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Limited Access and High Costs

What Can New Jersey Do About Prescription Drugs?

Background Information for . . .

THE NEW JERSEY POLICY FORUM

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ISSUE: For state level policymakers, three salient issues emerge from the complex arena of pharmaceutical policy, research, economics, financing, delivery and access: (1) prescription drug policy and state Medicaid programs; (2) state initiatives to provide prescription drug coverage beyond traditional Medicaid populations; and (3) Medicare prescription drug benefit design. In New Jersey and throughout the country, policymakers are confronted with the challenge of rapidly increasing costs for pharmaceuticals, which compromises access across all populations. What strategies are available to New Jersey policymakers to address issues of cost, access and coverage?

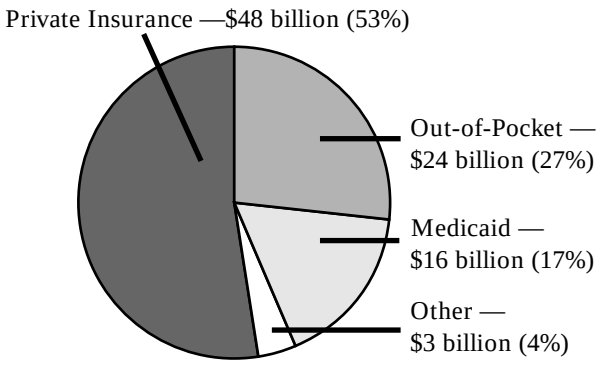
INTRODUCTION

Pharmaceuticals expenditures are the fastest-growing component of national health expenditures, tripling since 1990. According to one estimate, national prescription drug expenditures were projected to be $112 billion in 2000 (Health Care Financing Administration, 2001). Average annual growth rates are expected to be in double digits in the near future, though growth rates are projected to be lower than in recent years. As with other health expenditures, pharmaceutical expenditures are skewed towards a small share of individuals; about one-third of expenditures are for the top 2 percent of patients and more than half of expenditures are for the top 5 percent of patients (Motheral, et al, 2001). Prescription drug use among the elderly is nearly three times higher than among those under age 65 and prescription drug use among high-cost elderly users is growing faster than among elderly individuals with lower utilization (Thomas, 2001). High-cost elderly users average more than 50 prescriptions per year. These prescriptions are more likely to be brand name prescriptions, resulting in higher per prescription costs. High-cost users are also more likely to have chronic conditions.

The United States is both the largest producer and largest consumer of pharmaceuticals. Nearly half of the major medicines manufactured in the last 20 years were by United States companies, and approximately one-third of global pharmaceutical sales are in the United States. Three main factors appear to be driving increases in pharmaceutical costs: increased costs per prescription (cost inflation per existing drug), higher numbers of prescriptions (utilization), and new, more expensive drugs. Other factors explaining the growth in total drug expenditures include a growing elderly population, growth in third-party drug coverage, (which tends to drive demand), and record sales of new products (Kolassa, 1997; NIHCM, 2001). Drugs introduced since 1992 account for nearly half of every dollar spent on prescription drugs and the average wholesale price per prescription is about $50 (Express Scripts, 2001).

Private insurance covers the largest share of the nation's drug expenditures, 53 percent, while out-of-pocket costs constitute 27 percent of expenditures. Medicaid finances 17 percent with other smaller-scale programs financing the rest.

Figure 1 : Spending for Prescription Drugs by Payment Source, 1998



Source: National Health Statistics Group, Office of the Actuary, Health Care Financing Administration: National Health Accounts. Cited in U.S. Department of Health and Human Services, "Prescription Drug Coverage, Spending, Utilization, and Prices—Report to the President." Figure 2-16. U.S. Department of Health and Human Services, April 2000aspe.hhs.gov/health/reports/drugstudy.

The share of prescriptions purchased by cash customers has decreased markedly from 63 percent in 1990 to about 25 percent near the end of the decade (Hoadley, 2000; Coster, 2000). In 1999, approximately 30.5 percent of prescription drugs were obtained through chain drug stores, 18.3 percent at independent pharmacies, 14.2 percent at hospitals, 11.2 percent were obtained by mail, and the remainder through other venues.

