HB 1122

Department of Legislative Services

Maryland General Assembly
2002 Session

FISCAL NOTE

House Bill 1122 (Delegate Hammen, *et al.*)
Environmental Matters and Appropriations

Prescription Drug Manufacturer Rebates - Supplementary Appropriation - Medical Care Programs Administration

This bill requires the Department of Health and Mental Hygiene (DHMH), in consultation with the Department of Budget and Management (DBM), to establish a prescription drug spending control program within the Medicaid program, the Maryland Pharmacy Assistance Program (MPAP), and the State Employee Health Benefits Plan's prescription drug program. The bill also establishes the 11-member State Pharmaceutical and Therapeutics Committee.

The bill takes effect July 1, 2002.

Fiscal Summary

State Effect: DHMH rebate revenues could increase by $34.6 million (50% general funds, 50% federal funds) in FY 2003. DHMH expenditures could increase by $35.0 million (50% general funds, 50% federal funds) to pay Medicaid providers in FY 2003 only. State Employee Health Benefits Plan expenditures could increase in FY 2003 to establish a drug benefit management program. Future year estimates reflect inflation.

($ in millions)	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
GF Revenue	$17.31	$19.93	$22.92	$26.36	$30.31
FF Revenue	17.31	0	0	0	0
GF Expenditure	17.51	.29	.30	.31	.32
FF Expenditure	17.51	.29	.30	.31	.32
GF/SF/FF Exp.	-	-	-	-	-
Net Effect	($.39)	$19.35	$22.32	$25.74	$29.67

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary:

Medicaid and MPAP: The spending control program may include a preferred drug formulary and must establish a process for managing the drug therapies of Medicaid program and MPAP enrollees who are using a significant number of prescription drugs each month. DHMH may also negotiate supplemental rebates from drug manufacturers for the Medicaid program and MPAP that are no less than 10% of the average manufacturer price (AMP).

DHMH must make formulary decisions based on the efficacy of a drug, the recommendations of the State Pharmaceutical and Therapeutics Committee, and the price of competing products less federal and State rebates.

DHMH may elect to receive other program benefits that offset Medicaid or MPAP expenditures in lieu of a supplemental rebate, including: (1) disease management programs; (2) drug product donation programs; (3) drug utilization control programs; (4) prescriber, Medicaid, and MPAP enrollee counseling; and education, fraud, and abuse initiatives; or (5) other services or administrative programs which guarantee savings to the Medicaid program or MPAP in the fiscal year in which the supplemental rebate would have been applicable.

DHMH may establish prior authorization requirements for: (1) prescription drugs listed on the preferred formulary; (2) prescription drugs for specific populations; and (3) specific drug classes. DHMH must establish an appeals process for a Medicaid or MPAP enrollee wishing to challenge a preferred formulary decision made by DHMH.

DHMH must establish a drug benefit management program to manage the drug therapies of Medicaid and MPAP enrollees who are using a significant number of prescription drugs each month. The management program must include HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending. DHMH may seek any federal waivers or Medicaid program plan amendments necessary to implement the bill's requirements.

State Pharmaceutical Therapeutics Committee (P&T committee): The committee: (1) must develop recommendations for a preferred drug formulary for the Medicaid program and MPAP; (2) may make recommendations to DHMH regarding the prior authorization of any prescribed drug covered by Medicaid or MPAP; and (3) must ensure that manufacturers that have agreed to provide a supplemental rebate to Medicaid and MPAP are provided with the opportunity to present evidence supporting inclusion of a product on the preferred drug formulary.

In addition, in consultation with DBM, the committee:

- must review whether the State is receiving an appropriate level of rebates in the prescription drug benefit offered to State employees and retirees (State prescription drug program);
- make recommendations on mechanisms to maximize prescription drug cost savings in the State prescription drug program including a drug benefit management program to manage the drug therapies of State enrollees who are using a significant number of prescription drugs each month;
- develop a preferred drug formulary for the State prescription drug program by considering the clinical efficacy, safety, and cost-effectiveness of a product; and
- make recommendations to DHMH regarding the prior authorization of any prescribed drug covered by the State prescription drug program.

To the extent possible, the committee must review all drug classes included in the Medicaid program, MPAP, and the State prescription drug program preferred drug formularies at least every 12 months, and recommend additions to and deletions from the preferred drug formularies to ensure that each formulary provides medically appropriate drug therapies while providing cost savings. DHMH must provide staff support for the committee.

DHMH must report to the General Assembly by December 1 annually on the amount of supplemental rebates or other cost containment measures and their effect on prescription drug expenditures in the Medicaid program and MPAP.

State Employee Health Benefits Plan prescription drug program: DBM must adopt a preferred drug formulary and establish a drug benefit management program to manage the drug therapies of enrollees in the State Employee Health Benefits Plan prescription drug program who are using a significant number of prescription drugs each month, as recommended by the State P&T committee. DBM must attempt to negotiate prescription drug rebate agreements with prescription drug manufacturers. If a drug manufacturer refuses to enter into a rebate agreement, DBM must make a prompt determination of whether to place a manufacturer's prescription drug on the preferred formulary. DBM

must establish prior authorization requirements for prescription drugs listed on the preferred drug formulary. DBM must: (1) inform the State P&T committee of any decisions regarding prescription drugs subject to prior authorization; (2) publish and disseminate the preferred drug formulary to all enrollees in the program and retail pharmacies in the State that participate in the program; and (3) establish an appeals process for an enrollee to appeal a preferred drug formulary decision made by DBM.

DBM must report to the General Assembly by January 1, 2003 on the total amount of rebates obtained by the pharmacy benefits manager that administers the State employees prescription drug benefits program, whether the State is receiving an appropriate level of rebates obtained, and the cost savings to the State that would result from development of a preferred drug formulary, and a drug benefit management program.

