Background Brief on…

Prescription Drugs

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Background

The U.S. spent $1.6 trillion on health care in 2002, which is approximately 14.9 percent of the Gross Domestic Product **(GDP)** for that year.[1] Hospital inpatient/outpatient services, prescription drugs, and physician services contribute to the total increases in health care costs. The federal Office of the Actuary at the Centers for Medicare & Medicaid Services **(CMS)** annually projects health care expenditures. For 2003, CMS projects that hospital spending contributes 26.2 percent of overall health care spending, with prescription drug spending and physician spending accounting for 18.0 percent and 19.3 percent, respectively.[2]

Much of these health care costs are focused on prescription drugs, especially for seniors—who use a greater amount of medication—and for state Medicaid programs such as the Oregon Health Plan (OHP), where the state must contribute matching money to receive federal dollars for health care services. For more information on the OHP, see Background Brief on Oregon Health Plan.

Spending for Prescription Drugs

From 1995 – 2001, the annual change in spending for prescription drugs, per capita, has annually increased at a higher rate than for other health care components (see Table 1 below). People on Medicare, which until recently did not pay for most prescription drugs, are also experiencing increased out-of-pocket spending for medications. Beneficiaries' average annual out-of-pocket drug spending has risen from $644 in 2000 to $996 in 2003.[3] States are likewise spending more money on prescription drugs. Oregon's Health Resources Commission reports that OHP pharmaceutical costs increased from $275 million in 1997-1999 to $522 million in the 1999-2001 biennium, with a significant increase in the 2001-2003 budget year.

[1] Centers for Medicare and Medicaid Services (2004). http://www.cms.hhs.gov/statistics/nhe/historical/highlights.asp

[2] Centers for Medicare and Medicaid Services (2004). http://www.cms.hhs.gov/statistics/nhe/projections-2003/highlights.asp

[3] Medicare and Prescription Drugs (2003). The Henry J. Kaiser Family Foundation

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Table 1: Annual spending trends

Year	Hospital inpt.	Hospital outpt.	Physician	Rx
1995	-3.5%	7.9%	1.9%	10.6%
1996	-4.4%	7.7%	1.6%	11.0%
1997	-5.3%	9.5%	3.4%	11.5%
1998	-0.6%	7.9%	4.8%	14.1%
1999	1.6%	8.9%	5.7%	18.4%
2000	2.8%	11.2%	4.8%	14.5%
2001*	3.5%	12.5%	4.8%	15.2%

*Data through March 2001, change from corresponding months in 2000. Source: Milliman USA Health Cost Index ($0 deductible), Kaiser/HRET survey of employer-based health plans for 99-01 and KPMG survey for 1991-1998.

The reasons for increased spending on prescription drugs are debated among health care researchers, pharmaceutical manufacturers, state health officials, consumer groups and others. Many researchers and consumer groups state that the pharmaceutical industries' extensive advertising of newer and higher priced drugs influences consumers to seek brand name and often more expensive medications instead of using lower cost generic drugs. The response from pharmaceutical companies and others is that higher prices are due to expensive research and development costs to bring new drugs to market, and that advertising assists many people in recognizing conditions that may prompt them to seek medical help. A number of sources cite the drivers of pharmaceutical costs as being price inflation, increased drug utilization and a mix of more expensive drugs. There is general agreement that a higher utilization of drugs among the aging population, which is living longer, is one of the key variables of increased drug spending.

Medicare and Prescription Drugs

Until recently, Medicare generally did not pay for prescription drugs. The recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) creates prescription drug coverage for Medicare recipients. Currently, recipients can access a Medicare-approved discount drug card that will reduce certain drug purchases. By 2006, Medicare will terminate the discount card program and start providing outpatient prescription drug coverage through private plans. Most Medicare recipients who wish to use this new program in 2006 will have to enroll in a plan and pay a monthly fee, a deductible and co-payments in order to receive drugs at a discounted price. The program is designed to provide drugs at a greatly reduced price when recipients exceed high out-of-pocket costs within the year. Lower income Medicare recipients are eligible for additional assistance with both the discount card and the private plan programs.

