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May 26, 2005 Joint Committee on Finance Paper #371

Prescription Drug Reimbursement Rates (DHFS -- Medical Assistance, BadgerCare, and SeniorCare -- Eligibility, Payments, and Services)

[LFB 2005-07 Budget Summary: Page 243, #2]

CURRENT LAW

Medical Assistance (MA) Reimbursement Rate. Federal regulations require that states' 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 pharmacist's cost to dispense the drug. The EAC is considered reimbursement for the product, while the dispensing fee is considered reimbursement for the service.

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 13% discount. Readily available 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, Centers for Medicare and Medicaid Services (CMS), 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 $4.38. Other dispensing fees are paid under limited circumstances.

Currently, DHFS estimates that, on average, the MA program reimburses pharmacists approximately 73% of the pharmacists' usual and customary charges (the retail price of the drug).

SeniorCare Reimbursement Rate. For drugs purchased under SeniorCare, pharmacies receive a maximum reimbursement of the MA rate for the drug product (either AWP-13% or the MAC price, whichever is less), plus 5%, plus the applicable dispensing fee.

GOVERNOR

Reduce MA, BadgerCare, and SeniorCare funding by $16,217,900 (-$7,201,800 GPR and -$9,016,100 FED) in 2005-06 and by $23,597,100 (-$10,185,100 GPR and -$13,412,000 FED) in 2006-07 to reflect the administration's estimates of the savings that would be realized by reducing rates paid to pharmacies for the drugs pharmacies dispense to recipients under these programs. The bill would: (a) reduce, from the average wholesale price (AWP) minus 13%, to the AWP minus 16%, reimbursement to pharmacies for brand name drugs; (b) reduce the dispensing fee from $4.38 to $3.88 per prescription; and (c) eliminate the 5% enhancement the state pays to pharmacies for drugs dispensed under SeniorCare, a statutory change that would first apply to reimbursement for prescription drugs purchased on October 1, 2005. All of the projected savings assume an October 1, 2005, effective date.

In the Executive Budget Book, the Governor indicates that he has directed DHFS to research alternatives to the AWP methodology to reform pharmacy reimbursement for drugs dispensed under these programs.

DISCUSSION POINTS

1. It is estimated that MA, BadgerCare and SeniorCare costs would decrease by $15,488,400 (-$7,183,700 GPR and -$8,304,700 FED) in 2005-06 and by $23,100,000 (-$10,908,200 GPR and -$12,191,800 FED) if the MA reimbursement rate were decreased to AWP-16%, the dispensing fee was reduced to $3.88, and the 5% SeniorCare enhancement was eliminated, as recommended by the Governor. This estimate assumes that the rate change would be effective October 1, 2005. The difference between this reestimate and the funding provided in the bill primarily reflects differences in the projected federal participation rate and revised estimates of drug costs in the 2005-07 biennium, based on the MA, BadgerCare and SeniorCare base reestimates. Funding in the bill should be increased by $729,500 ($18,100 GPR and $711,400 FED) in 2005-06 and by $497,100 (-$723,100 GPR and $1,226,600 FED) in 2006-07 to reflect this reestimate of the projected savings of the Governor's proposal.

The following table summarizes the projected cost savings of each of these three items.

Summary of Projected Cost Savings of Reducing Pharmacy Reimbursement Rates

Item	2005-06 GPR	2005-06 FED	2005-06 Total	2006-07 GPR	2006-07 FED	2006-07 Total
Reduce MA Reimbursement to AWP -16%	-$3,921,300	-$4,941,300	-$8,662,600	-$6,020,000	-$7,334,500	-$13,354,500
Reduce Dispensing Fee to $3.88	-1,319,800	-1,582,400	-2,902,200	-1,880,500	-2,182,600	-4,063,100
Eliminate SeniorCare Enhanced Rate	-1,942,600	-1,781,000	-3,723,600	-3,007,700	-2,674,700	-5,682,400
Total	-$7,183,700	-$8,304,700	-$15,488,400	-$10,908,200	-$12,191,800	-$23,100,000

2. Annual MA fee-for-service gross drug expenditures have increased significantly during the past several years. These expenditures totaled $494.0 million for 2002-03 and $560.6 million in 2003-04. It is estimated that these costs will total $603.7 million in 2004-05.

