

**Opportunities to Increase Access and Availability
of Pharmacy Services in West Virginia**

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by

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I. Introduction

The West Virginia Center for Healthcare Policy and Research at the Robert C. Byrd Health Sciences Center (“Center”) engaged The Muskie School of Public Service (“Muskie”) to review existing prescription drug group purchasing arrangements in West Virginia. In addition, Muskie was directed to identify options for State policy makers’ consideration that could expand access to prescription services for the uninsured.

The specific scope of this analysis included:

- A summary of public programs in West Virginia that provide pharmacy services through centralized and collective purchasing arrangements.
- A descriptive overview of activities and experience of certain other selected states.
- A description of policy options.

The analysis and findings in this report are based on:

- Interviews with and information provided by a number of key individuals operating pharmacy programs in West Virginia. These individuals are listed in Appendix A.
- Cost and utilization data collected by the Center and provided to Muskie.

Background:

State policy makers are challenged to manage the rapidly increasing costs associated with existing pharmacy program commitments as well as respond to the needs of uninsured consumers who, more often than not, are elderly.

Pharmacy costs are increasing faster in West Virginia than most other health care services. The State’s Department of Health and Human Resources originally estimated that Medicaid drug costs would increase nearly 13 percent in fiscal year 2000. Updated estimates project the increase to be in excess of 23 percent in total expenditures of over \$226 million (\$183 million after rebates) for prescription coverage¹. When compared to an increase of slightly more than 4 percent for the entire program, prescription services are clearly a disproportionate contributor to

¹ Department of Health and Human Resources, June 11, 2000, Medicaid Report to Legislative Oversight Commission on Health and Human Resources Accountability. State Medicaid programs participate in a federally legislated program of pharmaceutical company rebates on the total costs of their drugs paid for by Medicaid.

increasing Medicaid costs. These increases parallel the experience of other public and private payers, both in West Virginia and the nation.

Notwithstanding Medicaid's commitment to nearly 19 percent of the population, a significant number of West Virginians do not have pharmacy coverage. These include populations who lack any medical insurance, estimated to be approximately 325,000 persons², almost 18 percent of those under 65.

A second group of West Virginians without pharmacy coverage include those who otherwise have reasonable medical insurance. The federal Medicare program provides hospital, physician and other acute care services to most elderly persons, age 65 or older, and persons with disabilities who meet certain eligibility criteria. In 1998 Medicare provided benefits to approximately 20 percent of the population, or nearly 350,000 persons³.

However, Medicare does not include pharmacy coverage. Unless a Medicare beneficiary purchases a supplemental prescription drug policy or enjoys coverage through a separate program (i.e., private retirement plan or Medicaid), the beneficiary is likely to pay all drug expenses directly. Nationally, it is estimated that nearly one-half of all Medicare beneficiaries do not have a supplemental prescription drug policy⁴. This estimate would represent up to 175,000 persons in West Virginia. In total, estimates of West Virginians without insurance coverage for pharmacy services may be as much as 500,000 persons.

While many complex issues contribute to rising health care costs, there are a number of factors that are particularly relevant to prescription drug services which underscore the fact that the issue of increasing pharmacy services is not likely to go away on its own. These factors include:

Demographics. There is strong relationship between age, increased morbidity and utilization of pharmacy services. The utilization of prescription drugs is, on average, three to four times greater for the elderly than the under 65-year-old adult. Given the aging of West Virginia's population, policy makers can expect the demand for prescription drug services to grow.

Technological Advancements. Recent years have seen an unprecedented growth in the number of new drugs introduced to the market. While due in part to speedier federal review and approval processes, the increased pace of pharmaceutical research has been very significant and sometimes overwhelms efforts to manage the drug benefit. For example, there are reports that changes to formulary programs

² Personal Communication, January 22, 2001, Center for Healthcare Policy and Research, Robert C. Byrd Health Sciences Center.

³ Ibid.

⁴ Senior Citizens Prescription Drug Task Force, October 1, 2000, Final Report of Recommendations.

have not kept pace with the introduction of new drugs. There is no reason to believe that the pace of technology will abate, particularly in light of breakthroughs related to gene therapy.

It is important to emphasize that the introduction of many prescription drug therapies, while very expensive, has dramatically improved clinical outcomes and the quality of life. In addition, prescription therapies have often served as a cost effective and far less invasive clinical intervention than previous medical and institutional approach.

For example, ACE inhibitors have dramatically reduced the incidence of hospitalizations due to coronary heart disease.

For policy makers, the issue is one of differentiating and supporting legitimate clinical breakthroughs in contrast to already existing drugs that have been slightly reformulated and reintroduced as “new.” These latter products, while healthy contributors to a manufacturer’s bottom line, often undermine utilization of more cost-effective therapies.

Consumer Expectations. As demographics and technology fuel expectations, health care consumerism has become, in recent years, a very significant factor. Given ongoing media and public attention, consumers have become wary of any managed care or regulatory requirements that reduce or otherwise limit access to what is increasingly perceived as necessary services.

Direct Consumer Marketing. Pharmacy manufacturers have become very astute at understanding consumer dynamics and have developed sophisticated strategies for communicating directly to consumers, to drive up demand for brand name drugs. While clearly providing some educational value to consumers, the downside of these marketing efforts has been to also promote certain drugs when far less expensive options exist, and undermine various utilization management programs that payers have established.

There are other factors that also contribute to increasing pharmacy costs, the underlying issue being that these “drivers” are complex and resistant to easy, single-step solutions.

II. Description of Centralized Purchasing Arrangements in West Virginia

A number of programs are presently operational in West Virginia that provides pharmacy services through centralized and collective purchasing arrangements.

The following organizations represent the larger purchasing arrangements in West Virginia and provided information to this study⁵:

- Medicaid
- Children's Health Insurance Program (CHIP)
- Public Employees Insurance Agency (PEIA)
- Free Clinics

The first two organizations can be categorized as public programs. While each provides prescription drug services to a unique population, both are publicly funded.

The PEIA program straddles both the public and private sector. Public funds clearly finance prescription benefits for State employees. However, these benefits are provided as a component of employment compensation. As such, program design and financing mechanisms more closely resemble private employers.

Free Clinics are grouped separately. Serving those West Virginians without any pharmacy coverage, the acquisition practices and financing arrangements are dramatically different when compared to the other two categories.

Program design, utilization and cost varied widely among each of these arrangements, reflecting different program goals as well as population needs and priorities.

