COMMITTEE REPORT

HOUSE

(11)

FURTHER:

3/27/85

Date: 4-27-85

The Committee on FINANCE has had HB 209

"An Act relating to pharmaceutical medical assistance for needy persons; and providing for an effective date."

under consideration and recommends:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[X] replace with CS for HB 209 (Finance) [ ] same title [X] new title

and recommends no recommendations

[ ] AND attaches a "Letter of Intent" [X] New Fiscal Note [ ] Zero Fiscal Note Attached

[ ] reports it back without recommendation

[ ] referred to the ______ Committee

MEMBERS SIGNING DO PASS

MEMBERS HAVING OTHER RECOMMENDATIONS:

CHAIRMAN

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Revision Date:

REQUEST

Bill/Resolution No.: CSHB 209(Fin)

Title: Act relating to Pharmaceutical Med. Assistance for needy persons

Sponsor: Rules Committee

Requestor: House Finance Committee

Date of Request: 4/27/85

FISCAL DETAIL

Agency Affected: Health & Social Services

Program Category Affected: Social Economic Assistance for the General Population

BRU, Program or Subprogram(s) Affected: Medical Assistance

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		25.0	0	0	0	0
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS		1450.0	1537.0	1629.0	1727.0	1830.0
800 MISCELLANEOUS						
TOTAL OPERATING		1475.0	1537.0	1629.0	1727.0	1830.0
CAPITAL						
REVENUE		1475.0	1537.0	1629.0	1727.0	1830.0

FUNDING: (Thousands of Dollars)

GENERAL FUND		325.0	318.0	337.0	357.0	378.0
FEDERAL FUNDS		1150.0	1219.0	1292.0	1370.0	1452.0
OTHER						
TOTAL		1475.0	1537.0	1629.0	1727.0	1830.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

AJA

Prepared By: Al Adams, Chair Phone: 465-3706

Division: House Finance Committee Date: 4/27/85

Approved by Commissioner: Date:

Agency:

Distribution (by Agency preparing fiscal note):

Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

7/1/84

ANALYSIS

"An Act relating to pharmaceutical medical assistance for needy persons"

Fiscal impact is in three parts: 1) added federal revenue earned by moving prescribed drugs under Medicaid; 2) increased state funds needed to pay pharmacists above the Medicaid price as required by Section 5 if permitted by federal law; and 3) increased state funds to modify the department's data processing system to effect the payment requirements of Section 5. This would be a one-time expense.

FY 86 Governor Request

Added Federal Revenues

	GF	TOTAL
General Relief Medical	10,769.1	10,769.1
Remove Pharmacy	(1,100.0)	(1,000.0)
GRM Balance	9,669.1	9,669.1

	FED	GFM	I.A.	TOTAL
Medicaid	32,909.5	33,696.5	633.3	67,239.3
Add Pharmacy	1,150.0	1,100.0	-0-	2,250.0
Medicaid Balance	34,059.5	34,496.5	633.3	69,489.3

With a move of prescription drugs from General Relief Medical Component to Medicaid component, Medicaid funds would become available at a 50/50 ratio. However, attendant to the federal funds would come mandatory federal regulations defining which pharmaceuticals are allowable and the prices to be paid for each.

6% is assumed as annual inflation for prescription drugs.

This fiscal note replaces the fiscal note dated 2/13/85 which shows overall program savings. This fiscal note reflects budget changes needed to the Governor's proposed FY 86 budget and does not show the $1,400.0 state G.F. savings already incorporated into the Governor's G.R. Medical budget.

Increased State Expenditures Related to Section 5.:

If the department were to pay pharmacists at their usual and customary price rather than the Medicaid allowable price, the difference in total prescribed drug payments could be $300.0 annually. None of this added expense would be federally reimburseable. This $300.0 is not included in the Governor's FY 86 budget request. The Senate version of the FY 86 budget already contains this $300.0 special fund. The House budget does not.

System Modification Expenses:

The Department's data system is presently capable of processing pharmacy billings using federal Medicaid pricing rules. If the provisions of Section 5 were to be adopted, the department's data system would require modification to compute the state only payments required in addition to the Medicaid payments. This is a one-time system change. This price, $25,000, is a "best guess" pending detailed analysis of the actual effort required to effect this change.

Original sponsor: Rules/Governor

IN THE HOUSE BY THE FINANCE COMMITTEE

CS FOR HOUSE BILL NO. 209 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to substitution of generic drugs by pharmacists; adding pharmaceuticals to the Medicaid program; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.80.295(a) is amended to read:

(a) Unless the prescriber expressly states that a prescription is to be dispensed only as written [EXCEPT AS LIMITED BY (b) AND (c) OF THIS SECTION, WITH THE CONSENT OF THE PURCHASER], the pharmacist may substitute a drug product with the same generic name in the same strength, quantity, dose and dosage form as the prescription, provided the substitute drug [PRESCRIBED DRUG WHICH] is, in the pharmacist's professional opinion, therapeutically equivalent and meets the standards of (g) of this section. The [UPON SUBSTITUTION THE] pharmacist shall notify the purchaser [AND THE PERSON WHO PRESCRIBED THE DRUG] of the substitution, and shall record on the prescription and keep a record of the name and manufacturer of the drug substituted.

* Sec. 2. AS 08.80.295 is amended by adding new subsections to read:

(i) A pharmacist who substitutes a drug in compliance with this section incurs no greater liability in filling the prescription by dispensing the equivalent drug product than would be incurred in filling the prescription by dispensing the prescribed brand name drug.

(j) Every pharmacy shall post a sign in a location easily seen by patrons at the counter where prescriptions are dispensed stating that "Under Alaska law a therapeutically equivalent but less expensive

drug may, in some cases, be substituted for the drug prescribed by your doctor. Please consult your pharmacist or physician." The printing on the sign shall be in block letters not less than one inch in height.

* Sec. 3. AS 47.07.030 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services, <u>prescribed drugs,</u> and reasonable transportation to and from the point of medical care. Additional services may not be provided unless approved by the legislature.

* Sec. 4. AS 47.07.035 is amended to read:

Sec. 47.07.035. PRIORITY OF SERVICES. If the funding in a fiscal year is inadequate to finance the total medical assistance program under this chapter, the department shall, to the extent that federal law and funding permits, provide medical assistance in the following order:

(1) aged, blind, or disabled persons who

(A) do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because

they do not meet income and resources requirements; and

(B) are eligible to receive an optional state supplementary payment;

(2) persons in a medical or intermediate care facility

(A) whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act); and

(B) who would not be eligible for an optional state supplementary payment if they left the facility;

(3) persons under 21 years of age

(A) who are under the supervision of the department;

(B) whose maintenance is paid in whole or in part from public funds; and

(C) who are in foster homes or private child-care institutions;

(4) persons under 21 years of age who

(A) receive treatment in a psychiatric hospital; and

(B) are financially eligible as determined by the standards of 42 U.S.C. 601 - 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);

(5) persons under 21 years of age who are

(A) in an institution designated by the department as an intermediate care facility for the mentally retarded; and

(B) financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) women who are pregnant;

(7) persons under 21 years of age who do not qualify for

benefits under the federal aid to families with dependent children program because they are not dependent children;

(8) intermediate nursing home services;

(9) prescribed drugs;

(10) eye examinations by an ophthalmologist or optometrist; or eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist;

(11) [(10)] treatment of speech, hearing, or language disorders;

(12) [(11)] physical or occupational therapy;

(13) [(12)] care at an intermediate care facility for the mentally retarded;

(14) [(13)] care at an inpatient psychiatric facility;

(15) [(14)] community mental health clinic services;

(16) [(15)] surgical care center services;

(17) [(16)] nurse midwife services;

(18) [(17)] medical supplies and equipment;

(19) [(18)] long-term care noninstitutional services.

* Sec. 5. AS 47.07 is amended by adding a new section to read:

Sec. 47.07.200. PAYMENT FOR PRESCRIBED DRUGS. Payment to a pharmacist for that portion of prescribed drug expenses reimbursable under Medicaid shall be made in accordance with 42 C.F.R. 447.331, 447.332, 447.333, and 447.334. If permitted under federal law,

(1) the payment to a pharmacist for prescribed drugs shall be made in accordance with a formula based on the usual and customary charges for those drugs; and

(2) an amount equal to the usual and customary charges for the drugs minus the portion of the drug expenses reimbursable under Medicaid shall be paid from state general relief medical funds.

* Sec. 6. AS 47.07.900 is amended by adding a new paragraph to read:

(7) "prescribed drugs" has the meaning given in 42 CFR 440.120.

* Sec. 7. AS 47.07.030 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services, [PRESCRIBED DRUGS,] and reasonable transportation to and from the point of medical care. Additional services may not be provided unless approved by the legislature.

* Sec. 8. AS 08.80.295(b), (c), and (f) are repealed.

* Sec. 9. AS 47.07.035(9), 47.07.200, and 47.07.900(7) are repealed.

* Sec. 10. Sections 1 - 6 and 8 of this Act take effect October 1, 1985.

* Sec. 11. Sections 7 and 9 of this Act take effect July 1, 1987.

STATE OF ALASKA 1985 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: 2/25/85

REQUEST
Bill/Resolution No.: HB 209
Title: An Act relating to Pharmaceutical Med. Asst. for needy persons
Sponsor: Rules Committee
Requestor:
Date of Request: 2/19/85

FISCAL DETAIL
Agency Affected: Health & Social Services
Program Category Affected: Social Economic Assistance for the General Population
BRU, Program or Subprogram(s) Affected: Medical Assistance

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS		1,150.0	1,219.0	1,292.0	1,370.0	1,452.0
800 MISCELLANEOUS						
TOTAL OPERATING		1,150.0	1,219.0	1,292.0	1,370.0	1,452.0
CAPITAL						
REVENUE		1,150.0	1,219.0	1,292.0	1,370.0	1,452.0

FUNDING: (Thousands of Dollars)

GENERAL FUND		-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS		1,150.0	1,219.0	1,292.0	1,370.0	1,452.0
OTHER						
TOTAL		1,150.0	1,219.0	1,292.0	1,370.0	1,452.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

SEE ATTACHED ANALYSIS

Prepared By: Rod Betit, Director **Phone:** 465-3
Division: Medical Assistance **Date:** 2/25/85

Approved by Commissioner: **Date:** 2/28/85 jcc
Agency: Health & Social Services

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget

ANALYSIS

"An Act relating to pharmaceutical medical assistance for needy persons"

FY86 Governor Request

	GF	TOTAL
General Relief Medical	10,769.1	10,769.1
Remove Pharmacy	[1,100.0]	[1,000.0]
GRM Balance	9,669.1	9,669.1

	FED	GFM	I.A.	TOTAL
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Add Pharmacy	1,150.0	1,100.0	-0-	2,250.0
Medicaid Balance	34,059.5	34,496.5	633.3	69,489.3

With a move of prescription drugs from General Relief Medical Component to Medicaid Component, Medicaid funds would become available at a 50/50 ratio. However, attendant to the federal funds would come mandatory federal regulations defining which pharmaceuticals are allowable and the prices to be paid for each.

