the National Alliance on Mental Illness (NAMI) in the local affiliate and statewide for over 10 years serving as the state coordinator, state president and current spokesperson. We are strongly in favor of HB1385 which would exempt medications used to treat mental illnesses from prior authorization and remove the sunset date of July 31, 2009.

From my interactions with consumers of mental health services and family members of consumers, it has been shown that access to a variety of psychiatric medications has made a profound effect on the person's quality of life. An example is a person who went from being on disability to being able to work part-time, then two part-time jobs, to obtain a college education and go off disability all because a new medication worked for him. However, a newer medication may not always work for an individual. Everyone is different and, therefore, the decision of which medication to try needs to be left up to the mental health provider and the individual.

At a time when a person needs to switch medications, it's usually because of severe side effects or ineffectiveness. Prior authorization takes time and paperwork meaning the person is exposed to a difficult situation longer and that may lead to unwanted behaviors.

A study of dual-eligible Medicaid and Medicare Part D patients published in the American Journal of Psychiatry in May 2007showed that among individuals with mental illnesses who were switched to a different prescription because the clinically preferred mental health medication was not covered or approved, one in three had an emergency-room visit and more than 15 percent were hospitalized. Nearly 22 percent of these patients experienced suicidal thoughts or behavior, and 14.5 percent experienced a rise in violent thoughts and behavior. These are potential consequences that we want to avoid.

When it comes to controlling health care spending, drug costs are the least of the problem. The Centers for Medicare & Medicaid Services report that U.S. prescription drug spending increased 4.9 percent in 2007 — the lowest growth rate in 45 years — while the growth rate for health care spending overall was 6.1 percent.

This was principally driven by high generic dispensing rates — from 19 percent of all U.S. prescriptions in 1984 to 64 percent in 2008. For example, the average price of SSRIs (newer antidepressant medications commonly

prescribed for major depression and anxiety disorders) declined from $108.49 per prescription in 2000 to $62.95 in 2007.

HB1385 addressing exemption of prior authorization of medications for mental illness, HIV/AIDS and cancer has been voted for favorably in the last two legislative sessions. It is now time to remove the sunset date and bring this bill into a permanent law.

Thank you for your time and support of HB1385.

Janet Sabol
701-852-8202
naminwnd@min.midco.net

#9

Testimony
House Bill 1385 – Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
March 10, 2009

Chairman Lee, members of the committee, I am Dr. Brendan Joyce, Administrator of Pharmacy Services for the Department of Human Services, providing information regarding House Bill 1385.

The 2007 Legislature, through House Bill No. 1422, asked the Drug Use Review (DUR) Board to review the utilization, cost, and effectiveness of the drugs identified in subsection 3 of section 50-24.6-04, and make recommendations for managing the utilization of the identified drugs or any other drugs for the conditions identified in that subsection. Their recommendations were developed during the 07-09 interim, with a final report provided to the Legislative Council in October 2008. See Attachment 1.

The classes of medications identified in this bill account for 46% of total Medicaid drug spend. Please see the chart below for August through October 2008 expenditures.

Drug Class	Amount Spent	% of Total Drug Spend
Antipsychotics	$1,294,263	16.4%
Mood Stabilizers	$912,278	11.6%
ADHD	$766,556	9.9%
Antidepressants	$478,762	6.1%
Oncology	$114,706	1.5%
HIV/AIDS	$32,959	0.4%
Total		45.9%

In order to have an idea of how many states manage some of the drug classes mentioned in HB 1385, please see Attachment 2 for the results of a recent survey completed by Nebraska, Kansas, and Oklahoma regarding the inclusion of antipsychotics, antidepressants, and anticonvulsants on state preferred drug lists. Having a class of medication on a preferred drug list generally, but not always, results in prior authorization of drugs in that class.

The Department would like clarification on which classes of medications are to be included in this carve-out. For instance, we included ADHD medications in the chart on page one of this testimony, but ADHD medications are not mentioned specifically in the bill. Is it the intent of the legislature to include ADHD medications in this carve-out, or is it only for the classes of drugs that are specifically mentioned in the language in the bill? The bill language states:

> ". . . antipsychotic, antidepressant, or other medications used to treat mental illnesses, such as schizophrenia, depression, or bipolar disorder . . ."

Also, there may be medications from other drug classes (e.g. anti-hypertensives) that are used in the treatment of mental illnesses. Is it the intent of the legislature for this bill to apply to those specific medications, or are the exemptions to be at a drug class level? Any clarifications of the drugs intended to be included in the carve-out would be helpful as the Department and the DUR Board complete future work.

I would be happy to answer any questions.

ND Department of Human Services
Medical Services Division
March 10, 2009

Attachmment 2

STATE	PDL	ANTIPSYCHOTICS	ANTIDEPRESSANTS	ANTICONVULSANTS
ALABAMA	Y	N	Y	Y
ALASKA	Y	Y	Y	Y
ARIZONA	n/a	n/a	n/a	n/a
ARKANSAS	Y	N	Y	Y
CALIFORNIA	Y	Y	Y	Y
COLORADO	Y	N	N	N
CONNECTICUT	Y	N	N	N
DELAWARE	Y			
FLORIDA	Y	Y	Y	Y
GEORGIA	Y	Y	Y	Y
HAWAII	Y	N	N	N
IDAHO	Y	N	Y	Y
ILLINOIS	Y	Y	Y	Y
INDIANA	Y	Y	Y	Y
IOWA	Y	N	N	N
KANSAS	Y	N	N	N
KENTUCKY	Y			
LOUISIANA	Y			
MAINE	Y	Y	Y	Y
MARYLAND	Y			
MASSACHUSETTS	Y			
MICHIGAN	Y	N	N	N
MINNESOTA	Y	Y	Y	Y
MISSISSIPPI	Y	Y	Y	Y
MISSOURI	Y	N	N	
MONTANA	Y	Y	Y	Y
NEBRASKA	Y	N	N	N
NEVADA	Y	N		
NEW HAMPSHIRE	Y	Y	Y	Y
NEW JERSEY	Y			
NEW MEXICO	Y			
NEW YORK	Y	N	N	Y
NORTH CAROLINA	N	n/a	n/a	n/a
NORTH DAKOTA	N	n/a	n/a	n/a
OHIO	Y	Y	Y	N
OKLAHOMA	Y	N	Y	N
OREGON	Y	N	N	N

PENNSYLVANIA	Y	Y	Y	Y
RHODE ISLAND	Y	Y	Y	Y
SOUTH CAROLINA	Y	N	N	N
SOUTH DAKOTA	N	n/a	n/a	n/a
TENNESSEE	Y			
TEXAS	Y			
UTAH	Y	N	N	N
VERMONT	Y	Y	Y	Y
VIRGINIA	Y			
WASHINGTON	Y	Y	Y	Y
WEST VIRGINIA	Y	Y	Y	Y
WISCONSIN	Y	Y	Y	Y
WYOMING	Y	N	N	N
RESPONSES		N-18/Y-18	N-13/Y-22	N-14/Y-21

3-24-09

#10

ND Medicaid Prior Authorization Fact Sheet

1. Prior Authorization process is a standard practice throughout all insurances
    a. Medicare Part D
    b. ND PERS
    c. Other State Medicaid programs
    d. Private insurance carriers such as BCBS, Aetna
2. Currently, 100% of prior authorization requests to ND Medicaid are answered within 24 hours
    a. Dec 2008 = 137 requests, 136 answered in < 8 hours
    b. Jan 2009 = 149 requests, 146 answered in < 8 hours
    c. Feb 2009 = 159 requests, 159 answered in < 8 hours
3. Reasons for Prior Authorization
    a. Cost Effectiveness
        i. If there are 6 drugs in a class, and all have been proven equally safe and equally effective, then and only then, cost comes into the equation.
        ii. If 5 of the drugs cost $4 per day, and 1 of the drugs costs $0.50 per day, and they are all equally safe and equally effective, than we ask that the $0.50 per day drug is tried first. If that doesn't work for that patient, then they could try any of the other 5 drugs.
    b. Safety
        i. The FDA may put limits on when a drug should be used. The limits can be complex, and can be forgotten. We may use the prior authorization process to ensure the limits are followed.
    c. Appropriateness
        i. Medications may be approved as second and third line treatments, only to be used when other medications haven't worked.
        ii. Medications may be approved only for certain disease subtypes.
        iii. Medications may be found to be detrimental for certain patient subtypes.
        iv. National guidelines may be written as a guide for appropriate use.
    d. Fraud avoidance
        i. Some medications have costs ($5,000 to $500,000 per month) that make them attractive to fraudulent providers.
        ii. It is only prudent and responsible to make sure claims are valid.
4. Physicians still decide what is used for their patients.
    a. Criteria for coverage checkboxes are included on forms.
    b. If physician has a different reason for asking for a specific drug, they can write in the reasons on the form.
5. Grandfathering process ensures patients continue receiving what they are currently receiving.
    a. The DUR Board has stated that if the medications covered under HB 1385 are subject to prior authorization, it would only apply to new medication starts. It would not apply to anyone currently receiving therapy.

Prior Authorization Results

1. Prior Authorization successfully drives utilization to the preferred product.
    a. New "green" formulation of albuterol inhalers
        i. Market share prior to prior authorization was 84% for more expensive albuterol inhaler.
        ii. Market share after prior authorization is 98% for preferred (less expensive) albuterol inhaler.
        iii. Savings to ND Medicaid of $100,000 per year (total dollars).
    b. Sleeping medications
        i. Ambien held 90% + of the market for years.
        ii. As Ambien was nearing the end of its patent protection, three alternatives were released.
        iii. Ambien market share dropped to 56%.
        iv. Prior authorization moved Ambien market share back to 83%.
        v. When generics subsequently came out changing the prices from $4.63 per day to $0.23 per day overnight, ND Medicaid was able to save immediately.
        vi. Savings of $700,000 since 2007.

DUR Board recommendations for HB 1385 Medications

1. Cancer
    a. Prior authorization to ensure proper utilization of the medications (e.g. third line agents shouldn't be used first line).
    b. Use third party insurance (e.g. ND PERS) as a guide.
2. HIV / AIDS
    a. No need for a law prohibiting prior authorization.
    b. No prior authorization at this time, and would only do so if physicians are prescribing outside of the state formulary (Dept. of Health AIDS Drug Assistance Program).
3. Depression
    a. Prior authorize brand name SSRI antidepressants.
    b. There are 8 SSRI antidepressants, and only two are brand name only (Prozac Weekly and Lexapro).
4. Anti-psychotics
    a. Prior authorize certain formulations of medications (dissolvable tablets, injections) to ensure they are only used when necessary since they cost more than the same dose of the normal tablets and capsules.
5. ADHD
    a. Would prior authorize one medication (Vyvanse) that is a follow-on to an existing medication that is losing its patent.
    b. Would prior authorize one medication that is formulated as a patch since the oral option is more cost effective.
6. Bipolar Disorder
    a. Did not have any recommendations.

#12

Lee, Judy E.

From: TIM HOLLAND [rxshop1@hotmail.com]
Sent: Wednesday, March 25, 2009 8:43 AM
To: Lee, Judy E.
Subject: p.a. nd medicaid

Judy

I though I would respond to our conversation last evening about ND MA and the prior authorization process.

I have always been of the opinion that Medicaid be handled in a similar manner as other insurances within the private sector. For years the Medicaid card was referred to as the "gold card", everything covered, no questions asked, the ultimate RX insurance. In recent years the process has become somewhat more restrictive on meds when comparable less expensive options are available. The patient still receives appropriate medication in a timely manner however the cost of that medication is now a factor as it is with other insurances. Quite frankly this process, whether involving Medicaid or any other insurance takes some of my time daily, however why should Medicaid be handled differently than other plans.

The patient is to receive the proper medication in a timely manner. If the doctor, pharmacist and medical staff work together the PA process works -- the state saves money the patient receives proper care.

Jon Holland

Lee, Judy E.