Both Medicaid and CHIP serve primarily low-income citizens. Pharmacy coverage levels tend to be extensive and, given the principal eligibility criteria, only nominal copayments are charged to the beneficiary at the time services are provided.

⁵ Discussions also took place with representatives of three other large purchasing arrangements: Blue Cross of West Virginia, Workers Compensation and United Mine Workers of America. The first two organizations reflect, in large part, the private employment sector. While originally grounded in labor agreements between the coal industry and bargaining unit, medical benefits (including pharmacy), benefits provided by UMWA to retired mineworkers are subsidized by federal funds. Indeed, Medicare recently announced an innovative trial program with the UMWA to determine if prescription benefits funded by Medicare would reduce hospital utilization and generate program savings (Associated Press, January 21, 2001). Relatively little utilization and cost data were available from these three groups for this analysis. Initially, it is unlikely that these purchasers would participate in a collaborative arrangement with the other organizations discussed in the text. Still, there is value for policy makers in continuing to monitor and engage these organizations.

Medicaid manages its pharmacy costs through very specific reimbursement formulas to pharmacies, mandatory generic substitution and prior authorization screening for certain classes of drugs. West Virginia also participates in the drug rebate program as established by federal legislation.

West Virginia has considered other approaches. Serious consideration was given to establishing a vigorous formulary program developed by a committee including representatives of Medicaid and PEIA. In late 1998, a task force appointed by the governor evaluated the committee's recommendation and narrowly voted to oppose implementation of the proposed formulary. Instead, more aggressive disease management and mandatory generic substitution programs were recommended and adopted.

Private purchasing arrangements (including PEIA for purposes of this discussion) also utilize reimbursement formulas and utilization management programs. Through its pharmacy benefits manager, PEIA's reimbursement formula is set at average wholesale price (AWP) less 15 percent, plus a dispensing fee of \$2.50 per prescription⁶. These arrangements are very competitive with those of Medicaid (*see Exhibit 5 on page 8*). However, manufacturers' rebates to PEIA are likely to be 20 percent of the rebate levels provided to Medicaid⁶.

The other very significant flexibility that PEIA and other private programs have is the capacity to impact consumer driven demand through cost sharing, or copayment arrangements.

The benefit design of choice is a three-tier copayment scheme. Typically, very modest copayments are charged for generic prescriptions. A larger copayment is associated with brand name prescriptions that are included on an approved list. Inclusion on the list is based on the drug's cost and efficacy. Copayments are greatest for brand name prescriptions that are not included on the approved list. The PEIA benefit plan provides a good illustration of this design⁷:

	<u>Up to a 34-day supply</u>
Generic Medication:	\$ 5.00
Listed Brand Name:	\$ 15.00
Non-listed Brand Name:	\$ 25.00

Neither mandatory generic substitution nor vigorous formularies characterize the PEIA program and other private programs. This absence underscores an important consideration in any effort to combine public and private purchasing arrangements to affect volume savings. In an effort to maintain consumer choice, private programs have opted for differential copayment strategies to manage costs.

⁶ Interview with PEIA, October 17, 2000.

⁷ PEIA PPB Prescription Drug Summary Plan Description, 2000, Merck-Medico Managed Care, L.L.C.

The populations covered under these private prescription plans accept additional payment levels in order to preserve access to certain drugs. Populations covered under the State's Medicaid program do not have this option. Any effort to combine public and private purchasing arrangements must accommodate these very different "customer" requirements.

Finally, the Free Clinic programs offer another contrast. For low-income persons who are neither insured nor eligible for a public program, these organizations access the free drug programs offered by the pharmaceutical firms. Administrative processes, qualifying income requirements, and manufacturers' generosity all serve to control utilization of these services.

III. Utilization and Cost of Public Programs in West Virginia

The above program differences and service populations are important to bear in mind when comparing cost and utilization data collected by the Center. These data are reported in *Table 1* and summarized in *Exhibits 1 through 4*.

Data were provided for four of the programs described above. These include CHIP, Medicaid, PEIA, and the Free Clinics. Caution must be exercised in making strict comparisons between the four programs since time periods, benefit plans, and other reporting conventions are different. In addition, because the Free Clinics do not serve an “enrolled” population, utilization patterns could not be calculated. Still, a number of observations can be made that underscore earlier comments.

Medicaid beneficiaries include populations with very significant morbidity, such as frail elderly, disabled children and adults with significant physical and behavioral disabilities. In contrast, CHIP includes only children and PEIA covers largely working individuals and their families⁸, two comparatively healthy populations. Not surprisingly, pharmacy costs vary widely, reflecting the very different needs of these different populations. Annual costs for CHIP, PEIA and Medicaid average nearly \$600 per beneficiary and range from under \$200 for CHIP to over \$700 for Medicaid (*Exhibit 1, page 13*). The greater expenditures for Medicaid reflect in large part the higher utilization, nearly 21 prescriptions per year in contrast to less than 6 for CHIP and about 15 for PEIA (*Exhibit 2, page 13*).

Claim payments per prescription are reported in *Exhibit 3 (page 14)* for the CHIP, PEIA and Medicaid programs. For the Free Clinics, the value of the free drugs is reported. Amounts for Medicaid and CHIP represent nearly 100 percent of the claim cost. In contrast, the amount reported for PEIA is net of copayment levels. If one approximates a copayment amount of \$5.00 per generic prescription and \$18.00 per brand, an average cost of about \$38.00 is calculated for the PEIA. This amount is very close to the experience of both the Medicaid and CHIP programs. In other words, the average per prescription cost is reasonably similar among the three programs.

The data also indicate the greater choice that PEIA beneficiaries have in access to brand name drugs (*Exhibit 4, page 140*). Utilization of brand name prescriptions is significantly higher for PEIA, as compared to Medicaid and CHIP data. Costs are, however, managed through the differential copayments that are illustrated above.

These data confirm the earlier program observations. While average prescription costs are similar, each program has adopted different cost management approaches that reflect the populations served.

⁸ While copayments may contribute to some dampening of utilization for the PEIA program, it is unlikely that these cost sharing arrangements contribute to the 33 percent less utilization that is observed.

The average cost reported by the Free Clinics is dramatically higher than any of the three other programs. It is suspected that this amount reflects full retail price without any discounts, rebates or management activities exercised by the other three programs. Comparing the average prescription cost at the Free Clinic to the average prescription cost of the three other programs (after increasing the PEIA amount for copayments) indicates that, collectively, PEIA, Medicaid and CHIP enjoy a discount on the order of 35 percent. This is likely to be a reasonable representation of the savings generated by the various cost management techniques employed by Medicaid, CHIP and PEIA.

