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June 4, 2001 Joint Committee on Finance Paper #474

Reimbursement Rates for Prescription Drugs (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 360, #10]

CURRENT LAW

Federal regulations require that states' medical assistance (MA) programs reimburse pharmacies at a rate equal to the lesser of the provider's usual and customary charge or the estimated acquisition cost (EAC) of the drug, plus a reasonable fee for the pharmacists' cost to dispense the drug. In Wisconsin, in addition to the reimbursement for EAC and the dispensing fee, the reimbursement to pharmacies is reduced by $0.50, based on provisions enacted in 1995 Wisconsin Act 27.

Currently, the EAC for brand name drugs is based on the average wholesale price (AWP), as reported in the First Databank Blue Book, less a 10% discount. Generic drugs are priced according to the maximum allowable cost (MAC) list. This list is initially developed by the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), based on a survey of prices at which generics are available from wholesalers. DHFS modifies the list to include additional drugs based on information available to DHFS about the price of generic drugs.

The dispensing fee for most prescriptions is $4.88. Other dispensing fees are paid under limited circumstances. Because 1995 Act 27 requires that total reimbursements for drugs must be reduced by $0.50, the dispensing fee is often identified as $4.38, rather than $4.88.

Currently, on average, MA reimburses pharmacists 77% of the pharmacists' usual and customary charges, or the retail price of the drug.

GOVERNOR

Reduce MA benefits funding by $11,521,700 ($4,781,500 GPR and $6,740,200 FED) in 2001-02 and $17,650,300 ($7,324,900 GPR and $10,325,400 FED) in 2002-03 to reflect projected savings in MA benefits costs that would result by reducing the MA reimbursement rates DHFS pays to pharmacies and pharmacists for brand name prescription drugs. Under the proposal, DHFS would reimburse pharmacies and pharmacists for these drugs at a rate equal to AWP - 15%, rather than AWP-10%, plus the applicable dispensing fee. DHFS would continue to pay pharmacies and pharmacists for generic prescription drugs a rate equal to the price listed in the MAC list, plus the applicable dispensing fee.

DISCUSSION POINTS

1. It is currently estimated that MA benefit costs would decrease by $17,370,100 ($7,165,200 GPR and $10,204,900 FED) in 2001-02 and $19,507,200 ($8,095,000 GPR and $11,412,200 FED) in 2002-03 if the Governor's proposal is approved. This reestimate reflects revised estimates of MA prescription drug costs in the 2001-03 biennium under the MA base reestimate prepared by this office. Therefore, if the Committee adopts the Governor's recommendation, the funding in the bill should be reduced by an additional $5,848,400 ($2,383,700 GPR and $3,464,700) in 2001-02 and $1,856,900 ($770,100 GPR and $1,086,800 FED) in 2002-03.

2. The Governor's proposal to reduce reimbursement rates for brand name prescription drugs addresses two issues in MA drug reimbursements. First, it would reduce costs for prescription drugs to partially offset rapidly rising prescription drug costs. Second, it would reduce the disparity between the MA reimbursement rate and rates paid by other plans that provide third-party coverage of prescription drugs.

3. The following table identifies total MA drug and rebate revenue for the 1998-99 and 1999-00 fiscal years and estimated reimbursements and rebate revenue for 2000-01 through 2002-03. Additionally, the table identifies total drug expenditures as a percent of total MA expenditures.

MA Drug Expenditures ($ in Millions)
Fiscal Years 1998-99 through 2002-03

	Actual		Projected		
	1998-99	1999-00	2000-01	2001-02	2002-03
Drug Reimbursements	$259.3	$325.9	$362.6	$418.0	$469.4
Manufacturer Rebates	-49.3	-58.2	-72.0	-82.9	-92.8
Total Drug Expenditures	$210.0	$267.7	$290.6	$335.1	$376.6
Percent of Total MA Expenditures	8.1%	9.5%	9.7%	10.9%	11.8%

4. It is estimated that approximately 80% of prescription drug expenditures under MA are for the purchase of brand name drugs.

5. Reducing reimbursement rates to pharmacies is one way to reduce MA prescription drug costs. DHFS has used other ways to minimize cost increases, while ensuring MA recipients have access to appropriate medications, by targeting the use of prior authorization and implementing automatic generic substitution. Generic substitution is required unless a prescribing physician indicates in his or her own handwriting that a brand name drug is medically necessary. Both of these cost and utilization control features are discussed in more detail in LFB Paper #482.

