

FISCAL POLICY NOTES\$

Escalating Prescription Drug Costs - The Reality and Options for Reform February 2005

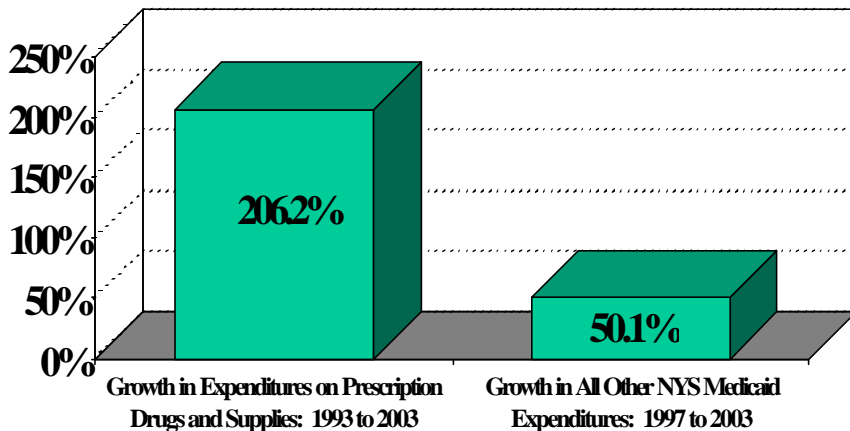
The rising cost of prescription drugs presents an enormous challenge to individual consumers and state governments alike. While most private insurance policies, especially those offered through employers, cover prescription drugs, three million nonelderly New Yorkers (17.9%) do not have any health insurance and therefore must pay “out of pocket” for all prescription drug costs.¹ Even for those with some insurance coverage, rising drug costs have prompted employers and their agents to impose higher co-payments and deductibles.

Total sales of retail prescriptions filled in New York grew by 18% between 2002 and 2003, more than twice the national growth rate. New Yorkers spent approximately \$12 billion to fill 192 million retail prescriptions in 2003.²

New York State pays for prescription benefits for Medicaid beneficiaries, participants in the EPIC program, employees and the prison population. Total state government expenditures on prescription drugs are expected to exceed \$5 billion dollars in SFY 2005-2006, including \$841 million for 358,000 EPIC beneficiaries and \$4.5 billion for Medicaid beneficiaries.

The NYS Department of Health publishes monthly statistics on Medicaid expenditures. This data combines expenditures on prescription drugs with expenditures on “supplies” but the growth rate of the expenditures in this category are indicative of the growth in expenditures on prescription drugs. Expenditures in this category have grown from \$1.4 billion in 1997 to \$4.3 billion in 2003, an annual average growth rate of over 20%, almost triple the 7% annual average growth rate for all other Medicaid expenditures. Almost one fourth (23%) of the total increase in New York’s Medicaid expenditures since 1997 can be attributed to increasing expenditures for prescription drugs and supplies.

Almost one fourth of the growth in Medicaid expenditures in NYS since 1997 can be attributed to increased expenditures on prescription drugs and supplies.



more prescription drugs and the prices of those prescription drugs (whether new or old) have been increasing at rates much higher than other goods and services. According to a study done by Families USA, the prices of the 30 brand-named drugs most frequently used by the elderly rose by 4.3 times the rate of inflation between 2002 and 2003. Among these 30 drugs, 14 increased in price by more than five times the rate of inflation. Over the two year period, January 2001 to January 2003, the prices of the 26 brand-name drugs most frequently used by the elderly (four of the 30 most frequently used drugs in 2003 were not on the market in January 2001) rose by 21.6 percent, 3.6 times the rate of inflation.³

What Can be Done to Control Escalating Expenditures

In response to escalating prices and utilization rates, states have tried to control costs by limiting the utilization of prescription drugs; pressuring manufacturers for price concessions; and changing the Medicaid payment formula for prescribed drugs. As part of the Health Care Reform Act amendments in early 2002, New York reduced the rate of reimbursement to pharmacies under the EPIC program, increased the rebates that drug manufacturers must pay to participate in the EPIC program and restricted Medicaid reimbursements for brand name drugs for which there is a generic equivalent unless previously authorized by the Department of Health. In response to the Governor's attempts to further limit the access of Medicaid recipients to certain brand name drugs, in the May 2003 budget bill the NYS legislature gave itself the sole right to limit drugs for Medicaid recipients, because it intended to legislate its own preferred drug list but no such system was ever approved. In August 2004, the legislature rejected the Governor's proposals for increased co-pays and a preferred drug list while reducing the pharmacy reimbursement rates even further.