3. Approximately 80% of prescription drug expenditures under MA, BadgerCare and SeniorCare are for brand name drugs. While most of the expenditures are for brand name drugs, generic drug prescriptions currently account for approximately 55% of total prescriptions.

4. The funding reductions in the bill do not reflect projected savings associated with future reductions in the capitation payments the MA program would make to managed care organizations that provide services to MA and BadgerCare enrollees. Because capitation payments are based on the rates paid under fee-for-service, a decrease in reimbursements for prescription drugs would result in a decrease in future capitation payments to managed care organizations.

5. Reducing reimbursement rates to pharmacies is one way to reduce MA prescription drug costs. DHFS has used other ways to reduce costs, such as requiring prior authorization for high-cost drugs for which a therapeutic equivalent is available at less cost, and limiting reimbursement to the amount for a generic drug unless a prescriber indicates that the brand name drug is medically necessary. In addition, DHFS has implemented some disease management programs that help to reduce the drug costs of individuals with chronic illnesses.

6. It is difficult to assess pharmacies' actual costs of providing drugs to MA, BadgerCare and SeniorCare enrollees because pharmacies do not typically pay the AWP to acquire a drug. A paper by the Congressional Budget Office (CBO) titled "Medicaid's Reimbursements to Pharmacies for Prescription Drugs," published in December of 2004, likened the AWP to a sticker price on a car, in that it is a published price, but very few purchasers actually pay that price. The CBO study concluded that manufacturers have an incentive to give pharmacies a significant discount on newer generic drugs, while establishing high list prices. This results in a higher mark-up on the newer generic drug than on equivalent brand name drugs that motivates the pharmacy to dispense the generic drug in order to maximize profit. Similar to purchasing a car, it is very difficult to assess true costs in relation to the list price. As a result, most MA programs use AWP minus a percentage-based discount.

7. According to a report titled "State Strategies to Contain Medicaid Drug Costs" by the U.S. Department of Health and Human Services, Office of the Inspector General (OGI) published in October, 2003, 43 states used the AWP method exclusively to determine drug reimbursement. The OGI report also found that AWP overstated pharmacy acquisition costs for brand name drugs, on average, by 22 percent.

8. The OGI report also discusses numerous other studies and reports that all lead to the conclusion that state MA programs pay more than several other federal and private purchasers for a wide variety of drugs. Six states also use the wholesale acquisition cost (WAC) methodology, reimbursing pharmacies the lesser of WAC plus some percentage-based mark-up or AWP less some percentage-based mark-down. The WAC, like the AWP, is a published price based on self-reported data that is hard to verify. The OIG report stated that audits by the OIG concluded that the WAC is unreliable. Because it is so difficult to assess pharmacies true acquisition costs, some states have asked the Centers for Medicare and Medicaid Services (CMS), to share the average manufacturer price (AMP) data that it collects as part of the federal government's drug rebate program. Currently, legal barriers prevent CMS from sharing this proprietary information. In addition, CMS has indicated that states need to determine accurate drug pricing using the data they have access to. The Executive Budget Book indicates that the Governor has directed DHFS to research alternatives to the AWP methodology to reform pharmacy reimbursement for drugs dispensed under these programs.

9. The primary causes for rising prescription drug costs are the result of national trends associated with the availability of newer, higher cost drug therapies. In short, more individuals are using more drugs and more costly drugs than in the past. Research and technological advances by pharmaceutical manufacturers make these drugs available and strong marketing efforts by manufacturers increases the sales of newer, more costly medications. Inflationary pressure on drug prices plays a role in the rising cost of drugs, but a less significant role than these other factors.