From: Sheri McMahon [dfmcmahon1@msn.com]
Sent: Tuesday, March 24, 2009 11:28 PM
To: Lee, Judy E.; Erbele, Robert S.; Dever, Dick D.; Heckaman, Joan M.; rmarcellias@nd.gov; Pomeroy, Jim R.; Robert S.Erbele - Vice Chairman rerbele@nd.gov; Dick Dever ddever@nd.gov; Joan Heckaman jheckaman@nd.gov; Richard Marcellais rmarcellias@nd.gov; Jim Pomeroy jpomeroy@nd.gov
Subject: HB 1385--do not pass

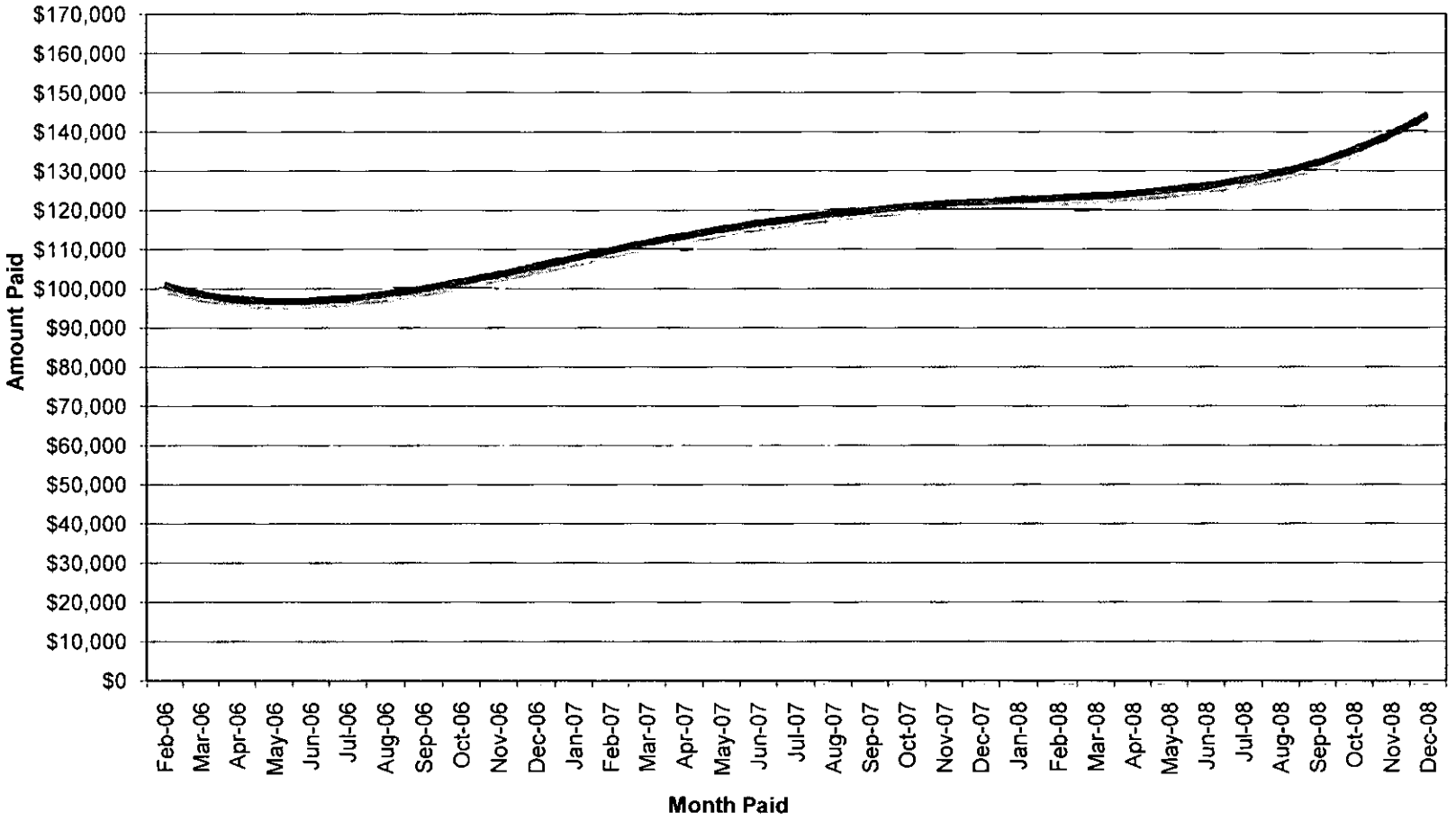
1. Marketing abuses by pharmaceutical companies do occur; one result is Eli Lilly's recent guilty plea to federal misdemeanor charges related to marketing Zyprexa ($1.4 billion settlement) along with litigation by 32 states whose Medicaid funds paid for Zyprexa. Zyprexa is a second-generation, or atypical, antipsychotic, or SGA; there have been issues with other SGAs made by other companies as well).
2. The newest drugs are not just costly, they are the least-known drugs, even in the absence of deceptive marketing practices. The link between SGAs and diabetes became apparent over time--but it took years for patient care recommendations to emerge, and those recommendations (monitoring blood sugar, weight, and girth for example) still do not seem to be standard practice.
3. My son spent two years in foster care; during that time I had no control over medication decisions. Before and after that period of time, my son had ongoing psychiatric care (he was diagnosed with a neurological disorder and associated psychiatric disorders in childhood), including medication--but our approach was cautious. In foster care, especially residential care, there was no caution. He received too many medications (5 psychiatric drugs at the same time, at doses that were too high (when I told her what he was receiving, our regular pharmacist said, "Yikes!"). His weight doubled (leading to other problems requiring additional prescriptions) and he was often too sedated to stay awake, let alone learn, in school. When he left residential treatment, several doctors had real concerns about the prescribing practices he had been subjected to.
4. A large federal study (CATIE) indicated that claims made about SGAs compared to older medications have been exaggerated.
5. A permanent psychiatric drug carve-out does not provide assurances for patient safety, especially for children, and lacks the nuances of discussion such as followed the CATIE study as to rational drug policy. We need to have a balance between access to effective medications and prescribing practices such as were used on my son. One approach to prescribing psychiatric drugs to children was presented by a Washington (state) physician at the November national conference of state Medicaid directors.

Suggestion: a sunset carve-out as before, with review of current research and practice recommendations to be done by the DUR board and presented to the committee during the interim session. This is a compromise between stepping either the brakes or the accelerator to the floor.

My opinion is contrary to that of many people I know involved with mental health advocacy. But I think we are too easily tempted to think of medication as the end-all and be-all of mental health treatment, while other essential components are too hard to come by. We can be vulnerable to inflated claims about the newest drug on the block. Science is certainly part of what the companies do--but so is marketing and promotion.

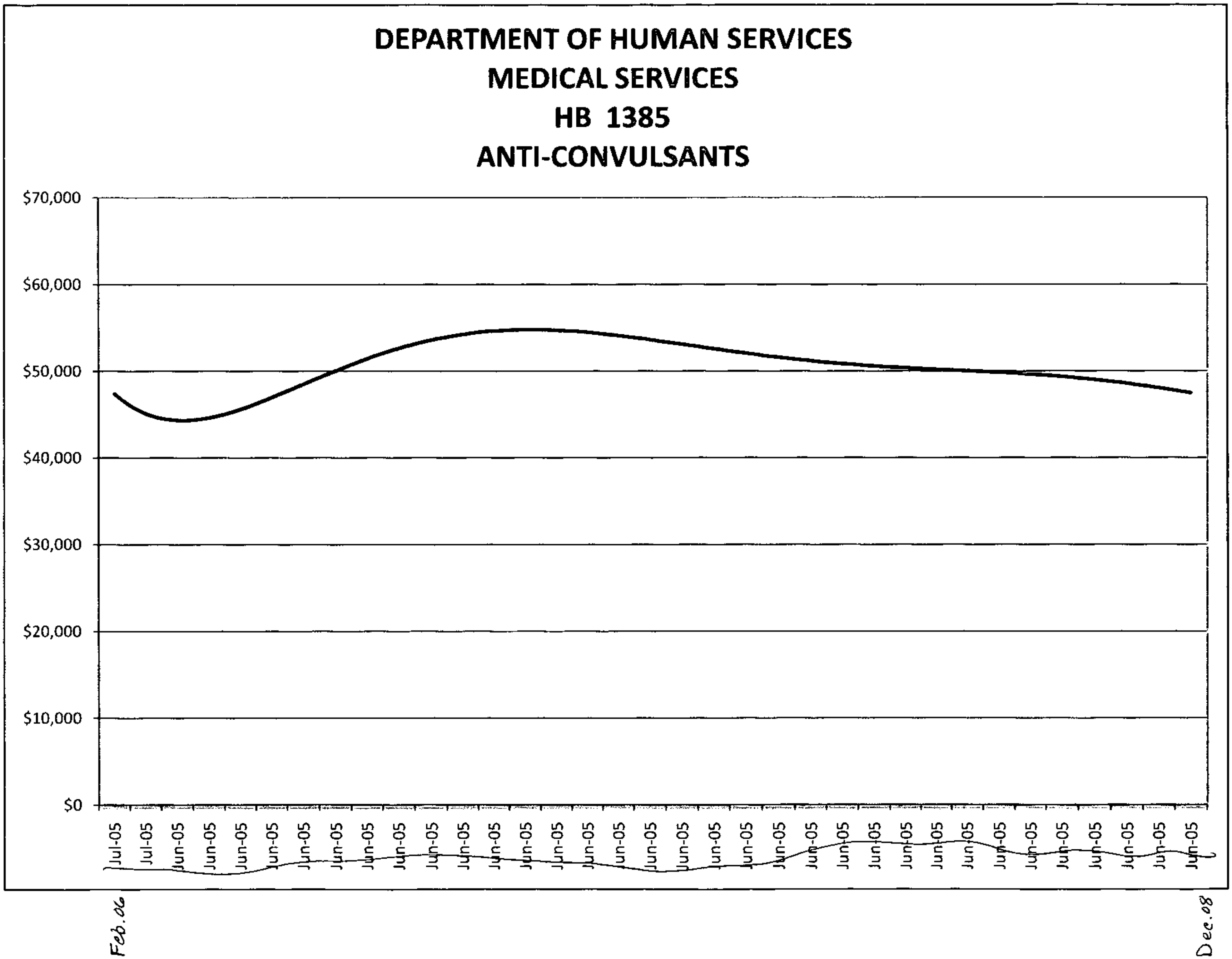
Sheri McMahon
717 7th Ave N
Fargo, ND 58102