Drug Costs in Other Countries and the U.S.

Prescription drugs are often priced lower in Europe, Canada, Mexico and other countries where the government generally oversees the health care system and requires lower prices from manufacturers for that companies' drugs to be used and sold . In the U.S., the federal government requires a reduced price for drugs that are used in federal health programs, like Veteran's Administration hospitals. State Medicaid programs also receive reduced drug costs (although generally not discounted as much as with the federal government).

Many seniors and others have been purchasing prescription drugs from Canada for less money than the cost of the same drug in the U.S. Although the MMA prohibits reimportation of drugs from other countries due to concerns about drug safety, the federal government is currently re-examining the issue.

Discount Cards and Assistance Programs

Many pharmaceutical manufacturers offer their own discount cards to low-income seniors and others. These cards allow a person to obtain discounts on some or all of companies' prescription drugs. These programs have varying eligibility requirements (level of income, age), annual fees, amounts that enrollees must pay and other requirements. Many pharmaceutical companies also provide free or low-cost drugs to low-income people through patient assistance programs operated by drug manufacturers. While

these programs are not meant to be a permanent solution to providing free or low-cost prescription drugs, they do serve as a stop-gap measure for those who may need temporary assistance.

States Initiatives on Prescription Drugs

Different states have passed or are exploring legislation and policies to control spending on prescription drugs in Medicaid programs, to assist seniors with their drug expenses and increase health coverage for low-income and uninsured/underinsured people. These programs and initiatives include:

Senior prescription drug programs – Numerous states have enacted or implemented programs specifically for low-income seniors who cannot afford or do not have third party coverage for prescriptions (e.g., Medigap policies). These programs usually use state general funds and criterion that limit the program to people below a certain poverty level, subsidize only a portion of drug costs and may require fees. Many of these states are examining how to modify or adjust their current programs to operate in conjunction with the MMA.

Specialized federal waiver – The federal government originally authorized Illinois to extend comprehensive prescription drug coverage to seniors up to 200 percent FPL (who normally would not qualify for Medicaid) using federal Medicaid matching funds. The waiver provides 50 percent funding for much of a senior drug program that the state had operated with general funds. By providing just Medicaid prescription drug coverage for more seniors, the state projects that, in five years, the program will deter 41,400 seniors from full Medicaid coverage due to failing health and/or poverty. More recently, Wisconsin, South Carolina, and Florida have received waivers to operate similar programs.

Formularies or preferred drug lists – Managed care providers normally require that enrollees use prescription drugs from a formulary or preferred drug list (PDL), which is basically a list of drugs with limited choices within the various "families" of drugs for different conditions. Drugs on the list usually require a co-pay due by the enrollee or a higher co-pay if an enrollee wants a drug not on the list. The list may be multi-tiered, meaning that the co-pay is contingent on the use of generic or brand-name drugs on the list. For example, the lowest co-pay amount may be for generic drugs, the next higher co-pay for brand-name drugs on the list and the highest co-pays for brand-name drugs not on the list. Some programs require prior authorization before a drug that is not on the list can be dispensed, which means the prescriber must receive approval by the source paying for the drugs before the prescription can be filled.

Supplemental rebate programs – Several states have redesigned their Medicaid programs to require that drug manufacturers give the state supplemental rebates for a drug in return for that particular drug being included on the state's Medicaid PDL. The supplemental rebates are on top of the previously mentioned Medicaid discounts. These programs vary in how they operate and conditions for drugs to be exempt from the supplemental rebate requirement. Some of these programs face legal challenges from the pharmaceutical industry.