MA Product Reimbursement

10. Reducing reimbursement to pharmacies would address the disparity between what MA currently pays pharmacies for brand name drugs and what other third-party payers reimburse pharmacies. In contrast with most provider groups, such as hospitals, physicians, and dentists, where MA payments are usually lower than amounts paid by other third-party payers and may not cover the cost of providing services to MA recipients, reimbursements for pharmacies are, on average, higher than the rates paid by other third-party payers. The state health insurance plans currently contract with Navitus Health Solutions for pharmacy benefits administration. The Navitus network reimburses pharmacies for brand name drugs at AWP-15%, plus a $2.00 dispensing fee. This rate is 2% less than the current MA reimbursement rate of AWP-13%. This is especially significant because 80% of drug expenditures are for brand name drugs. The only pharmacy that did not agree to these rates was Walgreens, which is paid AWP-14%, plus a $2.00 dispensing fee. Navitus uses the same MAC list as MA, and any drugs on the list are reimbursed at MAC price plus 20%, with a $2.50 dispensing fee. Generics not on the MAC list are reimbursed at AWP-25%.

11. According to the Pharmacy Benefit Report; Facts & Figures, 2001 Edition, prepared by Novartis Pharmaceutical Corporation, the average reimbursement paid by health maintenance organizations (HMOs) to their network providers in 2000 was AWP-15%. The range of payments was a minimum of AWP-10% to a maximum of AWP-18%.

12. Pharmacy representatives argue that Wisconsin's MAC prices are too aggressive and lead to pharmacies losing money on these transactions. Despite their concerns, nearly every pharmacy in the state participates in the MA program. It is unknown if pharmacies would stop participating in the program if the Governor's proposal were enacted.

13. Wisconsin's maximum reimbursement rates appear to be in the middle range, on average, compared to other state MA programs. Of those states that pay pharmacies based on a discount to AWP, 17 provide a maximum reimbursement rate that is lower than Wisconsin's current rate. Out of those seventeen, five are within 0.5% of the rate Wisconsin pays. Attachment 2 lists the reimbursement rates paid by other state MA programs, as reported by the American Society of Consultant Pharmacists, February, 2003.

Cost of Dispensing and Dispensing Fees

14. The Pharmacy Society of Wisconsin argues that pharmacies' margins on the product reimbursement are necessary to cover the costs of dispensing medications to MA recipients, since the current MA dispensing fee is not sufficient to cover such costs. A study conducted by David Kreling, Ph.D., with the Sonderegger Research Center at the UW School of Pharmacy, the most recent study of Wisconsin pharmacy dispensing fees, indicates that the average dispensing cost in 2000 was approximately $6.60 per prescription for Wisconsin pharmacies. The net MA dispensing fee for most prescriptions is $4.38 per prescription.

15. However, total MA reimbursement for both the product cost and the dispensing cost appears to exceed pharmacies' costs under the current payment formula for brand name drugs. Professor Kreling's study found that pharmacies in Wisconsin were able to acquire drugs at an average price of AWP-17.5% for brand name medications. As stated previously, an OIG report found that AWP overstated pharmacies true acquisition costs, on average, by 22%. Based on these findings and the current reimbursement of AWP-13%, it is estimated that pharmacies' margin on acquisition costs is an average of 4.5-9% of AWP, or approximately $4.78-$9.56 per prescription, based on the actual average MA reimbursement for brand name drugs of $106.20 per prescription (not including dispensing fees) in 2003-04. Therefore, the total MA reimbursement to pharmacies for costs other than the product acquisition is estimated to total $9.16-$13.94 per brand name prescription ($4.38 dispensing fee, plus a $4.78-$9.56 margin on AWP). Under the Governor's proposal, the total estimated reimbursement in addition to acquisition costs would total $5.47-$10.25 per brand name prescription ($3.88 dispensing fee, plus a $1.59-$6.37 margin on AWP).

