SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 320

SPONSOR: Health, Aging, and Long-Term Care Committee and Senator Aronberg

SUBJECT: The Florida Medicaid Program

DATE: March 14, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Liem	Wilson	HC	Favorable/CS
2.	White	Wilson	GO	Favorable
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

The Committee Substitute for Senate Bill 320 requires the Agency for Health Care Administration to publish on a free web site, available to the public, the most recent average wholesale price for the 200 drugs most frequently dispensed to the elderly, and to the extent possible, provide a mechanism that consumers may use to calculate the retail price that should be paid after the discount required under the Medicare prescription discount program is applied. The bill also requires the Agency for Health Care Administration to submit a report to the Legislature by January 1, 2004, regarding the cost-effectiveness of and alternatives to the use of average wholesale price in the pricing of pharmaceutical products purchased by the Medicaid program.

The bill amends s. 400.9066, F.S., and creates an undesignated section of law.

II. Present Situation:

Outpatient prescription drugs, which are not covered by Medicare, represent a substantial out-of-pocket burden for many elderly persons. This lack of prescription drug coverage is often cited as a major shortcoming of the Medicare program, the federal health insurance program for older and disabled Americans.

Florida is home to approximately 2.6 million elderly Medicare beneficiaries. Over 90 percent of these elders take one prescribed drug. On average, a Medicare recipient takes seven different medications. There is a direct correlation between advancing age and the number of prescription drugs taken. Although Americans over 65 make up only 12 percent of the population, they take 25 percent of all prescribed drugs sold in the United States.

Approximately 65 percent of non-institutionalized Medicare beneficiaries have some form of prescription drug coverage; however, the level of this coverage varies. Most (59 percent) of these individuals with prescription drug coverage receive their drug coverage through private supplemental insurance, either through employer-sponsored plans or individually purchased private policies. About one-fifth of Medicare beneficiaries with prescription drug coverage are members of Medicare HMOs, which, in an effort to attract seniors, have offered various levels of prescription drug coverage at no additional cost to the enrollee. The scope and availability of Medicare HMO prescription drug coverage varies widely within and across market areas. A number of HMO plans responded to the federal rate changes under the Balanced Budget Act of 1997 by ceasing operations in some counties in Florida, reducing coverage for some (often prescription drug) benefits, or raising prices in areas where the HMO plan determined that rates were inadequate to meet their operational costs. The future of these benefits is uncertain.

Approximately 10 percent of Florida Medicare beneficiaries have coverage through the Medicaid program. Medicaid covers prescription medications for elderly and disabled individuals whose incomes are under 90 percent of the federal poverty level. Medicaid will also pay some medical expenses not covered by Medicare, generally up to Medicaid limits for these individuals.

Out-of-Pocket Spending on Prescription Drugs by Seniors

Nationwide, Medicare beneficiaries spend an average of $415 per year on prescription drugs. Individuals who are older, who have poor health status, or who have limitations on their activities, spend twice the average amount per year.

Seniors, as individual purchasers of prescription drugs, tend to be charged higher prices than group purchasers, due in large part to the ability of large group purchasers to shop for and negotiate better prices for both the prescription drug and dispensing fees charged by pharmacists. Individuals rarely have the ability to influence either of these prices, and therefore are subject to cost-shifting from groups with more purchasing power.

Pharmaceutical Pricing

Pharmaceutical pricing in the United States is the product of a complex system of marketing and purchasing arrangements, government controls and competitive pressures. Pricing of a given drug eventually dispensed to a consumer is generally a factor of the distribution channel the drug in question flows through and the presence or absence of government regulation and control.

Cash customers are generally individuals who either lack prescription drug coverage and therefore pay out of their own pockets, or have indemnity-type insurance that reimburses them after they have made their cash purchases. Cash customers generally pay the highest prices for drugs because they lack the opportunity, let alone the bargaining power, to negotiate discounts from either the retail pharmacy or the manufacturer. They generally pay at or above a drug's average wholesale price (AWP), which is the manufacturer's list price.

Pharmacy Benefit Managers (PBM) are private third parties that manage drug benefits for large groups of individuals, such as enrollees in an insurance plan or employees of a self-insured company. By negotiating both discounts from participating pharmacies and rebates from

preferred manufacturers, PBM customers typically pay less than a drug's average manufacturer price (AMP) – which is about 20 percent below AWP – and as low as 40 percent below AWP.

Institutional Purchasers - Hospitals and group or staff model health maintenance organizations, that own and operate their own pharmacies generally receive favorable pricing from manufacturers because they do not have to buy through retail channels and can negotiate directly with manufacturers, either individually or as part of a group purchasing organization. Negotiated discounts for the purchase of drugs are subject to the requirements of the Robinson-Patman Price Discrimination Act. In 1936, Congress passed the Robinson-Patman Price Discrimination Act, which provides that price savings on quantity purchases must relate to quantitative differences and nothing more. The Robinson-Patman Price Discrimination Act provides exemptions to purchases of supplies by schools, churches, hospitals, public libraries, and other nonprofit institutions when those supplies are for the "use of the institution." The United States Supreme Court has held that the purchase of discounted drugs by a nonprofit hospital are exempt from the Robinson-Patman Price Discrimination Act if the drug purchases are for the institution=s own use and intended for the entity=s operation in the care of individuals who are its patients - *Abbott Laboratories et al v. Portland Retail Druggists Association*, 425 U.S. 1 (1976).