**Table 1
West Virginia Pharmacy Profile**

	<u>Time Period</u>	<u>Average # of Beneficiaries</u>	<u>Total Prescriptions</u>		<u>Avg Dollars per Script</u>	<u>Per Beneficiary, Per Year</u>		
			<u>Number</u>	<u>Dollars</u>		<u># of Scripts</u>	<u>Dollars</u>	
CHIP	10/1/99-9/30/00	9,031						
Generic			24,757	\$ 229,616	\$ 9	2.7	47%	\$ 25
Brand			28,431	\$ 1,469,039	\$ 52	3.1	53%	\$ 163
Total			53,188	\$ 1,698,656	\$ 32	5.9		\$ 188
PEIA	7/1/99-6/30/00	166,233						
Generic			1,071,163	\$ 8,632,511	\$ 8	6.4	42%	\$ 52
Brand			1,479,224	\$ 57,771,419	\$ 39	8.9	58%	\$ 348
Total			2,550,387	\$ 66,403,930	\$ 26	15.3		\$ 399
MEDICAID (i/o CHIPS)	10/1/99-9/30/00	265,801						
Generic			2,837,645	\$ 48,650,993	\$ 17	10.7	51%	\$ 183
Brand			2,680,671	\$172,138,906	\$ 64	10.1	49%	\$ 648
Total			5,518,316	\$220,789,899	\$ 40	20.8		\$ 831
Net of Rebate				\$192,485,235	\$ 35			\$ 724
CHIP, PEIA & MEDICAID		441,065						
Generic			3,933,565	\$ 57,513,120	\$ 15	8.9	48%	\$ 130
Brand			4,188,326	\$231,379,364	\$ 55	9.5	52%	\$ 525
Total			8,121,891	\$288,892,484	\$ 36	18.4		\$ 655
Net of Rebate				\$260,587,820	\$ 32			\$ 591
FREE CLINICS	fy 1999							
Morgantown			55,713	\$ 2,224,451	\$ 40			
WV Health Right			65,640	\$ 4,663,669	\$ 71			
Total			121,353	\$ 6,888,120	\$ 57			

Notes: Pharmacy benefit plans vary among the above groups.

Average number of beneficiaries is calculated by dividing the total number of months by 12.

Source:

- Personal Communication, Bureau of Medical Services, Department of Health and Human Resources, 1/8/01.
- Personal Communication, Public Employees Insurance Agency, 10/17/00.
- P. White, West Virginia Health Right, 10/17/00.
- Rebate discount based on Madhavan, 12/4/00 presentation of Speaker Kiss and Delegate Perdue.