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
HB 1385
STIMULANTS



Dr. Brendan Joyce
3-30-09

#13


DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
HB 1385
ANTI-CONVULSANTS
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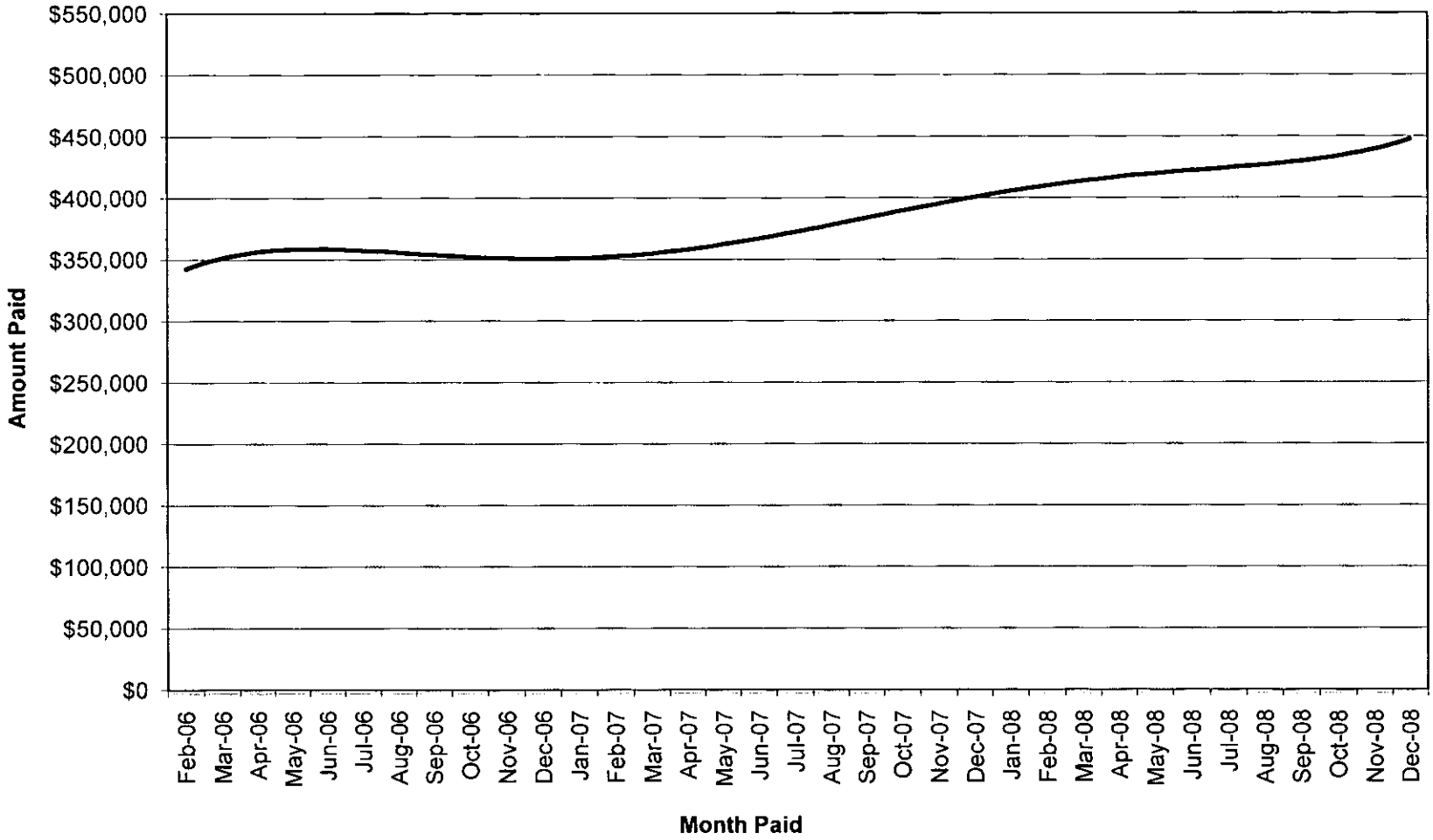
MEDICAL SERVICES
HB 1385
ANTIPSYCHOTICS



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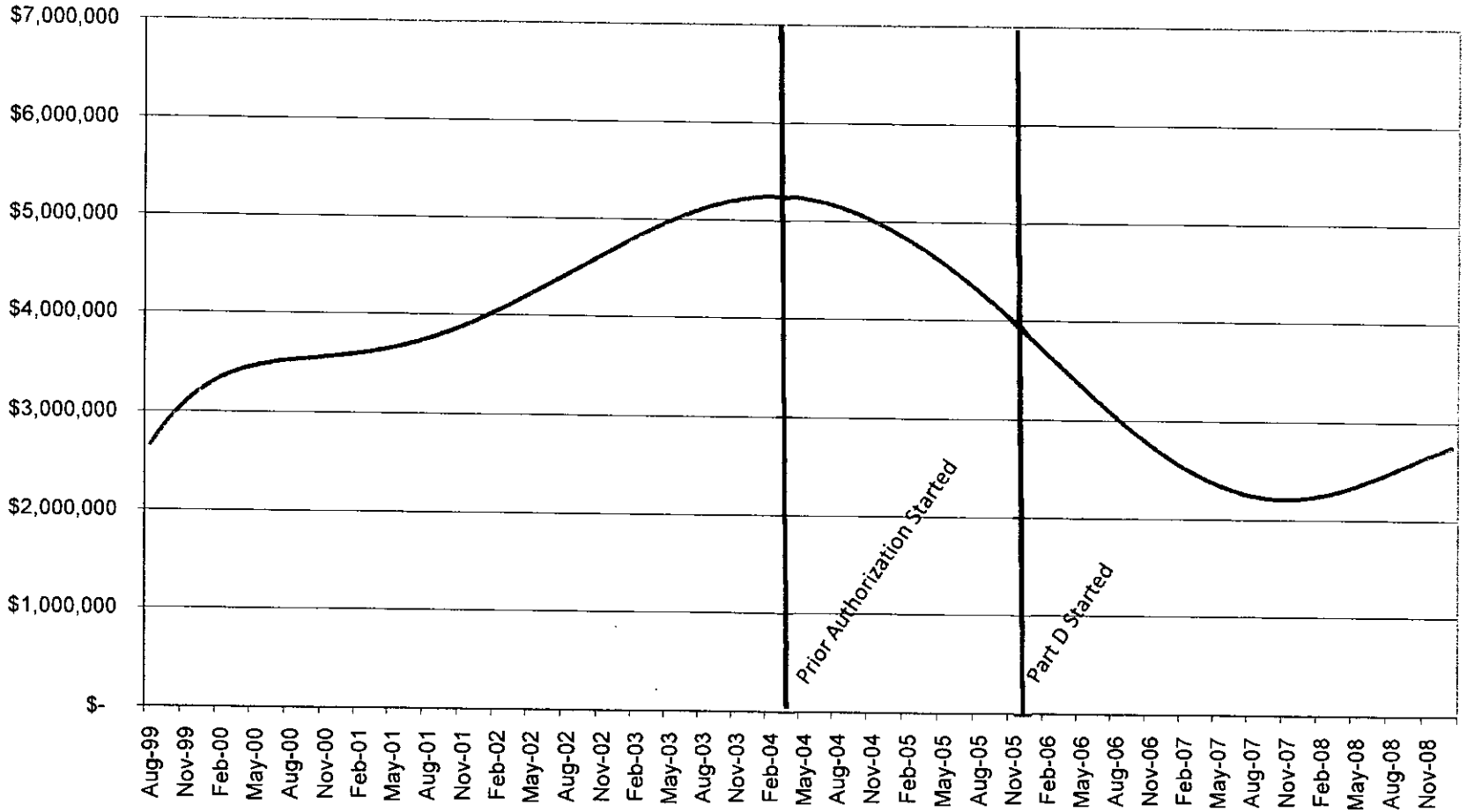
MEDICAL SERVICES
HB 1385
PAYMENT TO PHARMACIES - ALL DRUGS



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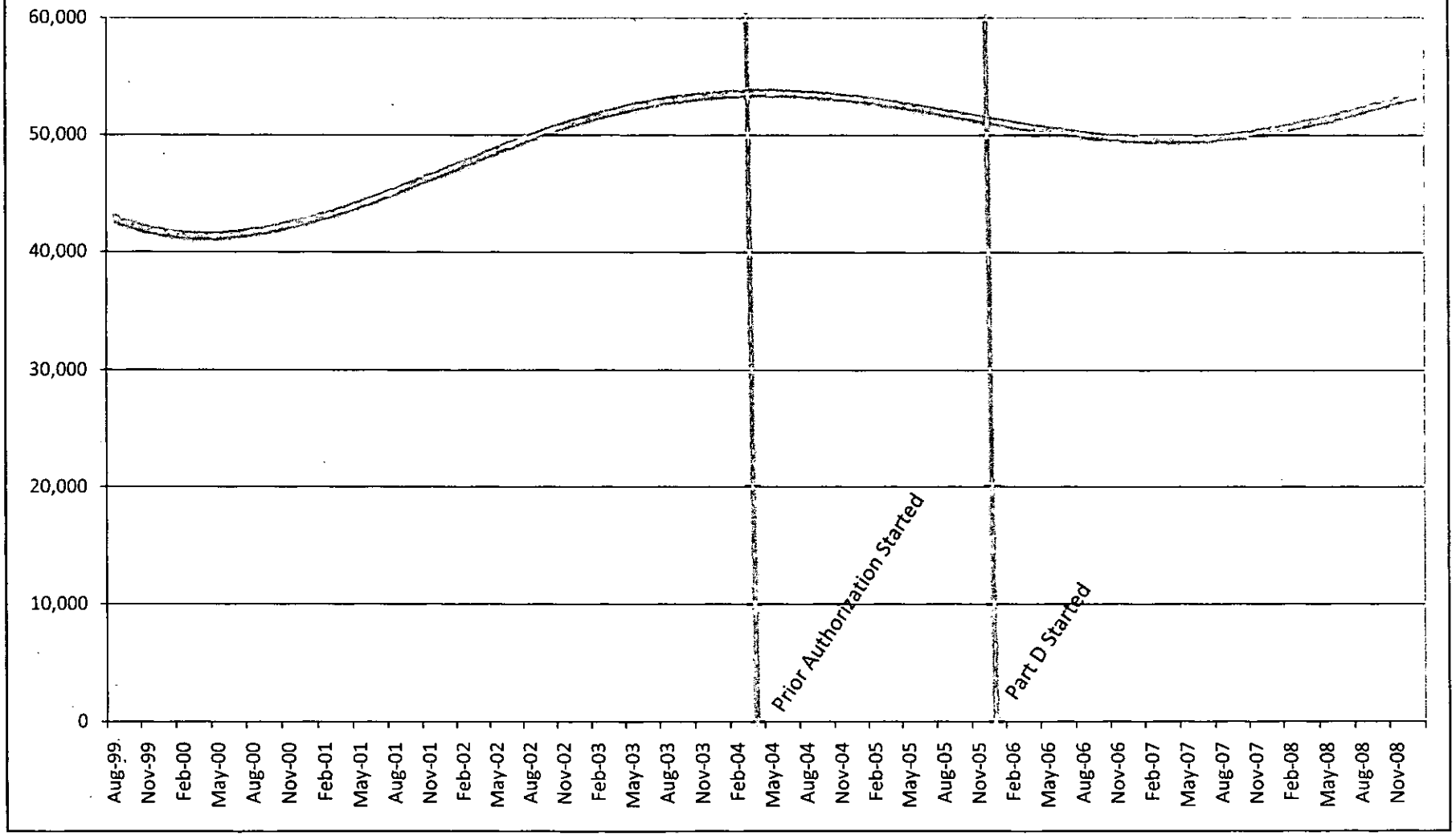
MEDICAL SERVICES
HB 1385
RECIPIENTS