340B Program - Many federally-funded clinics, health departments and hospitals are eligible for below-market discounts under section 340B of the Public Health Service Act. This act provides these clinics and hospitals with the same price discounts as Medicaid. However, 340B providers usually pay less than the Medicaid net price because they are able to negotiate sub-ceiling prices. They also save by not paying the drug mark-ups and dispensing fees to retail pharmacies.

Federal Supply Schedule (FSS) - The FSS is a schedule of contracts and prices for frequently-used supplies and services available for purchasing by federal agencies and other entities such as the U.S. territories and tribal governments. There are no statutory ceilings on prices, but the government often uses a "most favored customer" price as a starting point in negotiations to obtain below-market prices. FSS prices are on average slightly above 340B prices.

Federal Ceiling Price - The Veterans Administration, Department of Defense, Public Health Service, and Coast Guard often get pricing below FSS on brand name drugs because these drugs are subject to a maximum statutory price called the federal ceiling price (FCP). FCP is set at 24 percent below the non-federal AMP, often referred to as non-FAMP. FCP prices are on average slightly below 340B prices.

VA Contract - In 1992, Congress enacted the Veterans Health Care Act (s. 602, P.L. 102-585) allowing certain federal, state, and local government agencies to purchase prescription drugs at discounted public health service prices. Under this law, a drug manufacturer must enter into discount pricing agreements with the Department of Veterans Affairs and with covered entities funded by the Public Health Service in order to have its drugs covered by Medicaid. Covered entities include certain disproportionate share hospitals, federally qualified health centers, AIDS and tuberculosis clinics, and other outpatient clinics funded under the Public Health Service Act. To qualify for the drug pricing program, the covered entity must be a federal purchaser or federally-funded grantee recognized under section 340B of the Public Health Service Act.

Department of Health Pharmacy Purchasing - Section 381.0203, Florida Statutes, authorizes the Florida Department of Health to contract on a statewide basis for the purchase of drugs, to be used by state agencies and political subdivisions. The Office of Pharmacy Services within the Florida Department of Health contracts for the purchase of drugs for use by state agencies and political subdivisions. Under this program, the state negotiates a discounted price with drug manufacturers currently for county health departments, the Department of Corrections, and the Department of Children and Families. The negotiated contract language customarily contains a provision that limits the use of the discounted drugs purchased by the state for clients or patients of the state.

Medicaid Rebate Program - Federal Medicaid law requires drug manufacturers to pay state Medicaid agencies a quarterly rebate on brand name drugs equal to 15.1 percent off of AMP or the manufacturer's best price, whichever is lower, plus an additional rebate if the price of the drug has risen faster than the rate of inflation. The Medicaid net price is the effective price paid after the minimum price is reduced further by either the best price or inflationary adjustment, or both. Because Medicaid is entitled to a manufacturer's best price or better, the Medicaid net price will almost always be as good as or better than the best prices negotiated in the private sector (whether by a PBM, health maintenance organization, group purchasing organization or other private purchaser.) The Florida Medicaid program, in addition, has the authority to negotiate state supplemental rebates. Florida Medicaid, in its claims processing, tests the price a pharmacy submits against a logic routine which pays the lesser of AWP minus 13.25 percent, the wholesale acquisition cost plus 7 percent, the federal ceiling price, or the usual and customary charge. The system pays whichever is the lowest price, plus a dispensing fee.

Medicare Prescription Discount Program

During the 2000 Florida legislative session the Legislature enacted a program to require that, as a condition of participation in the Medicaid program or the pharmaceutical expense assistance program, a pharmacy must agree to charge any Medicare beneficiary who presents a Medicare card when they present a prescription a price no greater than the cost of ingredients equal to the average wholesale price minus 9 percent, and a dispensing fee of $4.50. In lieu of this requirement, and as a condition of participation in the Medicaid program or the pharmaceutical expense assistance program, a pharmacy must agree to provide a private, voluntary prescription discount program to state residents who are Medicare beneficiaries or accept a private voluntary discount prescription program from state residents who are Medicare beneficiaries. This discount must be at least as great as the above discount. Many Medicare beneficiaries have complained that they have no way to verify that they are getting the full discount.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.9066, F.S., to require the Agency for Health Care Administration to publish on a free web site, available to the public, the most recent average wholesale price for the 200 drugs most frequently dispensed to the elderly, and to the extent possible, provide a mechanism that consumers may use to calculate the retail price that should be paid after the discount required under the Medicare prescription discount program is applied.

Section 2. Requires the Agency for Health Care Administration to submit a report to the Legislature by January 1, 2004, regarding the cost-effectiveness of and alternatives to the use of average wholesale price in the pricing of pharmaceutical products purchased by the Medicaid program.

Section 3. Provides an effective date of July 1, 2003.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

According to the Agency for Health Care Administration, collecting the information required by the bill and publishing such information on a web page will require additional staff resources. The agency states that the costs will be $50,351 for the first year and $46,726 for the second and subsequent years. These costs will be 50 percent federally-reimbursable with a Medicaid administrative match. Accordingly, the agency states that it will incur a fiscal impact of $25,176 for the first year and $23,363 for the second and subsequent years.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.