Approved: February 12, 2000
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on February17, 2000 in Room 519-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Kansas Legislative Research Department
Dr. Bill Wolff, Kansas Legislative Research Department
Norman Furse, Revisor of Statute's Office
June Evans, Secretary

Conferees appearing before the committee: Jack Fincham, PhD, Dean, KU School of Pharmacy
Representative Carlos Mayans
Representative Kent Glasscock
Barbara Withee, AARP
Annette Graham, Central Plains Area on Aging, Sedgwick County
Greg Tugman, Department of Budget
Ken Grotewiel, Kansas Insurance Department

Others attending: See Attached Sheet

The Chairperson called the meeting to order and staff gave an update on the interpretation of current law on Tabled **HB 2755**. Representative Storm asked yesterday if she thought the bill restricted the laws that currently exist. My response was, yes, I thought it did. I am not ready to back off that interpretation because after consultation with several of my colleagues and they agree, but aside from that, I met with people from Health and Environment following the meeting and their attorneys in H&E are interpreting that not to include the names of licensees or registrants. That being the case under the Department's legal interpretation, they are now providing lists of names of licensees and registrants. There is confusion about what is included in the definition in child care facilities so asked Chris Ross-Baze to make a listing to be handed out of all the kinds of child care providers included in that Act. What happens now is that if the licensee or registrant is an individual person that person's name and address is made available to the public. If the licensee is a corporate entity like Kindercare what would go out and be made public would be the name Kindercare, not the name of individuals. As the law is currently being interpreted there are persons, individual persons whose names are not being withheld from even the internet listings or the public listings. Discussed with people from the Department, they would not oppose excluding or keeping private except for the exceptions created in the bill of any licensee or registrant so that all would be treated equally and there may be some circumstance. There aren't a lot of group homes, large residential foster care facilities, but there might be some of the same protections for children needed in that type of facility as an individual home but that is a policy decision for the Committee. It was felt the Committee's action yesterday was based, in part at least, on my response and wanted to clarify. (See Attachment #1).

The Chairperson opened the hearing on **HB 2814 - Establishing the Senior Pharmacy Assistance Program.**

The Chairperson stated the Fiscal Note for **HB 2814** had been distributed (See Attachment #2).

Jack E. Fincham, Ph.D., R.Ph., Dean and professor, the University of Kansas, School of Pharmacy, gave a synopsis of a very complex issue, current and future drug costs in the United States. The development of new drugs is changing dramatically from previous models and methods. The design and synthesis of new drugs has become increasingly more sophisticated. These changes in drug discovery have altered the landscape of the pharmaceutical industry, academic research, and the prescribing and utilization of these new drugs (See Attachment #3).

Representative Carlos Mayans, proponent to **HB 2814**, testified this is an innovative and cost efficient health care initiative that will assist Kansas senior citizens with the purchase of their medications. This investment in the health of our seniors will be another step in insuring that our most vulnerable citizens stay healthy and that their quality of life is enhanced.

HB 2814 provides for those individuals 62 years and older and with an income of less than $14,000 a year to apply for the prescription assistance program which would assist seniors after a $12 co-payment per prescription with the balance of the cost of purchasing that prescription (Attachment #4).

Representative Kent Glasscock, testified in support of **HB 2814** which creates the senior pharmacy assistance program providing eligible senior citizens financial assistance for prescription drugs. The drugs stop problems from getting worse, keeping seniors out of hospitals and adult care facilities. In the long run, this program could cut medical costs by helping seniors avoid serious medical problems that need more expensive treatments (See Attachment #5).

Barbara Withee, Vice-Chair, AARP State Legislative Committee, testified as a proponent for **HB 2814**. AARP legislative surveys in Kansas mirror those results from national surveys–seniors indicate that soaring costs of prescription drugs and reductions in coverage from private insurance or managed care plans have placed this as one of the priority issues of concern.

Much like inadequate preventive health care, those individuals who delay or neglect their prescriptions due to an inability to pay end up with acute health care needs and ultimately create a much higher burden to the state if institutionalization becomes necessary and their physical and financial state deteriorates to the point where they become Medicaid enrollees (See Attachment #6).

The Chairperson asked Greg Tugman, Division of Budget, to give a synopsis of the budget report, how they arrived at their figures.

Greg Tugman stated first of all there is not a Table because were uncomfortable nailing down an actual estimate. It is anybody's guess what the participation level would be. We basically laid out these assumptions of the fiscal impact. The population estimates, went to the Census Bureau, and came up with 425,000 Kansans over age 62. At the state house they went into the data base and pulled and projected about 425,000 age 62 or over. The Department of Revenue the number of people age 65 or over that filed tax returns and those whose income guidelines were between $8,000 and $14,000 a year - $16,000 for a household and they came up with 49,000 tax returns. That is net income and a lot of people don't file tax returns because they don't make enough income, but that is another estimate. The third estimate came from SRS and they keep population estimates for Medicaid eligibility and they came up with 111,000 and 41,000 already being on Medicaid, about 70,000 estimate is about as good as we can do right now without going into a full demographic estimate. That is certainly something everyone should consider. The second issue is the number of prescriptions per year. Called about 7 states that have the pharmacy program and also talked to Bob Day and remember people that are on Medicaid are pretty sick people, in nursing homes. The prescription drug program has finally cost more than in-patient hospital; that was last year and the first year that has happened. That trend is expected to continue. If a person is on Medicaid, 62 years old or older, they are going to be in pretty bad shape and would need a lot of prescription drugs. If 54 prescription drugs a year, some might by Tylenol III which is about 8 cents a pill, then designer drugs which are very expensive and they all blend to $36 a year. Those are a lot of assumptions. Called some other states and they came up with 18 prescriptions a year average per participant and we are around that with Blue Cross-Blue Shield's estimate and are assuming that people that are going to be participating in this program aren't going to be as unhealthy as the Medicaid participant and use less prescription drugs. Is the multiplier going to be Tylenol III or the arthritic drug. Those are assumptions we are stumbling into and it is a dangerous territory. Again, all 70,000 people, if everybody came in and stayed in the program and a full $1500 limit then talking about $105M. The Medicaid budget now, under the Governor's recommendation, the general fund portion of that Medicaid budget is about $240M state

general fund so that gives a sense of scale that is being put in for that population. These are assumptions. Childrens health insurance has had enrollment, a curve, and it might take a while for the interest to come along. Talked to Maryland yesterday and they said there is huge pressure, is fairly organized, and growing every single year. Everyone wants to get on board. The senior population is much more organized and would certainly generate a lot of interest.

