SB 623

Department of Legislative Services

Maryland General Assembly
2002 Session

FISCAL NOTE
Revised

Senate Bill 623 (Senator Hoffman, *et al.*)

Budget and Taxation and Finance Environmental Matters and Appropriations

Prescription Drug Manufacturer Rebates - State Funded Prescription Drug Programs

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 Prescription Drug Program. The bill also establishes a 13-member State Pharmaceutical and Therapeutics Committee and creates the Maryland Medical Assistance Prescription Drugs Fund to provide funding to offset the cost of prescription drugs and pharmacy reimbursement in the Medicaid program and MPAP.

The bill takes effect July 1, 2002.

Fiscal Summary

State Effect: DHMH special fund rebate revenues and expenditures could each increase by $16.9 million in FY 2003. State Employee Health Benefits Plan rebate revenues could increase by $7.9 million in FY 2003. DHMH general fund expenditures could increase by $386,100 in FY 2003. Future year estimates reflect inflation.

($ in millions)	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
GF Revenue	$7.92	$9.11	$10.47	$12.05	$13.85
SF Revenue	16.94	19.48	22.40	25.76	29.63
GF Expenditure	.39	.41	.42	.43	.44
SF Expenditure	16.94	19.48	22.40	25.76	29.63
Net Effect	$7.53	$8.69	$10.05	$11.62	$13.41

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 list and 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.

DHMH may implement other program benefits to offset Medicaid or MPAP expenditures instead of or in addition to 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 not listed on the preferred list; (2) prescription drugs for specific populations; and (3) specific drug classes. DHMH may not establish prior authorization requirements for drugs used to treat mental illnesses or HIV/AIDS. DHMH must establish an appeals process for a Medicaid or MPAP enrollee wishing to challenge a preferred list decision made by DHMH.

The bill also alters reimbursement under MPAP, providing MPAP may be limited to covering maintenance drugs, anti-infectives, and AZT as specified in regulations. The bill also permits DHMH to establish copayment amounts in regulation.

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 list 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 list for the State prescription drug program; and
- make recommendations to DBM 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 list at least every 12 months, and recommend additions to and deletions from the preferred drug lists 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 Prescription Drug Program: DBM must adopt a preferred drug list to offset costs in the State Employee Health Benefits Plan prescription drug program. DBM may contract with a person to negotiate prescription drug rebate agreements with prescription drug manufacturers, and administer the preferred drug list and prior authorization procedures. DBM must establish prior authorization requirements for prescription drugs listed on the preferred drug list. DBM must: (1) inform the State P&T committee of any decisions regarding prescription drugs subject to prior authorization; (2) publish the preferred drug list in the Maryland Register and maintain a current list on DBM's website; and (3) establish an appeals process for an enrollee to appeal a preferred drug formulary decision made by DBM.

Maryland Medical Assistance Prescription Drugs Fund: This special fund, administered by DHMH, provides funding to offset the cost of prescription drugs and the cost of pharmacy reimbursement in the Medicaid program and MPAP. The fund consists of any

funds received by DHMH as the result of supplemental rebates paid by manufacturers in the Medicaid program and MPAP, interest, and investment earnings. Expenditures from the fund may be made only in accordance with the State budget.

DHMH must consult with pharmaceutical and pharmacy industry representatives, authorized prescribers, and patient advocates to identify and implement alternative cost containment measures. In fiscal 2003, any cost savings obtained using alternative cost containment measures other than supplemental rebate revenues must be used by DHMH to offset pharmacy reimbursement cost containment measures. The bill prohibits DHMH from implementing pharmacy reimbursement cost containment until October 1, 2002 to see if similar cost savings can be achieved through alternative cost containment measures. If by October 1, 2002, the additional cost savings from the alternative cost containment measures will not meet the cost containment assumed in the fiscal 2003 budget, DHMH is required to implement the pharmacy reimbursement reduction in a manner that achieves the level assumed in the budget ($10.8 million). DHMH must report to various committees on the pharmacy dispensing fee for the Medicaid program and MPAP. DHMH must consult with representatives from the community and independent pharmacies. The report may include: (1) an analysis of the dispensing fee structure in other states; (2) an analysis of current reports and literature concerning dispensing fees in state prescription drug programs; and (3) a review of industry supplied surveys concerning the time and associated costs of dispensing.