16. The Kreling study noted that with increasing labor costs, it is likely that current median dispensing costs could range from $6.95 to $7.35 per prescription. Therefore, a margin of $5.47-$10.25 per prescription may not cover all of a pharmacy’s costs to dispense every

prescription. Further, reimbursement that pays for the average cost of dispensing drugs would not cover the cost of dispensing drugs for those pharmacies with higher than average costs. Findings from the Kreling study indicate that there is no evidence that it costs pharmacies more to dispense drugs to MA beneficiaries. Specifically, the study noted "there was no clear relationship between the cost of dispensing and [MA] prescription volume or [MA] prescriptions as a percent of total prescription volume."

17. It is likely that MA reimbursement for both product cost and dispensing costs for generic drugs on the MAC list do not fully cover pharmacies' costs. Pharmacies do not receive the same margin on readily available generic drugs that they receive on brand name medications, since the MAC list for readily available generic drugs is closer to the actual acquisition price for readily-available generic drugs. Readily available generic drugs represent approximately 55% of the number of prescriptions filled by MA recipients and approximately 20% of overall drug expenditures.

18. However, on average, third-party payers pay less for dispensing than MA. The Novartis Pharmaceutical Corporation's report indicates that in 2000, dispensing fees paid by HMOs to network pharmacies averaged $2.16 for generic drugs and $1.99 for brand name drugs, considerably lower than the current $4.38 for most prescriptions under MA. Further, Navitus Health Solutions, the pharmacy administration program for state employees, pays pharmacies $2.00 per prescription for dispensing. The current dispensing fee of $4.38 Wisconsin pays under MA is slightly higher than the average dispensing fee of approximately $4.23 paid by other states for brand name drugs. Because pharmacies do not have the same profit margin for generic drugs, a few states' MA programs pay a higher dispensing fee for generic drugs.

SeniorCare 5% Enhancement

19. It is estimated that if the five percent enhancement for SeniorCare was eliminated and the SeniorCare reimbursement rate were equal to the MA reimbursement rate, as proposed by the Governor, funding for SeniorCare could be reduced by $3,723,600 (-$1,942,600 GPR and -$1,781,000 FED) in 2005-06 and $ 5,682,400 (-$3,007,700 GPR and -$2,674,700 FED) in 2006-07. These savings estimates are $325,900 ($33,700 GPR and $359,600 FED) in 2005-06 and $497,100 (-$261,500 GPR and $758,600 FED) in 2006-07 less than the savings assumed in the Governor's bill.

20. At the time SeniorCare was created, it was argued that pharmacists should be paid more than the MA reimbursement rate because the MA rate represents a discount to pharmacies' usual and customary charges (the retail price charged by the pharmacies). It was expected that many of the individuals that would enroll in SeniorCare would not have had prescription drug coverage before they enrolled in SeniorCare and therefore, were paying retail prices for their prescription drugs. Therefore, having pharmacies paid at the MA rate, rather than retail price for drugs purchased by these individuals would reduce revenue to pharmacies.

21. However, while pharmacies receive less revenue per prescription on average under

SeniorCare compared with retail prices, it was also expected that the reduced revenue would be offset by an increase in the number of prescriptions filled by SeniorCare enrollees. Research and survey data show that individuals without prescription drug coverage use fewer drugs than individuals with such coverage. Therefore, SeniorCare enrollees are likely receiving more prescriptions now than they did before they enrolled in SeniorCare.

22. Another argument that was offered to support an enhanced reimbursement rate for drugs dispensed to SeniorCare enrollees is that these individuals have more complicated health care needs than MA recipients. Therefore, it was argued, these individuals might require more service from pharmacists to ensure they take their medications appropriately.