Bulk purchasing – To gain an economy of scale, several multi-state coalitions have formed to examine making bulk purchases of prescription drugs for their respective Medicaid and other programs (such as state employee prescription drug coverage). Private sector health care companies often negotiate discount price agreements with manufacturers in return for using these drugs in their formularies. In April, the federal Department of Health and Human Services announced approval of a five-state prescription drug purchasing pool for Medicaid beneficiaries. The states--Michigan, Vermont, New Hampshire, Alaska and Nevada--project that the purchasing pool will collectively save approximately $12 million in their Medicaid programs in 2004, and cover approximately 900,000 beneficiaries.

Oregon Prescription Drug Programs and Initiatives

Oregon has a number of current and upcoming programs and policies to both lower the state's cost for prescription drugs, while providing prescription drug coverage for more OHP clients[4] and many low-income seniors.

- Generic drugs – Under current state law, a doctor must prescribe generic drugs to OHP fee-for-service (FFS) clients. However, if a generic drug equivalent is available and the doctor still wants the patient to receive the brand name drug, the doctor must document the medical necessity of the brand drug before a pharmacist can receive approval for the brand drug price.
- OHP co-pays - The Oregon Health Plan requires some OHP recipients to make co-pays and implement other cost-sharing mechanisms to reduce prescription and other health care costs (see Background Brief on Oregon Health Plan).
- Co-payments – OHP FFS clients pay $2 for generic and $3 for brand drugs. The co-payments also apply to mental health drugs for all OHP clients, including those in FFS and fully capitated health plans. Some OHP clients and services, such as pregnant women, children under age 19, institutionalized clients (including community-based and those in Waiver services), Tribal Health Clinics, managed care, emergency services, mail order drugs, and family planning, are exempt from co-payment requirements.
- Pharmacy Management Program – OHP clients in the FFS system must choose one pharmacy for obtaining prescriptions. The purpose of the program is to identify and monitor high drug utilization. Clients can periodically change pharmacies and are exempt from the rule under certain conditions (e.g., enrolled in a fully capitated health plan, have private medical insurance, receiving services through a federally recognized Tribal Health Facility, child in state care, in a hospital, long-term residential care or other medical facility).
- Practitioner identification on prescriptions – Prescription drug claims without the prescribing practitioner's Oregon Medical Assistance Program number (OMAP is the state agency that oversees the OHP) will be denied. Having complete claims data allows OMAP to better analyze drug utilization trends.
- Senior Prescription Drug Program – The program, established by Senate Bill 9 (2001), helps low-income seniors pay for prescription drugs by allowing eligible people to purchase prescriptions at the Medicaid rate from participating pharmacies. The person must be at least 65 years old, have an income of not more than 185 percent FPL, not have more than $2,000 in liquid resources, and not have any public or private drug benefit for the previous six months.
- Practitioner-Managed Prescription Drug Plan (PMPDP) – The program is for OHP clients who are in the FFS system. Established by Senate Bill 819 (2001), the Health Resources Commission is charged with creating a PDL of the most effective drugs that can be obtained for clients at the best price. PDL drugs are being evaluated and added by classes (such as long-acting opioids for pain relief, proton pump inhibitors for treatment of heartburn, etc). Additional classes of drugs will continue to be added to the program.
- Diagnosis on prescriptions – Practitioners need to indicate on all prescriptions if their OHP patient's condition being treated is below the Health Services Commission Prioritized List funding line (OHP only covers conditions above a certain line on the list). If the condition is below the line and not covered by the OHP, practitioners must indicate in writing that the condition is not covered.

[4] Approximately 72 percent of OHP clients are in fully capitated health plans (FCHP or managed care programs), so already receive prescription drug coverage, usually within a formulary, from their managed care plan. The state's current and new programs are geared toward the 28 percent of OHP clients who are in the fee-for-service (FFS) part of the program (i.e., health care expenses are billed directly to the state).

