AARP Montana

SENATE FINANCE AND CLAIMS
EXHIBIT NO. 2
DATE 3-3-05
BILL NO. SB 324

Pay premium for folks to get deduct pd then they go onto part D.
Rx + if you don't have any other prog.

March 3, 2005

Senator Mike Cooney, Chair
Senate Finance Committee
Montana State Capitol
Helena, Montana

Testimony in Support of SB 324, The Affordable Prescription Drug Act

Mr. Chairman and members of the committee, my name is Claudia Clifford, advocacy consultant for AARP Montana and its 143,000 members in this state. I am here today because 85% of our members said in a survey prior to the session that "access to affordable prescription drugs is a top legislative priority, second only to "affordable, quality health care".

Paying for prescription drugs is a kitchen table crisis in Montana.
In an AARP survey of all Montanans over the age of eighteen, 66% of those taking prescription drugs regularly found that paying for prescriptions is a financial burden. In Montana today it is estimated that low income households spend 1/3 of their income on health care, including medicine. If you are living solely on social security (less than $900/month) that doesn't leave much for heating bills, groceries, transportation, property taxes or rent, phone and other necessities.

Twenty-five percent of our members said clearly in a survey that they cut corners to be able to afford medicines. They admitted to not filling scripts, delaying filling prescriptions, taking less medicine, ordering from another country and cutting back on necessities.

Rx can prevent more expensive health care, if consumers can afford their scripts.
Health care practitioners will tell you that today's prescription drugs can help prevent more costly care. Think about all medicine prescribed for high blood pressure, high cholesterol, and diabetes, to name a few. With this legislation you have an opportunity to help low-income and uninsured Montanans pay for medicine that could be a real cost saver in the future. You also have the opportunity to help patients who are take multiple prescriptions receive consultation from pharmacists on cost effective ways to save money and avoid harmful drug interactions. Finally, this bill will provide more educational resources to consumers and health care providers on independent research about the safety and effectiveness of drugs.

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Let me quickly step you through the bill and the handouts in your packet.

Section 1) is designed to help Medicare recipients access the federal prescription drug program so the federal government will pay most of their bills for medicine through the new Medicare Part D benefit. Page 5. of the pamphlet "Medicare Changes That Could Affect You" is a basic description of how Part D will work. SB 324 sets up Rx Access to help Medicare eligible people under 200% of the federal poverty level (FPL) by paying the premium for this coverage. If more funds are available, the program can help enrollees cover the cost of their deductible. These folks will still need to cover the co-pays, and coverage gap, known as the "donut hole".

The federal government is subsidizing the Part D benefit for people under 135% FPL, but this cut off level is too low. A couple at 150% FPL has an income of only $18,735 a year ($1,560/ month) to cover all the necessities. CMS data indicates that Medicare beneficiaries with incomes up to 150% FPL will have drug costs of $4,359 in 2006. Couples with incomes between 150% and 200% FPL are estimated to have drug costs of $3,300 a year per person. A couple at 200% FPL is estimated to spend 26% of their income on medicine if we don't help them access Part D. With Rx Access, the state pays $420 monthly premiums and the federal government will help pay a portion of their drug costs, about $3,000. It's a decent deal to ensure that these people have access to medicines. This is a way we can help prevent people from spending their last savings and ending up on Medicaid.

Section 2) Allows for the administration of Rx Access and asks the department to report back to the next legislature on the status of prescription drug use and costs in Montana. We believe that regular evaluation of state Rx models is essential to take advantage of new consumer pharmacy strategies.

Although section 3) is short, it does a lot to allow the department to educate consumers and providers on the prudent use of prescription drugs. First, it asks that the department to set up a program for consultations by local pharmacists with patients of all ages on how to avoid dangerous drug interactions and substitute more cost-effective drugs. This part of the bill takes advantage of the expertise and caring nature of our local pharmacists. AARP is very impressed with Wyoming's PharmAssist program (see handout) and strongly encourages the department to use this as a model for fulfilling this intent of this section.

In addition, section 3) makes use of evidence-based research to educate consumers and medical practitioners. DPHHS is working on a contract with Oregon Health Research Commission, a highly respected, independent research center on the efficacy and safety of drugs. Evidence-based research (EBR) looks at what the world's scientific literature tells us about the relative effectiveness of particular drugs for treating particular conditions. The bill provides for a website and other educational materials to make use of the Oregon information. Montana will be the 15th state to join Oregon Health

Research Commission. You have in your packet an example of educational materials used in Oregon to help people make better drug purchasing decisions.

Section 4. through the end of the bill amends current law passed last session setting up Healthy Montana, a Medicaid expansion discount card program. Unfortunately, CMS decided not to approve any Medicaid pharmacy waivers so the program was not put in place. This bill sets up a discount card program divorced from the need for a Medicaid waiver and renames it Rx Plus. Rx Plus programs are successfully running in Maine, Vermont, Hawaii, Rhode Island, and District of Columbia. Legislation is pending in Nebraska and Idaho. I refer you to the chart in your packet for a basic explanation of Rx Plus. This program only needs start up funds and will be self-sufficient from the rebate funds. The department has the option to start up the Rx Plus program with unspent funds from Rx Access.

The pharmaceutical companies may tell you that the Rx Plus discount cards are not necessary as they plan to provide discount cards. You need to ask them which drugs will be covered by their cards and will generic drugs be included. My guess is that their cards will not cover as many drugs as Medicaid and will not cover many generics. My final response to this is "more cards the merrier". The uninsured will be the one's to benefit.

<u>What this bill is not:</u>
This bill does not include price controls as some my lead you to believe. It simply uses market approaches used by most insurance companies to direct consumers to cost conscious, clinically effective medicine. It allows the state to bargain like insurers do for rebates from pharmaceutical companies, so our uninsureds don't have to pay full retail for prescriptions. It encourages Montana to participate in multi–state arrangements to get the advantage of being part of a larger pool. This is all part of today's free market of pharmaceuticals.

Finally, I want to conclude with information about a study that came out last week published in *Health Affairs*. It reported that half of all bankruptcies in the US are caused by soaring medical bills, and most people sent into debt by illness are middle-class workers with health insurance. The Ohio University and Harvard University study estimated that medical bankruptcies affect about 2 million Americans annually. This is a significant problem! Please pass this bill to help people access the prescription drugs that restore their health and prevent the very costly care that causes bankruptcy.

Thank you for the opportunity to speak on this comprehensive bill for Affordable Prescription Drugs.