Exhibit 1 Annual Dollars per Beneficiary per Year

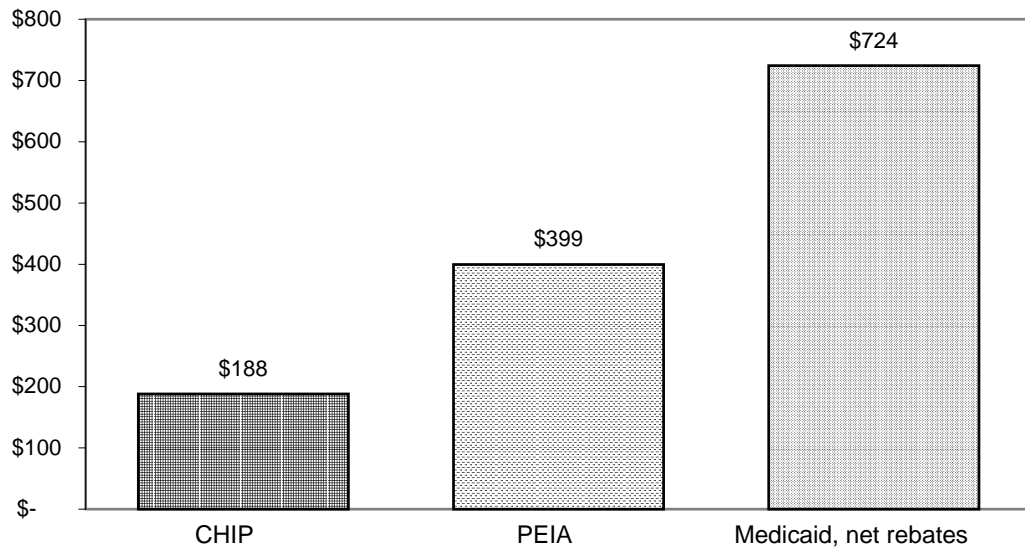


Exhibit 2 Number of Scripts per Beneficiary per Year

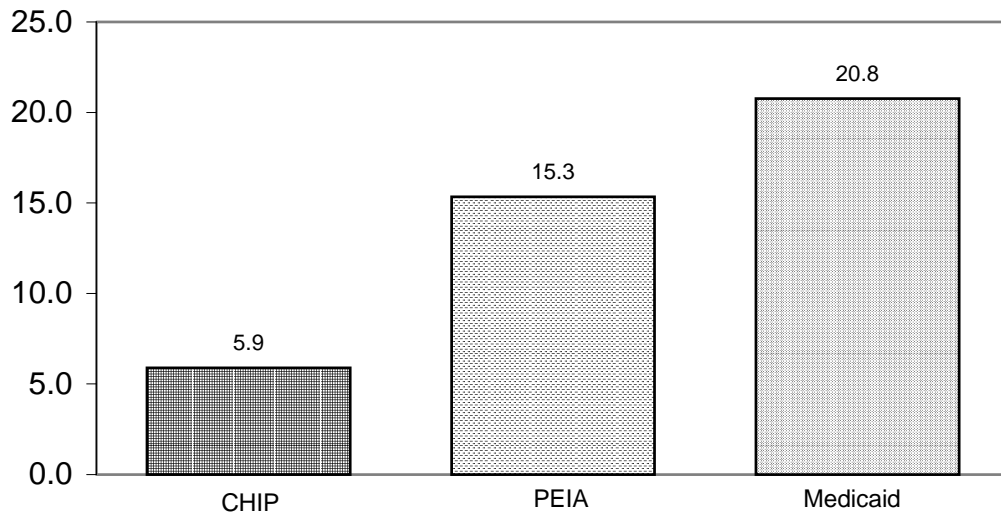
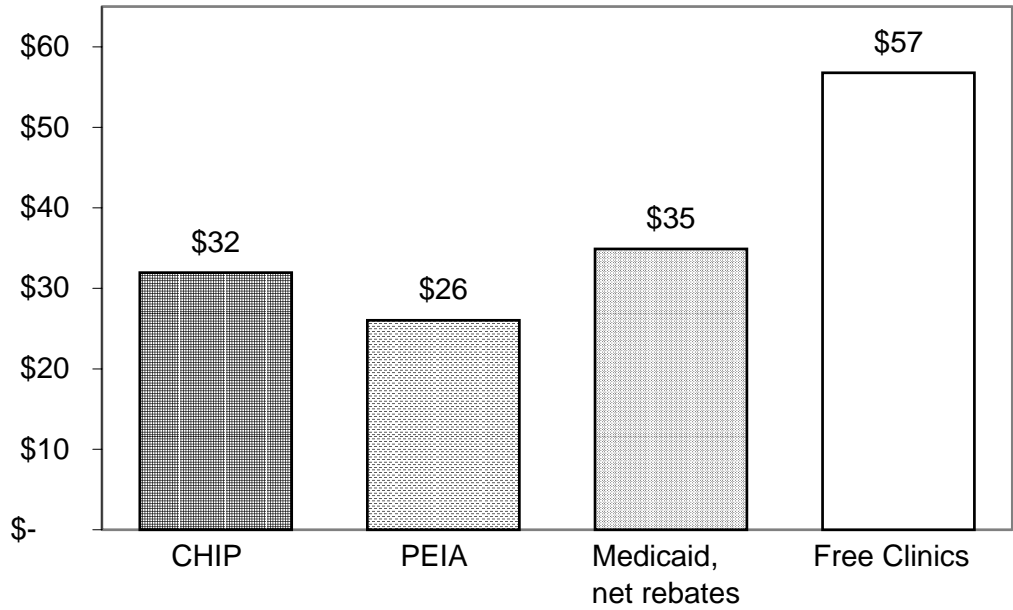
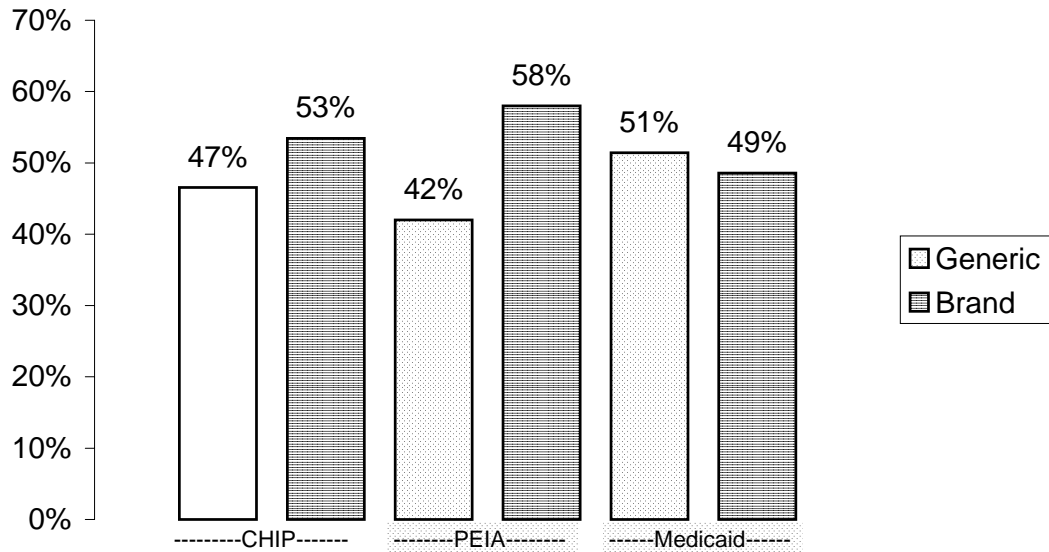


Exhibit 3 Average Dollars per Script



Bureau of Medical Services, DHHR,
1/8/01

Exhibit 4 Generic vs Brand by Payer Group



Bureau of Medical Services, DHHR, 1/8/01
PEIA, 10/17/00

IV. West Virginia Comparison to Arkansas, Maine, North Dakota and South Carolina

The pharmacy issues confronting West Virginia are shared by all states. Nearly all states have implemented reimbursement formulae, quantity limits, and prior authorization protocols to manage Medicaid costs. Disease management and managed care programs are two additional strategies that many state Medicaid programs have adopted to address pharmacy costs. To address the uninsured, nearly half the states have implemented assistance programs that usually focus on low-income elderly⁹. These strategies range from providing direct subsidies, expanded Medicaid eligibility, passing on negotiated discounts, offering tax credits and, in one instance, price controls.

The Center for Healthcare Policy and Research specifically identified four states for comparisons. Three include Arkansas, North Dakota and South Carolina. These largely rural states have been used as benchmarks in the past and share a number of similar economic indicators with West Virginia. The fourth state is Maine, which has recently developed and implemented a number of innovative pharmacy initiatives.

A summary of major program characteristics of the Medicaid program for these states and West Virginia is presented in *Exhibit 5 (page 17)*. While South Carolina limits coverage to only categorical need, most states include categorical and medical need. West Virginia does, however, limit the latter to aged, blind and disabled.

In light of the very significant differences between chronic and acute prescription needs supply limits are imprecise mechanisms to control prescription amounts. Yet these limits are easy to manage and do fix a state's liability. West Virginia's supply limits are generally consistent with most of the other benchmark states. Quantity limits, measured in terms of the number of prescriptions per month, vary among the five states. Maine and North Dakota have no limits. Arkansas and South Carolina are the most restrictive at generally 3 and 4 prescriptions per month for adults. West Virginia has a limit of 10 prescriptions per month. Given that the average number of prescriptions per month is less than two, a maximum of 10 prescriptions is effectively the same as if there were no limits.

Co-payment arrangements in West Virginia ranged from \$.50 to \$2.00 per prescription. This amount is within the range of most of other states, although Arkansas and Maine may reach \$3.00. There are no copayment requirements in North Dakota. As a means of controlling unnecessary utilization, the effectiveness of nominal copayments is unclear. It is usually not feasible for providers to bill and collect for these amounts, and they are unlikely to withhold a prescription if a beneficiary cannot pay when receiving the medication.

⁹ Health Insurance Association of America, 2000, "State Pharmaceutical Assistance Programs Continue to Grow," Washington, D.C., September 18.

In calculating provider payments, West Virginia's discount off of average wholesale price (AWP) is 12 percent, second only to South Carolina (13 percent). Similarly, West Virginia's dispensing fee amount, at \$3.90, is less than three of the other states (only Maine's dispensing fee of \$3.35 is less).