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 for a non-formulary drug. Advance PCS also offers the State plan enrollees a list of Preferred Performance Drugs, which have $3 copayments. In addition, the State plan has prior authorization requirements for certain drugs, such as Retin A and growth hormones.

Medicaid's fiscal 2003 budget allowance contains several cost containment measures to save money in the Medicaid and MPAP prescription drug programs. Cost containment measures include not funding the Maryland Pharmacy Discount Program (projected savings $16 million), increasing the Medicaid pharmacy discount from 10% to 13% of the average wholesale price ($10.8 million savings), implementing a step therapy program ($3 million savings), increasing MPAP copayments by $2.50 per prescription ($2.5 million savings), and increasing Medicaid copayments by $1 ($1.8 million savings).

State Revenues:

Maryland Medical Assistance Prescription Drugs Fund: Special fund revenues could increase by approximately $16,940,880 in fiscal 2003, which accounts for the bill's July 1, 2002 start-up date. This estimate assumes:

- Medicaid prescription drug expenditures are $313,720,000 in fiscal 2003;

- MPAP prescription drug expenditures are $78,430,000 in fiscal 2003;

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

- half the revenues (or $6,274,400) from new prescription drug rebates in the Medicaid program only must be paid back to the federal government;

- DHMH will use 80% (or $7,529,280) of the supplemental rebate revenues to make prescription drug and pharmacy reimbursements in the Medicaid program and 20% (or $1,882,320) of the revenues to make reimbursements in the MPAP program; and

- DHMH will receive federal matching funds (or $7,529,280) on drug and pharmacy reimbursements made in the Medicaid program only.

Only half the revenues generated from new prescription drug rebates in the Medicaid program may be credited to the fund. Under federal law, DHMH must pay 50% of rebate revenues received in the Medicaid program back to the federal government. This provision does not apply to rebates generated under MPAP, which is general funded. Future year estimates reflect 15% prescription drug cost inflation.

State Prescription Drug Program: General fund revenues could increase by approximately $7.9 million in fiscal 2003, which accounts for the bill's July 1, 2002 start-up date. This estimate assumes State prescription drug program expenditures are $198 million in fiscal 2003 and new rebates average 4% of drug expenditures. Future year estimates reflect 15% prescription drug cost inflation.

State Expenditures:

Maryland Medical Assistance Prescription Drugs Fund: Special fund expenditures could increase by approximately $16,940,880 in fiscal 2003. It is assumed DHMH will use all funds received from supplemental rebates to offset the cost of prescription drugs and pharmacy reimbursement in the Medicaid program and MPAP. Future year expenditures reflect 15% prescription drug cost inflation.

DHMH: DHMH general fund expenditures could increase by an estimated $386,143 in fiscal 2003, which accounts for the bill's July 1, 2002 effective date. This estimate reflects the cost of a private contractor to negotiate rebates and the cost of three new positions (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	17,994
Total FY 2003 DHMH Administrative Expenditures	**$386,143**

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.

Cost Containment Measures: The bill requires DHMH to use alternative cost containment measures, such as implementing disease management programs, before implementing cost containment measures specified in the fiscal 2003 budget. If additional cost savings from the alternative cost containment measures do not meet the cost containment assumed in the fiscal 2003 budget by October 1, 2002, DHMH is required to implement cost containment in a manner that achieves the level assumed in the budget. Since the cost containment level assumed in the budget must be met, regardless of which methods are implemented to achieve the necessary savings, the bill's provisions requiring alternative cost containment measures to be implemented first have no fiscal impact on DHMH.

Additional Information

Prior Introductions: None.

Cross File: HB 1122 (Delegate Hammen, *et al*.) – Environmental Matters.

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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