For fiscal 2003 only and from those additional revenues resulting from the bill's provisions that are credited to the general fund for fiscal 2003, $23.5 million general funds and $10 million federal funds is appropriated and authorized to be disbursed from those additional revenues received by the State. These funds are appropriated to be used to pay Medicaid provider reimbursements authorized by the General Assembly.

Current Law: The federal Omnibus Budget Reconciliation Act (OBRA) of 1990 requires drug manufacturers to enter into rebate agreements with the federal government for states to receive federal funding for outpatient prescription drugs dispensed to Medicaid enrollees.

Background: The federal Medicaid Drug Rebate Program was enacted to save money for the Medicaid program after federal officials realized drug manufacturers were providing greater price discounts to high-volume purchasers, such as HMOs and hospitals. Generally, drug rebates are based on a fixed percentage of the average price paid by wholesalers. Approximately 500 pharmaceutical companies participate in this program. All 50 states and the District of Columbia cover drugs under the Medicaid program.

Florida and Michigan are among the most aggressive states in seeking enhanced pharmacy rebates. In 2001, Florida enacted a program similar to the bill's requirements. Florida will continue to participate in the federal Medicaid Drug Rebate Program, but it will now negotiate directly with drug companies to obtain additional rebates. Florida expects to save the state $214 million per year, or about 15% of its annual Medicaid drug budget through its own negotiations with drug manufacturers and through implementation of a preferred drug list with prior authorization. For a drug to be included on Florida's preferred drug list, the manufacturer must first negotiate a rebate of at least 25% with the state, and a committee of medical professionals and consumers

must select the drug for inclusion on the formulary. Florida will still receive the same federal match for prescription drugs provided to Medicaid enrollees.

Medicaid and MPAP: Medicaid covers approximately 464,000 people, of whom, about 116,000 receive fee-for-service care, including prescription drug coverage. Medicaid enrollees pay $2 copayments for each prescription, and most drugs are covered under the program. MPAP provides prescription drug coverage for eligible low-income individuals. MPAP provides coverage for maintenance drugs, anti-infectives, and AZT. Enrollees must pay a $5 copayment for each prescription. Total prescription drug expenditures for Medicaid and MPAP are $341 million ($272.8 million Medicaid, $68.2 million MPAP) in fiscal 2002.

State Employee Health Benefits Plan: The State plan covers employees, retirees, and their eligible dependents, totaling approximately 250,000 covered lives. The plan offers a prescription drug carve-out benefit for employees, retirees, and their eligible dependents. The State plan contracts with a pharmacy benefit manager, Advance PCS, to manage its prescription drug benefit. Advance PCS has its own pharmaceutical and therapeutics committee that reviews and identifies prescription drugs with the highest therapeutic and economic value. State plan enrollees pay $5 for a formulary drug and $10.00 for a non-formulary drug. Advance PCS also offers the State plan enrollees a list of Preferred Performance Drugs, which have $3 copayments.

State Revenues:

Medicaid and MPAP: DHMH revenues could increase by approximately $34,623,200 (50% general funds, 50% federal funds) in fiscal 2003, which accounts for the bill's July 1, 2002 start-up date. This estimate assumes:

- State Employee Health Benefits Plan prescription drug program expenditures are $198 million in fiscal 2003;

- new rebates average 4% of State plan prescription drug expenditures (or $7.9 million), and these funds are used to pay Medicaid providers in fiscal 2003 only;

- Medicaid and MPAP prescription drug expenditures are $392,150,000 in fiscal 2003;

- new rebates average 4% of Medicaid and MPAP drug expenditures (or $15,686,000);

- all revenues ($3,137,200) from new prescription drug rebates in MPAP are used to pay Medicaid providers in fiscal 2003 only;

- half the revenues (or $6,274,400) from new prescription drug rebates in the Medicaid program are used to pay Medicaid providers in fiscal 2003 only; and

- DHMH receives matching federal funds ($17,311,600) on provider reimbursements.

Only half the revenues generated from new prescription drug rebates in the Medicaid program may be used to pay Medicaid providers. Under federal law, DHMH must pay 50% of rebate revenues received in the Medicaid program back to the federal government.

Future year revenues assume: (1) payments to Medicaid providers in fiscal 2003 only; (2) additional rebate revenue negotiated by DBM remains in the State Employee Health Benefits Plan; and (3) 15% prescription drug inflation.

State Expenditures:

Medicaid and MPAP: DHMH expenditures could increase by an estimated $35,010,019 (50% general funds, 50% federal funds) in fiscal 2003 which accounts for the bill's July 1, 2002 effective date. This estimate reflects $34,623,200 for Medicaid provider reimbursements and $386,819 for administrative costs. It includes the cost of contracting to negotiate higher rebates, and hiring one pharmacist, one administrative clerk, and one supervisor to staff the P&T committee. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$118,149
Contract to Negotiate Rebates	250,000
Operating Expenses	18,670
Total FY 2003 DHMH Administrative Expenditures	**$386,819**

Future year expenditures reflect: (1) full salaries with 3.5% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

State Employee Health Benefits Plan prescription drug program: State plan expenditures could increase by an indeterminate amount. The State plan's PBM, Advance PCS, currently performs all of the bill's requirements other than providing a drug benefit management program. There are insufficient data to reliably estimate the cost of

implementing a drug benefit management program or the number of State plan enrollees who would be eligible to participate.

Additional Information

Prior Introductions: None.

Cross File: SB 623 (Senators Hoffman and Bromwell) – Budget and Taxation and Finance.

Information Source(s): National Governors Association, Department of Health and Mental Hygiene (Medicaid), Department of Budget and Management, Department of Legislative Services

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