



Prescription Policy Choices

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Testimony to the Government Oversight Committee  
Regarding the Office of Program Evaluation & Government Accountability Report on  
Health Care Services in State Correctional Facilities

Senator Katz, Representative Burns and other members of the Government Oversight Committee.

I'm Ann Woloson, Executive Director of Prescription Policy Choices, a nonprofit, nonpartisan public policy and educational organization with the mission of improving access to safe, effective and affordable prescription drugs in Maine and the US.

PPC works with consumers, health care providers, payers and policy makers to promote evidenced-based prescribing and also to identify and limit possible conflicts of interest between policy makers, prescribers and the pharmaceutical industry.

PPC is funded primarily through grants from private and public foundations and contracts from consumer advocacy organizations such as Consumers Union. We accept no funding from the pharmaceutical industry. Currently we are receiving funding from the Maine Health Access Foundation to work with public and private payers to explore opportunities for containing health care costs by encouraging evidenced-base prescribing and greater use of "recommended" drugs.

I'm here today to provide a little information on how increasing the use of recommended, evidenced-based prescription drugs may help the MDOC continue to provide access to quality health care and contain costs. Recommendation 5 (pg. 22) in the OPEGA report suggested MDOC continue to pursue costs containment strategies through new health care services contracts.

MDOC response to the recommendation (pg 25) indicates it intends to explore several costs containment strategies through the upcoming RFP and has taken steps to reduce costs associated with current contracts, etc.

As MDOC continues its efforts to contain costs, instead of reducing access, it should instead consider whether or not the prison system is making the best use of recommended evidenced-based care, including prescription drugs. Evidenced-based, recommended drugs are drugs which have been proven to work best, are safest, and more often than not, less expensive than newer products on the market. Recommended evidenced-based drugs are reviewed independently by researchers who are not connected with the pharmaceutical industry. Reviews are non biased, comprehensive and compare drugs over an entire treatment class, for example diabetes, high blood pressure, etc.

Our experience working with both private and public payers is that many leave decisions regarding which drugs are covered or preferred to their pharmacy benefit manager. While it may be true that most benefit managers may be able to provide certain drugs at a reduced cost to their clients, it's also true that they make money by steering beneficiaries in plans they serve to more expensive drugs through agreements they make with drug manufacturers.

A study released late in 2010 analyzed 6 large health plans in Minnesota. It found that increasing the utilization of evidenced-based recommended drugs could have yielded cost-savings of more than

50% (in drug categories studied). \*Kjos, AL, et al. **A comparison of drug formularies and the potential for cost-savings.** *American Health & Drug Benefits*, vol 3, No. 5 (September/October 2010): 321-330. Please see attached report for more detail regarding the study.

I would point to an example to help you better understand savings that could have been achieved in the state Medicaid program with improved evidenced-based prescribing:

- Avandia (oral diabetes drug)

Avandia sales peaked at about \$3 billion in 2006 - world's best-selling diabetes Type II medication. Sales dropped sharply after a 2007 NE Journal of Medicine report linked it to increased heart attack and cardiovascular death risks, and found it no more effective than other drugs for most patients. The FDA has pulled the drug from the US market.

Avandia continued to be preferred through 2009

- Metformin, a generic oral diabetes drug, was and remains a recommended evidenced-based drug alternative (supported by independent research entities: DERP/Drug Effectiveness Review Program and Consumer Reports Health Best Buy Drugs, CRHBBD™ and AHRQ)
- Estimated potential savings if Avandia was replaced with metformin in 2009: \$150,000 (does not include potential savings related to improved quality)

I believe the MDOC could perform a simple analysis of drugs it pays for in certain therapeutic categories (mental health, diabetes, high blood pressure, etc.) to see if it is paying for evidenced-based recommend drugs or brand name drugs, etc. It's quite possible MDOC could create savings by working more closely with its drug benefit manager to make greater use of evidenced-based drugs. Increasing the use of recommended prescription drugs can help improve overall health care quality and create savings in other areas as well. We are working with other payers in formulating such an analysis of drug formularies and preferred drug lists. Such an analysis is even more important as top selling brand drugs like Lipitor come off patent. Several reports of the industry's strategy to keep people on the more expensive brand name drug have been made in recent weeks.

I'm not suggesting the prison system use lower quality drugs to treat illness in their patients. In fact, most evidenced-based recommended drugs are proven to be just as, if not more effective than newer products, safer and nearly always are less expensive. When I'm sick, or a member of my family is sick, we want to make sure the medication we are prescribe is proven to work best and is known to be safe; and I'm happy if the medicine we take cost me (or my health plan) less.

I also want to mention how important is to make sure prescription drug use is closely monitored and urge the department to strive for such monitoring in an effort to reduce unnecessary prescribing and improve prescription drug adherence. It's estimated poor medication adherence costs the US as much as \$290 billion annually in increased medical costs associated with patients not taking medications as instructed. Not taking medicine on time, as part of proper regimen, especially by those with chronic conditions like diabetes and high blood pressure will result in increased hospitalizations and a need for additional care and medicine. The MDOC should work with existing and new health care and prescription drug contractors to ensure regular and ongoing monitoring of prescription drug use and for effectiveness. Special consideration should also be made in terms of treating special minority populations, who may need additional assistance in understanding their drug regimen and the importance of adherence. Thanks for taking a few minutes to listen to my suggestions.