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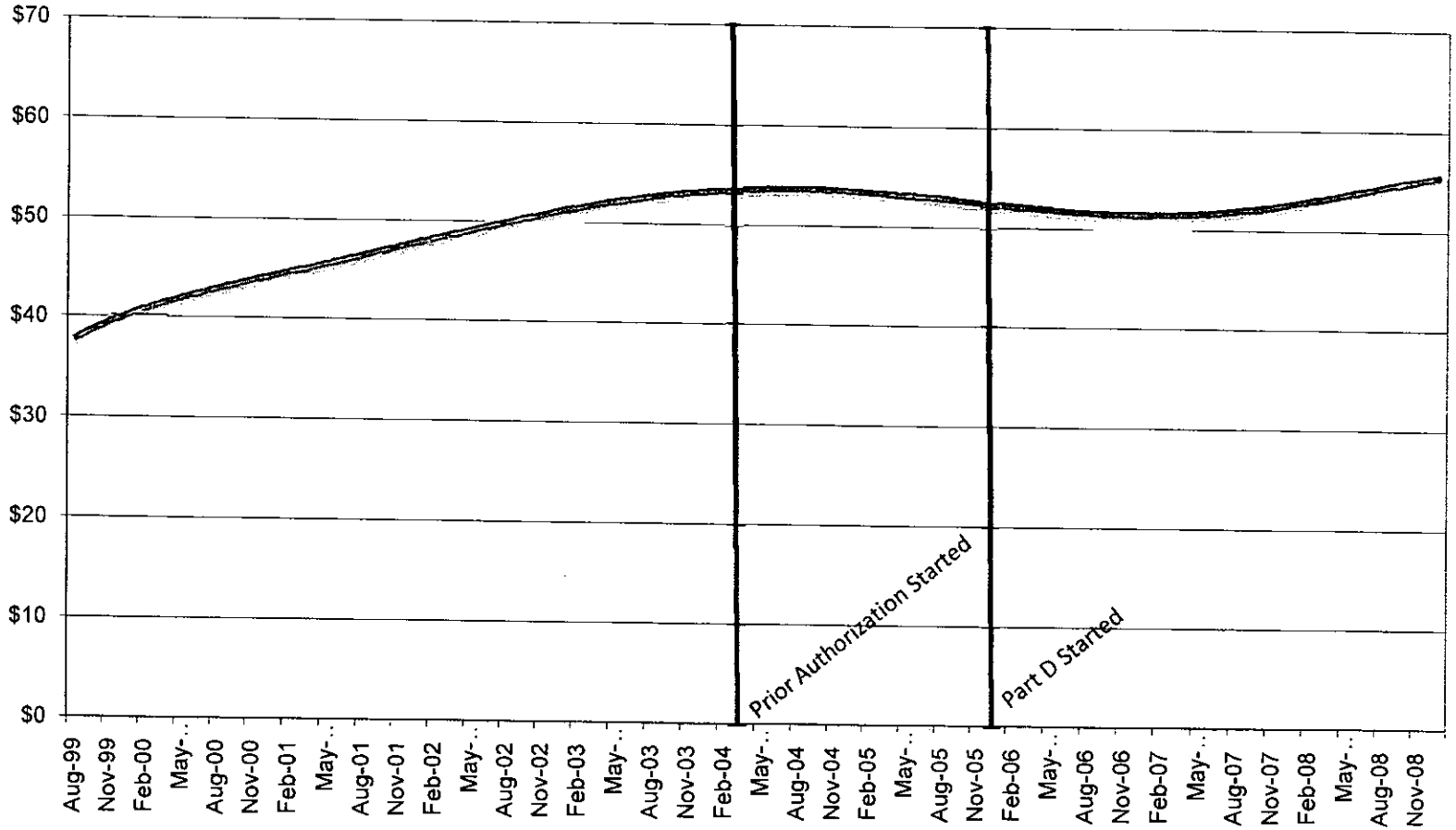
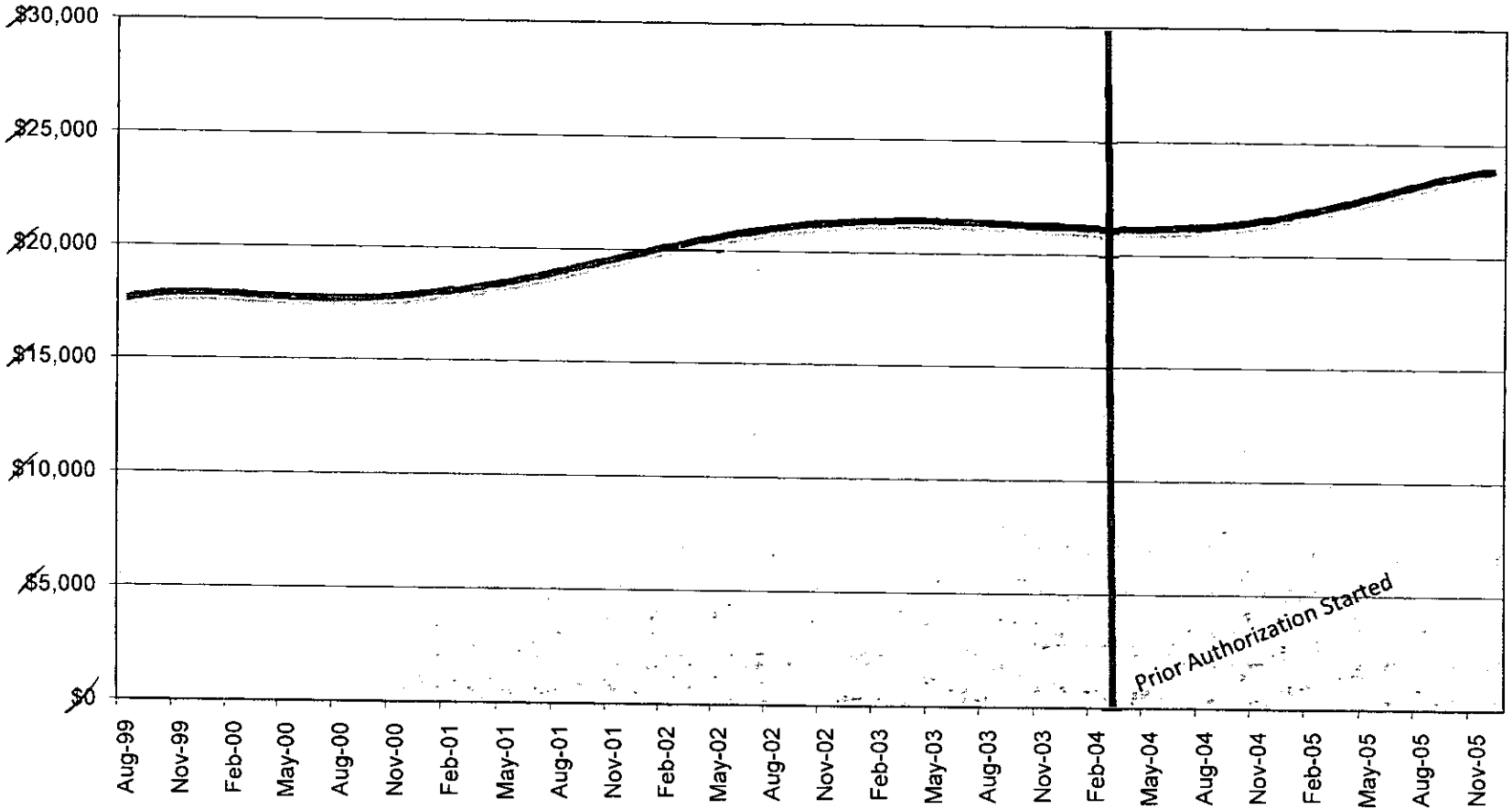
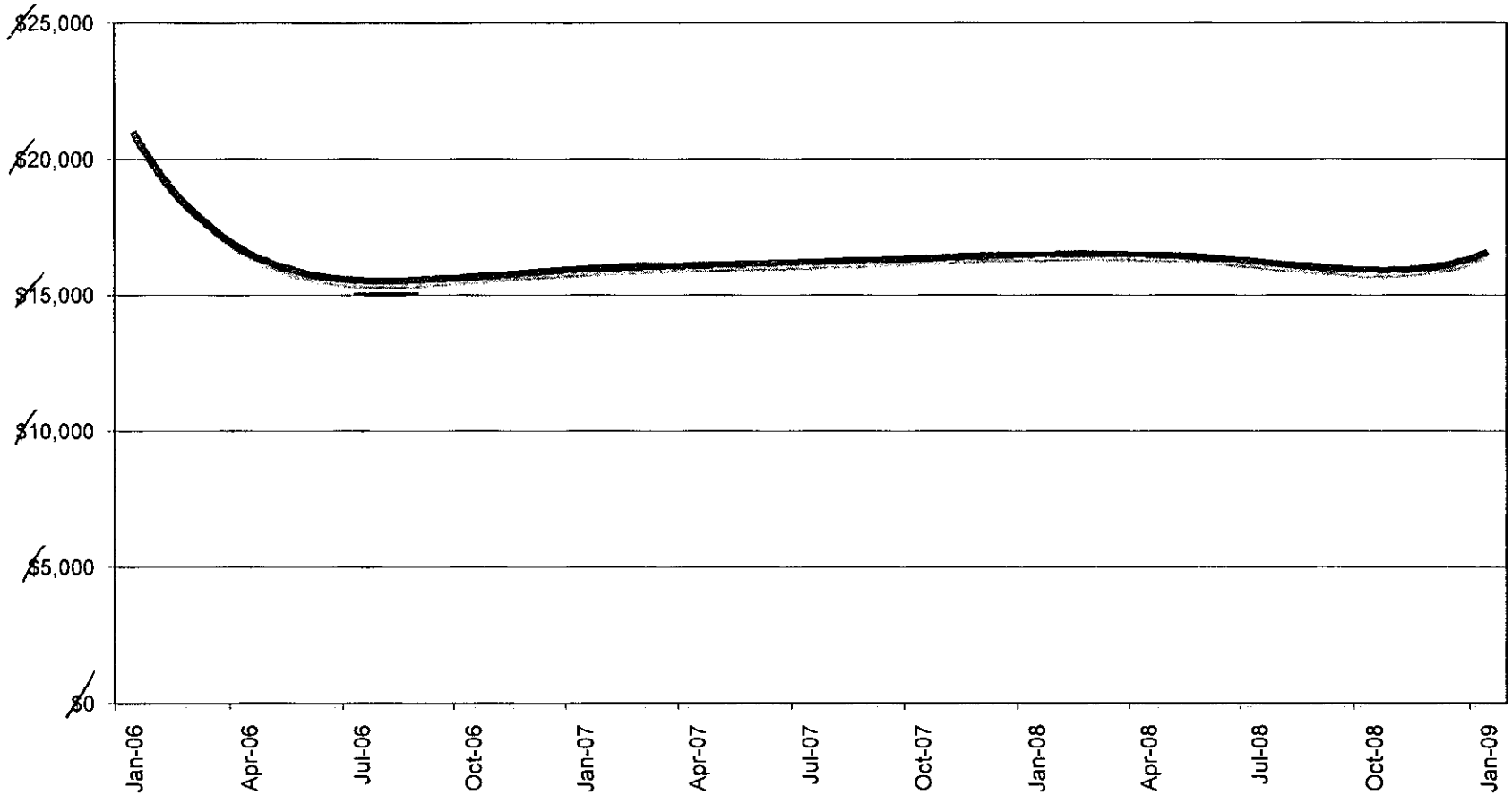
MEDICAL SERVICES
HB 1385
AVERAGE RX COST



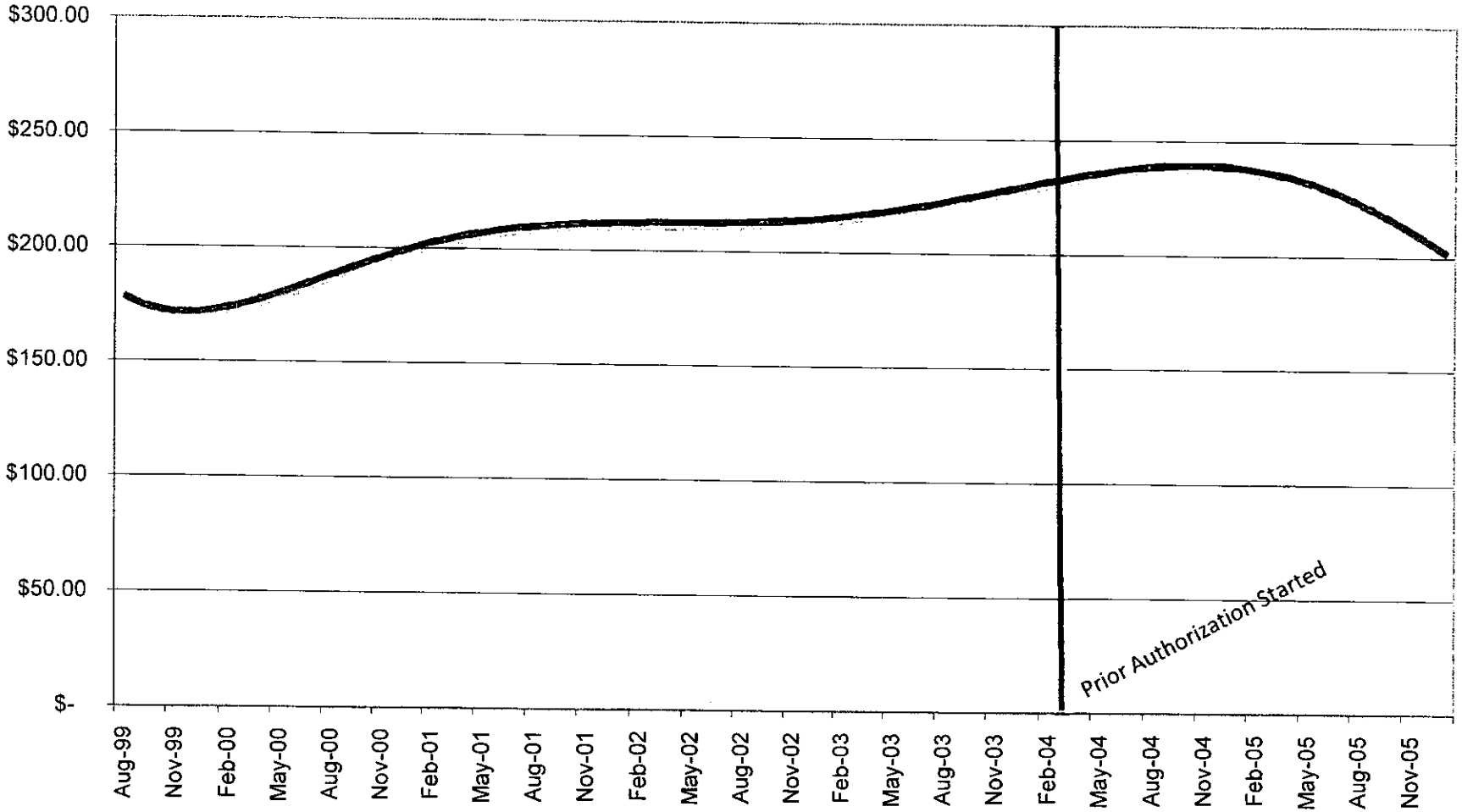
DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
HB 1385
UTILIZERS - PRE PART D