This issue brief focuses on three areas related to prescription drugs:

- *Prescription drug policy and state Medicaid programs:* Medicaid prescription drug policy is important for state policymakers seeking to constrain Medicaid expenditures in an era of emerging fiscal constraints. Prescription drugs are often cited as the fastest growing component of state Medicaid budgets, which are among the fastest growing—and largest—programs in state budgets;

- *State initiatives to provide prescription drug coverage beyond traditional Medicaid populations:* lessons learned from state prescription drug programs offer guidance to state policymakers hoping to refine or implement their own programs. They also offer valuable lessons regarding cost-sharing and other benefit design to federal policymakers seeking to create a Medicare prescription drug benefit; and,

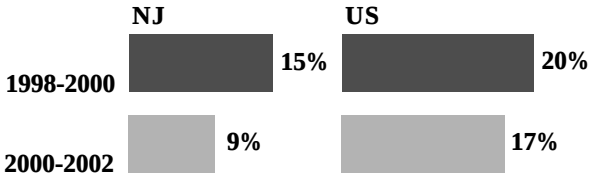
- *Medicare prescription drug benefit design:* a Medicare prescription drug benefit is important to all seniors because of the potential to impact prescription drug use and spending among all elderly populations. A Medicare prescription drug benefit is also important to state policymakers, especially in New Jersey, because of the potential to impact existing state pharmaceutical assistance programs.

MEDICAID AND PRESCRIPTION DRUG POLICY

To receive federal matching funds under Medicaid, states must provide coverage for certain basic or mandatory services, such as physician services. States are also eligible to receive federal matching funds for certain optional services, including prescription drugs. Though prescription drug coverage is optional, all states provide it in their Medicaid programs.

Medicaid expenditures on prescription drugs have increased markedly. Between 1993 and 1998, state Medicaid drug expenditures increased from $8 billion to nearly $13 billion, an average annual rate of 18 percent, double the overall growth rate in Medicaid expenditures (NGA/NASBO, 2001). Between 1998 and 2000, Medicaid prescription drug expenditures increased from $12.7 billion to $18.3 billion, representing an average annual growth rate of 20 percent, and states project that Medicaid drug expenditures will increase to $25.1 billion in 2002. In New Jersey, Medicaid drug expenditures have grown from $382.0 million in 1998 to $499.0 million in 2000, an average annual growth rate of 15 percent, and drug expenditures are expected to reach $595.0 million in 2002.

Figure 2: Average Annual Growth in Prescription Drug Expenditures, New Jersey and United States



Source: The National Governors' Association/The National Association of State Budget Officers, "The Fiscal Survey of States, June 2001—Special Feature: Medicaid." June 2001 "http://www.nasbo.org" www.nasbo.org Note: Actual prescription drug expenditure growth is reported for 1998-2000. Expenditure growth for 2000-2002 is projected.

In response to large increases in drug expenditures, states have sought to identify ways to control prescription drug expenditures. Tools available to policy makers to control Medicaid prescription drug expenditures are prescription limits, cost-sharing, restricted access, prior approval, and reimbursement (Schlosberg and Jerath, 1999). In some states, monthly or yearly prescription limits are used to control utilization and costs. State Medicaid programs may also impose co-payments for prescription drugs. State co-payments range from $0.50 to $5.00 with some categories of Medicaid recipients such as children, and some categories of services, including family planning, exempt from cost sharing under federal Medicaid rules. States are also permitted to exclude or restrict certain categories of drugs from coverage and require prior approval before it is dispensed.

Medicaid Drug Rebate Program

Among the most important cost-saving mechanisms in state Medicaid programs is participation in the Medicaid Drug Rebate Program, established in 1990.[1] The program requires participating drug manufacturers to pay a rebate to state Medicaid programs for each of the manufacturer's pharmaceutical products.[1] The program essentially requires pharmaceutical companies to give discounts to state Medicaid programs as a condition of receiving Medicaid payments (Schlosberg and Jerath, 1999). States participating in the rebate program are required to include in their formularies[2] all prescription drugs produced by manufacturers providing rebates.[3] More than 500

manufacturers with about 55,000 products participate in the rebate program. In 1997, Medicaid rebates were estimated to be worth $2.2 billion.

Historically, all states except California have participated in the rebate program.[4] However, in the summer of 2001, Florida enacted a law that allows the state to negotiate its own discounts on prescription drugs for Medicaid beneficiaries. When the law goes into effect, Florida will be the first state to cease participation in the rebate program. The Florida law also requires the state to create a limited formulary. Physicians who wish to prescribe a drug that is not included on the formulary will have to obtain prior approval from the state's Medicaid agency. The state expects that these changes will save about 15 percent of its Medicaid budget.

"Medicaid Recovery" Programs

One infrequently used tool for controlling Medicaid prescription drug expenditures is through state "Medicaid recovery" programs—efforts by states to recoup third-party costs paid for by Medicaid (Office of Inspector General, 2001). Significant shares of Medicaid beneficiaries have other pharmacy coverage through private health plans, employers, noncustodial parents, or other state and federal programs. If Medicaid pays for a service that is covered by another source of insurance, Medicaid has a legal right to payment from that source. As a result, other insurance sources are considered primary payers in relation to Medicaid. Medicaid, with few exceptions, is deemed to be the payer of last resort.