6% is assumed as annual inflation for prescription drugs.

This fiscal note replaces the fiscal note dated 2/13/85 which shows overall program savings. This fiscal note reflects budget changes needed to the Governor's proposed FY86 budget and does not show the $1,400.0 state G.F. savings already incorporated into the Governor's G.R. Medical budget.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

CSHB 209

"An Act relating to substitution of generic drugs by pharmacists; adding pharmaceuticals to the Medicaid program; and providing for an effective date."

I. Purpose of CSHB 209:

CSHB 209 has two purposes. First, it facilitates the substitution of lower cost generic drugs for prescribed name brand drugs. Secondly, it allows the Department of Health & Social Services to increase federal revenue by funding prescribed drugs for Medicaid recipients under the Medicaid Program rather than under the 100% state general funded General Relief Medical Program (GRM).

II. Sectional Analysis:

Section 1 permits the pharmacist to substitute an equally effective generic drug for a prescribed name brand drug and sets out the procedures to be followed by the pharmacist when substitutions are or are not made.

Section 2 establishes that the pharmacist will incur no greater liability by substituting an equivalent drug product and specifies the method of advertising to the public that such a substitution may be made.

Section 3 references sections 1 and 2.

Section 4 establishes prescribed drugs as a Medicaid service which allows the Department to claim 50 percent federal Medicaid funding. This alone will result in a $1.4 million savings of state general funds each year.

Section 5 adds prescribed drugs to AS 47.07.035 and provides the Department with legislative direction on the priority of prescribed drugs in the event of a funding shortfall.

Section 6 requires adoption of federal Medicaid procedures for purchasing prescribed drugs. An additional savings of $250,000 will be realized annually through the adoption of federal Medicaid rules for purchasing prescribed drugs.

Section 7 gives "prescribed drugs" the same meaning as in federal Medicaid regulations.

All states except Alaska have imposed limits on pharmaceutical reimbursement and have chosen to fund prescription drugs through the state administered federal Medicaid Program. There is no indication that this has in any way harmed medical assistance recipients or resulted in withdrawal of pharmacies from participation as medical assistance providers.

III. Recommendation:

The Department regards CSHB 209 as exceptionally beneficial to the majority of Alaskans. The increased substitution of lower cost generic drugs can make a significant financial difference to individuals who must purchase prescriptions within fixed budgets as well as to state administered assistance programs which pay thousands of pharmacy claims. The increase in the substitution of generic drugs also fits in with the shift to using Medicaid guidelines for reimbursement of prescriptions for low-income individuals.

The Department strongly recommends passage of CSHB 209 so that the state may begin to receive 50 percent federal financial participation for prescribed drugs through the Medicaid Program. The Governor's FY86 budget request assumes passage of CSHB 209 to the extent that the $1.4 million state fund savings are already reflected in the FY86 Medical Assistance BRU, General Relief Medical component. The enclosed fiscal note would transfer remaining state funds for drugs to Medicaid and combine them with available federal funds.

Recommended By: _____
FOR: Rod Betit, Director
Division of Medical Assistance

Date: April 1, 1985

Approved By: _____
John R. Pugh, Commissioner
Department of Health and
Social Services

Date: 4-2-85

Alaska State Legislature
House of Representatives
COMMITTEE ON HEALTH, EDUCATION
AND SOCIAL SERVICES

OFFICIAL BUSINESS

POUCH V
JUNEAU, AK 99811
465-3759

MEMORANDUM

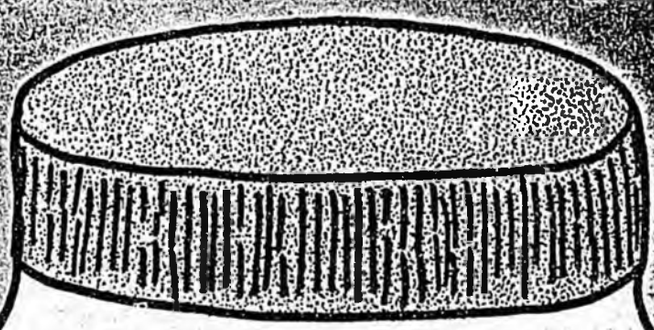
TO: MAX
FROM: NANCY
RE: SIGNS FOR GENERIC DRUGS
DATE: MARCH 18, 1985

THE FOLLOWING INFORMATION ABOUT THE HISTROY OF THE LANGUAGE RELATING TO SIGNS IN PHARMACIES CONCERNING GENERIC DRUGS, WAS RECEIVED FROM KEITH LEVY, LAA LEGAL, ON FRIDAY:

IN 1976, THERE WAS LEGISLATION RELATING TO GENERICS. IN THE HOUSE VERSION OF THE BILL WAS A PROVISION REQUIRING SIGNS TO BE POSTED IN A LOCATION EASILY VISIBLE TO PATRONS, WITH LETTERS A MINIMUM OF ONE INCH HIGH, STATING THAT THERAPEUTIC EQUIVALENT DRUGS ARE AVAILABLE IN SOME INSTANCES UNDER ALASKA LAW.

THE SENATE REMOVED THE LANGUAGE FROM THE BILL, BUT IT WAS RETURNED FOR A TWO YEAR PERIOD IN THE COMPROMISE VERSION OF THE LEGISLATION.

THE ONLY INFORMATION KEITH FOUND ABOUT PRO'S AND CON'S OF THE DEBATE WAS TESTIMONY BY RON SEDGEWICK, OF RON'S APOTHECARY, THAT IT OFFENDS PROFESSIONAL STANDARDS TO HAVE SUCH A SIGN IN THE WINDOW. AKPIRG SUPPORTED THE HOUSE VERSION OF THE BILL AND LOBBIED FOR THE SENATE TO RETAIN THE PROVISION.



Rx How to purchase drugs at less cost

Cutting the cost of prescription drugs is important to Mary J. Newcomb, a Juneau senior.

Newcomb routinely takes prescription medication for diabetes, high blood pressure and arthritic pain. Her monthly drug bill added up to $72.

Two of the three medications Newcomb takes are available generically at a Juneau pharmacy. (The generic name refers to the drug's chemical make up while the brand name is chosen by the manufacturer.)

By taking these two generic prescription drugs, Newcomb monthly prescription drug costs would drop to $52.

Newcomb (not her real name) now orders all three medications in a generic form from the American Association of Retired Persons' pharmacy in Portland, Oregon.

Her monthly prescription drug bill is now $25, a savings of 65 percent.

Buying generic prescription drugs can save seniors money. Savings of up to half are common when generics are purchased.

William Larson, a member of the Alaska State Board of Pharmacy and pharmacy director for Carrs Quality Centers, said the main reason seniors should consider using generics is because of the cost savings.

"Anyone on a fixed income would benefit."

Customers at Carrs, an Anchorage area food and drug store chain, are encouraged to purchase generic prescription drugs, Larson said.

While the cost savings available when generics are purchased have been established, some seniors are reluctant to use them.

They sometimes think generics aren't as good as brand name prescription drugs.

The Food and Drug Administration's position on generics, however, is that they are equivalent to brand name drugs.

"FDA believes that the prescribing of generic drugs can offer consumers an opportunity to cut the costs of their health care while assuring that

Continued on page 12

GENERIC

"There are not two classes of medicines on the market. There is only one class and it is safe and effective."

FDA encourages consumers to talk to their doctors and pharmacists about obtaining generic drugs.

If a generic is therapeutically equivalent (has the same effect in controlling or curing a condition), it can be prescribed instead of a brand name drug.

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Pharmacy law unclear

"Generic" can be a magic word leading to substantial savings when buying prescription drugs.

In Alaska, however, the state law allowing substitution of generics for brand name prescription drugs has a number of stumbling blocks for the potential generic purchaser. These pitfalls could prevent some seniors from realizing the financial savings available from generics.

Problem one: Pharmacists are not required to post a sign in the pharmacy letting consumers know an equivalent but less expensive drug may be substituted for the drug prescribed by their doctor.

Such signs inform consumers about generics and remind them of possible savings each time they go to a pharmacy.

The signs were required here in 1976 for a two-year period. The generic substitution law, originally passed in 1972, was amended at that time to include details on how substitutions should be made.

Problem two: Alaska's substitution law is not clear on what should be preprinted on prescription order forms, which prescribers have printed for themselves.

One section states the forms should have two boxes labled "dispense as written" and "substitution allowed" for prescribers to check each time they fill out a form.

However, another section gives prescribers the option of checking or initialing a box or handwriting the prescription order.

"It is truly confusing," said Diane Colvin, assistant attorney general for the Alaska's Department of Law. "You try to put the pieces together and it doesn't fit."

Colvin said the law needs to be amended. "What we have here is a badly drafted statute that should be revised."

Many physicians in Alaska do not have boxes on their preprinted forms.

If boxes are printed on all prescription blanks, physicians might consider the possibility of prescribing a generic each time they fill out a blank.

Physicians tend to think in terms of brand names when prescribing drugs because drug companies promote their products heavily and because brand names are easier to remember.

Problem three: Alaska's generic drug law discourages the substitution of generics.

In Oregon, a pharmacist is allowed to substitute a generic if there is nothing written on the prescription form that prohibits it, said William Frenzel, chief pharmacist for the Oregon Retired Persons Pharmacy, located in Beaverton, Oregon.

Not so in Alaska. If there is nothing about substitution on the prescription form, the pharmacist cannot substitute a generic unless he or she takes the time to call the physician for permission.

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Adapted from

Buying generic drugs can save seniors money

Continued from page 11

the products they use meet the same FDA standards as brand name drugs for safety, strength, purity and effectiveness," the agency reported in the June 1979 issue of FDA Consumer.