6. Because rising prescription drug costs are beyond the control of pharmacies, reducing reimbursement rates paid to pharmacies could be viewed as an inappropriate response to rising costs. The causes for rapidly rising prescription drug costs are complex and are primarily a result of national trends in the increasing availability of newer, higher cost drug therapies. The availability of these new drugs are primarily the result of research and technological advances by pharmaceutical manufacturers.

7. Further, most of the costs of prescription drugs are not paid to cover the pharmacies' service costs, but rather the costs of the product itself. The Kaiser Family Foundation reports that $0.74 of every retail dollar paid to a pharmacy is for the manufacturer's costs. The remainder is provided for the pharmacy ($0.23) and the wholesaler ($0.03).

8. However, the Committee may find it appropriate to reduce reimbursement to pharmacies to address the disparity between what MA currently pays pharmacies for brand name drugs and what other third-party payers reimburse pharmacies.

9. A recent report by Novartis Pharmaceutical Corporation indicates that, in 1999, the health maintenance organization (HMO) industry standard reimbursement rates for prescription drugs averaged AWP-14%, with commercial and MA HMO plans paying on average AWP-14% and Medicare HMO plans paying on average AWP-15%. For all three types of HMO plans, the minimum discount was AWP-9% and the maximum discount was AWP-18%.

10. Drug Topics.com, an on-line newsmagazine for pharmacists, reported a similar reimbursement level. According to Drug Topics.com, based on a survey of 446 employers representing more than 15 million beneficiaries, the average reimbursement to community pharmacies was AWP - 13% in 1999. The average dispensing fee that year was $2.30. According to the survey, 60% of employers surveyed paid either AWP-12% or AWP-13%, but over 20% paid AWP-15% or less.

11. Two studies, one by the U.S. Department of Health and Human Services, Office of the Inspector General and another study conducted on behalf of the Kentucky Department for Medicaid Services found that pharmacies' average acquisition cost for most brand name drugs is approximately AWP-18%. Both studies found small differences between chain and independent pharmacies, but the Kentucky study found no difference in acquisition costs for urban and rural

pharmacies.

12. Based on these studies, it appears that a reimbursement rate of AWP-15% would provide an average margin of 3% of the AWP price for drugs purchased under MA, compared with approximately 8% of AWP under current reimbursement rates.

13. The margin between the acquisition cost and the reimbursement rate, together with the dispensing fee, represents the pharmacies' total reimbursement for service costs. Therefore, in reviewing reimbursement rates paid for prescription drugs, it may also be worthwhile to review the amount of the dispensing fee paid to pharmacies. The current MA dispensing fee for most drugs is $4.88. This fee is then reduced by $0.50, for a total dispensing fee of $4.38.

14. The Novartis Pharmaceutical Corporation report indicates that the average dispensing fee paid by HMOs to retail and independent pharmacies in 1999 was $1.93 for brand name drugs and $2.13 for generic drugs. Dispensing fees ranged between $0.50 and $4.09 for brand name drugs and $1.00 and $6.13 for generic drugs. The Drug Topics.com report indicates that the average dispensing fee in 1999 was $2.30. Therefore, the dispensing fee paid by Wisconsin's MA program appears to be above average, but within the range of dispensing fees paid by other third-party payers.

15. Some representatives of pharmacies have expressed concern that studies identifying a pharmacy's acquisition costs as purely the invoice cost, or wholesale cost, do not take into account a pharmacy's true acquisition costs. Distribution costs and some overhead costs are not included in acquisition costs defined in these studies.

16. Compared with other states, Wisconsin's current MA reimbursement rates appears to be equivalent to the rates paid in many other states. The attachment to this paper identifies other states' MA reimbursement rates for drugs in 1999, as identified by the National Pharmaceutical Council. In 2000, 21 states paid AWP-10% for some drugs purchased under MA. However, a number of states, including, Colorado, Connecticut, Indiana, New Jersey, North Carolina, South Carolina, Oregon, Washington and Wyoming, have recently proposed reducing pharmacy reimbursement rates. Most of these proposals are pending approval by either the Governor or the Legislature in those states.

17. Virtually all eligible pharmacies are certified to participate in MA. Of these, approximately 86% submitted claims in the current fiscal year. Some representatives of pharmacies have indicated that a reduction in the MA reimbursement rate for prescription drugs would likely result in some pharmacies choosing to discontinue participation in the MA program. However, since reducing MA rates to AWP-15% would bring the MA rates in line with most other third-party payers, it is not clear why it would be disadvantageous for pharmacies to continue to participate in MA, compared with other health care plans.

