Prescription Drug Pricing

Through free market negotiations each state can substantially lower drug prices for both the 70 million Americans who lack access to prescription drug insurance coverage and the state Medicaid program.

★ 2004 POLICY SUMMARY ★

Prescription Drug Pricing

Summary

- **A health crisis is sweeping this country, threatening the lives of millions of Americans and the solvency of state health programs—soaring prices for prescription drugs.**
- **One in four Americans—70 million—do not have insurance covering prescription drugs.**
- **Drug manufacturers sell identical pharmaceuticals to different purchasers at widely varying prices.**
- **Through free market negotiations, each state can substantially lower drug prices for both the uninsured and for the state Medicaid program.**
- **In recent years, at least 26 states have implemented programs to lower drug prices.**
- **The Fair Market Drug Pricing Act is based on voluntary negotiations with drug companies and doesn't cost taxpayers a dime.**

A health crisis is sweeping this country, threatening the lives of millions of Americans and the solvency of state health programs—soaring prices for prescription drugs.

Drug prices are out of control, rising twice as fast as the inflation rate. The problem is literally an epidemic, as many Americans, especially seniors on fixed incomes, are forced to risk their health by sharing drugs, skipping doses, or doing without medicine altogether because it is simply too expensive. At the same time, skyrocketing drug prices could compel states to make cuts in critical medical assistance programs.

One in four Americans—70 million—do not have insurance covering prescription drugs.[1]

Not counting Medicare beneficiaries, more than 52 million Americans younger than 65 years old lack prescription drug coverage.[2] More than 10 million children are among the uninsured.

Drug manufacturers sell identical pharmaceuticals to different purchasers at widely varying prices.

On average, uninsured Americans pay about twice as much as the federal government pays for the same drugs. Uninsured families are charged far more for prescriptions than their insured neighbors, even in the same pharmacy. Similarly, state Medicaid programs pay a price, fixed by federal law, which is 20 to 40 percent higher than the federal government pays. Drug manufacturers make a healthy profit even on the lowest prices they charge the federal government.

Through free market negotiations, states have substantially lowered drug prices for Medicaid and other state programs.

Prior to 2001, only California authorized the use of preferred drug lists, and negotiating supplemental rebates to lower prescription drug prices paid by the state Medicaid program. Since 2001, at least 26 states have initiated these policies (AL, CT, FL, GA, HA, IN, IL, KY, LA, ME, MD, MA, MI, MN, NC, NM, OH, SC, SD, TN, TX, UT, VT, VA, WA and WV), saving states over one billion dollars per year.

INEQUITIES IN PRESCRIPTION DRUG PRICES

If the retail cost for a particular dosage and quantity of a brand name prescription drug is $100, on average:

- An uninsured resident pays $100 for that prescription.
- Medicaid and large HMOs pay $65.
- Federally-qualified health centers pay $54 (called the "340B" price).
- The federal government (largely, the U.S. Departments of Defense and Veterans Affairs) pays $46 or less.[3]

Drug manufacturers make a healthy profit on all of these prices.

Through free market negotiations, states have also lowered drug prices for uninsured residents.

In 2000, Maine enacted legislation that directs the state to use its bulk purchasing power to negotiate steep drug discounts for the uninsured. This law, called Maine Rx, was challenged in the courts and finally upheld in 2003 by the U.S. Supreme Court.[4] Hawaii enacted a version of Maine Rx in 2002. In 2003, Illinois, South Dakota, and Washington all enacted plans which direct the states to use their purchasing power to negotiate lower drug prices for individual residents.

The Fair Market Drug Pricing Act combines the approaches of several laws to lower drug prices for both state programs and state residents.

The Fair Market Drug Pricing Act is most similar to the law enacted in Hawaii. The Act:

- Directs the state Secretary of Health (or similar cabinet Secretary) to negotiate voluntary drug discounts or rebates from prescription drug manufacturers and labelers.

- Gives the Secretary the leverage to negotiate with drug companies in much the same way HMOs and health insurance companies negotiate—allowing the Secretary to place on the state Medicaid "prior authorization" list the products of any drug company that refuses to offer a substantial discount that is at least as favorable as the "340B" price.