"Consumers have been misled and are paying a lot more to the well established firms for prescription drugs when generics could be used," said Edward Nida, spokesperson for FDA, in a telephone interview from his Rockville, Maryland office.

"There are not two classes of medicines on the market. There is only one class and it is safe and effective."

FDA encourages consumers to talk to their doctors and pharmacists about obtaining generic drugs.

If a generic is therapeutically equivalent (has the same effect in controlling or curing a condition), it can be prescribed instead of a brand name drug.

Dr. Thomas P. Senter, president of the Anchorage Medical Society, said his organization's position on generic prescription drugs is the same as the American Medical Association's.

"For some people, generic drug use is fine; for others it's not. It's left to the discretion of the individual doctor."

Dr. LouAnn Feldman, a physician for the Anchorage Neighborhood Health Center, said she prescribes generics if they contain the same basic ingredients and if they are absorbed as rapidly as the brand name product.

"Most generics are OK," Feldman said.

Larson agrees. Generics must pass "pretty strict criteria (under state law) to be allowed in Alaska," Larson said.

However, Jacki Warren, president of the Alaska Pharmaceutical Association and a pharmacist for Providence Hospital, has reservations about generics.

Seniors should use caution when making decisions about generics and rely on the advice of their health care professionals, usually physicians and pharmacists, she said.

Warren thinks generics sold by large companies like Lederle Laboratories, Parke-Davis and E.R. Squibb, companies that have developed brand name drugs, are better quality than generics sold by generic houses.

But FDA's Nida doesn't agree. "Generics are frequently not made by the large pharmaceutical firm whose name is on it."

"Some of the little firms make drugs for the big ones and vice versa," Nida said. "The products come from the same production lines."

Savings for consumers on generics from brand name houses are not usually as great as from companies specializing in generics.

While the pros and cons of using generics are still being debated, more people are buying generics prescription drugs each year. (See article Page 12)

The American Association of Retired Persons (AARP) encourages its members to buy generics.

The organization has 10 pharmacies throughout the U.S. and Alaska members can order prescriptions from AARP's Oregon Retired Persons Pharmacy, P.O. Box 2755, Portland, OR 97208.

Consumers can save money by asking for generic prescription drugs and comparing prices available from mail order firms, chain drug stores and neighborhood pharmacies.

nacy law unclear

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How to save on drugs

- Check with your pharmacist to see if any of the medications you are now taking are available generically.
- Ask your physician to prescribe generic drugs when possible.
- Compare prices when buying prescription drugs and over-the-counter drugs.

gs in U.S.

30, patent time remaining after FDA
nd approval plus the extension may
nts. not be more than 14 years.

In congressional testimony, the American Association of Retired Persons (AARP) questioned the advisibility of extending patents.

"Though AARP is of the opinion that extension of brand name drugs' patent terms is unnecessary and undesirable, we realize that compromise is necessary in order to achieve a broad base of support essential for passage of this legislation," AARP officials said.

Just how big the growth of generics will be by the end of the decade is not known, but one thing is certain.

It's worthwhile for seniors to check to see if they can save money by using generic prescription drugs. (See main story page 1.)

patents

Patent expires 1985 Brand name	generic
Valium	Diazepam
Motrin	Ibuprofen
Triavil	Amitriptyline HCl perphenazine
Ludiomil	Maprotiline HCl

Frequently prescribed generics

Generic name	Type of drug	Brand name
Acetaminophen w/Codeine	Analgesic	Tylenol w/Codeine
Amitriptyline	Antidepressant	Elavil
Amoxicillin	Antibiotic	Lanotid, Amoxil
Ampicillin	Antibiotic	Principen
Aspirin w/Codeine	Analgesic	Empirin w/Codeine
Chlordiazepoxide	Tranquilizer	Librium
Chlorpromazine	Psychogenic	Thorazine
Chlorthalidone	Antihypertensive	Hygroton
Diphenozylate w/Atropine	Antidiarrheal	Lomotil
Dipyridamole	Vasodilator	Persantine
Erythromycin	Antibiotic	Erythrocin
Conjugated Estrogens	Estrogen	Premarin
Folic Acid	Hematinic	----
Furosemide	Cardiovascular	Lasix
Hydralazine	Hypertensive	Apresoline
Hydrochlorothiazide	Diuretic	Hydrodiuril
Imipramine	Antidepressant	Tofranil
Isosorbide Dinitrate	Cardiovascular	Isordil
Meprobamate	Tranquilizer	Equanil, Miltown
Metronidazole	Antibacterial, Antiprotozoal	Flagyl
Nitroglycerin	Cardiovascular	Nitro-Bid
Papaverine	Muscle Relaxant	Payabid
Paregoric	Antidiarrheal	-----
Penicillin G	Antibiotic	Pentids
Penicillin VK	Antibiotic	Pen-Vee K, V-Cillin K
Phenobarbital	Sedative	Luminal
Phenytoin Sodium	Antiepileptic	Dilantin
Potassium Chloride	Supplement	-----
Prednisone	Steroid	Meticortelone
Promethazine	Decongestant	Phenergan
Propoxyphene Compound-65	Analgesic	Darvon Compound-65
Quinidine Sulfate	Cardiovascular	-----
Spironolactone	Diuretic	Aldactone
Spironolactone w/ Hydrochlorothiazide	Diuretic	Aldactazide
Sulfisoxazole	Urogenital antiseptic	Gantrisin
Tetracycline	Antibiotic	Achromycin V, Sumycin
Thioridazine	Antipsychotic	Mellaril
Tolbutamide	Antidiabetic	Orinase
Trimethoprim w/ Sulfermethoxizol	Antibiotic	Bactrim, Septra
Trifluoperazine	Antipsychotic	Stelazine

- Adapted from Chain Drug Review

It's a new era for generic drugs in U.S.

It's a new era for generic prescription drugs in the U.S.

With a new federal law cutting approval time for generics and many brand name drugs losing their patent protection, an avalanche of generics is expected to flood the market, according to drug company analysts.

The use of generic prescription drugs has grown substantially since the early 1960s.

Generics accounted for 21 percent of all the dispensed prescriptions at the retail level in 1984 — 418 million out of 1.99 billion, according to the January 14 issue of *Chain Drug Review*.

While about half of the top 200 prescription drugs dispensed in the U.S. are available generically now, the number of generics on the market is expected to increase dramatically in the next few years.

A new law passed last year has streamlined the Food and Drug Administration application process for the marketing of generics.

Now, to get generic drugs approved, firms will have only to show FDA that a product is equivalent to an already approved drug in ingredients, routes of administration and therapeutic effect, Nida said. The costly testing that was needed for approval of the original drug will not have to be duplicated.

This simplified application procedure plus the fact that a number of major prescription drugs are coming off patent protection, makes it likely that hundreds of new generics will flood the market in the next few years.

Over the next two years, patents on some of the nation's largest-selling drugs, like Motrin and Valium, are expiring. By 1990, most all of the 50 top-selling brand name drugs will lose their patents.

When a drug's patent protection has ended, other companies can then manufacture it.

Patent protection usually lasts 17 years, but the new law that simplified the FDA generic drug application process also gave manufacturers of brand name drugs more patent protection for new drugs they develop.

Drug companies apply for patents as soon as they have a drug with some medical effect in test animals and in humans, Nida said. Later, they apply for FDA approval to sell the drug and that review process could take two years or more.

The new drug law passed last year allows the patent time to be extended up to five years. But the patent time remaining after FDA approval plus the extension may not be more than 14 years.

In congressional testimony, the American Association of Retired Persons (AARP) questioned the advisibility of extending patents.

"Though AARP is of the opinion that extension of brand name drugs' patent terms is unnecessary and undesirable, we realize that compromise is necessary in order to achieve a broad base of support essential for passage of this legislation," AARP officials said.

Just how big the growth of generics will be by the end of the decade is not known, but one thing is certain.

It's worthwhile for seniors to check to see if they can save money by using generic prescription drugs. (See main story page 1.)

Expirations due for brand name patents

Patent expired 1984

Brand name	generic
Inderal	Propranolol HCL
Aldomet	Methyldopa
Diabinese	Chlorpropamide
	Methyldopa w/ Hydrochlorothiazide
Ativan	Lorazepam
Daimane	Flurazepam HCl
Navane	Thiothixene
Meclomen	Meclofenamate sodium
Serax	Oxazepam
Depakene	Valproic acid
Tinactin	(not available)
Restoril	Temazepam
Zaroxolyn	Metolazone
Dymelor	Acetohexamide
Megace	Megestrol acetate

Patent expires 1985

Brand name	generic
Valium	Diazepam
Motrin	Ibuprofen
Triavil	Amitriptyline HCl perphenazine
Ludiomil	Maprotiline HCl
Desyrel	Trazodone HCl
Intal	Cromolyn sodium
Nubain	Nalbuphine HCl
Yutopar	Ritodrine HCl

Furosemide
Hydralazine
Hydrochlorothiazide
Imipramine
Isosorbide Dinitrate
Meprobamate

Metronidazole

Nitroglycerin
Papaverine
Paregoric
Penicillin G
Penicillin VK

Phenobarbital
Phenytoin Sodium
Potassium Chloride
Prednisone
Promethazine
Propoxyphene Compound-65

Quinidine Sulfate
Spironolactone
Spironolactone w/ Hydrochlorothiazid
Sulfisoxazole

Tetracycline

Thioridazine
Tolbutamide
Trimethoprim w/ Sulfermethoxizol
Trifluoperazine

Adapted from Chain Drug

APRIL 10. 1985
TO: HOUSE FINANCE COMMITTEE

FROM: RON SEDGWICK. PHARMACIST JUNEAU. AK. 789-0458

RE: HB 209 PHARMACEUTICAL MEDICAL ASSISTANCE

IN DEALING WITH THIS PROPOSED LEGISLATION WE MUST SPLIT IT INTO TWO PARTS TO PREVENT CONFUSING THE ISSUES. FIRST ARE THE ASPECTS CONCERNING INCLUDING PHARMACEUTICALS UNDER THE FEDERAL MEDICAID PROGRAM RATHER THAN PROVIDING THEM THROUGH A STATE CONTROLLED PROGRAM. SECONDLY THE BILL WAS AMMENDED IN THE HESS COMMITTEE TO INCLUDE SOME CHANGES IN THE SUBSTITUTION PROVISIONS OF THE PHARMACY STATUTES. SINCE THE SUBSTITUTION PROVISIONS ARE BASICALLY NOT CONTRAVERSIAL AND WOULD PROBABLY BE SUPPORTED BY THE MEDICAL COMMUNITY WITH MINOR CHANGES, I WILL FIRST ADDRESS THE PROBLEMS WE SEE IN THE PROPOSED PHARMACY MEDICAID PROGRAM.