To recoup third-party costs, each Medicaid program must have a Medicaid recovery program. In paying claims, state Medicaid agencies either use a cost-avoidance system or a "pay and chase" system. In the cost-avoidance approach, provider claims, including pharmacy claims, are flagged by the state's Medicaid information system as having a third-party liability. In this case, no payment is made to the pharmacy and it is the pharmacy's responsibility to seek reimbursement from the third-party.

By contrast, in the "pay and chase" approach, the state pays the claim first and then tries to recover the payment from the third party. States are mandated to pay and chase claims under certain circumstances, but in general, payment for claims with third-party liability must be avoided unless the state has a federal cost-avoidance waiver. The Centers for Medicare and Medicaid Services (CMS) may grant a cost-avoidance waiver for pharmacy claims if the state demonstrates that paying and chasing is cost-effective.

A recent study of state Medicaid recovery programs found that 17 states use cost avoidance (U.S. DHHS, OIG, 2001). States that use cost avoidance attest to its success. States that do not use cost avoidance are concerned about the burdens that cost-avoidance systems would impose on pharmacies. Almost three-quarters of states report problems with third parties' willingness or ability to process or pay Medicaid pharmacy claims.

New Jersey Medicaid

In New Jersey's Medicaid program, pharmaceuticals are the focus of several economizing initiatives. Medicaid payments to pharmacies in New Jersey have historically been based on the average wholesale price (AWP) minus 10 percent (Fair 2001). By contrast, drug benefits for state employees have been based on the AWP minus 13 percent. Under Medicaid, New Jersey is increasing the 10 percent discount below AWP to 15 percent for high-volume drugstores (mainly the chains).

A recent report by the Department of Health and Human Services' Inspector General (U.S. DHHS, August 2001) suggests that payment could be reduced further. The Inspector General claims that state Medicaid agencies are not receiving sufficient discounts, with discounts averaging 10.31 percent below AWP, while pharmacy acquisition costs average 21.84 percent below AWP. The Inspector General notes that if Medicaid agencies were able to increase their discounts from 10.31 percent, on average, to 21.84 percent, state Medicaid agencies could save over $1 billion.

New Jersey also expects to benefit from reduced AWPs as a result of federal investigation of the industry's pricing and reporting patterns, which has resulted in numerous settlements between some major drug companies and federal regulators. In addition, New Jersey is also making generic prescriptions the default, subject to explicit override by a prescribing physician. Some earlier state efforts to control Medicaid fee-for-service prescription drug costs were not implemented as stakeholders successfully blocked implementation (Fair, 2001).

State Pharmaceutical Assistance Programs

State Pharmaceutical Assistance Program

As of April 2001, a total of 26 states have some type of prescription drug program enacted or authorized (NCSL, 2001). The state programs vary in scope and states continue to diversify their approaches in developing these programs (CSHP 2001, Tilly and Wiener 2001). Some states rely on Medicaid policy and Medicaid purchasing power to expand prescription drug access to non-Medicaid populations. For example, in some states, Medicare recipients are eligible for discount prices based on Medicaid pharmaceutical rates. Two states—Vermont and Maine—have obtained Medicaid waivers to provide discounts to eligible persons. (See Appendix A, Table 1, Program Eligibility Levels and Benefits for 2001.)

Other states have made seniors eligible for discount prices based on other federal programs or the lowest market rate. In addition, states have purchased drugs in bulk, promoted commercial discount cards, and created purchasing cooperatives. Officials in Maine, New Hampshire, and Vermont have formed a multistate drug-buying pool, and other states are following suit by forming similar drug purchasing coalitions. The coalitions generally expect to save between 10 to 15 percent on prescription drug costs. State tax credits for pharmaceutical purchases are also available in a limited number of states. Table 1, "State Prescription Drug Program Eligibility Levels and Benefits for 2001," illustrates the range of programs and program elements.

One highly publicized initiative is Maine's new law that would allow the state to impose price caps on prescription drugs. Economists generally oppose price controls because of concerns that controls limit returns for developing new products and thus reduce drug-product innovation—an issue of particular relevance to the pharmaceutical industry with its very high research costs (McClellan, 2000). Maine enacted an initiative to leverage pharmaceutical discounts from drug companies by consolidating purchasing for nearly 325,000 residents without pharmaceutical coverage, including Medicare enrollees and the uninsured. The law allows the state to establish price caps on prescription drugs by January 2003 if negotiations don't lead to significant reductions in costs. The Pharmaceutical Research and Manufacturers' Association (PhRMA) has challenged the constitutionality of the law, claiming that the program unconstitutionally regulates transactions outside the state's borders and conflicts with federal Medicaid law. A temporary injunction against implementation was denied and the state was granted permission to proceed with implementation.