2005-2006 Executive Budget Proposals

In his 2005-2006 Executive Budget proposal, the Governor proposed a number of cost-saving measures. As he did last year, Governor Pataki proposed the establishment of Preferred Drug List for Medicaid recipients which would require drug manufacturers to provide an enhanced drug rebate in order for their drugs to be listed on the primary Medicaid "formulary." In order to limit the growth in the utilization of prescription drugs, Pataki proposed to increase the co-payments for Medicaid participants from 50 cents to \$1 for generic drugs and from \$2 to \$3 for brand name pharmaceuticals.

Other Cost Saving Strategies

New York should be able to use its clout as one of the world's largest purchasers of pharmaceuticals to drive down drug prices for Medicaid and other public health programs as well as for private employers and self-insured plans. To accomplish this, the state should examine the entire range of purchasing strategies employed by other states and localities. The savings of aggressive action on this front are substantial. For example, the Health Reform Program at Boston University's School of Public Health estimates that if all who bought prescription drugs in New York State paid prices that reflected the Federal Supply Schedule's average discount, New Yorkers would have saved \$4.6 billion in 2004 – a savings of 35.1%.⁴

Preferred Drug List with Strong Consumer Protections: A preferred drug list (PDL) can result in significant cost savings but it is essential to ensure that a PDL does not aim to control costs by reducing medically necessary utilization. A PDL without sufficient consumer protections can result in inappropriate and potentially harmful (and expensive) reductions in drug utilization by erecting barriers that will cause some Medicaid (or EPIC) beneficiaries to go without their needed medications altogether. These barriers will have a disproportionate impact on seniors and beneficiaries with serious illnesses and disabilities who use more drugs than the overall Medicaid population.

Medicaid Matters New York (MMNY), a coalition of over 100 groups advocating on behalf of New York State's Medicaid program and the people it serves has put forward a set of consumer protections that it believes should be included in any future PDL proposal. These include: (i) Clear prior authorization override criteria with the prescriber's judgment as decisive; (ii) Specific protections for vulnerable Medicaid populations like seniors and people with serious illnesses and disabilities with Medicaid beneficiaries successfully adhering to a drug regimen that could be interrupted by a new prior authorization requirement being provided with additional safeguards; (iii) A clear definition of emergency that is appropriate to

Regional Drug Purchasing Pools: One strategy for increasing the state's bargaining power is to join with other states. New York already participates in the Minnesota Multi-state Contracting Alliance for Pharmacy (MMCAP) which purchases flu vaccine, pharmaceuticals, and hospital and medical supplies for over 3,000 government-run health care facilities, including more than five hundred New York facilities. More significant savings are possible if Medicaid and/or state employee drug purchases were to be done through a pool. In its first year, the Michigan Multi-State Pooling Agreement (MMSPA), a drug-buying pool initially covering Medicaid purchases in Michigan and Vermont, realized savings of 25% to 50% from the levels achieved with individual preferred drug plans. As of November 2004, this initiative had expanded to include six more participants --- Nevada, New Hampshire, Minnesota, Alaska, Hawaii and Montana – covering about 1.5 million lives and annual drug spending of nearly \$2 billion. The "RX Issuing States" (RXIS) project, lead by West Virginia buys drugs for over 700,000 public employees in West Virginia and four other states (Delaware, Missouri, New Mexico and Ohio). West Virginia estimates that it has achieved 5% savings on its purchases.

the pharmacy context; (iv) Adherence to Medicaid fair hearing and notice requirements; (v) Representation of beneficiaries on the body charged with establishing the PDL which should be required to conduct business in open meetings; and (vii) Automatic inclusion of any new drug on the PDL until the governing body has had an opportunity to review it.⁵ The PDL proposed by the Governor in the 2005-2006 does not adequately address any of these consumer protections.

Reimportation from Canada: For several years, busloads of the elderly have been making trips to Canada to take advantage of significantly lower prices for prescription drugs across the border. In October 2004, the Foundation for Taxpayer and Consumer Rights, a Los Angeles based non-profit, sponsored a train from Miami to Toronto for East Coast seniors and consumers who wanted to purchase cheaper medicine in Canada. In 2003, the city of Springfield, Massachusetts became the first municipality in the nation to allow employees to purchase prescription drugs from Canada and saved \$3 million in the first year and expects to double savings in its second year. In July 2004, Boston followed suit and expects to save \$1 million in its first year. Many other cities and states around the country are considering similar programs. Technically, only drug manufacturers can legally import prescription drugs into the United States. However, the FDA has maintained a "lenient" enforcement policy that lets individuals bring a small amount (i.e., a 90-day supply) of drugs into this country for their own use.⁶

A number of counties in New York are offering or considering offering discount prescription drug cards for uninsured, underinsured and elderly residents. ChemungRx offers eligible users discounts at local participating pharmacies and through mail-order pharmacies in the U.S. and Canada. Westchester and Broome counties had already initiated similar programs and were seeing about 22 percent savings among participants over the retail costs of prescriptions. More than 1,000 people in Westchester County have enrolled in the program since it was launched in mid-February 2004. At least three other counties -- Niagara, Tioga and Ulster -- are considering starting similar programs.