18. Further, it appears that, for most pharmacies, a reduction in the MA reimbursement rate would not affect a significant portion of the pharmacy's revenues. According to Novartis

Pharmaceutical Corporation in Wisconsin, MA reimbursements represents 8.5% of total retail revenue for pharmacies in 1999. Because MA represents a small portion of revenue for most pharmacies, it is reasonable to conclude that a reduction in the MA reimbursement rate would not significantly affect total revenue for pharmacies.

19. However, some pharmacies, particularly in larger urban areas with higher concentrations of MA recipients, could be disproportionately affected by reductions in the MA reimbursement rates, since revenue from MA would likely represent a larger portion of total revenue for these pharmacies.

20. If the Committee does not want to reduce reimbursement rates to the level proposed in the Governor's bill, the Committee could reduce the reimbursement rates to AWP-12.5% or AWP-11% identifies the change to base for each of the alternatives.

Estimated Change to MA Base Funding Under Each of the Alternatives

	2001-02			2002-03		
Alternative	GPR	FED	Total	GPR	FED	Total
1. AWP-15% (as reestimated)	-$7,165,200	-$10,204,900	-$17,370,100	-$8,095,000	-$11,412,200	-$19,507,200
2. AWP-14%	-5,732,100	-8,164,000	-13,896,100	-6,476,000	-9,129,800	-15,605,800
3. AWP-12.5%	-3,582,600	-5,102,400	-8,685,000	-4,047,500	-5,706,100	-9,753,600
4. AWP-11%	-1,433,000	-2,041,000	-3,474,000	-1,619,000	-2,282,500	-3,901,500
5. AWP-10% (current law)	0	0	0	0	0	0

ALTERNATIVES TO BASE

1. Adopt the Governor's recommendation, as reestimated, by reducing funds budgeted for MA benefits by an additional $5,848,400 ($2,383,700 GPR and $3,464,700 FED) in 2001-02 and $1,856,900 ($770,100 GPR and $1,086,800 FED) in 2002-03 to reflect a reestimate of the reduction in MA expenditures as a result of the Governor's recommendations.

Alternative 1	**GPR**	**FED**	**TOTAL**
2001-03 FUNDING (Change to Base)	**-** $15,260,200	**-** $21,617,100	- $36,877,300
[Change to Bill	***-** $3,153,800*	***-** $4,551,500*	***-** $7,705,300]*

2. Modify funding in the bill by reducing MA benefit appropriation by $2,374,400 ($950,600 GPR and $1,423,800 FED) in 2001-02 and increasing the MA benefits appropriation by $2,044,500 ($848,900 GPR and $1,195,600 FED) in 2002-03 to reflect the estimated reduction in MA expenditures as a result of reducing the MA reimbursement rate for brand name prescription drugs from AWP-10% to AWP-14%.

Alternative 2	**GPR**	**FED**	**TOTAL**
2001-03 FUNDING (Change to Base)	**-** $12,208,100	**-** $17,293,800	- $29,501,900
[Change to Bill	***-** $101,700*	***-** $228,200*	***-** $329,900]*

3. Increase funding in the bill by $2,836,700 ($1,198,900 GPR and $1,637,800 FED) in 2001-02 and $7,896,700 ($3,277,400 GPR and $4,619,300 FED) in 2002-03 to reflect a decrease in the MA reimbursement rate for brand name prescription drugs from AWP-10% to AWP - 12.5%.

Alternative 3	**GPR**	**FED**	**TOTAL**
2001-03 FUNDING (Change to Base)	**-** $7,630,100	**-** $10,808,500	**-** $18,438,600
[Change to Bill	*$4,476,300*	*$6,257,100*	*$10,733,400]*

4. Increase funding in the bill by $8,047,700 ($3,348,500 GPR and $4,699,200 FED) in 2001-02 and $13,748,800 ($5,705,900 GPR and $8,042,900 FED) in 2002-03 to reflect the estimated reduction in MA expenditures as a result of reducing the MA reimbursement for brand name prescription drugs from AWP-10% to AWP-11%.