To help state pharmacy assistance programs, the Center for State Health Policy at Rutgers University is conducting a series of case studies and a survey of all states that had programs in place as of 2000. The project, funded by the Commonwealth Fund and the AARP Public Policy Institute, is examining a broad array of interventions, including direct benefit programs, programs that extend Medicaid discount prices to Medicare beneficiaries, coverage through state subsidized private insurance programs, statewide and interstate drug purchasing pools, and state tax credits that subsidize the purchase of prescription drugs (Center for State Health Policy, 2001).

New Jersey's Pharmaceutical Assistance Program [5]

New Jersey's pharmaceutical assistance program, Pharmaceutical Assistance to the Aged and Disabled, commonly referred to as PAAD, has subsidized prescription drugs for low-income elderly and disabled residents since 1975, reaching nearly 200,000 beneficiaries. In 1999, New Jersey's program had the second highest enrollment, covering slightly fewer enrollees, about 200,000 individuals, than in neighboring Pennsylvania. New Jersey's enrollment accounted for about one-quarter of the nation's total enrollment in state pharmacy assistance programs (U.S. GAO, 2000). As of January 1, 2001, annual income limits for PAAD were $19,238 for singles and $23,589 for married couples. Eligibility is based on income-only. No asset test is required. Before July 1, 1998, the program charged individuals $5 for a 34-day supply of medicine, or 100 doses, whichever was greater. Funding comes primarily from the state's Casino Revenue Fund.

PAAD spending has risen rapidly over time. After staying near $100 million a year in the early 1990s, spending after 1995 has grown at about 9 percent a year, well beyond the 3 percent rises in casino revenues. The most recent state budget projects appropriations of $360 million in 2002.

Rapid growth, primarily driven by general pharmaceutical expenditure increases, spawned attempts at

control. New limits were set for PAAD benefits in mid-1998, but political resistance was strong, and policymakers by November partially restored benefits. New prescriptions are still limited to a 34-day supply, but more generous policies apply for ongoing prescriptions. Senate President DiFrancesco responded by proposing not cuts but expansions—covering more seniors, to higher income levels, a proposal he called Senior Gold. Then-Governor Whitman's submitted 2002 budget provided $50 million of tobacco settlement funds to add Senior Gold for elderly people who earn too much to qualify for basic PAAD. Senior Gold was enacted in May 2001; its income limits are about $10,000 a year higher than for PAAD but with higher cost sharing ($15 plus half the remaining cost of each prescription until a beneficiary reaches the annual out-of-pocket ceiling, $2,000 for a single person).

MEDICARE PRESCRIPTION DRUG BENEFITDESIGN

General Issues

Medicare prescription design is important to state policymakers not only because it affects all seniors but also because any federal Medicare benefit would affect the delivery systems of prescription drugs within states and affect pre-existing state pharmaceutical assistance programs, such as PAAD. Medicare pays for in-patient prescription drug expenditures but not those obtained on an outpatient basis. A consensus has emerged that the exclusion of outpatient drugs from the Medicare benefit package is a significant shortcoming of the Medicare program. Consequently, there is great interest among both Democrats and Republicans in expanding Medicare coverage to include prescription drugs, but there is no consensus on how to pay for and administer the benefit.

About 53 percent of Medicare beneficiaries have pharmaceutical coverage obtained through supplemental Medicare benefits or other private programs not readily available or affordable to all Medicare recipients. Total prescription drug expenditures are 40 percent lower among Medicare beneficiaries without drug coverage compared to those with drug coverage ($546 vs. $999 in 1998). Similarly, the average number of annual, per-person prescriptions is lower for those without coverage, 16.65 versus 24.35. (Poisal. and Culis, 2001). An analysis of commercially insured individuals age 65 or older reported that 35 percent of all prescription claims were in five therapeutic categories, all used to treat cardiovascular disease. The study also noted that seniors are more likely to use medications for chronic conditions. As a result, prescription drug spending for the elderly, relative to younger individuals, is predictable (Express Scripts, 2001).

The FY 2002 budget agreement provides $300 billion to spend on drug benefits and other changes in Medicare in the next ten years. Key issues in designing an outpatient prescription drug benefit for Medicare include: eligibility; scope of the benefit and recipient contributions; and administration of the benefit.