23. However, other health care programs administered by DHFS, including BadgerCare, HIRSP and the chronic disease aids programs, all have reimbursement rates that equal the MA reimbursement rate. Many of the individuals served under these other programs have significant health care needs and may require additional service on the part of the pharmacist to ensure they are taking their medications appropriately.

Additional Points

24. Two additional points should be made regarding proposed changes to the MA reimbursement rate for prescription drugs.

First, on average, MA payments represent approximately 21.6% of retail pharmacy sales in Wisconsin, according to Novartis Pharmaceutical Corporation. Those pharmacies with higher shares of sales from MA recipients would be disproportionately affected by any reduction in MA reimbursement.

Second, for other services where MA reimbursement does not fully support the costs of serving MA recipients, such as hospitals, physicians, nursing homes, and dentists, unreimbursed costs are shifted to other third-party payers, such as commercial health insurance plans. To a certain extent, pharmacies may be able to make up a portion of the lost revenue by negotiating higher reimbursements from other third-party payers, similar to other MA providers. Where pharmacies are not able to shift such costs to other third-party payors, the reduction in the reimbursement rate would result in a reduction in revenue. Pharmacies that have a higher than average amount of MA revenue will be more adversely affected by the proposed changes and would likely either shift costs to other payors or lose revenue.

25. While it appears that pharmacies are, on average, being reimbursed at a level higher than cost, it is important to note that DHFS will need to continue to find other methods of reducing drugs costs in the MA program, since AB 100 would reduce pharmacy reimbursements to more closely reflect pharmacies' costs. DHFS will need to continue to analyze prescription drug use and identify the drugs that are most significantly responsible for cost increases. This includes continued use and expansion of the preferred drug list, prior authorization, and disease management programs.

26. As alternatives to the Governor's proposal, the Committee could consider maximum

reimbursement rates for brand name and non-readily available generic drugs, including AWP-15%, AWP-14%, and the current AWP-13 %. Attachment 1 identifies the estimated savings to MA, BadgerCare, and SeniorCare benefits appropriations with the Governor's recommendations and each of these alternatives, including maintaining the current reimbursement rate. The attachment also identifies the estimated savings for the option to reduce the dispensing fee, as recommended by the Governor.

27. Each of these estimates assumes that the rate changes would be effective October 1, 2005. The administration indicates that any change to the reimbursement rates could first apply October 1, 2005.

ALTERNATIVES

1. Adopt the Governor's recommendation, but increase funding by $729,500 ($18,100 GPR and $711,400 FED) in 2005-06 and $497,100 (-$723,100 GPR and $1,220,200 FED) to reflect revised estimates of the savings of the Governor's proposal.

Alternative 1	GPR	FED	TOTAL
2005-07 FUNDING (Change to Bill)	**-** $705,000	$1,931,600	$1,226,600

2. Modify the Governor's recommendations by choosing any of the alternatives presented in Attachment 2. These alternatives are presented as Part A and Part B, requiring a choice in each part.

3. Delete provision.

Alternative 3	GPR	FED	TOTAL
2005-07 FUNDING (Change to Bill)	$17,386,900	$22,428,100	$39,815,000

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Attachments

ATTACHMENT 1

Summary of Changes Expressed as Change to Bill

Part A

Alternative 1: AWP - 16% (AB 100)

	2005-06			2006-07		
	GPR	FED	Total	GPR	FED	Total
AWP - 16%	$96,200	$307,400	$403,600	-$327,600	$327,600	$0
A. Delete S.C. Enhancement	-33,700	359,600	325,900	-261,500	758,600	497,100
B. Maintain S.C. Enhancement	1,942,600	1,781,000	3,723,600	3,007,700	2,674,700	5,682,400

Alternative 2: AWP - 15%

	2005-06			2006-07		
AWP - 15%	$1,403,300	$1,954,500	$3,357,800	$1,892,800	$2,993,000	$4,885,800
A. Delete S.C. Enhancement	-56,900	338,400	281,500	-297,300	726,800	429,500
B. Maintain S.C. Enhancement	1,965,800	1,802,200	3,768,000	3,043,500	2,706,500	5,750,000

Alternative 3: AWP - 14%

	2005-06			2006-07		
AWP - 14%	$2,710,400	$3,601,600	$6,312,000	$3,685,700	$5,217,300	$8,903,000
A. Delete S.C. Enhancement	-80,000	317,200	237,200	-333,100	694,900	361,800
B. Maintain S.C. Enhancement	1,988,900	1,823,400	3,812,300	3,079,300	2,738,400	5,817,700

S.C. = SeniorCare.