Alternative 4	**GPR**	**FED**	**TOTAL**
2001-03 FUNDING (Change to Base)	**-** $3,052,000	**-** $4,323,500	**-** $7,375,500
[Change to Bill	*$9,054,400*	*$12,742,100*	*$21,796,500]*

5. Maintain current law.

Alternative 5	**GPR**	**FED**	**TOTAL**
2001-03 FUNDING (Change to Base)	$0	$0	$0
[Change to Bill	*$12,106,400*	*$17,065,600*	*$29,172,000]*

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ATTACHMENT

MA Pharmacy Payment and Patient Cost Sharing By State
2000

State	Dispensing Fee	Ingredient Reimbursement Basis	Copayment
Alabama	$5.40	AWP-10%; WAC+9.2%	$0.50-$3.00
Alaska	$3.45	AWP-5%	$2.00
Arizona*	-	-	-
Arkansas	$5.51	AWP-10.5%	$0.50-$3.00
California	$4.05	AWP-5%	G: $1.00; B: $1.00
Colorado	$4.08	AWP-10% or WAC+18%; whichever is lowest	G: $0.50; B: $2.00
Connecticut	$4.10	AWP-12%	None
Delaware	$3.65	AWP-12.9%	None
District of Columbia	$3.75	AWP-10%	$1.00
Florida	$4.23	AWP-13.25%	None
Georgia	$4.63	AWP-10%	$0.50
Hawaii	$4.67	AWP-10.5%	None
Idaho	$4.94 ($5.54 for unit dose)	AWP-11%	None
Illinois	G: $3.75; B: $3.45	AWP-10%, AWP-12% for multi-source drugs	None
Indiana	$4.00	AWP-10%	$0.50-$3.00
Iowa	$4.13-$6.42	AWP-10%	$1.00
Kansas	$4.50	AWP-10%	$2.00
Kentucky	OP: $4.75; LTC: $5.75	AWP-10%	None
Louisiana	$5.77	AWP-10.5%	$0.50-$3.00
Maine	$3.35 (+extra fees for compounding)	AWP-10%	$0.50-$3.00
Maryland	$4.21	Lowest of WAC+10% direct+10%; AWP-10%	$1.00
Massachusetts	$3.00	WAC+10%	$0.50
Michigan	$3.72	AWP-13.5% (1 to 4 stores), AWP-15.1% (5+ stores)	$1.00
Minnesota	$3.65	AWP-9%	None

State	Dispensing Fee	Ingredient Reimbursement Basis	Copayment
Mississippi	$4.91	AWP-10%	$1.00
Missouri	$4.09	AWP-10.43%	$0.50-$2.00
Montana	$2.00-$4.20	AWP-10%	G: $1.00; B: $2.00
Nebraska	$3.20-$5.05	AWP-8.71%	$1.00
Nevada	$4.76	AWP-10%	None
New Hampshire	$2.50	AWP-12%	G: $0.50; B: $1.00
New Jersey	$3.73-$4.07	AWP-10%	None
New Mexico	$4.00	AWP-12.5%	None
New York	B: $3.50; G: $4.50	AWP-10%	G: $0.50; B: $2.00
North Carolina	$5.60	AWP-10%	$1.00
North Dakota	$4.60	AWP-10%	None
Ohio	$3.70	AWP-11%	None
Oklahoma	$4.15	AWP-10.5%	$1.00-$2.00
Oregon	$3.91-$4.28 (based on annual # of Rx)	AWP-11%	None
Pennsylvania	$4.00	AWP-10%	$1.00-$2.00
Rhode Island	OP: $3.40; LTC: $2.85	WAC+5%	None
South Carolina	$4.05	AWP-10%	$2.00
South Dakota	$4.75 ($5.55 for unit dose)	AWP-10.5%	$2.00
Tennessee*	-	-	-
Texas	$5.27 + 2% of ingredient & dispensing fee	AWP-15% or WAC+12%, whichever is lowest	None
Utah	$3.90-$4.40 (based on geographic area)	AWP-12%	$1.00-$5.00
Vermont	$4.25	AWP-11.9%	$1.00-$2.00
Virginia	$4.25	AWP-9%	$1.00
Washington	$4.06-$5.02 (based on annual # of Rx)	AWP-11%	None
West Virginia	$3.90 (+ extra fees for compounding)	AWP-12%	$0.50-$2.00
Wisconsin	$4.88	AWP-10%	$0.50-$1.00
Wyoming	$4.70	AWP-4%	$2.00

WAC = Wholesalers Acquisition Cost; AWP = Average Wholesale Price; EAC = Estimated Acquisition Cost.
G = Generic; B = Brand Name; OP = Outpatient; LTC = Long Term Care.
*Within federal and state guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.
Source: As reported by state drug program administrators in the 2000 National Pharmaceutical Council Survey.