Eligibility

With respect to eligibility, policymakers must determine whether a new benefit would be available to all beneficiaries, or targeted to only low-income beneficiaries

Similarly, policymakers would have to decide the extent to which the benefit is subsidized. Most proposals provide universal premium subsidies. The disagreement among proposals is in how much subsidy to offer, with different political and policy implications on crowd-out of private coverage and uninsurance rates for each approach. Policymakers are concerned that a generous benefit will crowd-out private coverage—induce individuals with pre-existing private coverage to drop coverage to obtain more generous and less costly Medicare benefits.

Scope of Benefits

A key issue for policymakers is determining the scope of benefits. In most large-employer plans, drug benefits are comprehensive and providing comprehensive coverage in Medicare would impose large costs. There are two basic ways in which benefits could be reduced to limit costs. First, a catastrophic benefit with a high deductible would lower costs while still providing insurance. Under a catastrophic policy, beneficiaries would pay higher up-front costs but be protected against large drug expenditures. In contrast, policymakers could design a capped benefit with a low deductible. Under this policy, beneficiaries would pay little up-front costs but potentially be subject to high out-of-pocket expenditures once spending exceeds the benefit cap.

Benefits Administration

Another key issue is how the benefit would be administered. Would the benefit be administered by Medicare, states, or the private sector? Many proposals look to private-sector pharmacy benefit mangers (PBMs) to control costs. PBMs are used widely in the private sector. PBMs reduce drug costs by negotiating with drug manufacturers and pharmacies for discounts on formulary medications, and providing incentives for doctors and patients to use these drugs. PBMs are also designed to improve the effectiveness of drug use by implementing integrated information systems to help identify adverse interactions and more effective medications.

As noted by one of President Bush's health care advisors, "Overall, the policy debate over the subsidy and nature of the drug benefit seeks to balance a desire for controlling costs, avoiding crowding-out of private financing, and limiting any new transfers to wealthier elderly against a desire to reach near-universal coverage and avoid selection problems that lead to high premiums and low benefit quality. Complex as it is, the current debate largely boils down to whether the subsidy will be closer to 25 percent or 50 percent of the cost of a capped benefit"(McClellan, 2000).

Beneficiary Contributions

Although the interest of expanding prescription drug coverage for seniors is strong at present, a recent analysis of focus groups conducted with potential beneficiaries suggests lawmakers will have difficulty coming up with a realistic affordable plan. (Henry J. Kaiser Family Foundation, 2001). Focus group findings suggest that virtually any premium and a co-payment of more than a few dollars seems extremely high to these recipients. The study noted that a Medicare prescription drug benefit with a $25 premium seemed high to focus group participants, and a $50 premium was perceived to be out of reach for most seniors. Overall, the study found "a severe case of sticker shock" when focus group respondents were informed of premiums and benefits under discussion in various Medicare proposals (Henry J. Kaiser Family Foundation 2001; Pear, July 22, 2001).

Despite the existence of numerous state pharmaceutical assistance programs, focus group respondents expressed a preference for a national program. Respondents exhibited negative views of the potential for 50 different state plans. Elderly respondents, in particular, favored the federal government's involvement in administering a new drug benefit, as they believe the Medicare program is effective and could readily and efficiently expand to include a drug benefit (Henry J. Kaiser Family Foundation, 2001).

The President's Plan

President Bush issued the following principles for providing a Medicare prescription drug benefit (Pear, 2001):

- The private sector should play a major role in delivering drug benefits and managing drug costs, but the federal government must provide subsidies for all beneficiaries.
- Elderly people should be able to choose the company that, under the administration's plan for an overhaul, would manage their pharmacy benefits. No company should have a monopoly; there should be at least two 'pharmacy benefit managers' in each region.
- The federal government should set an overall limit on the out-of-pocket pharmaceutical expenses of Medicare beneficiaries.
- People content with their existing Medicare coverage could keep it. The government would pay employers to continue drug coverage as part of retiree health benefits.
- The government should, for the first time, make payments to HMOs to cover the cost of providing drug benefits.

President Bush has also proposed giving states $48 billion in temporary block grants over the next four years to help them cover the costs of drugs for low-income elderly Americans. Under the Immediate Helping Hand initiative, states would receive $12 billion a year for the next four years to provide full coverage for seniors with income up to 135 percent of the federal poverty level (FPL) and provide a 50 percent subsidy for those earning up to 175 percent of FPL. The program is designed to be temporary as Congress debates proposals to provide prescription drug coverage to Medicare recipients (State Coverage Initiatives, 2001).

In the interim, in July 2001, President Bush proposed a national prescription card for Medicare recipients so that they could immediately obtain lower prescription drug prices. The cards would be issued by "buyers' clubs" organized by private companies that negotiate discounts with drug manufacturers and pharmacies. By purchasing a card, which would cost a maximum of $25, seniors would be entitled to dis-

counts of 15 percent to 25 percent. The President's proposal is opposed by many drugstores and pharmacists, including the National Association of Chain Drug Stores, which sued to prevent implementation. In September 2001, a federal judge granted a temporary injunction barring the federal government from implementing the discount drug program, noting that the federal government may lack the authority to implement the program.