Alternative 4: Maintain AWP - 13%

	2005-06			2006-07		
	GPR	FED	Total	GPR	FED	Total
AWP - 13%	$4,017,500	$5,248,700	$9,266,200	$5,692,400	$7,662,100	$13,354,500
A. Delete S.C. Enhancement	-203,700	203,700	0	-162,500	162,500	0
B. Maintain S.C. Enhancement	2,112,600	1,936,900	4,049,500	2,908,700	3,270,800	6,179,500

Part B

Dispensing Fee

	2005-06			2006-07		
	GPR	FED	Total	GPR	FED	Total
Alternative 1						
Change to $3.88 (AB 100)	-$44,400	$44,400	$0	-$134,000	$134,000	$0
Alternative 2						
Retain Current $4.38	1,275,400	1,626,800	2,902,200	1,746,500	2,316,600	4,063,100

ATTACHMENT 2

Medicaid Drug Reimbursement Rates
By State

State	Ingredient Reimbursement	Dispensing Fee	State MAC
Alabama	WAC+9.2% then AWP-10%	$5.40	Yes
Alaska	AWP-5%	$3.45-$11.46 (based on pharmacy/Medicaid volume)	No
Arizona	AWP-15%	$2.00 (FFS only)	No
Arkansas	AWP-20% (generic); AWP-14% (brand)	$5.51	Yes
California	AWP-10%	$4.05	Yes
Colorado	AWP-35% (generic); AWP-13.5% (brand)	$4.00 (retail pharmacy); $1.89 (institutional pharmacy)	Yes
Connecticut	AWP-40% (generic); AWP-12% (brand)	$3.60	Yes
Delaware	AWP-14% (traditional - retail independent and retail chain pharmacies); AWP-16% (non-traditional - long-term care and specialty pharmacies)	$3.65	Yes
Florida	Lower of AWP-13.25% or WAC+7%	$4.23; $4.73 (NH-long term care)	Yes
Georgia	AWP-10%	$4.63 (brand for profit pharm); $4.33 (brand not for profit); $5.13 (generic for profit pharm); $4.63 (generic not for profit)	Yes
Hawaii	AWP-10.5%	$4.67	Yes
Idaho	AWP-12%	$4.94 ($5.54 for unit dose)	Yes
Illinois	AWP-25% (generic); AWP-12% (brand)	$4.60 (generic); $3.40 (brand)	Yes
Indiana	AWP-20% (generic); AWP-13.5% (brand)	$4.90	Yes
Iowa	AWP-12%	$4.26	Yes
Kansas	AWP-27% (generic); AWP-13% (single source)	$3.40	Yes
Kentucky	AWP-12%	$4.51	Yes