The level of mandatory generic substitution is similar among the five states.

Finally, West Virginia's approval rate for prior authorization (70 percent) is lower than three of the other states. At 62 percent, only Arkansas has a lower approval rate.

Overall, these program characteristics suggest that West Virginia's management of the Medicaid pharmacy benefit as measured by eligibility, reimbursement, mandatory substitution and prior authorization requirements are as vigorous as the other four states. This conclusion is supported by cost comparisons among the five states.

For both average drug payments per recipient as well as average prescription cost, West Virginia's experience in 1998 was the lowest (*Exhibits 6 and 7, page 18*). Average prescription utilization for West Virginia was greater than Arkansas and South Carolina, but less than Maine and North Dakota (*Exhibit 8, page 19*). Finally, West Virginia's rebate levels in 1998 were among the highest of the five states (*Exhibit 9, page 19*).

For drug spending as a percent of total Medicaid expenditures, West Virginia did report the highest level among the five states in 1998 (*Exhibit 10, page 20*). This may be less a function of effective pharmacy management programs than it is a reflection on the relative size of other Medicaid expenditures.

Information for comparisons of other purchasing programs in the five states was not available. Relative to the other states, it is likely that West Virginia's CHIP program would be similar to Medicaid. It is more difficult to predict public employee insurance plans. Differences in benefits and covered populations would make comparisons between the different states difficult. For example, in Maine and Arkansas, the public employees health benefit plan includes only State government employees. Different insurance arrangements cover public university employees, municipal employees as well as public school employees in these states. In contrast, North Dakota and South Carolina's public employee program includes State employees as well as university and college employees, public school employees, and city and county workers.

While all five states are similarly challenged to provide some level of pharmacy coverage to the uninsured, Maine has been particularly aggressive in its program development. The State has had a program in place for a number of years that provides coverage or assistance to eligible persons who do not qualify for Medicaid.

Eligibility criteria include age and income level, and a modest copayment is required. Program costs are subsidized by State funds.

Maine has been recently successful in obtaining federal approval to expand Medicaid eligibility for the purpose of extending rebate savings to persons with earnings in excess of those needed to qualify for Medicaid. The reductions in prescription costs are estimated to be approximately 18 percent. Interestingly, these savings are provided at little cost to the State. The pharmacy industry has challenged Vermont, which pioneered this approach. While the courts would not bar the Vermont program's implementation with a temporary restraining order, the industry has indicated that it will press forward with its legal case.

Last year, Maine also established the Maine Rx program, requiring manufacturers to negotiate acceptable pharmacy prices with the State. If these negotiations were not successful, the Commissioner of Human Services was authorized to establish maximum retail prices, effective July 1, 2003. This program has been successfully challenged by the pharmacy industry under the commerce clause, and the industry was granted a temporary restraining order.

On another front, Maine is one of three New England States (Vermont and New Hampshire being the others) to establish a purchasing coalition. The goal of this coalition is to increase purchasing volumes in order to reduce prescription drug prices within each Medicaid program, as well as extend the benefits of such action to other populations, including the uninsured, underinsured and State employees. While the coalition has drafted a request for proposal, the ultimate success of this program is still uncertain; the pharmaceutical industry has challenged the authority of State Medicaid programs to enter such arrangements, and variations in procurement requirements among the different states must be resolved.

Among the three other benchmark states, South Carolina has recently enacted an assistance program. Authorizing legislation was enacted in 2000 and program specifics are currently under development. Neither Arkansas nor North Dakota has established similar assistance programs.

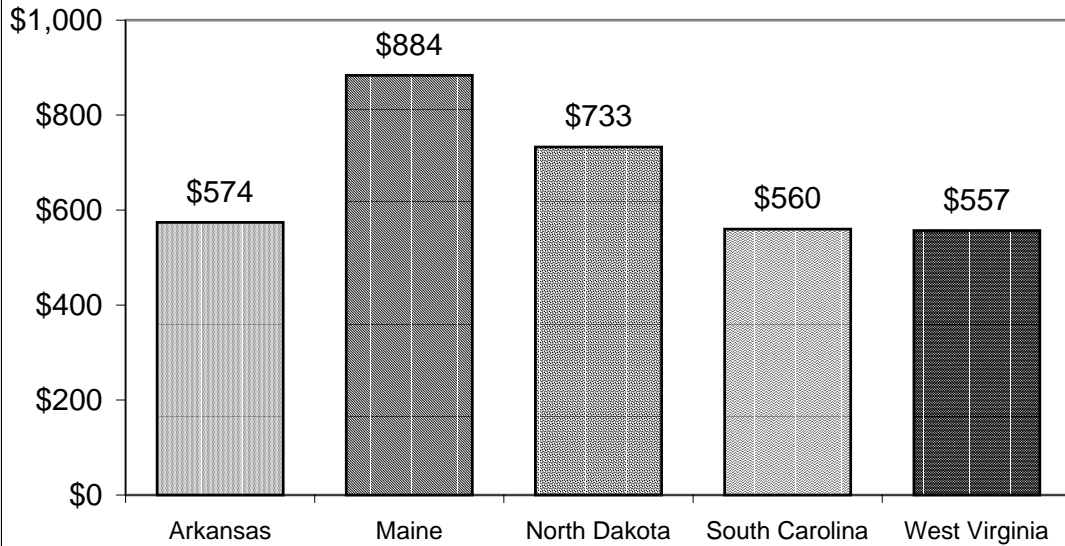
Exhibit 5
Pharmacy Characteristics in Medicaid Programs for 5 States (1999)

	<u>Arkansas</u>	<u>Maine</u>	<u>North Dakota</u>	<u>South Carolina</u>	<u>West Virginia</u>
Coverage					
• Categorical need	Yes	Yes	Yes	Yes	Yes
• Medical need	Yes	Yes	Yes		For aged, blind & disabled
Day limits	30 day supply	None	34 day supply	100 day supply	34 day supply
Quantity Limits	3 Rx/month (extend to 6)	None	None	None: children 4 Rx/month	10 Rx/month
1999 Cost Sharing	\$.50-\$3.00/Rx	\$.50-\$3.00/Rx	None	\$2.00/Rx	\$.50-\$2.00/Rx
Mandatory Substitution					
• Incentive for Generics	No	No (Incentive based on total profile)	No	No	No
• Must Dispense Generic Multisource	No	Yes	No	Yes (if M.D. authorizes)	Yes
• Must Dispense Lowest Cost Multisource	No	No	No	Yes	No
Payment Formula	AWP-10.5%	AWP-10%	AWP-10%	AWP-13%	AWP-12%
Prior Auth Approval	62%	90%	96%	90%	70%
Dispensing Fee	\$5.51	\$3.35+	\$4.60	\$4.05	\$3.90 +

Sources: Hearne, Jean, 2000, "Prescription Drug Coverage Under Medicaid", CRS Report for Congress, Congressional Research Service, The Library of Congress, October 30.