Annette Graham, Executive Director of the Sedgwick County Department of Aging, and of the Central Plains Area Agency on Aging, supported **HB 2814.** Would respectfully suggest to have the Secretary of Aging administer the program. Too often older Kansans are placed in the position of having to choose whether to eat or purchase necessary and expensive prescription medications. (See Attachment #7)

Ken Grotewiel, Director, Consumer Assistance Division, Kansas Insurance Department, testified on behalf of **HB 2814**, stating the purpose was to provide very needed assistance to seniors who cannot afford to pay for their prescription drugs.

Many people in their early 60's find that they have no prescription drug coverage. The most common instance is that they no longer have coverage from a group plan with an employer and are not yet eligible for medicare coverage which starts at age 65. Once on Medicare, prescription drugs are not part of the basic benefit package. While some coverage is available through three supplemental insurance plans, they are substantially more expensive than those plans without prescription drug coverage. Medicare HMO's do provide some prescription drug coverage. However, the HMO option is available only in a very limited number of counties. Prescription drug costs are rising (See Attachment #8).

Representative Showalter presented written testimony applauding Representative Mayans for bringing the bill forth. This is a problem that has plagued senior citizens for the past decade and is one that needs to be addressed (See Attachment #9).

Representative Troy Findley stated he supported the creation of a prescription drug assistance program for Kansas seniors. However, testimony will focus primarily on **HB 2966**. According to a recent report released by the American Association of Retired Persons, Medicare beneficiaries age 65 and older living in the community were projected to spend an average of $2,430 out-of-pocket, or nineteen percent of their income for health care in last year. Over half of this amount, fifty-four percent, will be spent on health care goods and services. Prescription drug costs account for the single largest component of out-of-pocket spending on health care, after premium payments. On average seniors are expected to spend as much out-of-pocket for prescription drugs as for physician care, vision services and medical supplies combined. (See Attachments #10 & 11).

Written testimony was distributed from Bob Williams, The Kansas Pharmacists Association (See Attachment #12).

The Chairperson closed the hearing on **HB 2814.**

The meeting adjourned at 3:15 p.m. and the next meeting will be February 21.

HEALTH AND HUMAN SERVICES

Date: February 17, 2000

Barbara Withee	AARP Manhattan Ks
Annette Graham	CPAAA - Wichita, Ks
John Robert Nabb	NC-FH Area Agency on Aging MANHATTAN
Ken Grotewiel	Kansas Insurance Dept.
Elaine Lynch	AARP Salina - SLC
[illegible]	AARP - KS-CCTF.
Vera Spencer	AARP - KS-SLC
Charles H. Freeman	AARP - KS-SLC
[illegible]	AARP KS SLC
William Gilliam	AARP KS SLC
Kathy Finney	Ks. Public Health Assn.
Donna L. Graves	AARP SLC
Frieda Jakobe	AARP Johnson County SLC MASG
Dennis Priest	SRS
Bill Hargill	Governor's office
Tom Bruno	AKH
Jennifer Schmidt	Majority Leader's office.
Diane Jensen	Majority Leader's Office
Sheli Sweeney	KDOA
Maria Russo	Jayhawk Area Agency on Aging
Michelle Peterson	PhRMA
Jeff Bottenberg	Merck
Chip Wheelen	Osteopathic Assn
Larry Froelich	Board of Pharmacy
Trudy Lowe	SRS
Brad Hubbs	Ks Pharmacists Assoc.
Brad Hoffman	Ks. Pharmacists Assoc
Bill Kenney	Ks Area Agencies on Aging

H&HS 2-17-00 Attch #1

HOUSE BILL No. 2755

By Committee on Health and Human Services

1-31

AN ACT concerning the department of health and environment; disclosure of certain information in possession thereof; prohibitions and restrictions on disclosure; amending K.S.A. 1999 Supp. 65-506 and 65-525 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1999 Supp. 65-506 is hereby amended to read as follows: 65-506. The secretary of health and environment shall serve notice of the issuance, suspension or revocation of a license to conduct a maternity center or child care facility or the issuance, suspension or revocation of a certificate of registration for a family day care home to the secretary of social and rehabilitation services, ~~to the~~ *juvenile justice authority, department of education, office of the state fire marshal,* county, city-county or multi-county department of health, and to any *licensed child placement agency or licensed* child care resource and referral agency serving the area where the center or facility is located. Neither the secretary of social and rehabilitation services nor any other person shall place or cause to be placed any maternity patient or child under 16 years of age in any maternity center or child care facility not licensed by the secretary of health and environment or family day care home not holding a certificate of registration from the secretary of health and environment.

Sec. 2. K.S.A. 1999 Supp. 65-525 is hereby amended to read as follows: 65-525. ~~Except as otherwise provided in K.S.A. 1999 Supp. 65-531 and amendments thereto, information received by the licensing agency through filed reports, inspections or otherwise authorized under K.S.A. 65-501 to 65-522, inclusive, and amendments thereto shall not be disclosed publicly in such manner as to identify individuals~~ *(a) Information in the possession of the department of health and environment* ~~*that identifies individuals, except for individuals operating a child care facility or a family day care home, shall not be released publicly, unless required by law.*~~

(b) ~~*An individual applying for or renewing a license or certificate of registration to operate a day care home or family foster home may request in writing that the department of health and environment not disclose publicly personal information of the individual, including street address*~~ received pursuant to K.S.A. 65-501 *et. seq* regarding child care facilities, maternity centers or family day care homes shall not be released publicly in a manner that would identify persons, unless permitted or required by law or the information is contained in an order as defined in subsection (d) of K.S.A. 77-502 and amendments thereto or the person is an employee or designated agent of the licensing agency.

The name, address and telephone number of a licensed child care facility, maternity center or registered family day care home shall not be released publicly unless permitted or required by law or the information is contained in an order as defined in subsection (d) of K.S.A. 77-502 and amendments thereto.

