Background Brief on …

Prescription Drugs

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The United States spent approximately $2.3 trillion on health care in 2008. In 2008, health care spending was approximately $7,681 per resident and accounted for 16.2 percent of the nation's Gross Domestic Product **(GDP)**. Hospital inpatient/outpatient services, prescription drugs, and physician services contributes to the total increases in health care costs.

For several years, spending on new medical technology and prescription drugs has been cited as a leading contributor to the increase in overall health care spending. However, in recent years, the rate of spending on prescription drugs has decelerated, according to the Kaiser Family Foundation, *U.S. Health Care Cost Brief (March, 2010).*

Spending for Prescription Drugs

The Oregon Health Authority **(OHA)** will spend approximately $1.2 billion (2013-15) on prescription drugs. There are four distinct areas of pharmacy expenditures within OHA:

- Oregon Health Plan **(OHP)**: A total of $750 million in the current biennium (2013-15, expanding to a projected $1 billion for the 2015-17 biennium). This includes drug costs paid out of the CCO/MCO capitated rates and trends forward the inflation of the increased covered lives.
- Oregon Prescription Drug Program **(OPDP)**-Oregon Educators Benefit Board **(OEBB)**: $252 million of which $133 million can be attributed to OEBB with the rest purchased by consumers through the discount card program.
- Public Employees Benefit Board **(PEBB)**: $125 million is estimated to be spent for state employees.
- Oregon AIDS Drug Assistance Program **(CAREAssist)**: estimated $34 million per biennium for medications purchased directly from a

wholesaler and dispensed through an in-network contract pharmacy.

The reasons for increased spending on prescription drugs are debated among health care researchers, pharmaceutical manufacturers, and state health officials. Consumer groups state that the pharmaceutical industries' extensive advertising of newer and higher-priced drugs influences consumers to seek brand name medications instead of using lower-cost generic drugs.

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 copayments 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.

State Discount Programs

Beginning in 1999, a growing number of states established prescription drug discount programs, sometimes termed "Rx Buying Clubs" or Discount Plans. These state-sponsored efforts differ from the State Pharmaceutical Assistance Programs (**SPAPs**) or subsidy plans in at least two ways: Discount programs do not use state or federal funds to pay for pharmaceuticals. Instead they generally rely on the large-volume purchasing power of the state to negotiate a sizable discount on a wide selection of prescription products, brands, and generics. Second, a majority of such programs have contracted with a management firm such as a pharmaceutical benefit manager (**PBM**) to handle the negotiations over price. The consumer still pays the resulting discounted price at the pharmacy counter, and the state is not involved in the individual transactions. Unlike most subsidized SPAP programs, there is no comparable federal program or federal regulation affecting these discount plans.

Drugs purchased in this way do not count as part of Medicare or Part D calculations. In the past three years, a growing number of states have emphasized serving residents under age 65, the population segment *not* eligible for Medicare or Part D.

Medicare is a federal-only program, about 20 states administer an optional subsidy program that wraps-around or adds to the federal benefit. The following 14 states authorize covering all or part of this "donut hole" as of March 2010: Connecticut, Delaware, Illinois, Maine, Maryland, Massachusetts, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, South Carolina, Vermont, and Wisconsin. The federal $250 annual subsidy increase could have a small, incremental effect in these states, potentially lowering the state subsidy expenditure for certain individuals.

Discount Cards and Assistance Programs

Many pharmaceutical manufacturers offer their own discount cards to low-income individuals. These cards allow a person to obtain discounts on some or all of a company's prescription drugs. The programs have varying eligibility requirements (level of income, age), annual fees, amounts that enrollees must pay, among others. 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.

Oregon Prescription Drug Program (OPDP)

The OPDP was established as a purchasing pool of prescription drugs for employer groups and facilities as well as a discount card program for underinsured residents in 2003.

OPDP negotiates discounts with pharmacies and seeks rebates from manufacturers Group Purchasing Organizations and Wholesalers in order to provide lowest possible cost to all participants in the program. For example, underinsured participants can enroll in the OPDP at no cost, receive an identification card that is recognized at most Oregon pharmacies and purchase prescription drugs at the same discount large employer groups receive.

All medications approved by the Federal Drug Administration that are prescribed by a clinician licensed in Oregon are eligible for a discount, and participants save an average of 55 percent.

Initially, participation in the OPDP was limited by age and income, but Ballot Measure 44 (2006) removed those criteria, opening the program to all Oregonians without prescription drug coverage. Also in 2006, the OPDP joined with Washington State's Prescription Drug Program to combine purchasing power, forming the Northwest Prescription Drug Consortium. In 2007, Senate Bill 362 expanded the program to include the underinsured, private entities, and labor organizations. Then in 2009, restrictions on contracting were lifted by Senate Bill 735 allowing OPDP to contract for discount prices available to group purchasing organizations **(GPOs)** and entities eligible under Section 340B of the federal Public Health Service Act.