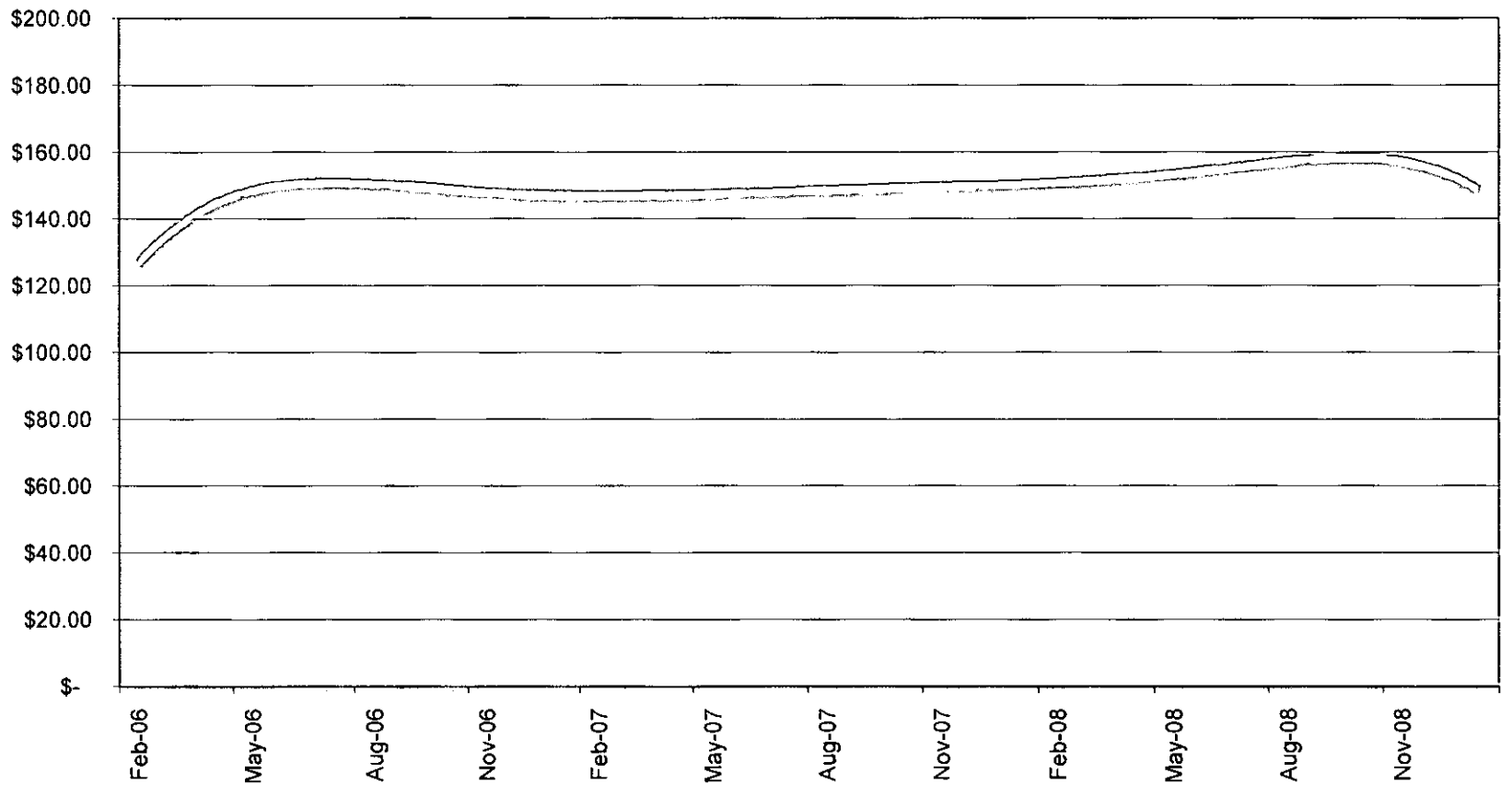
DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
HB 1385
UTILIZERS - POST PART D



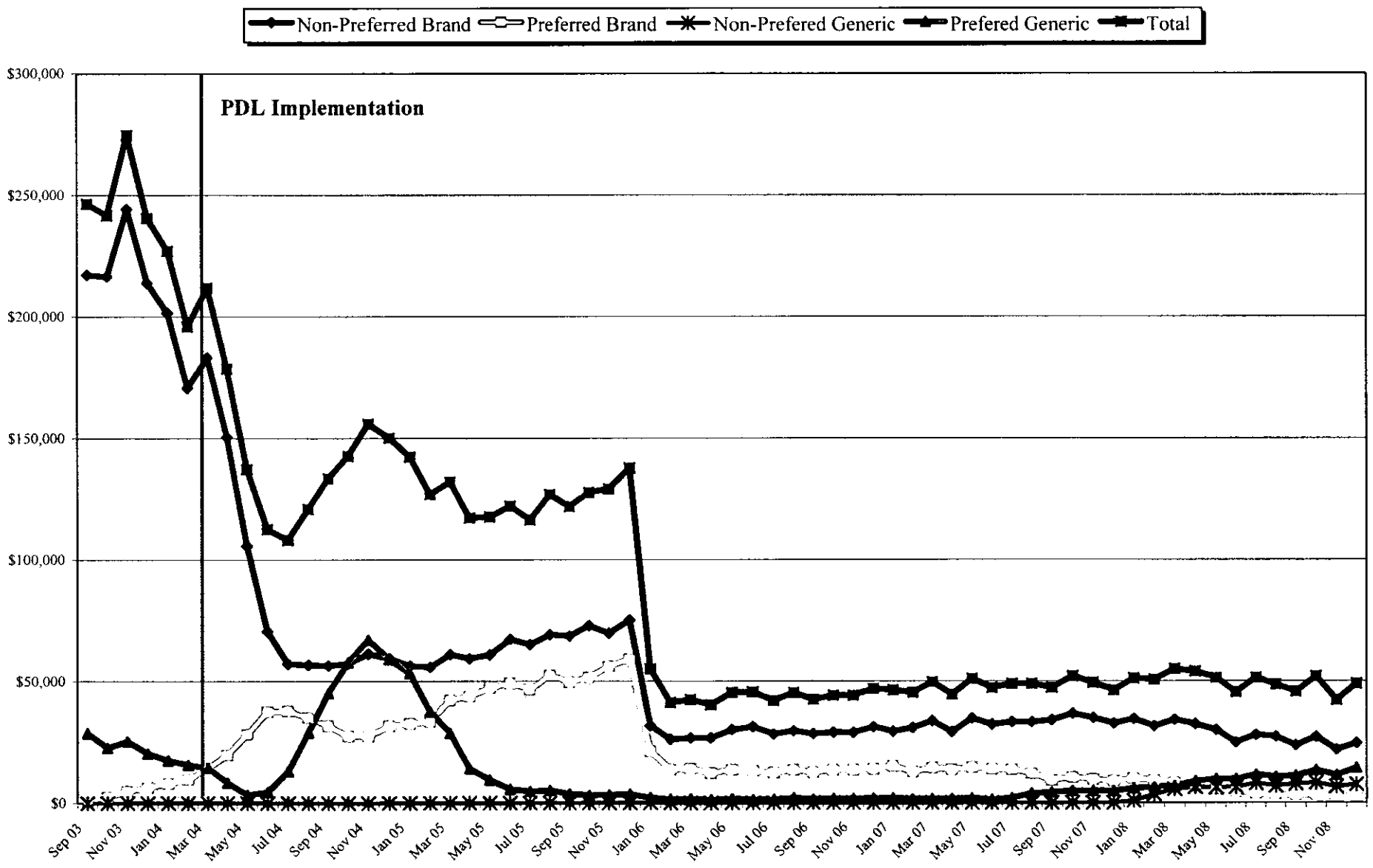
DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
HB 1385
PER UTILIZER PER MONTH - PRE PART D



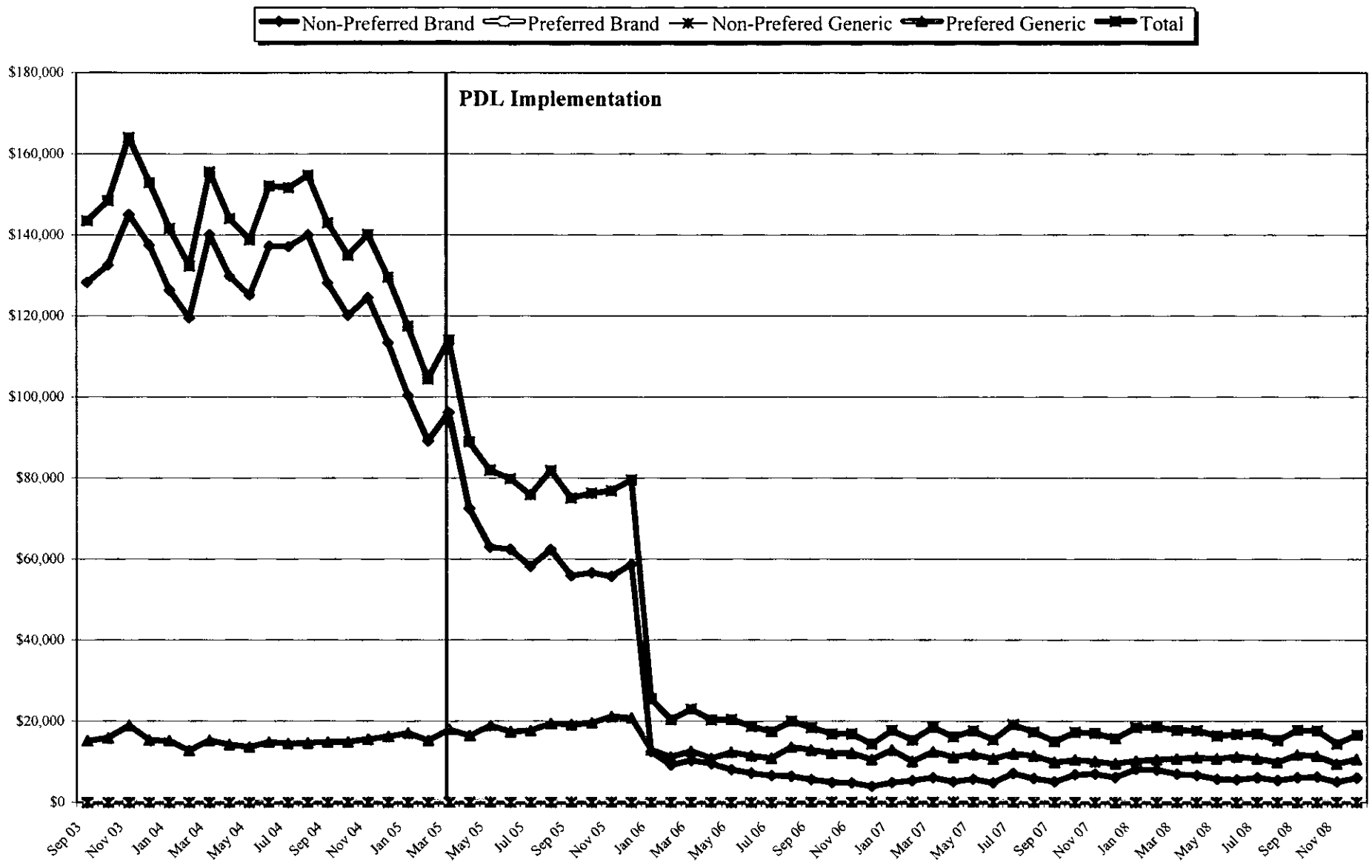
DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
HB 1385
PER UTILIZER PER MONTH - POST PART D