~~and telephone number. If the department receives written notice, the personal information of an individual licensed or registered to operate a day care home or family foster home shall not be released publicly, unless required by law or if the information is contained in an order as defined in subsection (d) of K.S.A. 77-502, and amendments thereto.~~

(c) Information that cannot be released by subsection (a) or (b) may be released to: (1) An agency or organization authorized to receive notice under K.S.A. 65-506, and amendments thereto; (2) a criminal justice agency; (3) any state ~~or federal~~ agency that ~~regulates child care~~ or provides child care services provides child protective services; (4) ~~an organization of persons who are licensed or registered child care providers for membership, informational or other purposes related to child care; or~~ (5) an organization providing professional or vocational training or education for the sole purpose of providing individuals with training or education required by regulation. Any state ~~or federal~~ agency receiving information under subsection (a) or (b) shall not disseminate the information without the consent of the ~~individual~~ person whose information will be disseminated unless required by law, the information is directly related to the administration of the agency's program or if the information is contained in an order as defined in subsection (d) of K.S.A. 77-502, and amendments thereto. Any person, other than a state ~~or federal~~ agency, receiving information under subsection (a) or (b) shall not disseminate the information without the consent of the ~~individual~~ person whose information will be disseminated unless required by law or if the information is contained in an order as defined in subsection (d) of K.S.A. 77-502, and amendments thereto.

(d) In any hearings conducted under the licensing or regulation provisions of K.S.A. 65-501 ~~to 65-522, inclusive,~~ *et. seq* and amendments thereto, the hearing officer may close the hearing to the public to prevent public disclosure of matters relating to ~~individuals~~ persons restricted by other laws.

Sec. 3. K.S.A. 1999 Supp. 65-506 and 65-525 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

HB 2755

STATE OF KANSAS

DIVISION OF THE BUDGET
Room 152-E
State Capitol Building
Topeka, Kansas 66612-1575
(785) 296-2436
FAX (785) 296-0231

Bill Graves
Governor

Duane A. Goossen
Director

February 17, 2000

The Honorable Garry Boston, Chairperson
House Committee on Health and Human Services
Statehouse, Room 156-E
Topeka, Kansas 66612

Dear Representative Boston:

SUBJECT: Fiscal Note for HB 2814 by Representative Mayans, et al.

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2814 is respectfully submitted to your committee.

The bill would create the Senior Pharmacy Assistance Program in the Department of Social and Rehabilitation Services to assist low income citizens with the cost of prescription drugs. To become eligible, a person must be age 62 or older and have a limited annual income of $14,000 for individuals or $16,000 for households. All prescription drugs covered by the state Medicaid program would be eligible for reimbursement. The bill would require a $12 copayment for each prescription. The annual maximum reimbursement per individual is capped at $1,500. Pharmacies would be reimbursed at the average wholesale price plus a $3.90 dispensing fee.

The key assumptions to estimating the fiscal impact of the bill would be the number of eligible seniors in the population, the average cost of a prescription drug, and how many prescriptions a person would use in a given year. The income limits prescribed in the bill are equal to approximately 174.0 percent of the federal poverty level. The Department of Social and Rehabilitation Services estimates there are approximately 111,000 senior citizens in the state ages 62 or older who are at or below the maximum limit. Of this population, Medicaid already covers 41,000, leaving a remaining eligible population of 70,000 persons.

The second variable is the average cost per prescription. State Medicaid data indicate that the average prescription cost for senior citizens totaled $36 in FY 1999. Using a

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pharmaceutical inflation rate of 12.5 percent each fiscal year, the estimated average prescription cost would total $45 in FY 2001.

The third variable is the number of prescriptions a senior will use over the course of a year. Using statewide data from Blue Cross/Blue Shield, the average number of prescriptions used by seniors is 18 per year. This factor is important, because each prescription would be multiplied by the co-payment of $12, so the average participant in the program would pay $216 annually out-of-pocket for prescription drugs.

Using these variables, the annual cost to the state per participant would total $594 ($45 average prescription cost X 18 prescriptions each year minus the $216 co-payment = $594). If all of the 70,000 individuals were to participate in the program in FY 2001, HB 2814 would have the potential cost of $41.58 million, all of which would be from the State General Fund.

There would also be an indirect impact on the state Medicaid population, although the estimate would be more difficult to determine. When the Children's Health Insurance Program began recruiting families at 200.0 percent of federal poverty level, several individuals were found to be eligible for Medicaid, thereby increasing that population almost 29.0 percent in the current year. Because children and their families are relatively healthy, the sharp population increases are not as expensive. The addition of more elderly to the Medicaid population would be far more expensive and would increase costs depending on their health and the number of pharmaceuticals they would use.

Sincerely,

Duane A. Goossen
Director of the Budget

cc: Lois Weeks, SRS

Current and Future Drug Costs in the United States

Health and Human Services Committee

Room 423-S

February 17, 2000

Jack E. Fincham, Ph.D., R.Ph.
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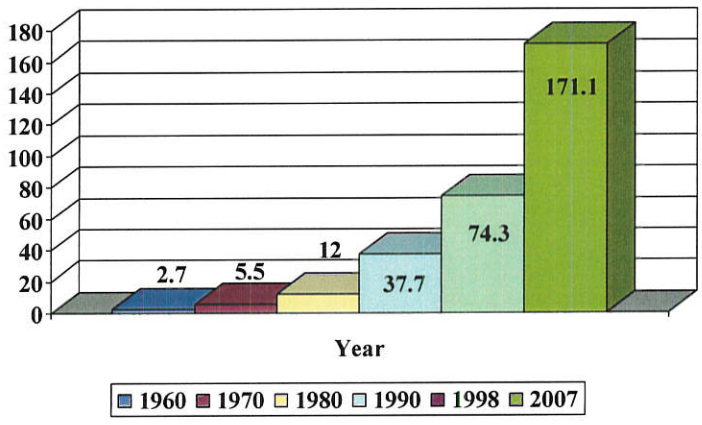
Presentation

1. Current trends in prescription drug use in the U.S.
2. Percentage of health care dollars spent on prescription drugs.
3. Managed Care drug use and expenditures.
4. Utilization within the top drug classes in the U.S.
5. Top drugs used per member in managed care organizations (MCOs).
6. Specific drugs utilized most extensively in U.S. MCOs.
7. Current variables increasing drug costs.
8. Future variables that will increase drug costs.