OVER THE PAST 10 TO 15 YEARS, MONTH AFTER MONTH WE HAVE BEEN READING IN OUR JOURNALS THE HORROR STORIES OF PHARMACY MEDICAID PROGRAMS IN THE OTHER STATES AS THE PRESSURE OF FEDERAL OVER REGULATION HAS CREATED PROBLEM AFTER PROBLEM. WE HAVE SEEN: PHARMACY PROGRAMS OPERATED UNDER FEDERAL REGULATIONS MANDATING RESTRICTING DRUG SELECTION BASED ONLY ON PRICE, (MAC OR MAXIMUM ALLOWABLE COST) REGULATIONS, STATES SETTING REIMBURSEMENT BASED ON DRUG AQUISITION COSTS WHICH ALL PHARMACIES ARE UNABLE TO OBTAIN, REIMBURSEMENT PROGRAMS THAT DO NOT TAKE INTO CONSIDERATION THE REALITIES OF FAIR REIMBURSEMENT BUT ARE BASED UPON METHODS THAT EASE THE CLAIMS PAYMENT PROCESS AND "SAVE MONEY" BY CUTTING THE REIMBURSEMENT FORMULAS AGAIN AND AGAIN UNTIL FINALLY PROVIDERS CAN NO LONGER PARTICIPATE. THE PRESSURE IS CONSTANTLY PUT ON THE STATES BY THE FEDERAL HEALTH CARE FINANCING COMMITTEE TO CUT COST, CUT COSTS, CUT COSTS UNTIL EVEN IN THOSE STATES WHICH STARTED WITH SEEMINGLY WORKABLE PROGRAMS THE PROVIDERS ARE FINDING THEMSELVES UNABLE TO CONTINUE PARTICIPATION, OR EVEN GO OUT OF BUSINESS COMPLETELY IN THOSE AREAS WHERE MEDICAID PRESCRIPTIONS ACCOUNT FOR A MAJORITY OF THEIR PRACTICE. RIGHT AT THIS TIME THERE IS AN EXTREME AMOUNT OF PRESSURE BEING PLACED UPON THE STATES IN REGION VI (TEXAS ETC.) BY THE FEDERAL REGULATORS TO CUT EVEN DEEPER INTO THEIR REIMBURSEMENT SCHEDULES BY USING PRICES 12 TO 15% BELOW WHAT PHARMACEUTICALS ARE CURRENTLY AVAILABLE FOR AT WHOLESALE AS THE SET INGREDIENT COST PORTIONS OF THEIR REIMBURSEMENT FORMULAS. PLEASE NOTE THAT I SAID THE PRESSURE COMES FROM THE FEDERAL AGENCY TO MAKE THE CUTS, REGARDLESS OF THE BEST OF INTENT OF THE STATE ADMINISTRATORS.

IN ALASKA'S CURRENT GENERAL RELIEF MEDICAL PROGRAM WHICH PROVIDES PHARMACY SERVICES TO MEDICAID RECIPIENTS WE HAVE

BEEN FORTUNATE TO HAVE BEEN ABLE TO WORK CLOSELY WITH THE STATE PROGRAM ADMINISTRATORS IN ACCOMPLISHING AN EASILY ADMINISTERED. FAIRLY COMPENSATED PROGRAM. FREE FROM THE ADDED LAYERS OF FEDERAL BUREAUCRACY. THE RECIPIENTS RECEIVE THE MAXIMUM BENEFITS FOR THE DOLLARS SPENT AND THE MEDICAL COMMUNITY FINDS THE PROGRAM FAIR AND EASY TO WORK UNDER. A FEW YEARS AGO. WHILE WORKING AS A CONSULTANT TO ALASKA'S MEDICAID PROGRAM. I COMPARED THE COSTS PER YEAR PER MEDICAID PATIENT IN ALASKA FOR PRESCRIPTION DRUGS TO SIMILAR COSTS IN OTHER STATES AND WE FOUND THAT WITH THE UNRESTRICTED PROGRAM OUR PER-PATIENT PRESCRIPTION COSTS WERE SIGNIFICANTLY LOWER THAN THOSE STATES WITH HIGHLY RESTRICTED PROGRAMS. DURING THIS PERIOD WE ALSO HAD NO PROBLEM IN INSURING THAT THE STATE WAS PAYING NO MORE THAN THE "USUAL AND CUSTOMARY CHARGES" BILLED BY THE PROVIDERS BY USING SIMPLE AND STRAIGHT FORWARD AUDIT PROCEDURES. THERE DOES NOT SEEM TO BE MUCH INCENTIVE TO OVERCHARGE WHEN THE PROVIDERS ARE TREATED FAIRLY AND REIMBURSED FAIRLY. SOME WOULD HAVE YOU THINK THAT THE STATE HAS ABSOLUTELY NO CONTROL OVER PHARMACY PROVIDER FEES BILLED IN THE EXISTING PROGRAM BUT THIS IS NOT A VALID POSITION.

NOW, WHAT IS THE ALTERNATIVE TO THE EXISTING PROGRAM, WHICH BY THE WAY, ACCOUNTS FOR ONLY A VERY SMALL PERCENTAGE < 2 PERCENT OF THE TOTAL MEDICAID DOLLARS.

TO GARNER THOSE MAGIC "FEDERAL MATCHING FUNDS" WE MUST FACE THE FEDERAL MONSTER WE HAVE BEEN HEARING ABOUT FOR SO LONG HERE IN ALASKA. FRANKLY, AFTER 15 YEARS OF HORROR STORIES WE ARE RELUCTANT TO TRY TO TAME THAT MONSTER HERE THAT THE OTHER STATES HAVE BEEN UNABLE TO DEAL WITH SUCCESSFULLY. THE ADMINISTRATIVE COSTS OF THE LAYERS OF FEDERALLY MANDATED STUDIES, PRICE SURVEYS, MAINTAINING ACUISITION COST SCHEDULES AND UPDATING THEM CONSTANTLY, AUDITS, ETC. WILL SURELY EAT UP THE MAJORITY OF THOSE AVAILABLE MATCHING FUNDS. COMMON SENSE TELLS US THAT THE ADMINISTRATIVE COSTS COULD ADD UP TO A SIZEABLE AMOUNT OF MONEY THAT COULD BE BETTER USED FOR DIRECTLY PROVIDING BETTER SERVICES TO THE RECIPIENTS. IN OTHER WORDS, IN CHANGING THE SYSTEM WE MIGHT JUST BE TRADING DOLLARS, PUTTING MORE INTO ADMINISTRATIVE AND BUREAUCRATIC EXPENSE AND REDUCING SERVICES TO RECIPIENTS. AND AS WE HEARD IN THE HEARINGS IN THE HESS COMMITTEE THE PRESSURES PLACED UPON SOME OF THE PROVIDERS IN SMALL TOWNS SUCH AS WRANGELL, VALDEZ AND SITKA COULD RESULT IN NO PHARMACY PROVIDERS AT ALL IN THOSE COMMUNITIES.

WE ARE NOT ALONE IN COMING TO THE CONCLUSION THAT ACCEPTING FEDERAL PARTICIPATION IS NOT A GOOD THING. THE LEGISLATURE IN THE STATE OF WYOMING CAME TO THIS CONCLUSION IN CHOOSING NOT TO PARTICIPATE IN A FEDERAL MEDICAID PHARMACY PROGRAM.

ANOTHER THING WE HEARD IN THE HESS HEARING WAS A LETTER FROM SENATOR TED STEVENS NOTING THAT IN HIS JUDGEMENT THE CHANCE OF RECEIVING FEDERAL FUNDING FOR A NEW PROGRAM IN ALASKA WAS PERHAPS QUITE SLIM UNDER THE PREVAILING FEDERAL BUDGET RESTICTIONS. ALTHOUGH WE HAVE BEEN TOLD THAT THIS WOULD NOT PRESENT A PROBLEM TO OUR STATE ADMINISTRATORS. WHY DISMANTLE THE EXISTING GOOD PROGRAM WHEN THIS CHANCE EXISTS AND NOT RECEIVING THE MONEY WOULD MEAN CUTTING OTHER PROGRAMS TO MAKE UP THE SHORT-FALL OR SEVERLY CUTTING PHARMACY SERVICES TO RECIPIENTS.

ANOTHER POSSIBLE PROBLEM THAT COULD HAVE MAJOR IMPACT ON A MEDICAID PHARMACY PROGRAM CONCERNS THE CROSS-OVER BY MEDICAID ELIGIBLE ALASKA NATIVES NOW SERVED BY PUBLIC HEALTH SERVICE PHARMACIES WITH THEIR NEEDS BEING PAID FOR WITH FEDERAL DOLLARS INTO THE PRIVATE SECTOR WHERE STATE DOLLARS WOULD THEN BE SPENT. THE IMPACT OF THIS CROSSOVER POTENTIAL WAS PERHAPS THE MAJOR REASON CITED IN THE TOUCHE-ROSS MEDICAID STUDIES DONE WHEN THE ALASKA MEDICAID PROGRAM WAS BEING PUT TOGETHER TO NOT INCLUDE PHARMACY SERVICES UNDER MEDICAID AT THAT TIME. THE RAMIFICATIONS OF THIS CERTAINLY NEED TO BE TAKEN INTO CONSIDERATION AT THIS TIME ALSO.

WE HAD HOPED THAT THIS HEARING COULD HAVE BEEN TELECONFERENCED SO THAT YOU WOULD HAVE HAD THE OPPORTUNTIY TO HEAR FROM THE PHARMACY PROVIDERS IN THE SMALL COMMUNITIES ABOUT HOW THEY VIEWED THE IMPACT OF THIS LEGISLATION. WE ARE CONFIDENT THAT ALONG WITH WHAT THE PHARMACY WITTNESSES TODAY ARE SAYING THAT YOU WOULD COME TO SIMILAR CONCLUSIONS TO THOSE OF THE MEMBERS OF THE HESS COMMITTEE WHERE ONLY ONE FAVORABLE RECOMMENDATION WAS GIVEN TO THIS BILL AND THAT WAS FROM THE AUTHOR OF THE SUBSTITUTION AMMENDMENTS.

