Background Brief on …

Prescription Drugs

Prepared by: Rick Berkobien & Erin Seiler

June 2008

Inside this Brief

Legislative Committee Services
State Capitol Building
Salem, Oregon 97301
(503) 986-1813

The U.S. spent $2.1 trillion on health care in 2006, which is approximately 16 percent of the Gross Domestic Product for that year. Hospital inpatient/outpatient services, prescription drugs, and physician services contribute to the total increases in health care costs. For 2006, the Centers for Medicare & Medicaid Services projected that hospital spending contributed 31 percent of overall health care spending, with prescription drug spending and physician spending accounting for 10 percent and 21 percent, respectively.

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 the *Oregon Health Plan* Background Brief)

Spending for Prescription Drugs

Oregon's Health Resources Commission reports that OHP pharmaceutical costs were $637 million in the 2005-2007 biennium and estimated to be $600 million in the 2007-2009 budget cycle.

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. However, pharmaceutical companies and others note that higher prices are often 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

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 **(MMA)** created prescription drug coverage for Medicare

recipients. Medicare recipients who wish to use this program 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.

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 those 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 for the federal government.

Many seniors and others have been purchasing prescription drugs from Canada for less 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. The 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 stopgap measure for those who may need temporary assistance.

States' Initiatives on Prescription Drugs

Below are summaries from the National Conference of State Legislatures' web site on several key programs that states have enacted or are considering:

- *Expanding Access: Discount and Subsidy Programs* – A majority of states have established subsidy or discount programs to reduce prescription drug costs and provide direct relief to qualified low-income residents. In 2006-2007, many states retooled their discount and subsidy programs to include Medicare Part D provisions; in 2008 proposed expansions and/or changes again are on the table in over 15 states.
- *Marketing and Advertising* – A few states already require pharmaceutical manufacturers to disclose marketing expenses, including gifts to drug prescribers. During 2008, at least 20 states have proposed legislation requiring marketing disclosures by drug manufacturers, regulating direct-to-consumer advertising of prescription drugs by pharmaceutical companies, or prohibiting prescription information from being sold for commercial purposes. The District of Columbia passed such a bill in January 2008.
- *Privacy and "Data Mining"* – In 2006, New Hampshire became the first state to prohibit the sale or redistribution of prescription sales record information that identified patients or prescribers. In 2008, at least 12 states have similar proposals, using examples from 2007 laws signed in Maine and Vermont.
- *Medicare Part D Wrap Around Benefits and Services* – A dozen states are considering bills and resolutions intended to modify or adjust state pharmaceutical assistance efforts in response to the federal MMA benefit launched in January 2006.
- *Pharmacy Benefit Managers* – At least 13 states are proposing legislation to regulate pharmacy benefit management companies -- the middlemen who negotiate directly with manufacturers. The bills seek to

assure financial reliability, regulate the licensing of pharmacy benefit managers, and/or mandate full disclosure of drug costs and financial contracts.

- *Prescription Drug Reuse/Recycling* – Allowing or encouraging donation of unused pharmaceutical drugs is a popular idea - nine states passed such laws in 2006. For 2008, interest continues in ten states, with some of the focus on cancer drug repository programs that allow an individual, health care facility or drug manufacturer to donate cancer drugs or supplies needed to administer cancer drugs for use by those who meet eligibility criteria.
- *Electronic Monitoring and Internet Prescribing* – This is a relatively recent trend that gained momentum during the past three years. Proposed laws would allow for the development and regulation of electronic transmission of prescription drug orders, as well as establishing Internet prescribing practices to provide increased protection for consumers purchasing prescription drugs over the Internet. Additionally, several more states seek to establish electronic prescription drug databases to monitor the misuse, abuse, and diversion of prescription drugs and controlled substances. In August, Alaska became the final state to change laws and regulations to allow for e-prescribing.

Oregon Prescription Drug Program

The Oregon Prescription Drug Program **(OPDP)** is a bulk drug purchasing program established in 2003. The OPDP purchases or reimburses pharmacies for prescription drugs in order to receive discounted prices and rebates, makes prescription drugs available at the lowest possible cost to participants in the program, and maintains a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices. Participants can enroll in the OPDP at no cost and receive an identification card that is recognized at major pharmacy chains in Oregon. All prescriptions by a licensed Oregon clinician are eligible for a discount, and participants save an average of 42 percent.