Trends in US Prescription Drug Expenditures (billions)



Source, Health Policy Report, ***New England Journal of Medicine***, 1999

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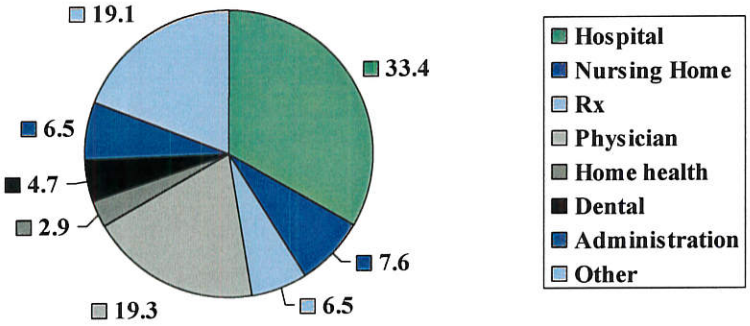
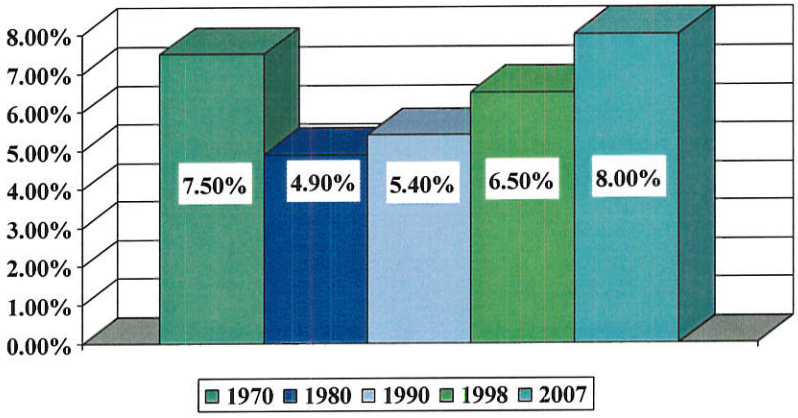
Health Care Spending Categories, 1998
(Percentages)



Source, Health Policy Report, *New England Journal of Medicine*, 1999

Percentage of Health Care Dollars Spent on Prescription Drugs



Source, Health Policy Report, *New England Journal of Medicine*, 1999

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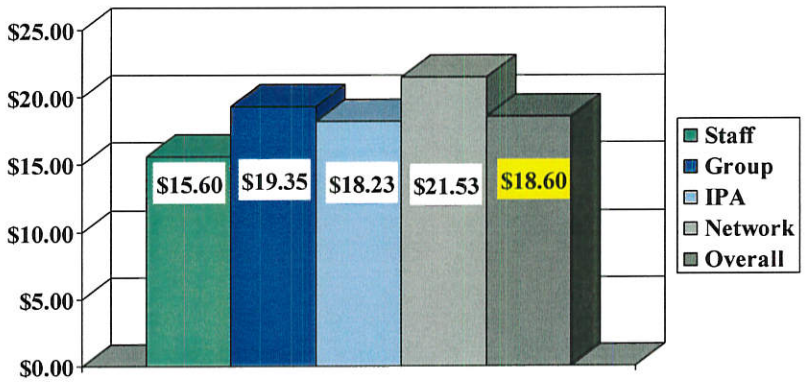
Managed Care Prescription Usage, US
(Per member per month usage)



Source: Novartis Pharmacy Benefit Report, CUE™-99,1999

1998 Top Drug Classes - $ Expenditures

1. Antidepressants
2. Gastrointestinal Agents
3. Cholesterol Reducers
4. Calcium Channel Blockers
5. ACE Inhibitors
6. Antihistamines

Novartis Pharmacy Benefit Report, 1999

1998 Top Drug Classes – Rxs/1000 members

1. Antidepressants
2. Estrogen products
3. ACE Inhibitors
4. Cholesterol Reducers
5. Gastrointestinal agents
6. Calcium Channel Blockers

Novartis Pharmacy Benefit Report, 1999

1998 Top Drugs PMPY and Rxs

1. **Prilosec®**
2. **Prozac®**
3. **Zocor®**
4. **Claritin®**
5. **Lipitor®**
6. **Zoloft®**
7. **Paxil®**
8. **Pravachol ®**
9. **Prevacid®**
10. **Imitrex®**

Novartis Pharmacy Benefit Report, 1999

Current Variables Increasing Drug Costs

- Access, coverage, and distribution.
- Biotechnology derived drugs (cancer, infectious diseases, heart disease, brain disorders, lung disease, diabetes).
- New agents in pipeline will be ever more expensive and focused: self-targeting of defective cells, liposomal delivery, individual specific drug treatments.
- Please see attached testimony from August, 1999.

Future Variables Increasing Drug Costs

- Outpatient prescription benefit for the elderly.
- Increasing population.
- Increasing demand.
- Success of programs that have allowed access and coverage.
- Longevity of life leads to further need for more drug therapies.

The Use of Technology and its Influence on Drug Discovery

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Health Care Reform Legislative Oversight Committee

August 23, 1999

The development of new drugs is changing dramatically from previous models and methods. The design and synthesis of new drugs has become increasingly more sophisticated. These changes in drug discovery have altered the landscape of the pharmaceutical industry, academic research, and the prescribing and utilization of these new drugs. No one involved in any and all related aspects to this profound change in drug discovery will be unaffected by these changes. Physicians and pharmacists will need to examine and reexamine what they know about drugs and their effects, payers and insurers will be under increasing pressure to control drug expenditures. Patients will use ever more costly drugs with ever narrower therapeutic uses. Legislatures from the federal through the state level will be dealing with pharmaceuticals that are more costly and more effective, if used properly, for use with governmental programs such as Medicare and Medicaid. These fundamental changes are occurring due to changes in how drugs are discovered, delivered to patients through dosage forms, and how they work in the body.

Changes in drug discovery methods.

The milestones in drug discovery over the past century include the synthesis of chemotherapeutic agents, the production of penicillin, understanding the structure of DNA and the genetic code, and the complete sequencing of entire genomes. Major advances in drug discovery and development have resulted from these milestones, providing us with an arsenal of curative, preventative and symptom relieving therapeutic agents. Whole new fields have

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emerged in the pharmaceutical sciences. For instance, the discovery of the structure of DNA led to the birth of pharmaceutical biotechnology. Currently, fifty-four biotechnology-derived products are available with hundreds more in development. The targets for these products include cancer, infectious diseases, heart disease, brain disorders, lung disease, diabetes, and many others.