- Directs the Secretary to set up and administer an Rx Card program, passing negotiated discounts to the people who need them—uninsured seniors on Medicare, and residents earning less than 300 percent of the poverty level.

- Empowers the Secretary to combine drug pricing negotiations for Medicaid, the Rx Card program, and any other state health programs, to maximize the Secretary's market clout.

- Directs the Secretary to seek a Medicaid waiver from the U.S. Department of Health and Human Services to set up a prescription drug discount program modeled after the highly successful "Healthy Maine" program.

The Fair Market Drug Pricing Act is based on a free market approach to pharmaceutical prices—states engage in voluntary negotiations with drug companies.

If the companies don't want to participate, they don't have to negotiate.

The Fair Market Drug Pricing Act doesn't cost taxpayers a dime.

On the contrary, it will save each state tens or hundreds of millions of dollars per year, depending on the size of the state's Medicaid budget.

Endnotes

[1] U.S. Department of Health and Human Services, "Prescription Drug Coverage, Spending, Utilization and Prices," April 2000.

[2] Ibid.

[3] U.S. Department of Health and Human Services, "Prescription Drug Coverage, Spending, Utilization and Prices," April 2000, and see William von Oehsen, *Pharmaceutical Discounts Under Federal Law: State Program Opportunities*, 2001.

[4] *PhRMA v. Walsh*, U.S. Supreme Court Docket No. 01-188, decided May 19, 2003.

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For more information...

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National Conference of State Legislatures
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Fair Market Drug Pricing Act

Summary: The Fair Market Drug Pricing Act lowers prices for the state Medicaid program and for uninsured state residents by directing the state Secretary of [HEALTH] to negotiate discounts and rebates from drug companies, and administer the Rx Card program, passing negotiated discounts to the uninsured.

SECTION 1. SHORT TITLE

This Act shall be called the "[STATE] Fair Market Drug Pricing Act."

SECTION 2. FINDINGS AND PURPOSE

(A) FINDINGS—The legislature finds that:

1. The State of [STATE] pays substantially more than the fair market price for many prescription drugs used in the Medicaid program. Considering the large volume of drugs purchased, the state will receive better drug prices by entering into voluntary negotiations with drug companies for supplemental rebates above and beyond the federally-designated rebates.

2. A number of states, including California, Florida, Illinois, Louisiana and Michigan, currently have programs to negotiate supplemental rebates. As a result, those states receive better Medicaid drug prices than [STATE].

3. In this time of economic difficulty, [STATE] needs to maximize its financial resources in order to provide as much health coverage as possible for low-income residents. Now more than ever, [STATE] needs to lower the prices it pays for prescription drugs.

4. At the same time, approximately one in four [STATE] residents are uninsured or underinsured for prescription drug coverage, and do not qualify for Medicaid. These uninsured or underinsured residents pay excessive prices for prescription drugs. In many cases, these excessive drug prices have the effect of denying residents access to medically necessary care, thereby threatening their health and safety.

5. Among these uninsured and underinsured residents, many require repeated doctor or medical clinic appointments, having gotten sicker because they cannot afford to take the drugs prescribed for them. Many are admitted to or treated at hospitals each year because they cannot afford the drugs prescribed for them that could have avoided the need for hospitalization. Many others enter expensive institutional care settings because they cannot afford the prescription drugs that could have supported them outside of an institution. In each of these circumstances, uninsured and underinsured residents too often become Medicaid recipients because of their inability to afford prescription drugs. Therefore, helping secure lower drug prices for the uninsured and underinsured directly benefits and supports Medicaid.

6. The state government is the only agent that, as a practical matter, can play an effective role as a market participant on behalf of all residents who are uninsured, underinsured or are Medicaid beneficiaries. The state already provides drugs and acts as a prescription benefits manager for a variety of programs, and should expand that role to negotiate voluntary drug rebates, using these funds to maintain and expand Medicaid services while offering lower drug prices to the uninsured who do not qualify for Medicaid.