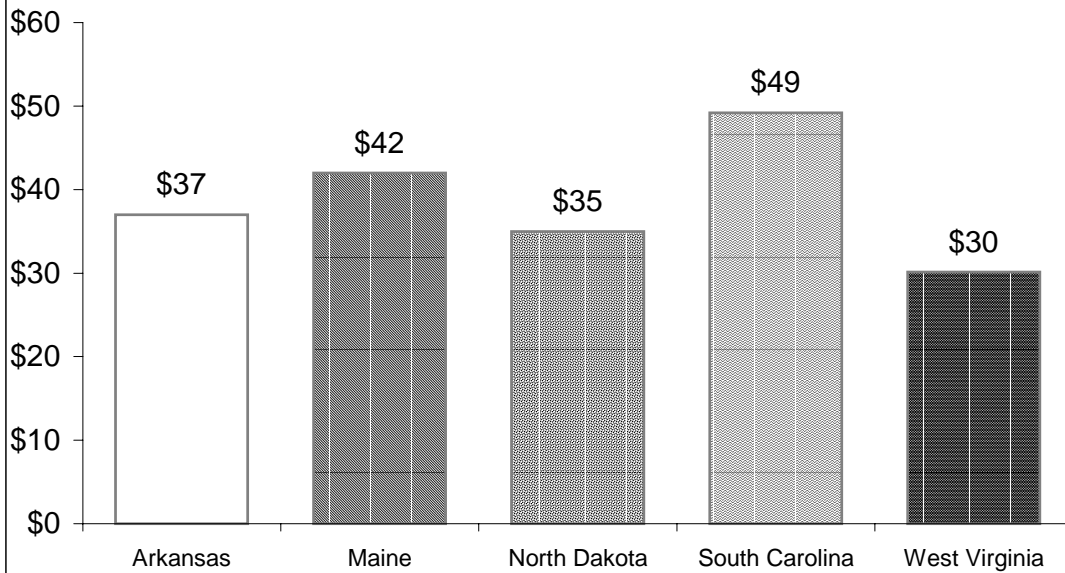
National Pharmaceutical Council, 1999, Pharmaceutical Benefits under State Medical Assistance Programs, Reston Virginia.

Exhibit 6
Drug Payments per Medicaid Drug Recipient per Year (1998)



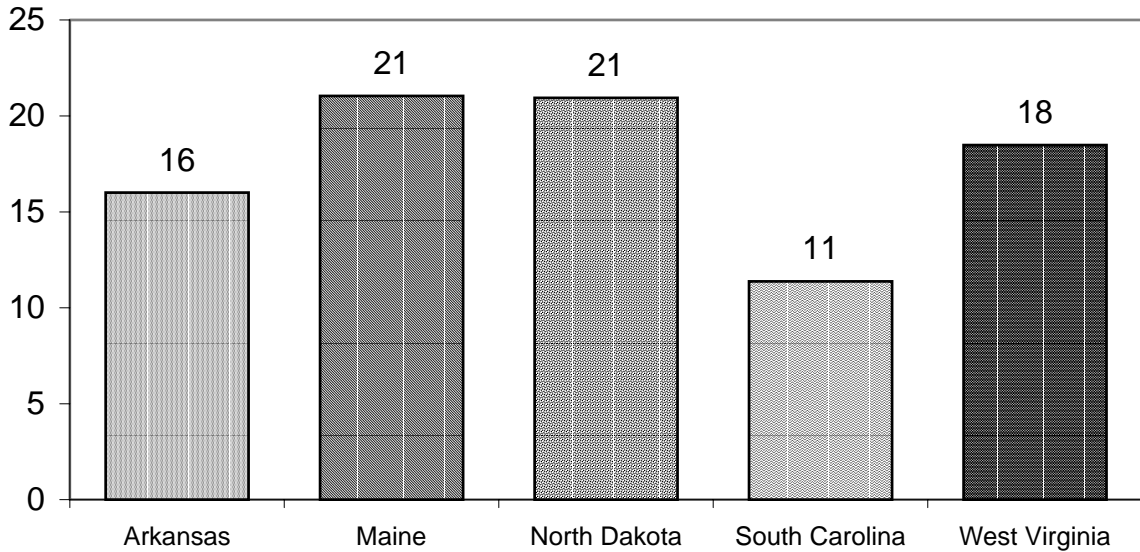
Source: National Pharmaceutical Council, 1999.

Exhibit 7
Average Medicaid Prescription Cost (1998)



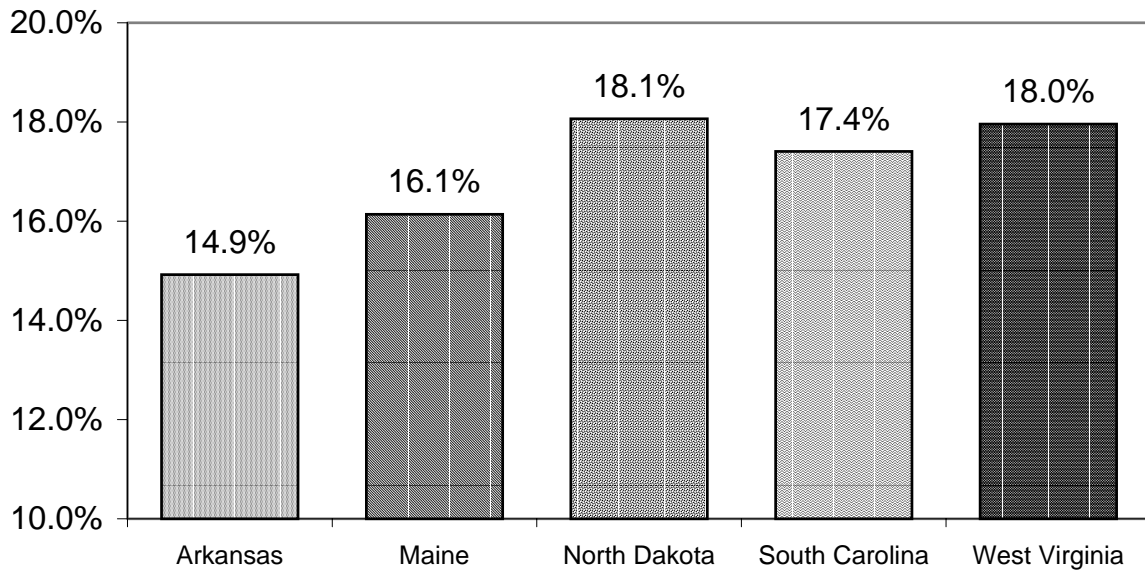
Source: National Pharmaceutical Council, 1999.