The pharmaceutical industry has seen a revolution in terms of critical technologies over the past decade. In the pursuit of the better-faster-cheaper paradigm, the nineties have been characterized by the evolution of powerful technologies like combinatorial chemistry, high-throughput screening and genomics. Combinatorial chemistry involves the use of thousands of compounds screened for therapeutic effects with microcomputer chip technology. High-throughput screening involves the assessing biological effects of molecular libraries, both in vitro (in the test tube) and in vivo (in the body). Gene therapy and genomics involves assessing genetic information translated efficiently into bona fide therapeutic targets and drug molecules.

Changes in how drugs are delivered to the body and within the body.

At the turn of this century, the German bacteriologist Paul Ehrlich started the quest for "magic bullets" or specific curative drugs that would provide operative control over disease. Central to this quest has been gaining an understanding of drug and "target" structure and function and the development of drug delivery strategies to achieve controlled release and targeting of drugs to specific sites in the body.

The science of how drugs are distributed in the body (pharmacokinetics) established during this century has allowed the optimization of drug therapy to maximize beneficial effects and minimize unwanted and toxic effects. Many major advances in this area are occurring in the later part of this century. Recent developments that are revolutionizing this field of the pharmaceutical sciences, including the identification of multiple metabolic isoenzymes, the importance of transporters in drug disposition, and the emergence of pharmacogenetics and pharmacogenomics.

These technologies will result in drugs that self-target defective cells and pathways, in effect self-contained drug delivery machines. At the United States National Cancer Institutes, approximately 10,000 compounds are screened every year against a panel of 60 human cell lines

from different organs. Over 70,000 compounds have been screened to date. In these drug discovery efforts, it has been possible to develop simple test assays by which a large number of compounds may be tested with regard to their biological efficacy. These techniques have shortened the drug identification phase of drug research anywhere from 12 to 24 months.

The development of new drug delivery technologies and techniques is at the forefront of pharmaceutical research and development. These technologies enable safer and more effective delivery of drug products and can often reduce side effects and increase cost effectiveness. Drug delivery systems and formulations have become an essential part of the development process. As these new technologies emerge, they open a wide range of new opportunities.

The principal aim of drug delivery technology is to improve the administration of drugs that are currently available, and enable the administration of highly toxic and unstable therapeutic agents. The beginnings of the drug delivery industry lay in the development of sustained release formulations of orally delivered agents, suppositories and inhalers, and now includes implantable osmostic pumps, advanced needleless injection systems, transoral patches and liposomal formulations. The therapeutic advantages of drug delivery are increased efficacy, improved safety profile, and improved patient compliance as a result of the factors above in addition to increased ease of administration. The business advantage of drug delivery technology includes extension of patent life, salvage of development stage products and poor market performers, saving valuable and potentially wasted research and development expenses, and increased return on investment and decreased time to market compared to development of New Chemical Entities (NCEs).

The science of drug formulation has moved from hand rolled pills and individually compounded dosage forms at the start of this century to an era of high speed tablet presses and encapsulation machines that turn out thousands of dosage forms per minute. Programmable, pulsatile delivery devices that control release and target "magic bullets" to specific sites in the body are now a reality. DNA can be delivered to cell nuclei using liposomal delivery devices. As this century ends, scientists are working toward the development of tissue scaffolds for regeneration of organs. These advances in technology have been achieved through the development of the science of physical pharmacy in the mid-part of this century, a better understanding of physiology, and advances in molecular and cell biology.

How does this affect you and I?

The basis research for these technologies is accomplished in research universities like the University of Kansas in our school of pharmacy. Through grants from the National Institutes of Health, our faculty are involved in these research activities. Currently our faculty are in the final stages of proposing and developing genomic, transgenic research projects in the school of pharmacy to study animal models of disease states such as Alzheimers Disease. Our faculty in the school of pharmacy, in combination with colleagues on the KU and KUMC campuses, are developing novel drug delivery techniques for these drugs of the future.

Financially, it will affect how money is spent on drugs and how much is spent. Currently, in the U.S., expenditures for drugs account for about 8% of health care costs. This $80 billion that is spent on drugs requires the spending of an additional $80 billion to cover drug related morbidity and mortality. These newer drugs that I have discussed earlier may be more expensive to begin with, but may save money long term if used properly. It is important to note that drugs that enter the market to take the place of other drugs seldom if ever cost less than the replaced therapy.

Difficult decisions lie ahead for those that prescribe, use, and pay for these new frontier drugs and targeted drug delivery systems. Whether they are available to all who need them, or to only those that can afford them, is a question to be pondered and answered.

Complete references are available on request.

3.10

STATE OF KANSAS

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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
CHAIRMAN: LOCAL GOVERNMENT
MEMBER: FEDERAL & STATE AFFAIRS
FINANCIAL INSTITUTIONS

The Senior Pharmacy Assistance Program
Thursday, February 17, 2,000

Mr. Chairman and members of the committee. Today, we bring you an innovative and cost efficient health care initiative that will assist Kansans senior citizens with the purchase of their medications. This investment in the health of our seniors will be another step in insuring that our most vulnerable citizens stay healthy and that their quality of life is enhance.

Prescription drug coverage is essential to the delivery of 21st century medicine. Prescription drugs help keep people healthy, independent and out of hospitals and adult care facilities. The cost of prescription drugs can create financial burdens for many older Kansans, particularly those with low incomes and not eligible for Medicaid. In addition, many seniors are burdened by high out-of-pocket prescription drug costs and some have to make a choice of going without food to buy their medications.

As of July 1999, 16 states had created pharmacy assistance programs with several features. **HB 2814** provides for those individuals 62 years and older and with an income of less than $14,000 a year to apply for the prescription assistance program which will assist seniors after a $12 co-payment per prescription with the balance of the cost of purchasing that prescription.

This program is not an entitlement as "new enrollment in the program during a fiscal year shall cease if the secretary determines that costs of the program will exceed funds appropriated for the program."

In 1999, the Health Care Reform Legislative Committee, recognized the issues associated with increasing costs of prescription drugs, increased

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utilization of high-cost drug therapies, the changing and expanding role of drug therapies, and the increased complexity of drug regimes and concluded among several concerns that Kansas should initiate a state prescription drug assistance program since ,as prescription drug costs increase, the number of Kansans who are unable to pay for prescribe drug therapies will also increase.

This legislation is a step in the right direction as prescription drugs benefits is smart medicine. We need your support!