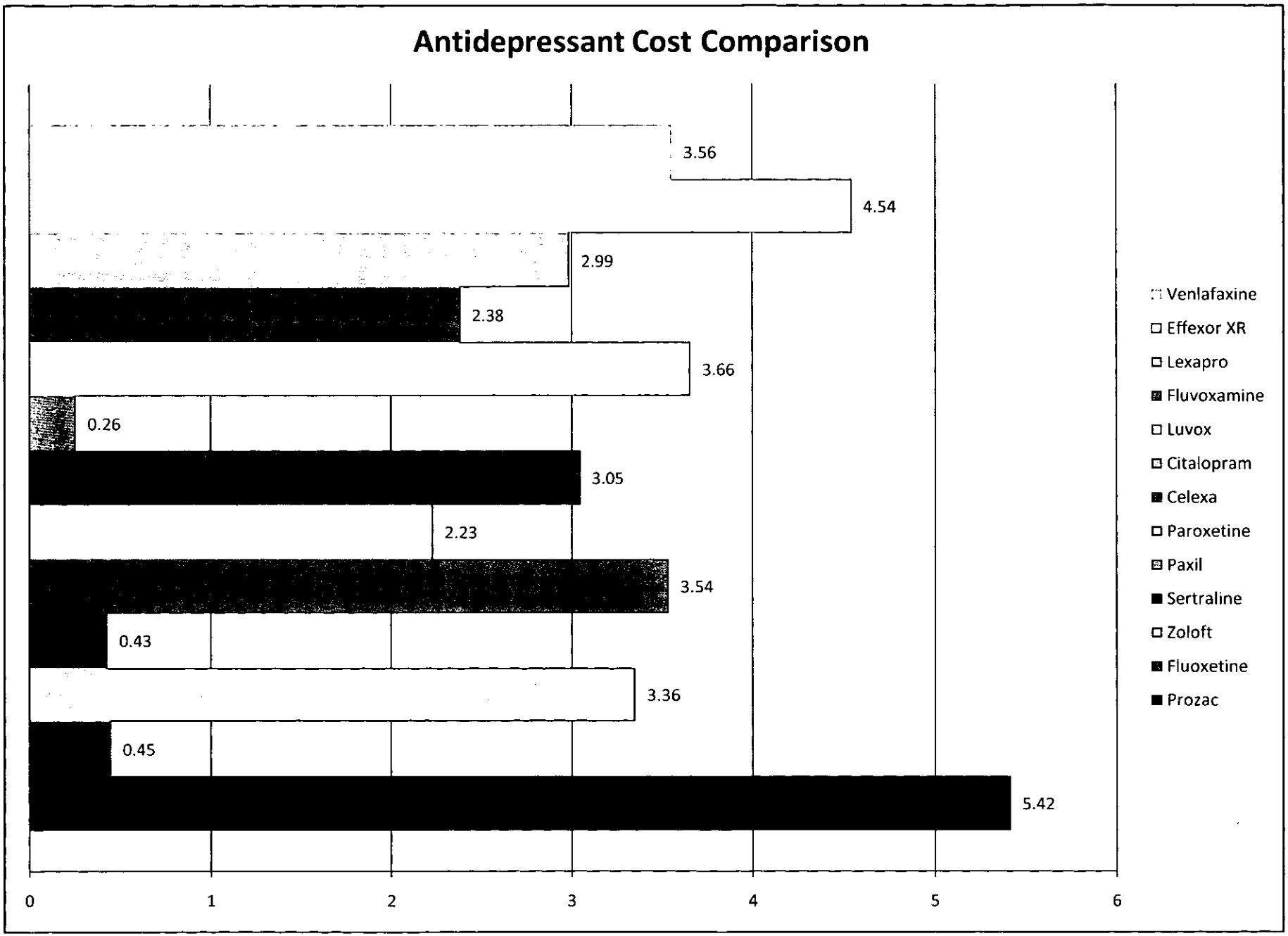


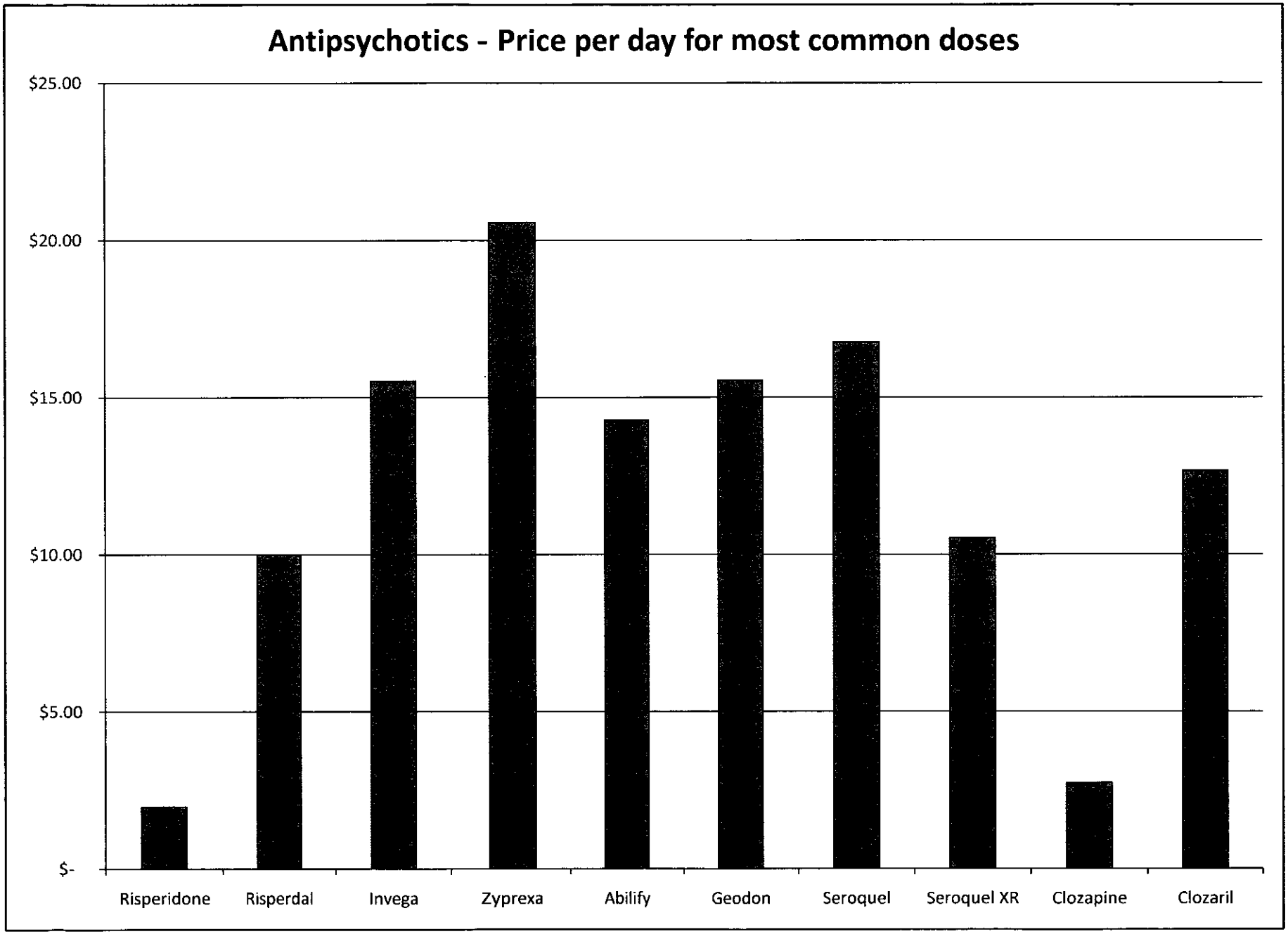
Proton Pump Inhibitors
Total Drug Costs by Month

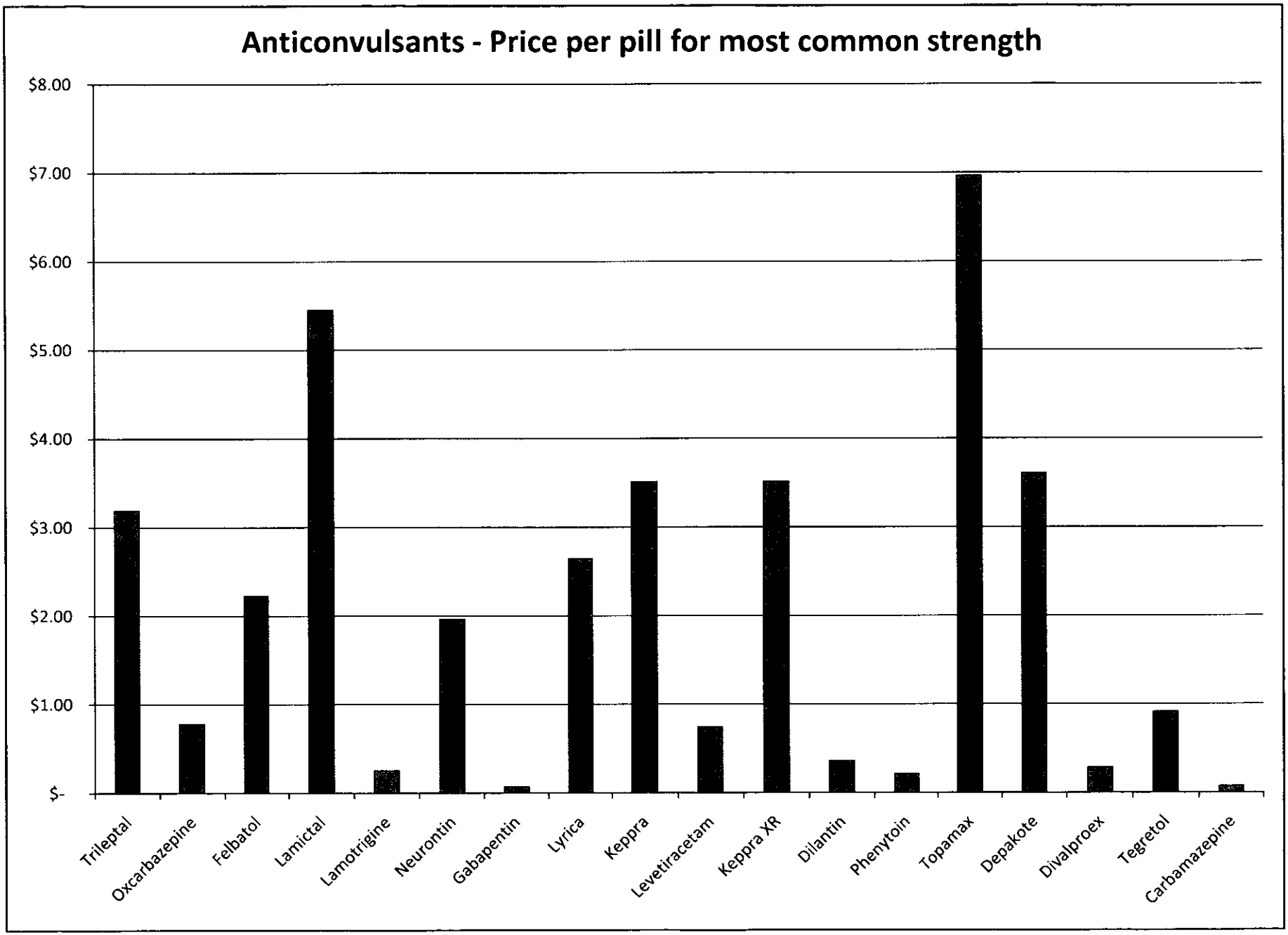


NSAIDS/COXII
Total Drug Costs by Month




Antidepressant Cost Comparison
3.56
4.54
2.99
2.38
3.66
0.26
3.05
2.23
3.54
0.43
3.36
0.45
5.42
0
1
2
3
4
5
6
Venlafaxine
Effexor XR
Lexapro
Fluvoxamine
Luvox
Citalopram
Celexa
Paroxetine
Paxil
Sertraline
Zoloft
Fluoxetine
Prozac


Antipsychotics - Price per day for most common doses
$25.00
$20.00
$15.00
$10.00
$5.00
$-
Risperidone
Risperdal
Invega
Zyprexa
Abilify
Geodon
Seroquel
Seroquel XR
Clozapine
Clozaril


Anticonvulsants - Price per pill for most common strength
$8.00
$7.00
$6.00
$5.00
$4.00
$3.00
$2.00
$1.00
$-
Trileptal
Oxcarbazepine
Felbatol
Lamictal
Lamotrigine
Neurontin
Gabapentin
Lyrica
Keppra
Levetiracetam
Keppra XR
Dilantin
Phenytoin
Topamax
Depakote
Divalproex
Tegretol
Carbamazepine

3-30-09

#14

Testimony for Human Service Committee
Wednesday, March 25th, 2009

Madam Chairman, Members of the Committee:

My name is Carrie Sorenson, PharmD. I am a clinical pharmacist and have served on the ND Medicaid DUR Board for the past 4 years and I am the current chair.