Initially, the OPDP participation was limited by age and income, but Ballot Measure 44 (2006) removed the eligibility criteria, opening the program to all Oregonians without prescription drug coverage. In 2007, Senate Bill 362 expanded the program to include the underinsured, private entities, and labor organizations. In 2006, the OPDP joined with Washington State's Washington Prescription Drug Program to combine purchasing power, and form the partnership Northwest Prescription Drug Consortium. As of March 2008, the consortium has about 360,000 members; 80,000 are Oregonians.

Other Initiatives

Oregon has a number of current and upcoming programs and policies to lower the state's cost for prescription drugs while providing prescription drug coverage for more OHP clients 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 name drug price.
- *OHP copays* – The OHP requires some OHP recipients to make copays and implement other cost-sharing mechanisms to reduce prescription and other health care costs (see *Oregon Health Plan* Background Brief). Effective on March 1, 2008, the Division of Medical Assistance Programs **(DMAP)** reduced OHP Plus copayments to eliminate copayments on a majority of drug classes to reduce barriers to essential medications and improve health outcomes.
- *Copayments* – OHP FFS clients pay between $0 and $3 for generic and brand drugs medications prescribed from the preferred prescription drug list. The copayments 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. Clients receiving coverage through the OHP Standard benefit package are also exempt from co-payments.

- *Pharmacy Management Program* – OHP clients in the FFS system who are in a Pharmacy Management Program based on prescription drug usage 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 and/or Medicare, child in-state care, in a hospital, long-term residential care or other medical facility).
- *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 of the federal poverty level, not have more than $2,000 in liquid resources, and not have any public or private drug benefit for the previous 6 months. With the development of the Oregon Prescription Drug Program, enrollment in this program has significantly declined.
- *Practitioner-Managed Prescription Drug Plan* – 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 preferred drug list **(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.
- *Reimbursement* – Payment for eligible prescription drugs is 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. (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.)
- *Disease case management* – The OHP provides a disease management program to eligible FFS clients who have costly acute and chronic conditions. Clients who have asthma, diabetes, heart failure, coronary artery disease, and chronic obstructive pulmonary disease may receive additional care management support to help improve their health outcomes. The program promotes self-care management, adherence to providers' treatment plans, and evidence-based guidelines by providing individualized counseling through face-to-face, telephonic, and mail interaction with specially trained registered nurses. In addition, all FFS clients, regardless of health conditions, have access to a nurse advice line 24 hours a day, 7 days a week for health care questions and concerns.
- *Oregon-specific Maximum Allowable Cost (**OMAC**) for generic drugs* – The state pays the lesser of the federal maximum allowable amount: AWP less 15 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* – The DMAP continues to work with its pharmacy benefit manager to obtain rebates for drugs dispensed in a physician's office and to

pursue other reimbursements due to the state for prescription drugs.

- *Polypharmacy program* – The DMAP imposes prescription drug payment limitations on clients with more than 15 unique FFS drug prescriptions in a 6-month period. The DMAP will review the client's drug therapy in coordination with the client's prescribing practitioner to evaluate for appropriate drug therapy.
- *Contracted Mail Order Program* – The contracted mail order pharmacy is a voluntary program available to OHP FFS clients. Compared to retail pharmacy (AWP-15 percent), the mail order contract specifies AWP-21 percent for brand name and AWP-60 percent for generic drugs. To increase mail order pharmacy use, the Department of Human Services **(DHS)** has implemented a communication strategy with clients through notices included in Medical ID mailings throughout the year, through DHS caseworkers, through OHP regional meetings, and with targeted provider populations such as clinics and Primary Case Managers.
- *Behavioral Pharmacy Management* – This program is a collaboration between the state's mental health office, the Oregon Health Plan, and Comprehensive NeuroScience, Inc. to analyze claims data to identify prescribing practices that are not consensus-based and that may be inconsistent with quality care for patients. The program provides consultation support through letters and peer-to-peer psychiatric consultations.
- *Cost savings opportunities* – A data-driven method for giving 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.

Prescription Drug Web Sites

- AARP Health and Wellness
- Center for Studying Health System Change
- National Academy for State Health Policy
- National Conference of State Legislatures Health Page
- PhRMA (Pharmaceutical Research and Manufacturers of America)
- The Henry J. Kaiser Family Foundation
- Oregon Prescription Drug Program

Staff and Agency Contacts

Kathy Ketchum
Department of Human Services
503-947-5220

Missy Dolan
Oregon Prescription Drug Program
800-913-4146

Rick Berkobien
Legislative Committee Services
503-986-1485

Jean Phillips, Kathy Ketchum, Kathy Mickenham, and Missy Dolan of the Department of Human Services assisted with the development of this document.