KENT GLASSCOCK

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HOUSE OF REPRESENTATIVES

Testimony
Submitted by
House Majority Leader Kent Glasscock
to the
House Health and Human Services Committee

Today I come before you in support of House Bill 2814, a bill creating the senior pharmacy assistance program, which provides eligible senior citizens financial assistance for prescription drugs. As prescription drug costs soar, the limited incomes of many older Kansans are not. This program gives eligible senior citizens a way to provide for their needed prescriptions without neglecting their other necessary expenses.

In their report to the 2000 Kansas Legislature, the Health Care Reform Legislative Oversight Committee recommended a state pharmacy assistance program be created to ensure access to necessary prescription drugs for our low-income senior population. House Bill 2814 designs a program that is not a hand-out but provides targeted assistance to Kansans who need it the most.

The prescription drugs included in this program are same as those covered by the state medicaid program. These drugs stop problems from getting worse, keeping seniors out of hospitals and adult care facilities. In the long run, this program could cut medical costs by helping seniors avoid serious medical problems that need more expensive treatments.

HB 2814 and the senior pharmacy assistance program will work. It will work for our seniors on a limited income with prescription drug needs. It will work for those of us who love and are concerned for older relatives and friends. And it will work for Kansas by keeping our state healthier and providing a way to avoid higher medical costs. I hope you will support this bill, which will improve the lives of so many senior citizens in Kansas.

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AARP *in Kansas*

February 17, 2000

Good afternoon Representative Boston and Members of the Health and Human Services Committee. My name is Barbara Withee. I am a volunteer and the Vice-Chair of the AARP State Legislative Committee. We represent the views of our more than 340,000 members in Kansas. It is my privilege to provide testimony today in support of House Bill 2814.

Our AARP legislative surveys in Kansas mirror those results from national surveys—seniors indicate that soaring costs of prescription drugs and reductions in coverage from private insurance or managed care plans have placed this as one of the priority issues of concern.

While almost two-thirds of Medicare beneficiaries have some form of prescription drug coverage, the annual out-of-pocket expense is over $1,200. Those with lower incomes who can least afford to pay for their drugs are those least likely to have prescription drug coverage; since their prescription needs amount to over 10 percent of their annual income, too many of these individuals must face the tough decision of choosing between paying for groceries or renewing their prescriptions.

In 1999, it was estimated that 45 percent of noninstitutionalized beneficiaries with incomes below the poverty level are projected to receive no Medicaid assistance. This does not include the vast numbers of individuals who would be classified as low income if you deducted their annual prescription bills from their annual income.

Much like inadequate preventive health care, those individuals who delay or neglect their prescriptions due to an inability to pay end up with acute health care needs and ultimately create a much higher burden to the state if institutionalization becomes necessary and their physical and financial state deteriorates to the point where they become Medicaid enrollees.

A possible solution to a significant portion of this problem is to follow the lead of 16 other states and develop a pharmacy assistance program for low income individuals. This notion has already received the endorsement of the Kansas Interim Health Care Reform Legislative Oversight Committee.

House Bill 2814 has most of the same conditions for coverage and cost-sharing responsibilities that exist in the other 16 state programs. AARP has previously shared copies of a lengthy analysis of the various programs to members of the Kansas Legislature

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and considers the various elements within HB 2814 appropriate as a proper first step in alleviating many of the worst case scenarios that currently exist.

While as of yesterday there is talk of action at the national level, we are somewhat cynical that election year politics may interfere with due progress. Regardless, most of the conditions within House Bill 2814 would be a logical base to add on to any future national legislation. As such, AARP lends its full support to this legislation.

Thank you for the opportunity to provide testimony.

Barbara Withee
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AARP Topeka Office
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TESTIMONY ON HB2814
FEBRUARY 17, 2000

ANNETTE GRAHAM, EXECUTIVE DIRECTOR

Good morning, my name is Annette Graham. I'm the Executive Director of the Sedgwick County Department on Aging, and of the Central Plains Area Agency on Aging. I'm testifying in behalf of the Kansas Association of Area Agencies on Aging in support of HB2814.

I thank you, Chairman Boston and the other members of this committee for the opportunity to comment in favor of HB2814. We, the members of the Kansas Association of Area Agencies on Aging support the establishment of the senior pharmacy assistance program and are excited about the possibility of having this much needed assistance available to seniors across the state. Daily we see the need for this type of financial help with the ever-increasing costs of medications. Too often older Kansans' are placed in the position of having to choose rather to eat or purchase necessary and expensive prescription medications. This program would be a lifesaver for many older citizens of Kansas.

We would respectfully suggest one change in HB2814 that would be in the administration of the program. We believe that it would be more effective, efficient and user friendly to have the senior pharmacy program administered by the Secretary of Aging. When the Home and Community Based Services Frail Elderly waiver program (HCBS FE) was transferred to the Kansas Department on Aging and the Area Agencies on Aging the intent was to provide for single point of entry. This concept contributed to the successful transfer of the program. The reasons we believe that this program should be administered by the Secretary of Aging and managed by the Area Agencies on Aging are as follows:

- The Area Agencies on Aging are the recognized experts on aging.
- Area Agencies on Aging currently have staff in the community, in older Kansans' homes.

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- The Area Agencies on Aging are required to provide information and assistance.
- The Area Agencies on Aging assess the need for services and coordinate the provision of services.
- The Area Agencies on Aging have contact with many of the older citizens most in need of financial assistance with prescription medication.
- We administer the Senior Health Insurance Counseling for Kansas (SHICK) program which utilizes volunteer counselors who can assist with applying for low-cost prescription drugs and explain differences in insurance policies. This program would blend well with this new program.

We encourage the administration of the senior pharmacy program by the Secretary of the Department on Aging. With the Area Agencies on Aging managing the enrollment into the program it would be easily accessible to older individuals who are in financial need of assistance. The individual or their family would not be required to go to another agency to apply for the service. This would maintain the concept of single point of entry for aging services, and it would avoid the necessity of setting up a new system in the Department of Social and Rehabilitation Services.

Again, thank you for allowing me this time to present these comments to you. I will be happy to answer any questions you have. Julie Govert-Walter, the Executive Director from North Central Flint Hills Area Agency on Aging is also here today to assist with providing additional information.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

Senior Pharmacy Assistance Program (HB 2814)
House Health and Human Services Committee

February 17, 2000

Testimony by Ken Grotewiel, Director, Consumer Assistance Division

On behalf of Commissioner Kathleen Sebelius, I am pleased to appear today to discuss with you HB 2814, the purpose of which is to provide very needed assistance to seniors who cannot afford to pay for their prescription drugs.