CONCLUSION:

I FEEL THAT THE PRESENT PROGRAM IS WELL WORTH KEEPING:

IT PROVIDES THE MEDICAID RECIPIENT WITH AN UN-RESTRICTED PROGRAM UNDER WHICH ANY NEEDED PRESCRIPTION IS AVAILABLE.

IT ALLOWS THE PHYSICIAN TO CHOOSE THE DRUG THERAPY HE DEEMS NECESSARY AND HE IS NOT ENCUMBERED BY RESTRICTIVE FORMULARIES THAT FORCE DRUG SELECTION BASED ON INGREDIENT COST RATHER THAN THERAPUTIC EFFECTIVENESS.

IT ALLOWS THE PHARMACIST TO TREAT THE MEDICAID PATIENT IN THE SAME MANNER AS THE GENERAL PUBLIC, BE REIMBURSED FAIRLY FOR HIS SERVICES, AND BE FREE FROM OVERLY EMCUMBERING PAPER WORK. THE PER RECIPIENT COSTS ARE NOT OUT OF RANGE WITH PROGRAMS IN OTHER STATES.

IT ALLOWS THE STATE ADMINISTRATORS THE VERSATILTITY TO SHAPE A PROGRAM THAT WORKS WELL IN ALASKA WITHOUT THE PRESSURES FROM THE FEDERAL GOVERNMENT TO CONFORM TO THEIR "STANDARDS". ONCE WE ACCEPT THE "HELP" OF THE FEDERAL ADMINISTRATORS, WE NO LONGER CONTROL THE PROGRAM, THEY DO!

BECAUSE WE ARE TALKING ABOUT SUCH A SMALL PERCENTAGE OF THE MEDICAID BUDGET BEING SPENT FOR PHARMACEUTICALS AT PRESENT THE SMALL OVERALL SAVINGS AFTER PAYING FOR THE ADDITIONAL ADMINISTRATIVE COSTS CAN NOT POSSIBLY JUSTIFY HURTING RECIPIENTS AND PROVIDERS ALIKE BY CHANGING TO THE FEDERAL NIGHTMARE.

BEFORE WE SHIFT DOLLARS FROM GOOD PATIENT CARE TO ADMINISTERING THE ADDED LAYERS OF FEDERAL RESTRICTIONS IN A MEDICAID PHARMACY PROGRAM WE SHOULD BE SURE THERE ARE BENEFITS OTHER THAN EXPANDING THE BUREAUCRACY AND A MINIMUM OF DETRIMENTS TO RECIPIENTS, PRESCRIBERS AND PHARMACY PROVIDERS.

IF IT IS POSSIBLE TO PROTECT OURSELVES FROM THE WHIMS OF THE FEDERAL BUREAUCRACY BY SETTING UP A PROGRAM THAT MEETS THE FEDERAL STANDARDS BUT KEEPS CONTROL WITHIN STATUTE THAT ONLY THE ALASKA LEGISLATURE CAN CHANGE THEN PERHAPS GOING AFTER THE FEDERAL MATCHING MONIES WOULD BE ADVISABLE. SUCH AN APPROACH WOULD BE ADVISABLE ONLY IF THE TIME AND EFFORT WAS EXPENDED BY THE DIVISION OF MEDICAL ASSISTANCE IN A COOPERATIVE EFFORT WITH THE ALASKAN HEALTH CARE COMMUNITY TO INSURE THE OUTCOME WOULD BE WORKABLE FOR ALL. WE WOULD LIKE TO SEE THE PRESENT GENERAL RELIEF MEDICAL PHARMACY PROGRAM

FUNDED AS IN THE PAST AND AN INTERIM WORKING COMMITTEE STRUCTURED TO COME UP WITH POSSIBLE LEGISLATION FOR THE NEXT LEGISLATIVE TERM.

ALL FEDERAL MATCHING FUNDS ARE NOT WORTH JUMPING FOR IMMEDIATELY WITHOUT CARFULLY CONSIDERING THE CONSEQUENCES. LET'S NOT FALL INTO THE TRAP AS HAVE SO MANY OTHER STATES.

NATIONAL PHARMACEUTICAL COUNCIL, INC.
1030 15TH STREET NW
WASHINGTON, DC 20005

NB 209

8 MARCH 1985

In response to your inquiry regarding the medicaid situation in Alaska, the following information is provided:

The situation in Alaska is unique:

1. Alaska has a medicaid program but has not included a drug benefit. It does provide prescription drugs to some or all of the indigent population through the General Relief-Medical Budget and the Indian Health Service. The dollar amounts spent for drugs in these programs is not available in my records.
2. Alaska's geographic position places it over 1500 land miles from its nearest stateside distribution point and in fact a significant proportion of its drug distribution is shipped airfreight, resulting in higher unit costs, to which must be added the in-state distribution costs.
3. Alaska has a high unemployment rate and a low age 65 and over population in comparison to other states.
4. Alaska has a higher population to pharmacy ratio than the national average. Alaska: one pharmacy per 4700 pop. vs U.S.: one pharmacy per 3600 population.

If we assume that Alaska is currently meeting the drug needs of its indigent population with the current expenditure of $ 1.5 million, plus whatever Federal dollars are being spent on the Indian Health Program, it is unrealistic to believe that the state can save large amounts of money by instituting a Federal cost sharing medicaid drug program for the following reasons:

1. There is a strong possibility that there will be a spillover of native americans into the medicaid eligibiles, increasing the total number of medicaid eligibles for which the state must bear a 50 percent responsibility.
2. The HCFA reporting and MMIS requirements will require additional personnel and administrative costs not now borne by the unique and cost-effective drug reimbursement system.

The State of Alaska anticipates a substantial saving in total drug costs via the implementation of the Federal Maximum Allowable Cost progam. The Federal MAC program currently covers only

twenty-two drugs and has not added a new drug since 1983, primarily because the estimated savings from any additional drugs is too low to offset the administrative costs. In addition, the MAC drugs by law must be "Widely and consistantly available" and it is doubtful that the State would qualify with its limited and unusual distribution system.

I have enclosed a number of articles relating to the MAC program which cast a shadow on the actual cost-savings realized.

The State of Alaska is in much the same situation as the State of Arizona, in not having a drug benefit program and having a large native american population. Arizona's move to be innovative has been a costly one; estimated at $1,468 per AHCCCS enrollee under the proposed state budget.

I sincerely hope that the above statements and enclosures are helpful to you, and if we can be of further assistance as the issue matures, please call.

Best regards,

Dick

Richard W. Fowler, R.Ph.
Vice-president, Health Programs

(1) Rep. Brucebo, 1, feds 1.9 medicaid HB 209

I AM CHUCK RUSH AND I AM A PHARMACIST AND THE VICE PRESIDENT OF V.F. GRACE INC. WE ARE WHOLESALERS OF PHARMACEUTICALS LOCATED HERE IN ANCHORAGE. WE SERVICE MANY PHARMACIES IN ALASKA WITH THEIR PHARMACEUTICALS. AS A WHOLESALER I AM CONCERNED WITH THE FEDERAL MEDICAID LAWS THAT THIS BILL WOULD DEMAND. WHOLESALERS IN OTHER STATES HAVE HAD PROBLEMS IN TRYING TO STOCK THE FEDERAL MAC DRUGS AT THE PRICES AT WHICH THE FEDERAL GOVT SAYS THEY SHOULD BE AVAILABLE. MAC PRICES ARE THE MAXIMUM ALLOWABLE COSTS THAT THE FEDERAL GOVERNMENT WILL ALLOW FOR THE ACQUISITION COST IN PRICING A PRESCRIPTION. IF THE MAC PRICE IS $30.00 ON A PHARMACEUTICAL THEN THE PHARMACIST CHARGES $30.00 PLUS THE FEE WHICH MIGHT BE $6.00, SO THE BILLING IS FOR $36.00. NOW THAT MAC CHARGE OF $30.00 CANNOT BE INCREASED EVEN IF THE PHARMACEUTICAL IS NOT AVAILABLE FOR $30.00. IF IT IS ONLY AVAILABLE FOR A $37.00 COST THEN THE PHARMACIST EITHER REFUSES THE PRESCRIPTION OR TAKES A $1.00 LOSS OVER AND ABOVE HIS NORMAL OVERHEAD COST OF SALARY, RENT, HEAT, ETC.

I CHECKED WITH NWDA (OUR NATIONAL WHOLESALE DRUGGIST ASSOC) THIS MORNING AND ASKED THEM IF THERE WERE ANY PROBLEMS WITH MAC PRICES IN THE LOWER 48 STATES. THEY INDICATED THERE WERE SEVERE PROBLEMS IN MANY STATES AND GAVE ME MICHIGAN AS AN EXAMPLE. MICHIGAN SURVEYED AND FOUND THAT 19 FEDERAL MAC DRUGS WERE NOT AVAILABLE AT THE FEDERAL MAC PRICES. MR PAUL ALLEN, WHO IS THE HEAD OF MICHIGANS MEDICAID PROGRAM, WROTE TO CAROLYN DAVIS, WHO IS THE HEAD OF THE FEDERAL MEDICAID PROGRAM ADVISING HER OF THIS AND ASKING FOR THESE PRICES TO BE INCREASED. NO ACTION HAS BEEN TAKEN AND THE STATE OF MICHIGAN IS POWERLESS TO TO SOLVE THE PROBLEM. MEANWHILE THE PHARMACISTS EITHER SUBSIDIZE

THE PROGRAM OR REFUSE TO FILL WELFARE PRESCRIPTIONS. WHILE THE 22 FEDERAL MAC DRUGS ARE BEING EXAMINED AS TO THEIR WORTH AND NO NEW ONES HAVE BEEN ADDED SINCE 1983 WE ARE ADVISED THAT OUR DEPARTMENT IN ALASKA PLANS TO ADD SOME 80 MORE THAN THE FEDERAL GOVERNMENT HAS. AS I HAVE EXPLAINED IT IS VERY QUESTIONABLE WHETHER OUR WHOLESALE HOUSE COULD EVEN OBTAIN THE 22 MAC DRUGS REQUIRED BY THE FEDS BUT TO EVEN CONSIDER TRYING TO STOCK 80 MORE IS UNREALISTIC. EVEN SOME OF THE 22 FEDERAL MAC DRUGS CAN BE REAL LOSERS TO STOCK IF THE MANUFACTURER DOES NOT ACCEPT RETURN GOODS THAT HAVE REACHED THEIR EXPIRATION DATE OR IF THEY DO NOT MAINTAIN THE RECALL CAPABILITIES FOR UNSAFE OR DEFECTIVE DRUGS. THERE IS ANOTHER PROBLEM IN THIS REGARD IN USING THESE PRODUCTS BECAUSE THEY DO NOT MEET THE REQUIREMENTS OF OUR STATE STATUTES FOR SUBSTITUTION. THIS SUBSTITUTION LAW WAS MAINLY WRITTEN BY THE DOCTORS AND THEY FELT IT WAS THE PROTECTION THE PATIENTS NEEDED IF SUBSTITUTIONS WERE TO BE MADE ON PRESCRIPTIONS. I THINK EVERYONE IN THE PHARMACY AND MEDICAL COMMUNITY FEELS IT IS A VERY WELL WRITTEN, NECESSARY LAW AND PROVIDES THE NEEDED SAFEGUARDS FOR THE PUBLIC.