As of April 2014, the Consortium has 919,771 members; 441,665 are Oregonians. The OEBB is the largest group with 104,700 members in OPDP.

In 2013, OPDP implemented a Pilot GPO program for OEBB in a limited number of pharmacies. By July 2014, that program will be expanded to include a larger retail footprint enabling it to increase savings for OEBB. OPDP's goal is to invite other GPO-eligible employer groups into this program during 2015. Traditional GPO arrangements for facilities are also available through the Consortium and currently the Washington Department of Corrections participates in that model.

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.

Copayments – OHP FFS clients pay between $0 and $3 for generic and brand name drugs prescribed from the preferred prescription drug list. The copayments also apply to mental health drugs for all OHP clients, including those in FFS and Coordinated Care Organizations **(CCOs)**. 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, emergency services, mail order drugs, and family planning, are exempt from copayment requirements. CCOs may impose co-payments up to $3.00 per prescription but are not required to do so.

Pharmacy Management & Polypharmacy 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 Pharmacy Management Program is to identify safety concerns and monitor high drug utilization. Clients can periodically change pharmacies and are exempt from the program 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). OHP clients in the FFS system who are in the Polypharmacy Program have added oversight of their prescriptions in order to ensure appropriate drug therapy. OHA's Division of Medical Assistance Programs (**DMAP**) imposes prescription drug payment limitations on select clients with more than 15 unique FFS drug prescriptions in a six-month period. DMAP reviews the client's drug therapy in coordination with the client's prescribing practitioner to evaluate for appropriate drug therapy.

*Practitioner-Managed Prescription Drug Plan (**PMPDP**)* – In 2001, Oregon established the PMPDP for OHP clients in the FFS system. Using the latest evidence, the Health Resources Commission (**HRC**) reviewed all drugs within a given class (such as long-acting opioids for pain relief, proton pump inhibitors for treatment of heartburn, etc.), and identified which drugs have the highest safety profile and are the most effective. Under authority granted to it by House Bill 2126 (2009), DMAP began to negotiate with drug manufacturers for discounts on specific drugs. Since then, only those drugs that are both effective and, based on discounts, the most cost efficient, are added to the PMPDP. Only those drugs that are listed on the PMPDP are available to OHP FFS clients, unless specifically requested by a doctor. OHP clients who receive a drug on the PMPDP pay no copayment; otherwise they pay $1.00 for nonlisted generic products and $3.00 for nonlisted branded products. Clients may also use the contracted mail order pharmacy to receive nonpreferred products with no copayment.

*Statewide Preferred Drug List (**PDL**)* – House Bill 2009 (2009) authorized the establishment of a statewide PDL. The OHA began with the 32 classes of drugs contained in the PMPDP and expanded the number of drug classes to 80 in 2010 using the latest evidence-based information. This PDL will become the benchmark for all state-financed programs that purchase drugs.

House Bill 2126 (2011) abolished the HRC and the Drug Utilization Review **(DUR)** Board and created the Health Evidence Review Committee and the State Pharmacy and Therapeutics (P&T) Committee which makes recommendations to OHA based on safety, efficacy, and cost on PDL composition and utilization controls.

Reimbursement – Payment for eligible prescription drugs is made to pharmacies according to an Average Actual Acquisition Cost **(AAAC)** reimbursement model. The goal of the model is to establish a transparent, timely, and accurate pharmacy reimbursement system based on the actual cost (invoice) to the pharmacy for the drug dispensed and an appropriate professional dispensing fee.

Cost savings opportunities – Oregon belongs to the Sovereign States Drug Consortium, a purchasing pool to help leverage Medicaid drug rebates. The pool includes the states of Maine, Vermont, Utah, Iowa, West Virginia, Mississippi, and Wyoming. Federal health care reform has also allowed OHA to take advantage of additional rebates on Medicaid drugs.

AIDS Drug Assistance Program (CAREAssist) DHS-Public Health. This program provides payment for prescription drugs (full cost or as copayment behind a primary health insurance) for low-income persons with documented HIV disease, who are residents of Oregon and have income at or below 400 percent of the federal poverty level.

Funding for this program is received from The Ryan White HIV/AIDS Treatment Extension Act of 2009, state General Funds, and revenue from client fees and rebates paid by manufacturers. The program pays for any drug deemed by a primary care medical provider as necessary for the management of HIV disease and other co-occurring disorders. The program

implemented the mail order pharmacy option and contracted with a network of retail pharmacy sites in fall 2010. Participating contract pharmacies are paid on a fee-for-service basis.

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