Concluding Comments

The most recent budget projections, which show a deterioration of the budget surplus, will have an impact on the Medicare prescription drug debate. Many observers believe that the $300 million originally allocated for a prescription drug plan will decrease or evaporate. Some newspaper articles have suggested that news of a deteriorating federal budget surplus has ended any chance of a Medicare prescription drug benefit being enacted in 2001.

As a result, New Jersey's efforts to expand pharmaceutical coverage through the state's PAAD/Senior Gold program may become more important as a source of prescription drug coverage to elderly and disabled individuals. Containing pharmaceutical expenditure growth through reimbursement, limits on brand-name drugs, and other cost-saving mechanisms will remain a priority in both the New Jersey PAAD/Senior Gold and Medicaid programs. At present, several bills related to prescription drug benefits and oversight have been introduced by New Jersey legislators. (See Appendix B for references to current bills.) The policy issues of prescription drugs – their financing, costs, availability and utilization – will continue to be a challenge to public and private policymakers, especially at the state-level.

Policy Implications

- At the federal level, debate concerning the design and implementation of a Medicare prescription drug benefit continues. If it moves forward, what impact would a Medicare prescription drug benefit have on state Medicaid expansion programs? If it fails, what are the implications for state policymakers and their responsibilities towards promoting access and coverage?

- How will new strategies that states are implementing—such as group purchasing arrangements and discounting programs—fare over time? How will such new programs be monitored and evaluated?

- Dr. Patricia Danzon has observed that the United States differs from other industrialized countries in that it maintains no direct controls over prices of patented, brand-name prescription drugs (Levine et al, 2000). Prescription drug costs – related to higher prices and increased rates of utilization – continue to escalate. In an environment of free market pricing, how will employers and third-party payers, who will continue to carry the greatest share of expenditures for prescription drugs, balance providing coverage with meeting costs and maintaining their financial viability?

- Recent surveys of employer health benefits spending indicate trends of greater premium increases and employers' considering the imposition of higher contributions from employees towards their health benefits (Employee Benefit Research Institute, 2001). In a slowing economy, what are the implications for the private sector and its decisions regarding prescription drug benefits and coverage for employees as part of their health plans?

- The Kaiser Foundation's 2001 focus group study of potential senior citizen prescription drug beneficiaries found that "virtually any premium and a co-payment of more than a few dollars seems extremely high." Such findings have significant implications for policymakers designing prescription drug benefit programs. How will enrollment and plan choice be affected when co-payments and cost-sharing are a factor?

- What level of commitment do state policymakers have to support researchers in their efforts to measure and evaluate the effectiveness of new pharmaceuticals on the public's health? How will we measure the cost benefits provided by new medications and biotechnological advances and their relative costs to payers?

- In November 2000, the U.S. General Accounting Office released a report finding that Patient Assistance Programs, which are voluntarily offered by pharmaceutical companies to provide prescription drugs to low-income persons who lack prescription drug coverage, do in fact aid some individuals who are without coverage. How do such programs tie in with the overall issue of prescription drug access and coverage?

ENDNOTES

1 The Omnibus Budget Reconciliation Act of 1990 (OBRA) established the Medicaid rebate program. The basic formula requires that, in exchange for having their products reimbursed (that is, on the formulary), pharmaceutical manufacturers rebate to the states the greater of (a) 15.1 percent of the average manufacturer price (AMP) paid by wholesalers for brand-name drugs that Medicaid beneficiaries purchase as outpatients or (b) the difference between AMP and the manufacturer's "best price." [Average manufacturer price is the weighted average price to wholesalers for products distributed to the retail pharmacy class of trade, where wholesaler is defined as any entity to whom the manufacturer sells (except re-labelers) and where retail pharmacy class of trade excludes hospitals and HMOs) The best price is the lowest price offered to any other customer, excluding FSS prices to state pharmaceutical assistance programs. Similarly, manufacturers pay a rebate equal to 11 percent of the AMP on generic and over-the-counter drugs.] If a brand-name drug's AMP increases faster than the inflation rate, an additional rebate is imposed so that manufacturers cannot offset the basic rebate by raising their AMP. The additional rebate is equal to the difference between the current AMP and a base-year AMP increased by the inflation rate as measured by the consumer price index. (NHPF, 2001).