Exhibit 8
Average Prescription Utilization per Medicaid
Drug Recipient per Year (1998)



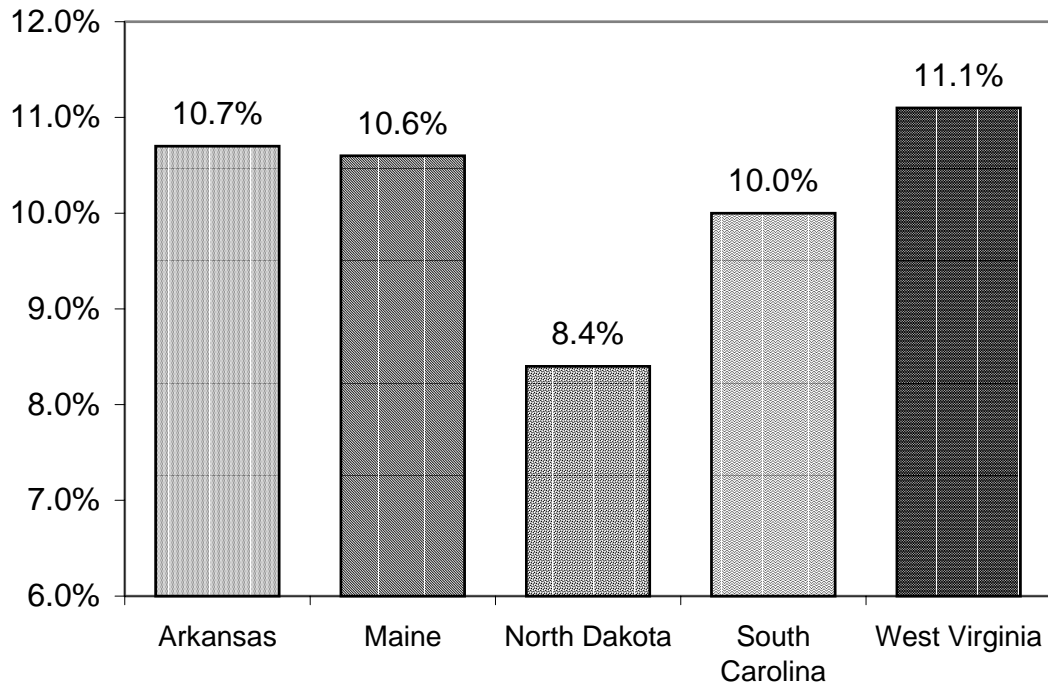
Source: National Pharmaceutical Council, 1999.

Exhibit 9
Rebates as % of Total Medicaid Drug Payments (1998)



Source: National Pharmaceutical Council, 1999.

Exhibit 10
Drug Spending as Percent of Total Medicaid (1998)



V. Findings and Policy Options

As noted throughout this analysis, two fundamental issues confront State policy makers. The first is one of expanding access to pharmacy services for those who are presently uninsured. Managing pharmacy costs is the second issue. Within the context of each issue, there are a number of policy and program options that include:⁹

Expand Access

Provide direct assistance to the uninsured. As discussed above, more and more states are providing and directly financing some prescription drug assistance to the uninsured. Our research indicates that a similar program does not exist in West Virginia. Instead, the Free Clinics serve as the primary vehicle for providing drug services to the uninsured.

Should West Virginia more formally centralize and structure an assistance program, significant decisions will be needed with regard to eligibility, benefits and funding. These parameters are reviewed below.

Negotiate discounts. In lieu of a direct assistance program, West Virginia may wish to negotiate reductions in the cost of prescription drugs and pass these reductions on to uninsured populations.

One application of this policy would be to expand the existing rebate program through a Medicaid waiver that includes certain uninsured populations who would otherwise not be eligible for Medicaid.

A second approach would be one of negotiating maximum price levels with manufacturers. Such negotiations are difficult if the State lacks negotiating clout with manufacturers. As witnessed by Maine's experience, the options that are available to a State in successfully negotiating with manufacturers may be very limited.

A third and more indirect approach is one that supports the free drug programs that presently exist through Free Clinics operating in the State. Additional resources may enable these organizations to expand necessary administrative activities to access the free programs sponsored by manufacturers and, consequently, expand access.

¹⁰ For sake of completeness, it is important to note that existing pressure upon states to meet the needs of most elderly would be dramatically reduced should pharmacy coverage be added to Medicare. Petitioning federal policy makers to expand Medicare benefits to include prescription drugs may be West Virginia's most cost effective strategy for expanding access to a large number of those who are presently uninsured.

Collaborative/Cooperative purchasing. Another way to negotiate discounts is cooperative purchasing arrangements are more compatible with a market orientation.

States are considering using a number of approaches to increase purchasing volumes and reduce unit costs. As noted above, three New England states are investigating a purchasing consortium to increase volumes. By reducing drug maker's prices to Federal Supply Schedule (FSS) prices, a separate analysis estimated that eight states in the northeast could generate savings in the order of one third¹¹.

Instead of organizing an inter state purchasing cooperative, a second approach would be one of grouping different purchasers within West Virginia that would in turn contract with a single pharmacy benefits manager ("PBM") for prescription drug benefits. The State's Medicaid program, PEIA (including CHIP) and uninsured Medicare beneficiaries would represent three obvious populations. Workmen's compensation, municipal insurance programs and certain select private employers (such as the UMWA Health and Retirement Funds) may be also interested in this approach.

The benefits of such an arrangement include opportunities to share data, streamline administrative processes and facilitate education of providers, all in addition to price discounts that would presumably accompany the larger volumes.

PBMs have extensive experience in administering multi divisional accounts for many of their clients. There would be little difference, or difficulty, in establishing separate benefit plans and financing accountability for each of the purchasers within a statewide purchasing cooperative. There is no sharing of claims experience on subsidization of premium costs across different programs or populations. It should be noted that this approach is very different than one that underwrites all public sector beneficiaries in a single group.