(B) PURPOSE—Recognizing that the state already acts as a prescription benefits manager for a variety of health plans and assistance programs, this law is enacted to cover new populations by expanding the state's role as a participant in the prescription drug marketplace, negotiating voluntary rebates from drug companies, and using the funds to make prescription drugs more affordable to the state Medicaid program and to state residents. Such a program will improve public health and welfare, promote the economic strength of our society, and both directly and indirectly benefit the state Medicaid program.

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SECTION 3. FAIR MARKET DRUG PRICING

After section XXX, the following new section XXX shall be inserted:

(A) DEFINITIONS—In this section:

1. "Secretary" means the Secretary of the Department of [HEALTH], or the Secretary's designee(s).

2. "Department" means the Department of [HEALTH].

3. "Manufacturer" means a manufacturer of prescription drugs as defined in 42 U.S.C. Section 1396r-8 (k)(5), including a subsidiary or affiliate of a manufacturer.

4. "Labeler" means an entity or person that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale, and that has a labeler code from the Food and Drug Administration under 21 Code of Federal Regulations, 207.20 (1999).

5. "Participating retail pharmacy" means a retail pharmacy or other business licensed to dispense prescription drugs in this state that (a) participates in the state Medicaid program, or (b) voluntarily agrees to participate in the Rx Card program.

6. "Wholesaler" means a business licensed under [CITE EXISTING STATE LAW SECTION] to distribute prescription drugs in this state.

(B) NEGOTIATED DRUG DISCOUNTS AND REBATES

1. Drug discount and rebate agreements. The Secretary shall negotiate discount prices or rebates for prescription drugs from drug manufacturers and labelers. A drug manufacturer or labeler that sells prescription drugs in this state may voluntarily elect to negotiate: (a) supplemental rebates for the Medicaid program over and above those required under 42 U.S.C. Section 1396r-8, (b) discount prices or rebates for the Rx Card program, and (c) discount prices or rebates for any other state program that pays for or acquires prescription drugs.

2. Rebate amounts. In negotiating rebate terms, the Secretary shall take into consideration: the rebate calculated under the Medicaid rebate program pursuant to 42 U.S.C. Section 1396r-8, the price provided to eligible entities under 42 U.S.C. Section 256b, and any other available information on prescription drug prices, discounts and rebates.

3. Failure to agree.

a. The Secretary shall prompt a review of whether to place a manufacturer's or labeler's products on the prior authorization list for the state Medicaid program and take similar actions involving prior authorization or formularies for any other state-funded or operated prescription drug program, if:

(1) the Secretary and a drug manufacturer or labeler fail to reach agreement on the terms of a supplemental Medicaid rebate or a discount or rebate for the Rx Card program, and

(2) the discounts or rebates offered by the manufacturer or labeler are not as favorable to the state as the prices provided to eligible entities under 42 U.S.C. Section 256b.

b. Any prior authorization must meet the requirements of 42 U.S.C Section 1396r-8(d)(5) and be done in accordance with [CITE EXISTING STATE LAW SECTION]. The Secretary shall promulgate rules creating clear procedures for the implementation of this section.

c. The names of manufacturers and labelers that do not enter into rebate agreements are public information and the Department shall release this information to the public and actively distribute it to doctors, pharmacists, and other health professionals.

(C) RX CARD

1. Rx Card program established. The Department shall establish the Rx Card program as a state pharmaceutical assistance program under 42 U.S.C. Section 1396r-8(c)(1)(C)(i)(III), to provide discounts to participants for drugs covered by a rebate agreement. Using funds from negotiated rebates, the Department shall contract with wholesalers and / or participating retail pharmacies to deliver discounted prices to Rx Card participants.

2. Amount of discount. The drug discounts received by Rx Card participants shall be calculated by the Secretary on a quarterly basis. That calculation shall provide discounts approximately equal to the average amount of the negotiated drug rebate minus an amount to cover the reasonable administrative costs of the Rx Card program.