2 Formularies are lists of drugs covered by a plan. Formularies, which are generally tied to reimbursement rates, are a primary tool of pharmacy benefit management. Formularies vary in restrictiveness. "Open" formularies place few restrictions on drugs available to members of the plan, whereas "closed" formularies generally provide coverage only for drugs listed on the formulary.

3 A 1993 amendment to federal law stipulated that a drug could be excluded if significant evidence that it had therapeutic advantages over other drugs was lacking.

4 California did not participate in the federal discount system when it was created because the state had previously negotiated discount contracts with pharmaceutical companies.

5 Information on New Jersey's PAAD program is taken from Bovbjerg, Randall R. and Frank C. Ullman, "Recent Health Policy Developments for Low-Income People in New Jersey," The Urban Institute Assessing the New Federalism Project, forthcoming October 2001.

Notes for Appendix A: "Table 1: State Prescription Drug Program Eligibility Levels and Benefits for 2001"

6 Source: ĽCSHP Associate Director Testifies on State Pharmacy Assistance Programs before U.S. Senate Finance Committee,îCSHP News-The Newsletter of Rutgers Center for State Health Policy, Volume 2, Issue 3, Summer 2001.

Notes: The FPL for year 2000 income was $8,350 for single individuals. In some states, eligibility requirements are set as a percentage of poverty line; in others the Rutgers Center for State Health Policy has calculated percentage of poverty line based on eligibility levels set in dollar terms.

a Applicants in Delaware who have prescription drug expenses in excess of 40% of their income are eligible for the program regardless of their income.

b Maine covers most brand name and generic drugs for all conditions once a $1,000 spending cap on prescription drugs has been reached. If an applicant spends 40% or more of his/her income on prescription drugs, the income limits are 25% higher.

c Massachusettsínew program in effect April 2001 has no upper income limit. Premiums and deductibles are subsidized in a sliding scale for enrollees with incomes below 500% of FPL. Enrollees with incomes below 188% of FPL pay no premiums or deductibles.

d The new Senior Gold program will expand income eligibility to approximately 350% of poverty for singles, with enrollees paying a $15 co-pay plus 50% of the remaining cost. The 50% coinsurance will be waived once out of pocket expenditures reach $2,000 ($3,000 for couples).

e When calculating income eligibility, Rhode Islandìs program excludes medical and pharmaceutical expenses exceeding 3% of an applicantìs annual income.

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APPENDIX A

TABLE 1: STATE PRESCRIPTION DRUG PROGRAM ELIGIBILITY LEVELS AND BENEFITS FOR 2001[6]

State Program	Eligibility Income (%FPL)	Eligible Age of Seniors	Disabled	Drugs Covered	Cost Sharing
CT	180%	65	18	Most	$25 annual fee, $12 co-pay
DE					
(Nemours)	150%	65	—	Limited by budget	20% coinsurance plus $5 dispensing fee. $2,000 annual benefit cap.
(DPAP)[a]	200%	65	19	Most	Greater of $5 or 25% co-pay and $2,500 annual cap
FL	120%	65	—	Most	10% coinsurance and $80 monthly benefit cap
IL	254%	65	16	Drugs for 8 conditions	$0 or $5 co-pay and $5 or $25 annual fee
IN	135%	65	—	Most	50% coinsurance with $500 to $1,000 tiered annual benefit cap
KS	150%	67	—	Most	30% coinsurance and $1,200 annual benefit cap
ME[b]	185%	62	19	All drugs for 15 conditions, generic for other conditions	Greater of $2 or 30% coinsurance
MD	116%	No age restrictions		Maintenance drugs	$5 co-pay
MA[c]	500%	65	No limit	Most	$0 to $82 sliding scale monthly premium, $0 to $500 sliding scale annual deductible and $5, $12, or 50% tiered co-pay
MI	150%	65	—	All	$0.25 voluntary co-pay and 3 month prescription limits
MN	120%	65	—	Most	$35 monthly deductible
NV	257%	65	—	Most	$75 to $98 monthly subsidized premiums, $100 annual deductible, $10 to $40 tiered co-pay, and $5,000 maximum annual benefit
NJ[d]	230%	65	18	Most	$5 co-pay
NY	419%	65	—	Most	Fee program: sliding scale $8 to $300 annual fee deductible program: sliding scale $530 to $1,715 annual deductible. Both programs have a t iered $3 to $20 co-pay.
NC	150%	65	—	Drugs for 2 conditions	$6 co-pay
PA					
(PACE)	168%	65	—	Most	$6 co-pay
(PACENET)	192%	65	—	Most	$500 deductible and $8-$15 copay
RI[e]	419%	65	—	Drugs for 15 conditions	Tiered 40%, 70%, or 85% coinsurance
SC	175%	65	—	Most	$500 deductible and $10 or $21 co-pay
VT					
(VHAP)	150%	65	No limit	Most	$1 or $2 co-pay
(Vscript)	175%	65	No limit	Maintenance drugs	$1 or $2 co-pay
(Vscript Exp)	225%	65	No limit	Maintenance drugs	50% coinsurance
WY	100%	No age restrictions		Most restrictions	$25 co-pay

APPENDIX B

PHARMACEUTICAL-RELATED BILLS DURING THE 2000-2001 NEW JERSEY LEGISLATIVE SESSION

At present, the bills cited below are under review by the New Jersey legislature and represent a broad range of issues. Additional information, including bill sponsors, can be found at www.njleg.state.nj.us, the legislature's homepage.