The 2007 Legislature, through House Bill No. 1422, asked the Drug Use Review (DUR) Board to review the utilization, effectiveness, and cost of the drugs identified in subsection 3 of section 50-24.6-04 and make recommendations for managing the utilization of the identified drugs or any other drugs for the conditions identified in that subsection. As stipulated in this subsection, the classes of drugs currently exempt from the Prior Authorization (PA) program include HIV/AIDS, Oncology, Attention Deficit/Hyperactivity Disorder (ADHD), Antidepressants, Antipsychotics, and Mood Stabilizers/Anticonvulsants.

The following is the Board's summary of proposed recommendations.

1. HIV/AIDS-An Infectious Disease Specialist was consulted and he reviewed current utilization data. His opinion was that ND Medicaid should not prior authorize any HIV/AIDS medication, but he did not believe that a law should exist to prohibit action in the future-specifically if a physician prescribed outside of the AIDS Drug Assistance Program (ADAP) guidelines. The DUR Board concurred with the Infectious Disease Specialist's opinion.

2. Oncology-DUR Board consulted with an Oncologist. The specialist stated that no law was needed to prevent antineoplastics from being placed on prior authorization as long as recommendations for PA come from the DUR Board and that the turnaround time for PA's also remained the same (98% reviewed in 8 hours or less and 100% in 24 hours). The DUR Board recommended that antineoplastics no longer be exempt from prior authorization and that the DUR Board be involved in the PA of certain agents using private insurance as a guideline.

3. Attention Deficit/Hyperactivity Disorder (ADHD)-A physician member commented that there is really nothing to predict one ADHD medication would work better than another; therefore trying the most cost effective agent first would be a very valid approach. Possibly step therapy could be incorporated. A psychiatrist board member made a motion for the Board to manage and review ADHD medications. DUR Board recommended removing the exemption for this class, prior authorizing Vyvanse after Adderall XR trial, and prior authorizing Daytrana.

4. Antidepressants-DUR Board recommended placing certain SSRI (Selective Serotonin Reuptake Inhibitor) medications on prior authorization and therefore removing the exemption for the antidepressant class of medications.

5. Antipsychotics-DUR Board recommended prior authorizing alternate dosage forms and Invega if the exemption was removed from this class of medications.

6. Anticonvulsants-DUR Board made no recommendation on the Anticonvulsant class of medications.

In conclusion: I would just like to close by making a few comments about the Prior authorization program. The purpose is to guide practitioners to prescribe efficacious medication that is the most cost effective to the state. Often these expensive medications are new formulations of older drugs to provide in essence, patent extensions to the company.

We are all aware that medications costs are rising at an alarming rate, and it is imperative that we identify rational ways to control drug expenditures. Antipsychotics, Mood Stabilizers/ Anticonvulsants, Antidepressants and ADHD medications are the **top four most costly** classes of medications (by cost) paid by ND Medicaid.

Contrary to what some people have been led to believe, this type of program does not mirror a closed formulary system, such as many hospitals and health insurance administrators have in place to control drug expenditures. These programs simply direct practitioners to the best choice for ND Medicaid recipients. A practitioner may not have any idea that the most expensive medication dispensed at a hospital where he/she practices may be the most cost-effective medication to a Medicaid patient. If there is a reason the practitioner wants a PA medication, he/she simply has to submit justification. The ND Medicaid PA program has a record of excellent turn around time of responding to requests (98% in 8 hours and 100% in 24 hours).

Please support the ND Medicaid DUR Board by allowing us to use sound judgment in providing Medicaid recipients the most cost effective medications and ultimately minimize the economic burden to our taxpayers.

HB 1385

#16

Minding th Detailers

drug in the pre- hysicians.

Drug companies spend $23 billion a year marketing pharmaceuticals to America's doctors. More and more states are challenging them.

BY JOHN BUNTIN

It's a gray Friday morning in Allentown, Pennsylvania. Kristin Nocco is in the parking lot of Primary Care Associates, putting on her game face. She's about to call on one of the biggest independent medical practices in the Lehigh Valley. The half-dozen clinicians who work there write thousands of drug prescriptions a year. That makes them prized clients among the region's drug reps, such as the well-dressed young man with the burgeoning suitcase headed out as Nocco walks in.

Today, Nocco has gotten permission to make a lunchtime pitch to the practice. She's ordered pizza and chicken salad. Her hope is that Dr. David Stein, the practice's founding partner, and his brother Scott, a physician assistant, will grab a slice of pie and listen to her talk for a few minutes about how to treat geriatric depression. With her quick, throaty laugh and outgoing personality, Nocco has all the moves of a salesperson who's spent years winning over doctors. And she has. Only now she's not promoting the latest blockbuster

ristin Nocco, a one-time Eli Lilly rep, now pitches impartiality the state of nnsylvania.

drug. Instead, she's working to counter the hype of drug-company marketing, for the state of Pennsylvania.

Last year, Pennsylvania spent $2.5 billion—about 10 percent of the total state budget—filling more than 40 million prescriptions for roughly 2 million residents. To drug reps, every prescription written represents a sale. Every day, thousands of drug reps—known in the business as "detailers"—are out hustling, dropping by practices large and small with coffee or donuts, handling out samples, bringing in lunch, making friends—friends that will hopefully translate into greater sales. Nocco used to be a drug rep herself—she started out at Eli Lilly back in 1992, fresh out of pharmacy school. Now, she has a different mission. Instead of pushing specific brand-name drugs, Nocco provides something that doctors don't get enough of these days: independent, evidence-based information on how best to treat complex medical conditions.

Nocco is what's called an "academic detailer." Pennsylvania has hired 10 other people like her—a sales team that seeks to balance Big Pharma's marketing blitz with more balanced information. The strategy, the state hopes, will improve health outcomes for patients and save the taxpayers money by encouraging doctors to avoid untested, expensive new medications. The small program is one part of a broad and controversial battle that a growing number of states are waging against drug marketing practices. Massachusetts, South Carolina and Washington, D.C., all have followed Pennsylvania's lead and hired academic detailers of their own. Minnesota and Vermont have passed laws requiring drug companies to disclose gifts they give to doctors. Meanwhile, Maine, New Hampshire and Vermont are embroiled in litigation over laws banning for-profit "health information organizations" from using data-mining tools to case individual physicians' prescribing habits for drug-company sales reps. The offensive, ironically, comes at a time when drug-price inflation is slowing. Yet drugs continue to attract policymakers' attention, for a variety of reasons. Drug prices are highly visible, particularly to people without insurance. Drug companies also consistently boast some of the highest rates of return on capital of any industry. Critics say their profits are based in part on high-pressure sales tactics that lead doctors to prescribe expensive brand-name medications when similar, generic alternatives would be safer and less expensive. The evidence of distorted prescribing patterns "is very clear cut," says Dr. Jerry Avorn, a professor at Harvard University's medical school who studies the use and effectiveness of prescription drugs. He blames the practice of detailing for much of the problem.

Are all those good-looking perky drug reps really so harmful? Nocco doesn't have time to reflect on that just now. She's worried about lunch.

"Has the pizza arrived?" she asks the woman behind the front desk.

It has. The receptionist waves her in, through the door marked "employees only." She greets Scott Stein, who's waiting for her in the kitchen, with a big smile.

90,000 Reps

The pharmaceutical industry spends about $23 billion a year marketing its products to America's doctors. The largest portion of that—about $15 billion—is spent on samples. About $7 billion goes to what are known as "direct-to-physicians" strategies, which include fielding a sales force of 90,000-odd drug reps. That works out to about one detailer for every five office-based physicians.

According to critics such as Avorn, the drug industry's reliance on detailers has several negative side effects. It encourages doctors to prescribe costly, patented drugs when a generic would work equally well. Detailing also encourages physicians to write scripts for new medications that "don't have the track record for effectiveness and safety that some of the old drugs have." The result, says Avorn, is higher prices and worse outcomes.

Not surprisingly, the drug industry rejects this critique. Marjorie Powell, senior assistant general counsel to the trade association PhRMA, argues that drug reps play a valuable role in educating doctors on the most up-to-date information about new treatments. She sees no evidence for the claim espoused by "at least some state legislators" who "seem to think their doctors can't be trusted to get information from pharmaceutical representatives without being sort of hoodwinked into prescribing a drug that's not appropriate."

Doctors themselves have a more ambiguous view of the situation. Surveys show that most physicians give themselves high marks for personal integrity. One study of medical residents found that 61 percent believed they were not influenced by free lunches, handouts and other forms of pharmaceutical company marketing. However, doctors weren't so confident about the morals of their colleagues. Only 16 percent believed that other doctors were immune to drug-company blandishments.

Researchers who have studied gift-giving say there are good reasons to be concerned.

> Some state legislators "seem to think their doctors can't be trusted to get information from pharmaceutical representatives without being sort of hoodwinked."
>
> **– Marjorie Powell, senior assistant general counsel for PhRMA**

Arthur Caplan, who directs the Center for Bioethics at the University of Pennsylvania, says that even small gifts, regularly given, can influence behavior. When it comes to doctors, he says, that's problematic. "You expect doctors to make objective decisions based on the evidence," notes Caplan. "If I bring you a box of donuts every week, you start feeling positive."

It's costly, too. In 2004, the prestigious *Journal of the American Medical Association* published a study by Avorn that examined how doctors were prescribing hypertension drugs for the elderly. It found that doctors could have reduced total spending on hypertension drugs by $1 billion, or 10 percent, by adhering more closely to evidence-based guidelines. Given the fact that Americans spend more than $300 billion per year on prescription drugs, it's clear that even small reductions in unnecessary prescribing would generate huge savings. That's prompted a growing number of states to take aim at direct-to-physician marketing. And it's led them to some interesting fights.

"One of My Targets"

In mid-2005, New Hampshire state Representative Cindy Rosenwald began to explore a strange phenomenon that her husband, a psychologist, had brought to her attention. When drug reps came to his office, he told her, they seemed to know a lot about what he was prescribing. Once, a drug rep told Dr. Rosenwald that he was "one of my targets." Dr. Rosenwald was disturbed. When he related the conversation to his wife, she remembered reading a newspaper article about the practice of "physician profiling." She decided to look into the matter.

At first, Rosenwald found only wisps of information about how drug reps profiled doctors for their marketing efforts. However, conversations she had with a hospital pharmacist and the head of the state pharmacy board led her to believe that drug companies were engaging in data mining that allowed them to see what drugs individual physicians were prescribing. The more she looked into it, the more convinced she became that drug companies were "manipulating prescribing" by using practices that were "not in the best interest of the public." The New Hampshire Medical Society agreed. So Rosenwald introduced legislation that would bar pharmacies from selling prescribing information to outside vendors. She admits that she had no idea how her bill would be received.

"There was so little information available that I didn't know what would happen at the public hearing," Rosenwald says. "I didn't know if the pharmaceutical companies or anybody would come in and basically say, 'She's imagined the whole thing. We really don't do this.'"