Many people in their early 60's find that they have no prescription drug coverage. The most common instance is that they no longer have coverage from a group plan with an employer and are not yet eligible for Medicare coverage which starts at age 65. Once on Medicare, prescription drugs are not part of the basic benefit package. While some coverage is available through three supplemental insurance plans, they are substantially more expensive than those plans without prescription drug coverage. Medicare HMO's do provide some prescription drug coverage. However, the HMO option is available only in a very limited number of counties.

Our department has first hand knowledge of this need among seniors with our responsibility to run the Senior Health Insurance Counseling for Kansas program (SHICK), a program funded by the Kansas Department on Aging through a grant from the Health Care Financing Administration. SHICK is a network of over 300 volunteers in the state that help Medicare beneficiaries sort through questions and problems related to their health care. These beneficiaries include seniors as well as people under 65 with disabilities. Assistance is provided over the phone and in person.

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Topeka, Kansas 66612-1678

785 296-3071
Fax 785 296-2283

Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

One of the primary reasons people hook up with our SHICK network is to get help paying for their prescription drugs. Our counselors help individuals apply for and get some of their prescriptions at little or no cost through assistance programs run by pharmaceutical manufacturers. SHICK does not provide any direct financial assistance for prescription drugs.

Demand for this help continues to increase as more and more seniors struggle to pay for their prescription drugs, which are not generally covered by Medicare. Our counselors served 2877 people, an increase of 38% over 1998, with total savings for Medicare beneficiaries of $904,658 in 1999. These are out-of-pocket costs Medicare beneficiaries would have paid for prescription drugs had it not been for our assistance.

These assistance programs sponsored by the pharmaceutical companies are for people of all ages, and anyone wanting to apply can do it on their own. Information on available drugs and participating companies is listed on SHICK's home page at www.ksinsurance.org/SHICK.

However, let me be clear that this assistance, while extremely valuable, is a hit and miss system. Almost all applications must be made by a person's doctor, the drugs are distributed in a wide variety of ways, and most approvals cover a 90 day period at which time people must re-apply to continue to receive their prescription drugs. As well, the prescriptions applied for are for the treatment of on-going or chronic conditions, and are not useful in cases of acute or sudden illness. The process is time consuming with an average of a 4-6 week delay between application and actual delivery of the prescription drugs.

If this committee and the legislature were to provide direct financial support for seniors in need of help to purchase their prescription drugs, it would help fill one of the biggest gaps in Medicare coverage. It would also help those seniors nearing 65 years old without health insurance coverage. Thank you for your attention today, and I would stand for any questions you might have.

Overview of Medicare A & B

Key: Shaded areas – Medicare Pays
White areas – You pay

Excess Charges
(15% over Medicare Allowed Charge)

A

Each benefit period *

In-patient Hospital

First 60 Days	$768 Deductible
Days 61-90	$192 per day coinsurance
Lifetime Reserve Days 91-150	$384 per day coinsurance

Skilled Nursing Facility

First 20 days	100% (No co-pay)
Days 21-100	$96 per day coinsurance

100 % Services
- **Home health**
- **Hospice**

***Benefit period ends when patient is out of the hospital or skilled nursing facility for 60 consecutive days.**

B

$100 Deductible
(per calendar year, Jan.1 to Dec. 31)

80%

20% COINSURANCE

Physician's Charges (in or out of hospital)

Durable Medical Equipment & Supplies

Ambulance

Outpatient Hospital Charges

Blood The first 3 pints

Lab Services

Preventive Services
- **Screening Mammograms**
- **Annual Pap Smears**
- **Diabetes Self-Management**
- **Bone Mass Measurements**
- **Flu Shots (Paid at 100%)**

Standard Medicare Supplement / Medicare Select Benefit Plans

	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F/F*	Plan G	Plan H	Plan I	Plan J/J*
Part A Hospital (Days 61-90)	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Lifetime Reserve (Days 91-150)	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
365 Life Hosp. days - 100%	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Parts A and B Blood	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Part B Coinsurance ♦ (Generally 20%) (End of Basic Benefits)	♦	♦	♦	♦	♦	♦	♦	♦	♦	
Skilled Nursing Facility Coinsurance Days 21-100			♦	♦	♦	♦	♦	♦	♦	♦
Part A Deductible		♦	♦	♦	♦	♦	♦	♦	♦	♦
Part B Deductible			♦			♦				♦
Part B Excess Charges						100%	80%		100%	100%
Foreign Travel Emergency			♦	♦	♦	♦	♦	♦	♦	♦
At-Home Recovery				♦			♦		♦	♦
Basic Prescription Drugs **								$1,250	$1,250	
Extended Prescription Drugs **										$3,000
Preventive Medical Care					♦					♦

* Plan F* and J* have a $1500 calendar year deductible before benefits will be paid.
** Plans "H" and "I" have a $250 deductible, plus a 50% co-payment to a maximum of $1,250. Plan "J" has a $250 deductible, then pays 50% to a maximum of $3,000.

See pages 38-49 for the cost comparison data

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TOPEKA

HOUSE OF
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COMMITTEE ASSIGNMENTS
AGRICULTURE
HEALTH AND HUMAN SERVICES
EDUCATION
INSURANCE
TASK FORCE ON LONG-TERM CARE

February 17, 2000
House Bill 2814

Chairman Boston and Members of the House Health and Human Services Committee:

Thank you for allowing me to offer testimony on this bill. I applaud Representative Carlos Mayans for bringing this bill forth for your consideration. This is a problem that has plagued Senior citizens for the past decade and is one that needs to be addressed.

During the past decade, we have seen an increase in the types of prescription drugs available. These new medications help people live a more rewarding life and allow them to be able to remain in their homes and with families by controlling illnesses.

The down side is that the cost of these medications has increased dramatically as drug companies spend more money on research and development to fund the products. This cost has to be passed on to the consumer. The very people who need the medications can no longer afford them. Rep. Mayans' bill will help to defray these costs.

While I applaud his efforts, I do believe there are some changes that need to be added to this bill. Most of all, I feel we need to allow the patient the opportunity to choose a generic over a brand name if they want to have their health care dollars go further. Therefore I propose they pay on third of the cost of the medication. This will allow them to know the cost of the medication and they can make a choice.