THE OTHER PROBLEM THAT NWDA INFORMED ME OF WAS FEDERAL REQUIREMENTS USING AN ACQUISITION COST ON CERTAIN COMPANIES THAT IS WHAT WE REFER TO AS THE "DIRECT COST". THIS MEANS THAT INSTEAD OF THE PRICE THE WHOLESALER CHARGES FOR THE ITEM THEY USE A PRICE THAT CAN ONLY BE OBTAINED BY THE PHARMACY BUYING IT DIRECT FROM THE MANUFACTURER. SOMETIMES THE LARGER STORES DO THIS BUT IT IS REALLY UNFAIR TO THE SMALLER STORES WHO CANNOT BUY THE QUANITIES NECESSARY TO BUY DIRECT AND DUE TO OUR GEOGRAPHY IT IS MANY TIMES NOT FEASIBLE DUE TO FREIGHT COSTS AND TIME ENROUTE. IF THIS IS A PROBLEM IN THE LOWER 48 IT CERTAINLY WOULD BE MUCH WORSE IN ALASKA.

I AM JOY DONELSON, I HAVE PRACTICEDP PHARMACY IN ALASKA 25YEARS. I OWN TWO
:EDICAL BUILDING PHARMACIES IN ANCHORAGE. I SPEAK FOR MYSELF REGARDING HB 209.
:T IS MY UNDERSTANDING THAT THE STATE ASSUMS THAT STORES IN ALASKA NOW ACCEPT
'RIVATE INSURANCE COMPANIES OFFERS OF A FEE FOR SERVICE. TO MY KNOWLEDGE NO STORES
)UTSIDE OF ANCHORAGE NOW DO AND THERE ARE SEVERAL OF US IN ANCHORAGE THAT DO NOT
.CCEPT THESE PROGRAMS. LONG AGO I DETERMININED THAT IF I ACCEPTED SUCH A FEE I WOULD
'AVE TO PASS THE INCREASED COST TO MY CASH PAYING CUSTOMERS AND I AM NOT COMFORTABLE
OING THAT. IN OUR PARTICULAR PRACTICE WE SPECIALIZE IN COMPOUNDING UNAVAILABLE
'ORMULAS, A LABOR INTENSIVE PROJECT. WE ALSO SPECIALIZE IN SUPPLYING THE INFREQUENTLY
'SED.. OFTEN UNAVAILABLE DRUGS.? FOR EXAMPLE WELLCOVORIN 25 mg.. A DRUG USED TO TREAT
ANCER.. A BOTTLE OF 24 TABLETS my cost to put on my shelf is 705.89. the average
prescription is for six tablets at a cost of 176.89 before i even consider the cost
F THE MONEY TO PUT THE ITEM ON THE SHELF, THE PHARMACIST SALARY, RENT AND A HOST
F OTHER EXPENSES.. THE STATE NOW PROPOSES TO PAY ME 5.15 LESS THAN 2.5%..NOW IF I
APPEN TO FILL NONE THREE MORE PRESCRIPTIONS BEFORE THE REST OF THE BOTTLE GOES OUT OF
ATE I WILL HAVE 20.60 on my 705.89 investment to cover my cost of doing business.
UCH A DEAL.. OBVIOUSLY MANY OF THESE AND I WILL BECOME A CLIENT OF THE DEPARTMENT
NSTEAD OF A VENDOR.
N THIS COUNTRY SEVERAL THOUSAND DRUG STORES HAVE BEEN PUT OUT OF BUSINESS BY TITLE 19.
O THE POINT THAT IN MANY CITIES WELFARE INTENSIVE NEIGHBORHOODS NO LONGER HAVE A PHARMACY
ND THEIR PROBLEMS ARE COMPOUNDED BY HAVING TO TRAVEL ELSEWHERE USALLY BY CAB AT THE
EPARTMENTS EXPENSE ROUND TRIP TO OBTAIN PHARMACEUTICAL SERVICES. IN ALASKA WHEN THIS
ROGRAM PUTS AN ALREADY MARGINAL DRUG STORE OUT OF BUSINESS. THE WHOLE POPULATION
AY TRAVEL HUNDREDS OF MILES TO OBTAIN SERVICE. OR BE UNDERSERVED BY UNDEPENDABLE MAIL
ERVICE.
EXT MONTH IN CHICAGO THE NATIONAL ASSOCIATION OF STATE PHARMACEUTICAL
SSOCIATION EXECUTIVES ARE MEETING IN A SUMMIT MEETING TO LOOK AT THE
ROBLEMS ASSOCIATE WITH COMPLIANCE WITH PAGES AND PAGES OF REGULATIONS THAT COME
ITH THE ONE LINE OF THIS PROPOSED LAW THAT SAYS THE STATE WILL BE JOINING THE
FEDERAL DRUG PROGRAM. I AM CONVINCED THAT WITHOUT A COMPUTER TO DEAL
ITH STATE AND CSC COMPUTERS THERE IS NO WAY A STORE CAN EVEN BEGIN TO COMPLY WITH THE
)UNTAINS OF REGULATIONS, PRICE CHANGES AND PAPER WORK. AT THIS TIME MY TWO STORES ARE
E ONLY FULLY COMPUTERIZED PRESCRIPTION DEPARTINES IN THE STATE AND OUR COMPUTER WILL
VE TO BE COMPLETELY REPROGRAMMED, SHOULD BE DECIDE TO PARTICIPATE.

I RECOGNIZE WE ARE FACED WITH DIMISHING REVENUES AND I WOULD NOT BE HERE TODAY IF I BELIEVED THAT THIS PROPOSAL COULD BE A WORKABLE,COST EFFECTIVE PLAN FOR OUR STATE. THIS IS NOT SUCH A PROGRAM ..I HAVE A LOT OF TROUBLE WITH THE RATIONALE OF TAMPERING WITH A PROGRAM THAT IS WORKING WELL FOR THE CLIENT, THE PHYSICIAN WHO PRESCRIBES UNDER IT AND THE PHARMACIST. THE 1.6MILLION COST LAST YEAR IN A TOTAL WELFARE PROGRAMOF ALMOST SEVENTY MILLION DOLLARS IS WELL BELOW THE PRECENTAGE NATION AVERAGE FOR DRUGS IN WELFARE PROGRAMS. THE DRUG BILL IS PROBABLY THE MOST COST EFFECTIVE HEALTH CARE BILL PAID BY THIS STATE.

IF OUR PHARMACY PROGRAM COES UNDER THE FEDERAL PROGRAM THE STATE LOSES CONTROL.IT IS A FEDERAL PROGRAM AND THEY CALL THE SHOTS.

ORGINALLY IN THE EARLY SEVENTIES THE TOUCHE ROSS STUDY done BEFORE MEDICAID WAS JOINED BY ALASKA ~~WAS~~ was AND IT ~~IS~~ DETERMINED THAT DUE TO ADMINISTRATIVE COST AND THE NATIVE CROSSOVER WE WOULD NOT SAVE MONEY BY JOINING THE FEDERAL DRUG PROGRAM.

ORIGINALLY THE STATE TRIED TO IMITATE THE FEDERAL PROGRAMS UNDER THE GR MED PROGRAM AND THE PHARMACIES REALIZING THEY COULD NOT SURVIVE WITH THE PAPERWORK, SLOW PAYMENTS, AND LOW PROFIT WITHDREW FROM THE PROGRAM.. ALL OF THEM. THE STATE THREATENED TO SUE THE PHARMACIST TO FORCE THEM BACK IN THE PROGRAM AND IT WAS AT THAT POINT THAT OUR PRESENT PROGRAM WAS WORKED OUT.

THE DEPARTMENT HAS NOT ADMITTED TO ANYONE CERTAINLY NOW TO THIS COMITTEE, THE COST OF IMPLETMENTING AND ADMINISTERING THIS ~~COMPLED~~ Complicated PROGRAM. THE STATE OF FLA HAS JUST COMPLETED AN AUDITED STUDY OF7&) STORES TO DETERMINE THE COST OF FILLING A PERSCRIPTION.. THERE WAS ALMOST NO TRAVEL MONEY INVOLVED .. THE COST OF THE STUDY WAS 95,000/00

THE DEPARTMENT HAS MADE NO EFFORT TO SEEK IMPUT FROM PHARMACY.. IN FACT SUGGESTIONS MADE IN 1982 BY THE STATE PHARMACEUTICAL ASSOC OF WAYS TO CURB COST HAVE NOT EVEN BEEN ACKNOWLEDGED.

NO ONE HAS ADDRESSED THE NATIVE CROSSOVER.. ARIZONA RESISTED THE PRESCRIPTION PART OF MEDICAID DUE TO THEIR LARGE NATIVE POPULATION SIMILAR TO OURS. THEY HAD 80,000 recipients in the program when they added pharmaceuticals and one year lated they had ~~2~~ 180,000 recipients and this has created a serious financial problem for their state. The native health service is a 100% fed funder operation medicaid is 50% funded. When they crossover it isn't just for pharmaceuticals but hospitals, doctors, nursing homes.