State	Ingredient Reimbursement	Dispensing Fee	State MAC
Louisiana	AWP-13.5% (AWP-15% for chains)	$5.77	Yes
Maine	AWP-15%; direct supply drug list-usual and customary charge or AWP-17% plus $3.35 professional fee or FUL or MAC plus $3.35 professional fee (Mail order lowest of usual and customary charge, AWP-20% plus $1.00 professional fee-for exceptions see state plan, FUL or MAC plus $1.00 professional fee)	$3.35; $4.35 & $5.35 (compounding); $12.50 (insulin syringe)	Yes
Maryland	Lower of AWP-12% or WAC+8%, direct price+8% or distributor price when available	$4.69 (generic); $3.69 (brand); $5.65 (generic-NH); $4.65 (brand-NH); $7.25 (home IV therapy)	Yes
Massachusetts	WAC+6%	$3.50 (single source), $5 (multiple source)	Yes
Michigan	AWP-13.5% (independ pharm (1-4 stores)); AWP-15.1% (chain (5+stores))	$3.77	Yes
Minnesota	AWP-11%	$3.65	Yes
Mississippi	AWP-12%	$3.91; allows for a reasonable dispensing fee for OTC)	No
Missouri	Lower of AWP-10.43% or WAC+10%	$4.09	Yes
Montana	AWP-15%	$4.70	No
Nebraska	AWP-11%	$3.27-$5.00 (based on service delivery, unit dosage or 3rd party payors)	Yes
Nevada	AWP-15%	$4.76	No
New Hampshire	AWP-16%	$1.75	Yes
New Jersey	AWP-12.5%	$3.73; $4.07 (addt'l services)	No
New Mexico	AWP-14%	$3.65	Yes
New York	AWP-12%	$4.50 (generic); $3.50 (brand)	No
North Carolina	AWP-10%	$5.60 (generic); $4.00 (brand)	Yes
North Dakota	AWP-10%	$5.60 (generic); $4.60 (brand)	No
Ohio	Lower of WAC+9% or AWP-12.8%	$3.70	Yes
Oklahoma	AWP-12%	$4.15	Yes
Oregon	AWP-11% (institutional), AWP-15% (noninstitutional)	$3.50 (retail); $3.91 (institutional)	Yes

State	Ingredient Reimbursement	Dispensing Fee	State MAC
Pennsylvania	AWP-10%	$4.00	No
Rhode Island	WAC+5%	$3.40 (outpatient), $2.85 (long term care)	No
South Carolina	AWP-10%	$4.05 (independ pharm); $3.15 (institutional)	Yes
South Dakota	AWP-10.5%	$4.75 ($5.55 for unit dose)	Yes
Tennessee	AWP-13%	$2.50 (long term care dual eligib); $5.00 (NH only-if 28 days+)	Yes
Texas	Lower of AWP-15% or WAC+12%	$5.14	Yes
Utah	AWP-15%	$3.90 (urban); $4.40 (rural)	Yes
Vermont	AWP-11.9%	$4.25	Yes
Virginia	AWP-10.25%	$3.75; $5.00 (unit dose drugs)	Yes
Washington	AWP-14% (single source and multiple source (w/2-4 manufact)), AWP-50% (multiple source from 5+ manufact), AWP-19% (brand-mail order), AWP-15% (generic-mail order)	$4.20-$5.20 (based on 3-tiered pharmacy volume); $3.25 (mail order)	Yes
Washington, D.C.	AWP-10%	$4.50	No
West Virginia	AWP-12%	$3.90 (+$1.00 for compounding)	No
Wisconsin	AWP-13%	$4.38	Yes
Wyoming	AWP-11%	$5.00	No

B = Brand
G = Generic
LTC = Long Term Care
FUL = Federal Upper Limit
WAC = Wholesale Acquisition Cost
MAC= Maximum Allowed Cost

Notes:
Georgia - $0.50 incentive for preferred drug list
Idaho - additional reimbursement for unit dose
Maine - additional fee for compounding
Montana - $0.75 for repackaging in unit doses
New Jersey - additional fees for counseling, impact add-ons, and long-term care pharmacies
Oregon - $3.80 for unit dose
Tennessee - $2.50 dispensing fee for less than a 30 day supply
Washington - fee based on annual number of prescriptions
West Virginia - additional fee for compounding
Wisconsin - $0.50 is subtracted from entire claims, therefore dispensing fee is typically considered $4.38

Sources: American Society of Consultant Pharmacists, February, 2003, The Kaiser Family Foundation, January 2003