I agree with the cap on the limit of money. The state does not have deep pockets as we well know and we need to limit the assistance we can provide to reach the largest number of persons.

I have included other changes I think would make a good bill better. I have included those proposals and would appreciate you taking the time to look over them at your leisure and consider them when working the bill.

Thank you very much for your time.

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HOUSE OF
REPRESENTATIVES

DEMOCRATIC POLICY CHAIR

COMMITTEE ASSIGNMENTS
MEMBER: ECONOMIC DEVELOPMENT
FEDERAL AND STATE AFFAIRS
FISCAL OVERSIGHT
TAXATION

Testimony Supporting the Creation Of Senior Prescription Drug Assistance Program

Chairman Boston and Members of the House Health and Human Services Committee:

Thank you very much for this opportunity to provide testimony supporting the creation of a prescription drug assistance program for Kansas seniors. My testimony will focus primarily on House Bill 2966 introduced by Rep. Showalter, myself and a number of other legislators, however, I would also like to take this opportunity to applaud the hard work and leadership of Rep. Mayans on this issue as well.

If you ask a typical Kansan over the age of 65 what is the most pressing problem they face today, regardless of their income level, the answer almost to a person will be the skyrocketing cost of prescription drugs. The statistics from a wide variety of sources substantiate these concerns.

An issue brief published in July 1999 by the National Institute of Health Care Management cited one HCFA report that growth in prescription drug expenditures had grown at a whopping 18.4% in 1998. Prescription drug cost inflation exceeds the rate of inflation in other areas of health care.

According to a recent report released by the American Association of Retired Persons (AARP), Medicare beneficiaries age 65 and older living in the community were projected to spend an average of $2,430 out-of-pocket, or nineteen percent of their income for health care in last year. Over half of this amount, fifty-four percent, will be spent on health care goods and services. Prescription drug costs account for the single largest component of out-of-pocket spending on health care, after premium payments. On average seniors are expected to spend as much out-of-pocket for prescription drugs as for physician care, vision services and medical supplies combined.

In Kansas, and across America, these rapid increases are literally choking off access to adequate, quality health care for thousands of senior citizens. In more and more instances seniors are being forced to make a choice between spending their relatively small fixed incomes on groceries or prescription drugs.

HB 2966 has been introduced to help begin addressing at least a part of the problems associated with rising prescription drug costs. This proposal to create the Kansas Senior Prescription Drug

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Assistance Program is aimed at insuring access to necessary prescription drugs for some of our most needy citizens, low-income Kansans over the age of 65 who are unable to qualify for assistance through Medicaid.

HB 2966, if enacted into law, would provide a maximum benefit of $1,500 per year in prescription drug assistance to qualified enrollees. To qualify a person would have to be age 65 or older and have an income of no more than 200% of the federal poverty level (which in 1999 would be approximately $16,480 for an individual). Additional eligibility requirements include being a Kansas resident for at least six months, being enrolled in Medicare Part A or B, and prospective applicants must also be able to demonstrate that they have had no coverage for prescription drugs under any health insurance policy for the last six months.

Under the proposal, the administering state agency (the Kansas Department on Aging) would be able to establish an annual registration fee not to exceed $15 to help off-set some of programs associated administrative costs. Additionally, each enrollee will be required to pay a co-payment, not to exceed 30% of the cost of each prescription. The size and scope of the program would be limited to the amount of money annually appropriated by the Legislature.

The concept of a prescription drug assistance program geared toward helping seniors is not a new idea. As of mid-1999 sixteen other states operated such programs. Other states are expected to join the ranks this year. The Health Care Reform Oversight Committee of the Kansas Legislature endorsed such a concept last fall. As I indicated at the outset of my testimony, it is a concept that clearly has bipartisan support and interest as witnessed by the introduction of HB 2814 by Rep. Carlos Mayans. If endorsed by the Kansas Legislature this session, the Senior Prescription Drug Assistance Program will be a crucial first step in our efforts to insure that low-income seniors will not be denied access to the prescription drugs they need to enjoy the quality of life they have earned through years of hard work.

I would respectfully ask the committee to give favorable consideration to HB 2966. Thank you again for this opportunity to testify. I would be pleased to stand for questions.

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Kansas Senior Prescription Drug Assistance Program

Program Goals:

Provide financial assistance to help insure access to necessary prescription drugs for low-income Kansas seniors over the age of 65 who do not qualify for Medicaid and have no prescription drug coverage under a private health insurance plan.

Eligibility Requirements:

Applicants must:

- Be at least 65 years of age.
- Have an income of no more than 200% of the federal poverty level.
- Have been a Kansas resident for at least six months.
- Demonstrate that they have had no prescription drug coverage under a health insurance policy for the last six months.
- Be enrolled in Medicare part A and part B

Additional Considerations:

- Program shall be administered by the Kansas Department on Aging.
- Enrollment shall be limited to the amount of money appropriated on annual basis for the program by the Legislature.
- The maximum annual per person benefit shall be capped at $1,500.
- Secretary of Aging may establish an annual registration fee not to exceed $15.
- Enrollees shall pay a co-payment of up to 30% of the cost of each prescription.
- The plan would not cover non-prescription medications.
- Each enrollee shall be given an identification card to present with their prescriptions. A photo identification or another form of non-photo identification shall also be required.
- Implementation of this act shall be effective July 1, 2001.

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ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY
HB 2814
House Committee On Health and Human Services
February 17, 2000

My name is Bob Williams, Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the Committee regarding HB 2814.

The cost of prescription medication has been a major concern for pharmacists in Kansas for a number of years. This is particularly true for pharmacists working with elderly patients who take a number of different drugs and are on limited, fixed incomes. Many pharmacists offer "senior discounts."

Representative Mayans has spoken with me on several occasions regarding the provisions in HB 2814. Of particular concern to Representative Mayans was whether or not the reimbursement to pharmacists, as outlined in the bill, would be reasonable enough to encourage participation by pharmacists. To that end, I did an unscientific "straw poll" of KPhA members. The majority of respondents indicated the reimbursement outlined in the bill would be the "minimum" reimbursement they would accept for such a program.

Because of our concern for senior adults and the need for appropriate, rational drug therapy, KPhA supports HB 2814.

Thank you.