I URGE YOU TO HOLD THIS BILL IN COMMITTEE. THE DEPARTMENT NEEDS TO ESTABLISH A DIALOGUE WITH PHARMACY AND PHYSICIANS TO DEVELOP A PROGRAM OF COST CONTAINMENT, YET ASSURE CONTINUED HIGH PHARMACEUTICAL SERVICES IN CONVIENT LOCATIONS FOR THE WELFARE CLIENTS OF OUR STATE.

D&I

3222 Anella Avenue
Fairbanks, AK 99701
ph- 479-6793 - 452-2328(W)

To Members of the House Health, Education and Social Services Committee:

Yesterday I was given 2 minutes at the end of a rather lengthly HESS Committee hearing on HB 209 to give testimony or ask questions of the Committee regarding the Committee Substitute amendments to our current Pharmacy Statute AS 08.80.295.This Statute currently allows for the substitution of a generic drug for the drug prescribed as long as it meets all the requirements of therapeutic equivalence, dosage form, strength, and other standards as set forth in this Section of our Pharmacy Statutes. I do not understand why Sec 08.80.295(a) was offered as a substitute for what is currently a very effective law allowing substitution in this state. I am especially puzzled by the last sentence in Section 1 of the amendment and do not see what is supposed to accomplish.

I have no problems with the addition of the new subsections (i) and (j) but why didn't you repeal section (e) that is so out of date? The Pharmacy Board has submitted this request through the Division of Occupational Licensing along with several other "housekeeping" measures, but have found it was either too late to submit to the Legislature or it was very low on the list of priorities that the Department of Commerce eventually compiles from all such requests. Consequently, nothing has been done to remedy the situation.

I think this is a <u>very hastily</u> prepared amendment with little, if any, input from the practitioners it involves. I know that the Pharamcy Board was not consulted and I did not receive a copy of the amendment until I came to the hearing on the Medicaid portion of HB 209. I feel that more thought must be put into this amendment, particularly with regard to AS 08.80.295 <u>part (a)</u>.

Sincerely yours,

Margaret D Soden RPh

Margaret D. Soden, RPh, Secretary
Alaska Board of Pharmacy

My name is Thomas Miklautsch, residing in Fairbanks. I am a pharmacist and I am testifying against HB 209 which deals with Medicaid, specifically its inclusion of prescription medications in its program.

Since this committee considers health and social services in the public's best interest, my comments here are to emphasize these aspects although some remarks may overlap with the area of economics. They should also be considered and understood from the standpoint of health.

First of all, having prescribed medications in Medicaid without an understood and economically workable program is not in the best interest of the public. They will either be poorly served or not at all. The most critical reason for this would be the absence of pharmacies participating in the program. If the pharmacies cannot work with the program as set up, then the patient has to accept the stress. This means seeking out a pharmacy that would be participating in the program, if any, possibly having to travel longer distances at additional self-cost or at cost to the State for transportation to and from medical care.

In the case of areas of single store providers, it would simply be disastrous for the patient who would be forced to find a provider in another city or town, having to go there at self-expense (or the State's), <u>OR</u> mail in their prescriptions to a provider somewhere and wait a week or so to receive them, <u>OR ELSE</u> simply have them filled at their nearest pharmacy and pay for them somehow. Is this the manner intended to provide for the needy?

When Medicaid first came to Alaska and the State attempted to include prescription medications in the program, the program was so unworkable for the

pharmacies that none of them agreed to participate. As a result that portion of Medicaid was dropped. In 1982, the Dept. once again submitted an unworkable program which was also defeated by the Legislature.

Secondly, you have been told in your Legislative Update that the State expects to save $1.4 million with a footnote that reduction of this amount has already been made in the Governor's FY86 budget request, and that if this bill is not passed Major GR Medical reductions will be necessary. Simply stated, medical care will be reduced in a vital area.

The above information certainly prompts various questions that, although touching on economics and finance, still have a relationship to proper medical care. Do you know (or does the Legislature know) how the $1.4 million in savings has been calculated? We don't because we don't know what the program is. We know that the Federal Government will pay one-half the cost of the program. We also know that the total program FY84 was $69 million and that the cost of prescribed medications for the whole state was under $1.6 million which is about 2.3% of the program. We also know that the largest and costliest item in medical care is hospitalization, and we know that what keeps thousands of patients out of the hospital is self treatment by prescribed medications. Let's just say that because of inaccessible care, on an annual statewide basis, 25 patients per month need to be hospitalized for just 4 days. This would be 100 hospital days per month x 12 months x $500 per day equaling $600,000. It's very likely that the additional patient hospitalizations of 25 per month is a conservative figure. Is the State then realizing a cost saving? Further, what's the risk of death because of lackof proper care when it's first needed?

Other questions:

Is the Dept. aware of all the Federal requirements for participation in the program? Establishing MAC's, (Maximum Allowable Costs), EAC's (Estimated Allowable Costs), Establishing fixed fee for all AK pharmacies.

What will it cost to establish, monitor and update the program?

What is the cost of computer changes by CSC to comply with Federal regulations?

How many additional employees will be required to run the program?

Finally, we seriously wonder if this committee realizes what it is considering. HB 209 is essentially an amendment to an Alaska Statute by adding two words, "prescribed drugs" and giving it a priority number. Has a program backing this bill been unveiled and does the Committee know what it is?

We don't know what it is, so we don't know if it is workable. We do know that the Dept. has had two years to draft a plan, however we have had no input into it. In the past, we have recommended to the Dept. ways of cutting costs but have received no response. We cannot testify for HB 209 without knowing the program and we cannot recommend its passage for the same reason.

Just a few days ago we received a verbal invitation to meet with the Dept. and consider a proposed draft of a program. We most certainly wish to accept this offer but we need time for preparation. We need time to arrange our schedules, time to analyze the Dept.'s draft, time to respond and eventually come with a program satisfactory to all parties. Some of our participants

are out of the State at present and we will need time for them to be involved.

We don't wish to leave the impression that we have a closed mind to HB 209 if a program can be found to be satisfactory and workable for pharmacies. We are willing to work with the Dept. to find this common ground but please understand we need time for this.

We feel that there is a definite lack of information on HB 209 and that it should not proceed beyond this point. We ask you, our Legislators, to agree with our request.

We too believe in our State and in the best interest of the public. We think that over the years we have discharged our professional conduct and responsibilities remarkably well.

We also believe in what our State Constitution says in its first paragraph about all persons having a natural right to the enjoyment of the rewards of their own industry.

March 10, 1985

My name is David L. Swanson, a 20 year Alaska resident, practicing pharmacist and general manager of two pharmacies located in Fairbanks. I have served six years as a member of the State's Medical Care Advisory Committee (2 years as Chairman), a Committee which meets quarterly in an advisory capacity to the Commissioner and the Department of Health and Social Services. I wish the following to be entered as testimony regarding HB209.

I. Background

When the State of Alaska adopted the Federal Medicaid program, payment for pharmaceuticals was and still is an optional service to be provided. Initial efforts in the early 1970's to place pharmacy under the Federal program were unsuccessful due to marginal savings and opposition from pharmacy providers. The most recent attempt to move pharmacy into Medicaid was in 1982 via SB817. The Legislature in 1982 chose not to change the program, and today pharmaceutical services are funded through the General Relief-Medical component of the budget for the Department of Health and Social Services.

II. Why I am opposed to HB209

On the surface, one would wonder why any group or individual would be opposed to a plan that would supposedly save money for the State of Alaska. My opposition is based upon the following.

A. HB209 should be viewed as enabling legislation which allows the State of Alaska to claim 50% of monies spent for pharmaceutical services from the Federal Medicaid program. Unfortunately, these Federal funds are not granted without strings attached. My opinion is that the Department of Health and Social Services has not closely examined the Federal requirements for payment for pharmaceutical services. If HB209 is enacted, the Department must do the following to qualify for Federal Medicaid funds. The State or its agency (in this case the Department of Health and Social Services) must adopt Title 45 - Public Welfare, Subtitle A - Department of Health and Human Services, Part 19 - Limitation on Payment or Reimbursement for Drugs. This Federal regulation forces the Department to adopt the Federal schedule of Maximum Allowable Cost (MAC) for some twenty to thirty drug products and to establish an Estimated Acquisition Cost (EAC) and a method of updating these costs for all other drug products. In addition to establishing estimated acquisition costs of literally thousands of drug products, the Department must establish a dispensing fee to be paid to Alaska's pharmacies in addition to the Maximum Allowable Cost or Estimated Acquisition Cost. Because of the Sherman Anti-Trust Act, the dispensing fee must be established unilaterlly by the Department and cannot be negotiated with participating pharmacies.

These regulations which arbitrarily determine costs of purchasing drug products and unilaterally set payments for services rendered are unacceptable to me as a practitioner and I believe to the great majority of pharmacists in Alaska. Studies in the continental United States have shown that a substantial percentage of participating pharmacies cannot purchase pharmaceuticals for what the Federal government has determined to be the Maximum Allowable Cost. A study published in the August 1982 issue of American Pharmacy statesthat "58% of all responding pharmacists stated they fill prescriptions with a product priced above the MAC limit and absorb the loss". Other studies have shown that those pharmacies continuing to participate in the Medicaid program are doing so at an economic loss and are raising prices charged to non-Medicaid patients to offset the losses.

B. Pharmacy participation

Under the current system of the State paying usual and customary charges to pharmacies, I believe there is 100% participation in the program. Should HB209 become law, I believe the resultant mandatory regulations outlined above would force many pharmacies to seriously reconsider their participation in the program. There is a strong probability that many pharmacies would choose not to provide pharmaceuticals to Medicaid eligibles. This could result in an enormous impact on the cost of health care in other areas should these patients require additional hospitalizations or incur state funded travel expenses to obtain medications.