In June 2004, Schenectady County signed a collective bargaining agreement with CSEA which included a Prescription Drug Cost Containment Program – a mail order prescription drug plan from providers in the U.S. and Canada. The county spends approximately \$4 million per year to provide prescription drug coverage to 2,000 employees and their dependents and expects the purchase of Canadian drugs and a low-cost domestic mail order program that is also available will cut the cost of prescription drugs by \$1 million per year. In December, Lewis County agreed to include an Ontario company, CanaRX Services, in its health insurance package for its 750 employees and their families. With 100 percent participation they anticipate a savings of \$850,000 per year.

Medicare Prescription Drug Benefit: A well designed Medicare prescription drug program might have provided significant fiscal relief for New York and other states' prescription drug expenditures. Unfortunately, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) which became law at the end of 2003 will provide only minimal cost savings for the state. This law established a short-term prescription drug discount card program that began June 2004 and the full Medicare prescription drug benefit which will begin in 2006. Effective January 1, 2006, the approximately 400,000 New Yorkers eligible for both Medicaid and Medicare will have to be transferred to the new program. While this will reduce expenditures on prescription drugs by Medicaid program, the MMA included a "claw back" provision which in 2006 will offset 90% of the Medicaid savings realized by the state. At the same time, new administrative responsibilities will require additional state expenditures.

New York must now decide how the EPIC program, Medicaid and its retiree benefits will interact with the full Medicare drug benefit when it begins in January 2006. According to the Executive Budget, New York will encourage participation in the Medicare Part D program by waiving EPIC enrollment fees for those who participate in Part D. DOB expects that this coordination will save the EPIC program \$40 million annually.⁷ New York accepted a \$34 million transitional grant to begin to work out the policies and procedures required for this coordination.

Recommendations

- (1) New York should use its purchasing power to drive down drug prices for Medicaid and other public health programs as well as for private employers and self-insured plans. To accomplish this, the state should examine the entire range of purchasing strategies employed by other states and localities, including joining multi-state drug purchasing pools, issuing discount cards and exploring reimportation options. New York should implement a preferred drug list with adequate consumer protections and require substantial discounts from pharmaceutical manufacturers included on the list.
2. New York should continue its efforts to reform the Medicare Prescription Drug Part D to ensure adequate protections for both dual eligibles and current EPIC participants. Savings that accrue from coordination with Medicare Part D should stay in the EPIC program and be used first to include the non-elderly disabled in the EPIC program. Unless coordination is seamless and changes are minimal, enrollment should be voluntary for EPIC participants and any auto-enrollment should provide an option to decline. A major portion of the \$34 million in transitional assistance should be used to provide direct grants to community based organizations for education and case management of disabled and elderly individuals needing assistance with the transition to Part D coverage.
3. New York should exercise caution regarding further efforts to limit utilization by imposing higher co-pays and deductibles and/or reduce reimbursement rates to pharmacies in ways that would threaten the continued existence of independent, neighborhood pharmacies and therefore jeopardize access to pharmaceutical assistance for low-income New Yorkers.

END NOTES

1. Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey," December 2003.
2. State Health Facts on Line, The Kaiser Family Foundation.
3. Families USA, "Sticker Shock: Rising Prescription Drug Prices for Seniors," June 2004, pp. 2-3.
4. Alan Sager and Deborah Socolar, "New Yorkers Would Save \$4.6 billion (35%) on Brand Name Prescription Drugs in 2004 by Paying Federal Supply Schedule Prices. 2004 Update" January 26, 2004.
5. Medicaid Matters New York, "Finding a Better Way: Ten consumer-friendly ideas to improve New York's Medicaid program and save money for New York taxpayers." February 2004.
6. In August 2004, Vermont Governor James Douglas and Attorney General William Sorrell filed a lawsuit over the FDA's denial of a pilot program that would have allowed state employees to buy prescription drugs from Canada. The Food and Drug Administration has postponed its response to Vermont's first-in-the-nation lawsuit over the importation of prescription drugs from Canada. The agency now has until November thirtieth to answer the state's allegations.
7. In order to prevent existing retiree benefit plans from dropping prescription drug coverage, the MMA provides for the payment of subsidies to employers, including state governments, that maintain prescription drug coverage for retirees. The 2005-2006 Executive Budget anticipates \$5.9 million in revenues for 2005-2006 and \$70.3 million in revenues for 2006-2007 related to this provision.

For more information or additional copies contact:

*Fiscal Policy Institute, 1 Lear Jet Lane, Latham, NY 12110; (518) 786-3156
www.fiscalpolicy.org*