Bill #	Synopsis
A180/A2167/S179	Requires insurers that provide certain prescription drug benefits to cover costs of contraceptives.
S86	Permits physicians to dispense drugs when a pharmacy is not conveniently available to the patient.
A133	Requires health benefits coverage for prescription drugs for treatment of epilepsy.
A1339	Permits school nurse to designate additional trained school employees to administer epinephrine via epi-pen.
A520/A2782/A2765/S6	"Senior Gold Prescription Discount Act"
S1563	Requires foundation created by conversion of a health service corporation to a domestic stock insurer to fund Senior Gold pharmaceutical assistance program.
A2611	Regulates Internet pharmacies and electronic prescriptions.
S2118	"Medicaid Prescription Drug Benefit Act."
A3217	Requires fee-for-service prescription drug benefits under Medicaid.
S172/A1231	Increases pharmacy dispensing fees in Medicaid and PAAD by $1.00 over three-year period; appropriates $6,481,000 in State funds and $3,325,000 in federal funds.
A1522	Allows PAAD recipients freedom of choice in selecting a pharmacy and prohibits the imposition of a mail order system.
AR193	Commends pharmaceutical companies that have donated, or significantly reduced prices for, their medicines for treatment of HIV and related infections in developing countries.
A1483	Requires pharmaceutical manufacturers to provide rebates to Medicaid for lower drug prices in foreign countries.
A1838	Requires prescribers to use pharmaceutical numerical codes on New Jersey Prescription Blanks.
A1879	The "New Jersey Pharmacist Business Assistance Act."
A3483	Enacts new law to regulate and license pharmacists.
A1878	Establishes a community service/loan redemption program for pharmacists.
A1532	"Pharmacy Benefit Manager Act."
A2377/S1330	Requires health insurers that provide prescription drug coverage to issue standardized pharmacy identification cards. (P.L.2001, c.200.)
ACR160	Urges Congress to address issue of price increases of prescription drugs for elderly.
A840	Prohibits pharmacists from disclosing certain information concerning prescription purchases for use in commercial solicitations unless authorized by consumers.
A3195	"Prescription Drug Cost Containment Act."
A3108	Requires DHSS to prepare and make available to public consumer guide on reducing prescription drug costs; appropriates $200,000.
A3388	Establishes the New Jersey Prescription Drug Cost Reduction Study Commission.
A2226	Prohibits imposition of prior authorization requirement upon pharmacist for monthly prescription drug purchases by Medicaid, NJ KidCare, GA and PAAD recipients.

A2314	Prohibits managed care carriers providing prescription drug coverage from requiring covered persons to purchase prescription drugs that are in form of double-dose tablets or pills.
A506	Reduces minimum age of a person to whom a prescription drug price may be discounted from 62 to 60 years of age.
A2940	Requires prescription drug labels to indicate if prescribed drug is a generic product.
A2292	Requires prescription drug labels to bear brand name of prescribed drug as well as name of any generic drug substituted for brand name drug.
A3689	Establishes New Jersey Prescription Drug Pricing Review Commission.
A370	Provides a refundable gross income tax credit for certain prescription drug expenses.
A1628	Requires printing of prescription drug's expiration date on drug container label.
A1264	Permits pharmacists to change prescription dosage forms.
A398	Requires insurer that provides prescription drug coverage to provide verification of coverage to pharmacists from date that coverage becomes effective.
A3129	Allows prescription of 90-day supply for Ritalin.
A1120	Requires insurers which provide prescription drug benefits to cover costs of medications for treating sickle cell anemia.
AR175	Urges Commissioner of Human Services to provide fee-for-service prescription drug benefits for SSI recipients under Medicaid.
A3705/S2488	Exempts one-time payment for policyholders from Prudential reorganization to domestic stock insurer from calculation of income for PAAD and Senior Gold Prescription Discount Program.
A604/S341	Permits person ineligible for Work First New Jersey benefits because of a drug distribution conviction to receive prescription drug benefits for life-saving or life-sustaining medications.