C. Cost savings

The term "cost savings" is really a misnomer and should correctly be called "cost shifting". It should be obvious that if the State does not pay usual and customary charges, the private sector will have to pay the difference for a pharmacy to remain profitable. Pharmacy is already a highly competetive business with the Lilly Digest, the financial benchmark of the industry, indicating a consistent decline in net profits over the past several years. Net profit after taxes for the average pharmacy for the last year reported (1983) stood at less than 3% of sales. It is my belief the Department's projection of a cost shifting of $1.4 million is highly suspect. Total expenditures for FY84 for pharmaceuticals was $1.592 million, and the Medical Payments Section could not give me an estimate of payments for FY85. Assuming an annual 10% increase over FY84 would result in an expenditure of approximately $1.926 million for FY86. From these numbers, I cannot determine how the Department expects to "save" $1.4 million. In addition, I am unaware of any estimates of additional costs that would be incurred by the Department to establish, monitor and update the program as required by the Federal government. Furthermore, as alluded to by Commissioner Pugh as recently as March 4, 1985, in an address to the Alaska State Hospital Association in Juneau, there is a possibility that a Federal Medicaid Cap would preclude the State from any Federal funding for pharmacy under Medicaid. I quote from Commissioner Pugh's prepared address as distributed; "I'd like to mention

our support of HB209. This is a bill designed to move the purchase of drugs from General Relief Medical to Medicaid. This would allow for 50% Federal funding instead of the current 100% cost to the General Fund and would save the State $1.4 million in FY 86. That money has already been removed from the Department of Health and Social Services' budget and passage of the bill is imperative. Of course, this is another issue that could be affected by a Medicaid Cap. At the present time, however, we are moving foreward as if that possibility did not exist and hoping that we get some support on the waiver and the equity issue. If the Cap occurs, we will be forced to reconsider our priorities and make choices about what we will be able to fund."

I must question the fiscal soundness of a decision to remove $1.4 million from the Department's budget based on two highly speculative assumptions; these being that HB209 will become law and that there will not be a Federally mandated Medicaid Cap.

Another potential area of impact that the Department has apparently ignored is the potential utilization of the entire Medicaid system by those beneficiaries currently receiving services from the Alaska Native Health Service. Earlier studies conducted by the State have indicated that the increased utilization of Medicaid services by this "crossover" would negate any potential savings.

D. Pharmacy and the Department of Health and Social Services

It is my understanding that the Department strongly supported the introduction of HB209 with the knowledge that Alaska's pharmacists would strongly oppose the bill. To the best of my knowledge, no pharmacist or pharmacy organization was approached to determine if there might be a common "middle ground" from which we could work together to curb the cost of pharmaceuticals. The Department has been uncommunicative with the profession regarding how HB209 would be implemented should it become law. An example of this is a formulary of drugs which would or would not be covered. A formulary is a State option under Medicaid, and has been implemented in about half the states, with equivocal results. Should the Department try to impose a formulary, I think it would require a Legislative change in the State's anti-substitution law which prohibits drug product selection by the pharmacist unless authorized by the prescriber. I believe this change would be unacceptable to most prescribers.

The Department has not explored other alternatives within the General Relief - Medical program for cost containment. Suggestions made to the Department by the Alaska Pharmaceutical Assoc. in 1982 have never been acknowledged nor discussed with the profession. These suggestions included dispensing quantity limits, limitations on over-the-counter medications and non-covered drugs. The Department has also ignored the recommendation of the Medical Care Advisory Committee of June 5, 1982 that pharmacy not be tranferred to Medicaid and that the Department consider the cost containment suggestions offered by the Alaska Pharmaceutical Assoc. In conclusion, I would hope that HB209 be held in committee and the Department and pharmacy representatives work together to develop an acceptable plan for cost containment that will continue to provide the highest quality of pharmaceutical services.

Offered: 3/27/85
Referred: Finance

Original sponsor: Rules/Governor

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 209 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to substitution of generic drugs by pharmacists; adding pharmaceuticals to the Medicaid program; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.80.295(a) is amended to read:

(a) Unless the prescriber expressly states that a prescription is to be dispensed only as written [EXCEPT AS LIMITED BY (b) AND (c) OF THIS SECTION, WITH THE CONSENT OF THE PURCHASER], the pharmacist may substitute a drug product with the same generic name in the same strength, quantity, dose and dosage form as the prescription, provided the substitute drug [PRESCRIBED DRUG WHICH] is, in the pharmacist's professional opinion, therapeutically equivalent and meets the standards of (g) of this section. The [UPON SUBSTITUTION THE] pharmacist shall notify the purchaser and the prescriber [PERSON WHO PRESCRIBED THE DRUG] of the substitution, and shall record on the prescription and keep a record of the name and manufacturer of the drug substituted. If a substitution is permitted under this section but the pharmacist does not make the substitution, the pharmacist shall inform the purchaser that a substitution was not made and the reason why it was not made.

* Sec. 2. AS 08.80.295 is amended by adding new subsections to read:

(i) A pharmacist who substitutes a drug in compliance with this section incurs no greater liability in filling the prescription by dispensing the equivalent drug product than would be incurred in

filling the prescription by dispensing the prescribed brand name drug.

(j) Every pharmacy shall post a sign in a location easily seen by patrons at the counter where prescriptions are dispensed stating that "Under Alaska law a therapeutically equivalent but less expensive drug may, in some cases, be substituted for the drug prescribed by your doctor. Please consult your pharmacist or physician." The printing on the sign shall be in block letters not less than one inch in height.

* Sec. 3. AS 17.20.105(b) is amended to read:

(b) In preparing a prescription, a pharmacist may [NOT] substitute a drug only in accordance with AS 08.80.295 [FOR A REGISTERED BRAND OR TRADE NAME PRODUCT SPECIFIED UNLESS THE PHARMACIST OBTAINS PERMISSION FROM THE AUTHOR OF THE PRESCRIPTION; BUT IF THE PRESCRIBING PHYSICIAN, OSTEOPATHIC PHYSICIAN, DENTIST OR VETERINARIAN IS TEMPORARILY UNAVAILABLE, THE PHARMACIST MAY, IF UNABLE TO SUPPLY THE DRUG REQUESTED, SUBSTITUTE A DRUG OR PREPARATION OF APPROXIMATELY EQUAL THERAPEUTIC VALUE SO LONG AS THE PHARMACIST NOTIFIES THE AUTHOR OF THE PRESCRIPTION AT AN EARLY OPPORTUNITY].

* Sec. 4. AS 47.07.030 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of

speech, hearing and language disorders, physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services, prescribed drugs, and reasonable transportation to and from the point of medical care. Additional services may not be provided unless approved by the legislature.

* Sec. 5. AS 47.07.035 is amended to read.

Sec. 47.07.035. PRIORITY OF SERVICES. If the funding in a fiscal year is inadequate to finance the total medical assistance program under this chapter, the department shall, to the extent that federal law and funding permits, provide medical assistance in the following order:

(1) aged, blind, or disabled persons who

(A) do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because they do not meet income and resources requirements; and

(B) are eligible to receive an optional state supplementary payment;

(2) persons in a medical or intermediate care facility

(A) whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act); and

(B) who would not be eligible for an optional state supplementary payment if they left the facility;

(3) persons under 21 years of age

(A) who are under the supervision of the department;

(B) whose maintenance is paid in whole or in part from public funds; and

(C) who are in foster homes or private child-care

institutions;

(4) persons under 21 years of age who

(A) receive treatment in a psychiatric hospital; and

(B) are financially eligible as determined by the standards of 42 U.S.C. 601 - 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);

(5) persons under 21 years of age who are

(A) in an institution designated by the department as an intermediate care facility for the mentally retarded; and

(B) financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) women who are pregnant;

(7) persons under 21 years of age who do not qualify for benefits under the federal aid to families with dependent children program because they are not dependent children;

(8) intermediate nursing home services;

(9) prescribed drugs;

(10) eye examinations by an ophthalmologist or optometrist; or eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist;

(11) [(10)] treatment of speech, hearing, or language disorders;

(12) [(11)] physical or occupational therapy;

(13) [(12)] care at an intermediate care facility for the mentally retarded;

(14) [(13)] care at an inpatient psychiatric facility;

(15) [(14)] community mental health clinic services;

(16) [(15)] surgical care center services;

(17) [(16)] nurse midwife services;

(18) [(17)] medical supplies and equipment;

(19) [(18)] long-term care noninstitutional services.

* Sec. 6. AS 47.07 is amended by adding a new section to read:

Sec. 47.07.400. PAYMENT FOR PRESCRIBED DRUGS. Payment for prescribed drugs must be made in accordance with 42 CFR 447.331, 447.332, 447.333, and 447.334.

* Sec. 7. AS 47.07.900 is amended by adding a new paragraph to read:

(7) "prescribed drugs" has the meaning given in 42 CFR 440.120.

* Sec. 8. AS 08.80.295(b), (c), and (f) are repealed.

* Sec. 9. This Act takes effect October 1, 1985.

Introduced: 2/18/85
Referred: Health,Education &
Social Services and Finance

IN THE HOUSE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

HOUSE BILL NO. 209

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to pharmaceutical medical assistance for needy persons; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 47.07.030 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services, <u>prescribed drugs,</u> and reasonable transportation to and from the point of medical care. Additional services may not be provided unless approved by the legislature.

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(A) do not receive supplemental security income under 42 U.S.C. 1381 -- 1383c (Title XVI, Social Security Act) because they do not meet income and resources requirements; and

(B) are eligible to receive an optional state supplementary payment;

(2) persons in a medical or intermediate care facility

(A) whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 -- 1383c (Title XVI, Social Security Act); and

(B) who would not be eligible for an optional state supplementary payment if they left the facility;

(3) persons under 21 years of age

(A) who are under the supervision of the department;

(B) whose maintenance is paid in whole or in part from public funds; and

(C) who are in foster homes or private child-care institutions;

(4) persons under 21 years of age who

(A) receive treatment in a psychiatric hospital; and

(B) are financially eligible as determined by the standards of 42 U.S.C. 601 -- 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);

(5) persons under 21 years of age who are

(A) in an institution designated by the department as an intermediate care facility for the mentally retarded; and

(B) financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) women who are pregnant;

(7) persons under 21 years of age who do not qualify for benefits under the federal aid to families with dependent children program because they are not dependent children;

(8) intermediate nursing home services;

(9) prescribed drugs;

(10) eye examinations by an ophthalmologist or optometrist; or eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist;

(11) [(10)] treatment of speech, hearing, or language disorders;

(12) [(11)] physical or occupational therapy;

(13) [(12)] care at an intermediate care facility for the mentally retarded;

(14) [(13)] care at an inpatient psychiatric facility;

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Sec. 47.07.400. PAYMENT FOR PRESCRIBED DRUGS. Payment for prescribed drugs must be made in accordance with 42 CFR 447.331, 447.332, 447.333, and 447.334.

* Sec. 4. AS 47.07.900 is amended by adding a new paragraph to read:

(7) "prescribed drugs" has the meaning given in 42 CFR

440.120.

* Sec. 5. This Act takes effect October 1, 1985.