3. Eligibility for participation.

a. An individual is eligible to participate in the Rx Card program if s / he is a resident of the state and is eligible for participation in the Medicare program or has a net family income below 300 percent of the federal poverty level.

b. An individual is ineligible to participate in the Rx Card program if s / he is eligible for assistance under the state's Medicaid program or is covered by an insurance policy that provides benefits for prescription drugs equal to or greater than the benefits provided under the Rx program, as delineated by rules promulgated by the Secretary.

c. The Department shall establish simple procedures for enrolling Rx Card participants and shall undertake outreach efforts to build public awareness of the program and maximize enrollment by eligible residents.

4. Operation.

a.The Secretary shall adopt rules requiring disclosure by participating retail pharmacies to Rx Card program participants of the amount of savings provided as a result of the Rx Card program. The rules must protect information that is proprietary in nature.

b. A participating retail pharmacy shall verify to the Department the amounts charged to Rx Card participants and non-participants, and shall provide the Department with utilization data necessary to calculate rebates from manufacturers and labelers. The Department shall protect the confidentiality of all information subject to confidentiality protection under state or federal law, rule or regulation. The Department may not impose transaction charges on wholesalers or participating retail pharmacies that submit claims or receive payments under the program.

c. Wholesalers and / or participating retail pharmacies shall be paid in advance for Rx Card discounts or shall be reimbursed by the Department on a weekly basis.

d. The Department may require a wholesaler or participating retail pharmacy to segregate drugs under the Rx Card program from other drug inventory. The Department may require a wholesaler or participating retail pharmacy to maintain records of acquisition and disposition of drugs under the Rx Card program separately from the wholesaler's or pharmacy's other records.

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(D) ADMINISTRATION

1. Discrepancies in rebate amounts. Disputes or discrepancies in rebate amounts must be resolved using the process established in this subsection.

a. If there is a discrepancy in the manufacturer's or labeler's favor between the amount claimed by a pharmacy and the amount rebated by the manufacturer or labeler, the Department, at the Department's expense, may hire a mutually agreed-upon independent auditor. If a discrepancy still exists following the audit, the manufacturer or labeler shall justify the reason for the discrepancy or make payment to the Department for any additional amount due.

b. If there is a discrepancy against the interest of the manufacturer or labeler in the information provided by the Department to the manufacturer or labeler regarding the manufacturer's or labeler's rebate, the manufacturer or labeler, at the manufacturer's or labeler's expense, may hire a mutually agreed-upon independent auditor to verify the accuracy of the data supplied to the Department. If a discrepancy still exists following the audit, the Department shall justify the reason for the discrepancy or provide a refund to the manufacturer or labeler.

c. Following the procedures established in paragraph (a) or (b), either the Department or the manufacturer or labeler may request a hearing. Supporting documentation must accompany the request for a hearing.

2. Annual summary report. The Department shall report the enrollment and financial status of the Rx Card program and report savings from supplemental Medicaid rebates to the legislature by February 1 each year.

3. Coordination with other programs. Where the Secretary finds that it is beneficial to both the Rx Card program and another state program to combine drug pricing negotiations to maximize drug rebates, the Secretary shall do so.

4. Rulemaking. The Department shall adopt rules to implement the provisions of this section.

5. Waivers. The Department may seek any waivers of federal law, rule or regulation necessary to implement the provisions of this section.

SECTION 4. MEDICAID WAIVER DISCOUNT PLAN

In addition to the Rx Card program established in Section 3 of this Act, the [Department of HEALTH] shall seek a Section 1115 Medicaid waiver to establish a pharmacy discount program modeled after the Healthy Maine Prescriptions Program. If the waiver is approved, the Department shall implement that program following consultation with the [insert appropriate legislative oversight committees].

SECTION 5. SEVERABILITY

The provisions of this Act shall be severable, and if any phrase, clause, sentence, or provision is declared to be invalid or is preempted by federal law or regulation, the validity of the remainder of this Act shall not be affected. The Secretary shall administer the provisions of this Act in a manner that benefits the largest number of residents while preventing it from being preempted by federal law or regulation. This includes, if necessary, separating Medicaid from non-Medicaid negotiations and preferred drug list decisions, or limiting participation in the Rx Card program to a smaller segment of residents.

SECTION 6. EFFECTIVE DATE—This Act shall take effect on July 1, 2004 and discounts to participants in the Rx Card program shall begin by January 1, 2005.