That's not what happened. Instead, a Connecticut-based company called IMS showed up at the legislature to testify against the proposal. "I had never really heard of it," Rosenwald says of IMS. The company, she learned, had $2 billion a year in revenue, 80 percent of which came from the drug industry. By aggregating prescription data purchased from pharmacies with physician masterfile data purchased from the American Medical Association, IMS was able to identify and track the prescribing patterns of individual doctors. Pharmaceutical companies, in turn, paid IMS for that information in order to put it in the hands of their detailers, allowing them to hone their pitches to doctors. One recent study estimated that physician profiling adds about 3 percent to drug-company profit margins.

Rosenwald's legislation was designed to disrupt that business. Less effective marketing, she believed, would reduce the pressure on physicians to write inappropriate or unnecessary scripts. The New Hamsphire legislature passed the bill easily, despite heavy lobbying against it. Legislatures in Vermont and Maine promptly followed suit, passing their own bans on prescription data mining.

To IMS, New Hampshire's law represented an existential threat. The company filed suit, asking federal courts in both Maine and New Hampshire to overturn those states' laws as violations of the company's First Amendment free speech rights. IMS won both cases, prompting the attorney general in Vermont to suspend enforcement of its law, too. New Hampshire appealed. In November, the First Circuit Court of Appeals reversed course and upheld the prohibition on prescription data mining. The door now seems open for other states to pursue similar bans, should they so choose.

Opponents of data-mining bans include the American Medical Association, which earns $44 million a year—16 percent of its annual budget—by selling companies like IMS access to its database. The AMA argues that legislation such as Rosenwald's is no longer necessary. In 2006, the AMA created a voluntary program that allows doctors who are uncomfortable with physician profiling to opt out of having their data sold. Since then, only 18,000 physicians (out of roughly 750,000

JOHN BUNTIN

licensed physicians nationwide) have taken advantage of that opportunity. The AMA sees this lackluster response as evidence that doctors aren't very worried about having their prescribing habits revealed.

Supporters of the bans read the low opt-out number differently. They see it as nothing more than a sign that the average doctor is too busy to bother filling out the paperwork. That's ironic, in a way, because the fact that doctors are so busy is precisely the reason why drug companies spend so much money trying to get face-to-face with them through detailers. And it's why states such as Pennsylvania have decided to push back with detailers of their own.

Academic Detailing

Several years ago, Tom Snedden, the head of Pennsylvania's prescription-assistance program, or PACE, started to talk with Harvard's Avorn about an unusual idea. For years, Avorn had done epidemiological research using PACE data. But Snedden also knew that Avorn had a longstanding interest in pharmaceutical marketing. In the early 1980s, Avorn had proposed that governments try a new way of communicating with physicians that borrowed a page from the drug industry.

The idea was to hire informed, independent consultants who could visit physicians and provide them with academic research about how best to treat complex conditions. Avorn called the idea "academic detailing." Since then, countries such as Australia and Canada had followed through on the idea. Studies in those countries had shown that every dollar spent on academic detailing yielded savings of as much as two dollars in avoided expense. But the idea had never been tried on a large scale in the United States. Snedden and Avorn thought that PACE should try it in Pennsylvania. Governor Ed Rendell quickly agreed, and Harvard set out to train 11 detailers to work for the state.

PACE's claims data gave the state its own trove of information about how doctors were prescribing. Insurance companies and the firms who manage their pharmacy benefits routinely mine similar data in order to determine which doctors might be misprescribing drugs or writing expensive scripts in what they deem as excessive numbers. However, Snedden and Avorn decided early on not to simply target "bad" doctors.

"The first questions a doctor asks when our people come in, besides 'Who really sent you?' and, 'Is this a drug company front?' is, 'Why me?'" says Avorn. "It's a lot better to be able to say, 'Because you see a lot of PACE patients,' rather than, 'I know you're using too much Crestor.'"

Snedden and Avorn also decided against focusing merely on cutting costs and pushing generics.

"Doctors don't want the cost-cutting message," says Michelle Spetman, who runs the nonprofit that trains Pennsylvania's detailers. "They're not so concerned about what the state is paying as they are about Patient Jones... If we had started purely with a message about saving money, they'd say, 'I know why you're here, I'm not interested.'"

The pharmaceutical industry is a major force in Pennsylvania. No other state has more drug-industry jobs. So Snedden was careful about how he introduced the academic detailing initiative. Instead of presenting it as a way to counter drug-company marketing, he described it as a way to promote better medical care by disseminating evidence-based best practices—nothing more, nothing less. Harvard Medical School would be responsible for developing "modules," or presentations summarizing the latest research on how to treat conditions such as diabetes in elderly patients. In hiring academic detailers to present the modules, Avorn and Snedden decided to hire only nurses or pharmacists. That used to be the norm in the pharmaceutical field, too, until the mid-1990s,

ree drug samples make up $15 billion of Big Pharma's
arketing tab. Dr. David Stein says those samples "make
difference in the lives of my patients."

ıen drug companies realized that hiring ractive, extroverted young people, many th backgrounds in athletics or cheer- ıding, made for more effective market- ʒ. The state soon learned just how deeply trenched these hiring practices had be- me. Some of the résumés submitted for ² academic detailing positions came with adshots—glossy photos that emphasized ² candidates' good looks.

Kristin Nocco was one of the people who plied. She'd started her career at Eli Lilly, st as a general drug rep, later as a detailer · specialized cancer drugs. She loved the m and the work. Eventually, however, she cided to get her MBA. She then moved on a job at an ad company, many of whose ents were drug companies. But she ssed sales (and the flexible hours). So ıen an opportunity arose to work as a de- ler for the state, she leapt at it. "I liked the a of evidence-based information that was n-commercial," says Nocco.

As an academic detailer, Nocco occupies interesting space in the marketplace. ce traditional drug reps, she depends on r people skills. Office managers must be ıoed, doctors chatted up. Physicians ini- lly seemed wary of her requests for ap- intments with them. They warmed up ıen they realized she was pushing knowl- ge, not products. Nocco's colleagues have perienced the same thing. "There's been out 1,100 unique doctor visits," says edden. "I don't think there's been one ıo didn't like it. And it's not because 're taking them to Broadway plays."

Ve're Being Treated ke Whores.'

Primary Care Associates in Allentown, ıcco is talking with Dr. David Stein, his ıther Scott and a few other staff mem- ·s about treating depression in the eld- y. The conversation is fast-paced and ghly technical. It covers Paxil's with- ıwal effects; problems with Pristiq; and 15-point geriatric depression scale ver- the five-point scale. Asked afterward if this is typical of most drug reps' presentations, one of the physicians in the room just laughs. "Usually, they talk about home life, what's going on at school," he says. Most conversations, he adds, end with the reps asking, "Is there anything I can do for you?"

Every doctor in the room knows that the gifts and minor-key friendships that develop are all geared toward selling drugs. But Dr. Stein and his brother don't really have a problem with that.

"It was stupid to send people to ball games and things like that," says Dr. Stein. But he and his colleagues believe that recent attempts to crack down on handouts such as drug samples and gifts go too far. Drug companies donate lavishly to politicians, he notes. They also donate lavishly to academic medical centers, which set guidelines for the profession as a whole. Why are trinkets for doctors such as him the problem?

"The government is saying that you can have a license to prescribe narcotics, but we can't trust you with gifts of pens and paper," says Stein, shaking his head. "That's the way we're being treated... The best term I can use is we're being treated like whores."

"Pharmacy companies are not the tobacco companies," he continues. "They are not evil. They are not bad people. The reps are not trying to offer me sexual favors, cars, money, cash. They come in, they do their job, we're professional with each other. I appreciate the fact that the samples they leave me make a difference in the lives of my patients."

As for being profiled, Dr. Stein doesn't particularly like it. But he hasn't taken up the AMA on its opt-out offer, either. A visit to the practice's drug sample pantry suggests why. Along one wall, bins stacked from the floor to the ceiling form picturesque towers of multi-colored drug samples. When a physician needs a sample to give to a patient, it's right there. And the drug companies always seem to know just what they need.

As Nocco checks out the sample room, a raven-haired, rosy-cheeked rep from Schering-Plough pokes her head in.

"Restocking!" she says brightly, as she shovels a handful of samples into a bin and then ducks out. Moments later, Dr. Stein hauls her back in.

"This Christmas," he tells her with a heavy dose of sarcasm, "I would definitely like the new Mercedes, please."

John Buntin can be reached at
jbuntin@governing.com

3-30-09

Marcellais, Richard

From: Doug Demontigny [dougd@pmc-rolla.com]
Sent: Wednesday, March 25, 2009 12:30 PM
To: Marcellais, Richard
Subject: hb1385

Hi Senator Marcellais

The hospital situation I'm currently in is not usually impacted by prior authorization issues. I have made observations when I worked in retail however. It appears that the prior authorization program for Medicaide is finance driven first and patient care driven second. While I understand the need to use less expensive medications where possible the prior authorization program should no be used as a deterrent.The patient's prescription needs are best determined by the physician, not the insurer.The list of medications requiring paperwork from the pharmacy and the prescriber is ever increasing. My recommendation is to leave prescribing in the hands of physicians and not in the hands of insurers.

As Always
Doug

NDLA, S HMS

From: Lee, Judy E.
Sent: Thursday, March 19, 2009 11:34 AM
To: NDLA, S HMS
Subject: FW: DUR Board chair availability

Mary –
Let's plan to discuss 1385 at 3 p.m. on Wednesday, March 25.

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
home phone: 701-282-6512
e-mail: jlee@nd.gov

From: Joyce, Brendan
Sent: Thursday, March 19, 2009 11:24 AM
To: Lee, Judy E.
Cc: Sorenson, Carrie; Anderson, Maggie D.; Olson, Carol K.
Subject: RE: DUR Board chair availability

Sen. Lee,

She would be fine with Wednesday afternoon (March 25th) after 3 pm.

[redacted]dan K. Joyce, PharmD
Administrator, Pharmacy Services
ND Medicaid
Phone: 701-328-4023
Fax: 701-328-1544

***New e-mail address ***
bjoyce@nd.gov

From: Sorenson, Carrie [mailto:Csorenson@primecare.org]
Sent: Thursday, March 19, 2009 11:20 AM
To: Joyce, Brendan
Subject: RE: DUR Board chair availability

Wednesday afternoon.

-----Original Message-----
From: Joyce, Brendan [mailto:bjoyce@nd.gov]
Sent: Thursday, March 19, 2009 8:34 AM
To: Sorenson, Carrie
Subject: FW: DUR Board chair availability

Carrie,

[redacted] What is your preference?

Brendan K. Joyce, PharmD
Administrator, Pharmacy Services
ND Medicaid
Phone: 701-328-4023
Fax: 701-328-1544

***New e-mail address ***
bjoyce@nd.gov

From: Lee, Judy E.
Sent: Wednesday, March 18, 2009 6:14 PM
To: Joyce, Brendan
Subject: RE: DUR Board chair availability

Tuesday or Wednesday would work, probably no earlier than 3 p.m., depending on how long we are in floor session. We have no hearings on Tuesday or Wednesday, so if one of those morning would be better for her, that could also work.

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
home phone: 701-282-6512
e-mail: jlee@nd.gov

From: Joyce, Brendan
Sent: Wednesday, March 18, 2009 10:39 AM
To: Lee, Judy E.
Cc: Olson, Carol K.; Sorenson, Carrie; Anderson, Maggie D.
Subject: RE: DUR Board chair availability

Sen. Lee,

Carrie Sorenson, doctor of pharmacy from St. A's, is the current DUR Board chair. She is available for your committee as listed below.

Brendan K. Joyce, PharmD
Administrator, Pharmacy Services
ND Medicaid
Phone: 701-328-4023
Fax: 701-328-1544

***New e-mail address ***
bjoyce@nd.gov

From: Joyce, Brendan
Sent: Wednesday, March 18, 2009 9:55 AM
To: Anderson, Maggie D.
Cc: Sorenson, Carrie
Subject: DUR Board chair availability

Carrie is available next week (week of March 23rd) for Sen. Lee's committee as follows:

Monday afternoon is ok
Tuesday after 1:30 pm
Wed after 1:30
Thursday afternoon is ok

Brendan K. Joyce, PharmD
Administrator, Pharmacy Services
ND Medicaid
Phone: 701-328-4023
Fax: 701-328-1544

***New e-mail address ***
bjoyce@nd.gov