The success of such an approach must also preserve the integrity of each participant organization's goals and objectives. As demonstrated earlier, different populations are prepared to accept different trade-offs in access and cost of prescription benefits. Failure to incorporate these different priorities will make any cooperative purchasing arrangement difficult, if not impossible, to implement.

Universal, single payer program. While clearly the most dramatic policy option, pharmacy services do provide a unique opportunity to establish a universal, single payer program. Unlike other health care services, pharmacy benefit limits are more easily defined and budgeted. Because Medicare does not include pharmacy

¹¹ Sager, Alan and Socolar, Deborah, 2000, "Cutting Prescription Drug Spending by Paying Federal Supply Schedule Prices-Savings in Eight Northeast States", Northeast Legislative Association on Prescription Drug Pricing, Boston University School of Public Health, Boston, MA, August 5, 45 pages.

services, a universal, community rate program can be designed for all West Virginians. It is suspected that the purchasing volume represented by the entire State in addition to reasonable management protocols would provide for universal coverage at a total cost approximately equal to the entire State's present expenditures.

Under this approach, it is envisioned that the State would contract with a single PBM and all West Virginians would need to participate. A citizen covered under an existing employer sponsored plan would satisfy the participation requirement. For an uninsured person who has adequate means, premium payments would be collected through state income taxes. For others, premium assistance would be provided by the State.

Control Costs

Policies targeted to control pharmacy expenditures are not mutually exclusive from policies aimed at improving access. Indeed, the argument can be made that the long-term ability to expand access will rest on effective cost management practices.

As compared to other states, West Virginia has effectively and successfully adopted many of these management practices. While listed below for sake of completeness, they also provide an inventory of options that the State may wish to revisit as part of a comprehensive review of its pharmacy program.

Eligibility. While seemingly self evident, this issue will require reexamination should West Virginia adopt one or more programs to provide direct assistance to the uninsured.

Benefit Design. A number of specific cost management decisions are inherent in the benefit design. These include:

- Which drugs are covered?
- What are the dispensing limits?
- What is the number of prescriptions that can be filled?
- What are the cost sharing arrangements?

These decisions can be very targeted to meet specific program objectives and again will be appropriate to carefully review if West Virginia elects to expand access.

Pre-Authorization. Prescription drugs that are very expensive, subject to abuse of questionable efficacy are often subject to pre-authorization review. These controls are typically implemented at the time the prescription is filled by the pharmacy. As a result, these approaches are often perceived as administratively burdensome to the pharmacist, inconvenient to the beneficiary and avoid the key issue, that is, education of the prescribing physician.

Formularies. All formularies establish an explicit list of “approved” drugs. It is critical that this list is regarded as clinically sound and not simply a collection of the cheapest drugs. Implementation of a formulary can follow one of two paths.

An “open” formulary provides for consumer choice. A prescription for a non-listed drug can be filled and some coverage provided. The consumer, however, is responsible for a significant copayment. In contrast, drugs listed on the formulary are available to the consumer at a more modest copayment cost. Open formularies are the approach of choice for many privately insured pharmacy programs.

The alternative approach, or closed formulary, mandates a list of acceptable generic and brand drugs. If a prescription is written for a non-listed drug, there is no coverage provided, unless the patient’s medical needs are deemed to be exceptional, as determined through a pre authorization process. As might be expected, the closed formulary is a very effective cost management strategy but will generate some consumer dissatisfaction.

As noted above, to the extent a formulary is driven by consumer cost sharing arrangements, it may have limited application in a Medicaid environment. Similarly, a closed formulary may undermine opportunities to develop purchasing arrangements if imposed on consumers who want to self-select certain medications.

Finally, West Virginia must evaluate any formulary strategy within the context of its impact on the existing rebate program. While formulary savings may exceed those presently enjoyed through the rebate, this analysis is necessary.

Education. Education of both providers and consumers as to appropriate and cost effective utilization of pharmacy services must be part of any long term strategy to impact demand as well as generate acceptance of other cost management initiatives.

An educational program may be grounded, or at least linked, to disease management initiatives where different treatment modalities, including pharmacy, are explicitly coordinated in order to enhance quality and cost control.

Provider incentives. Some states have established programs to share savings generated by modified prescribing patterns that reduce Medicaid expenditures. Maine’s initiative includes a number of financial as well as quality factors. These latter measures are important to assure physicians and consumers that clinical quality is not being sacrificed for financial savings.

VI. Conclusion

Barring federal changes to the Medicare program, access to affordable pharmacy services will continue to be an issue of significant priority among large numbers of consumers. At the same time, there is little indication that the costs of prescription drugs will moderate in the near future.

Within the context of this environment, states are likely to explore and adopt increasingly aggressive policy and operational initiatives that satisfy the demand for pharmacy services within existing financial resources.

While it is not possible to identify one strategy as the best option for West Virginia, it is appropriate to emphasize that the State will need to maintain program and financial flexibility in order to respond to the rapidly changing economic, clinical and provider marketplace that characterizes pharmacy services.

Appendix A. Persons Interviewed for Report

Robert Ayers, Public Employees Insurance Agency

Robert P. Brauner, WV Dept. of Health and Human Resources, Office of Health Facility Licensure & Certification

Peter Dans, Advanced Paradigm

Robert Fulda, Dr.P.H., West Virginia Center for Healthcare Policy and Research

Pam Garrett, WV Dept. of Health and Human Resources, Office of Health Facility Licensure & Certification

Raymond L. Goldsteen, Dr.P.H., West Virginia Center for Healthcare Policy and Research

Earl F. Jarvis, Kanawha Valley Senior Services, Inc.

Felice B. Joseph, Public Employees Insurance Agency

Matthew C. Keefer, WV Dept. of Health and Human Resources, Office of Health Facility

Licensure & Certification

David Lambert, Mountain State Blue Cross & Blue Shield

S. Suresh Madhavan, Ph.D., Robert C. Byrd Health Sciences Center of WVU, School of Pharmacy

Jerry Massenburg, M.D., Mountain State Blue Cross & Blue Shield

Scott McClanahan, Kanawha Valley Senior Services, Inc.

Marsha K. Morris, WV House of Delegates, House Finance Committee

Gloria Pauley, WV Dept. of Health and Human Resources, Office of Health Facility Licensure & Certification

Sally K. Richardson, West Virginia Center for Healthcare Policy and Research

Janet Reed, Mountain State Blue Cross & Blue Shield

Patricia Holmes White, WV Health Right, Inc.