- Reimbursement – Payment for eligible prescription drugs are made to pharmacies at Average Wholesale Price (AWP) less 15 percent plus a $3.50 dispensing fee. Institutional pharmacy prices are at AWP less 11 percent plus a $3.91 dispensing fee.[5]
- Disease case management – OMAP is contracting with a health care company for the disease case management of the OHP's 700 most expensive FFS clients, as well as FFS clients with diabetes, asthma or congestive heart failure. Many clients with high utilization also have high medication needs and should benefit from disease case management.
- Oregon-specific Maximum Allowable Cost (OMAC) for generic drugs – The state pays the lesser of the federal maximum allowable amount: AWP less 14 percent or the OMAC. The OMAC is determined on selected multiple-source drug designations (at least two drugs that are equally effective in treating a condition) when bio-equivalent (usually generic) drugs are available from at least two wholesalers serving the State of Oregon.
- Expedite drug rebates – In July 2001, the state developed a plan with First Health, the company that manages many of Oregon's pharmacy services, to obtain rebates for drugs dispensed in a physician's office and to pursue other reimbursements due to the state for prescription drugs.
- Supplemental drug rebates review – HB 3624 (2003) directed DHS to explore getting supplemental rebates from drug manufacturers and to enter into purchasing pools as necessary in seeking supplemental rebates. The state received a proposal from First Health, which is currently under review, but appears that effectively requiring supplemental rebates would require a prior authorization that the state is precluded from doing under current law.
- Pharmacy Benefits Manager proposal – HB 3624 also directed DHS to develop a request for proposal for a pharmacy benefit manager (PBM) agreement to purchase prescription drugs in bulk or reimburse pharmacies for prescription drugs for eligible persons in the medical assistance program. The PBM agreement would be directed to establish two programs: 1) A system for optional use by fully capitated health plans; and, 2) A fee-for-service program.
- Polypharmacy program – HB 3624 allows DHS to implement a program to require prior authorization for OHP clients who use over 15 unique drugs within a 180-day period.
- Contracted Mail Order Program – The contracted mail order pharmacy is a voluntary program available to OHP FFS clients. Compared to retail pharmacy (AWP-15%), the mail order contract specifies AWP-21% for brand name and AWP-60% for generic drugs. To increase mail order pharmacy use, DHS has implemented a communication strategy with clients through a monthly Medical ID mailing, through DHS caseworkers, through OHP regional meetings, and with targeted provider populations such as clinics and Primary Case Managers.
- Partnership for Psychiatric Medication Access that consists of three initiatives focusing on the cost and use of mental health drugs:
    1. Behavioral Pharmacy Management System (BPMS) - A collaboration between the state's mental health program, Oregon Health Plan and Comprehensive NeuroScience to analyze claims data to identify prescribing practices that are not evidence-based and that may be inconsistent with quality care for patients. The program will provide consultation support through letters to providers whose practices are identified as varying from expected practice and/or provide peer-to-peer psychiatric and pharmacy consultations.

[5] The AWP is the average of the prices charged by national drug wholesalers for a given drug. The dispensing fee is the amount paid to a pharmacist for professional services (labor/administrative effort) in filling prescriptions.

2. Cost savings opportunities - A data-driven method for giving the same providers feedback on ways that they can be more economical in their prescribing decisions without compromising the quality of care primarily by using such methods as dose consolidation and pill splitting when it is therapeutically appropriate, the patient is physically and cognitively able, and the patient and physician agree that it is acceptable.
3. Medication Management Algorithm Project - The development of practice guidelines for the use of certain psychiatric medications, especially for major psychiatric illnesses, such as schizophrenia, bipolar disorder, and severe depression. It includes training providers about the guidelines and documentation of appropriate outcome measures. It also includes a comprehensive patient education curriculum so that patients will be better educated about their illnesses and treatments.

Prescription drug web sites:

- AARP Health and Wellness www.aarp.org/health/
- Center for Studying Health System Change www.hschange.org/
- National Academy for State Health Policy www.nashp.org/index.cfm
- National Conference of State Legislatures Health Page www.ncsl.org/programs/health/pharm.htm
- PhRMA (Pharmaceutical Research and Manufacturers of America) www.phrma.org/
- The Henry J. Kaiser Family Foundation www.kff.org/

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