

**CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

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LEGISLATIVE PROGRAM REVIEW
& INVESTIGATIONS COMMITTEE

Pharmacy Benefits And Regulation

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PHARMACY BENEFITS AND REGULATION

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Introduction

The cost of prescription drugs is a nationwide concern, and states are facing growing expenses for pharmaceuticals provided through medical assistance programs and employee insurance plans. Likewise, individuals with limited or no health care coverage are seeking ways to obtain the prescription drugs they need at affordable prices.

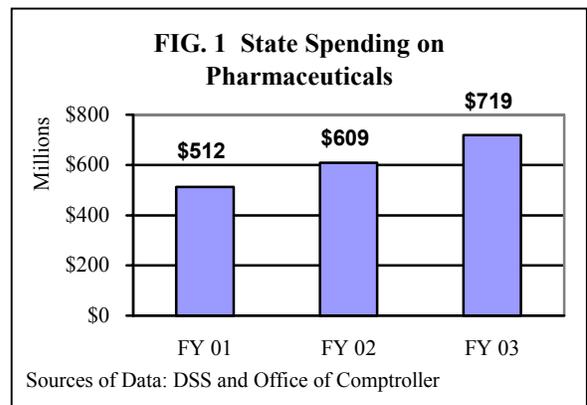
Spending on prescription drugs accounts for 10 percent of all health care expenditures in the United States, and it is the fastest growing segment. Nationally, pharmaceutical expenditures tripled from 1993 to 2002, increasing from \$51 billion to \$162 billion.¹ From 2001 to 2002 alone, spending increased 15 percent compared to only 9 percent for all health expenditures nationally. Private health insurance and out-of-pocket payments by consumers cover three-quarters of the cost of prescription drugs in the United States. In 2002, those two sources expended \$126 billion on pharmaceuticals; public spending totaled \$36 billion.

Increases in prescription drug spending have been attributed to multiple factors, including:

- the availability of newer, more expensive drugs;
- increased use of existing drugs;
- more requests from patients for drugs, due to greater awareness of drug treatment options as a result of increased direct-to-consumer advertising;
- the aging of the population; and
- use of improved drug therapies to decrease hospitalizations and lengths of stay.

The spiraling cost of prescription drugs has had a major impact on state budgets, and Connecticut is not exempt from this trend. Figure 1 summarizes state spending on pharmaceuticals for the past three fiscal years. In FY 02, the state spent about \$609 million on pharmaceuticals, 19 percent more than in FY 01. In FY 03, the state spent approximately \$719 million or 5.3 percent of the state's budget. This was an 18 percent increase over FY 02 and a 40 percent increase since FY 01.

Individuals enrolled in medical assistance programs operated by the Department of Social Services (DSS) accounted for two-thirds of the money spent in FY 03. Prescription drug coverage for state employees and retirees consumed nearly one-quarter. In both of those cases, the money was used to reimburse pharmacies for drugs dispensed to covered



¹ Centers for Medicare and Medicaid Services, Statistics: National Health Expenditure Tables, Estimates of Expenditures, Tables 2 and 3 (www.cms.gov/statistics/nhe/historical).

participants. Most of the remaining money bought pharmaceuticals to be dispensed within state facilities or through public health programs.

Scope of Review

In February 2003, the Legislative Program Review and Investigations Committee voted to study pharmacy benefits and regulation in Connecticut. The study was divided into two parts. The first, which this report covers, looked at how the state purchases prescription drug benefits for a variety of program beneficiaries and examined whether the state maximizes opportunities to contain costs. The study focused on issues related to expenditures, management of drug purchasing activities by state agencies, and accessibility of drugs for individuals not covered by existing state programs.

The second part, to be completed in 2004, will focus on the regulation of pharmacy-related entities, including the controls placed on pharmacies by the Department of Consumer Protection (DCP). It also will look further at how the activities of pharmacy benefit managers (PBMs) are regulated by the state and whether this is adequate.

Currently, at least a dozen governmental entities are involved in the state's efforts to provide prescription drug benefits. Program costs are impacted by eligibility criteria, the scope of services covered, cost-sharing requirements, utilization management strategies, and reimbursement formulae. During the study, the committee identified a number of steps taken to contain costs in recent years, particularly within the medical assistance programs operated by the Department of Social Services.

The program review committee considered a variety of options to reduce the cost of pharmaceuticals paid for by the state. Some concerned the quantity of drugs purchased; others targeted the price paid. In deciding what changes to make, questions about who should pay how much for prescription drugs had to be answered since some common cost-reduction proposals represent a cost shifting to other parties rather than overall cost savings. For example, increasing beneficiary co-pays and reducing dispensing fees paid to pharmacists do not change the price charged for a drug; they only change the party responsible for making the payment.

The program review committee's recommendations for modifying the state's current system of providing prescription drug services are grouped separately for each major program area. However, the opportunities for savings can be summarized within four categories:

- increased bulk purchasing;
- enhanced monitoring;
- greater scrutiny of specific drugs prescribed; and
- improved consumer education.

Methodology

A variety of resources and methods were used to gather and analyze information for this report. The general literature on pharmaceutical pricing and distribution was reviewed, as was

information on steps other states have taken to contain prescription drug costs. Interviews were conducted with staff from the major governmental entities involved in the state's acquisition of pharmaceuticals as well as members of organizations representing pharmacists, chain pharmacies, managed care organizations, and pharmaceutical manufacturers. Committee staff also examined agency data related to enrollment, utilization, and cost for those who were eligible for the various state medical assistance programs reviewed as part of the study.

The program review committee held a public hearing on September 16, 2003. The members adopted the findings and recommendations in this report on December 9, 2003.

Report Format

The report contains five chapters. The first provides information about the key players in the pharmaceutical marketplace and their functions. The second identifies purchasing models used by the state to pay for drugs, explains how drug prices are determined, and indicates how much the state spends on pharmaceuticals for the populations it covers. The third chapter describes general approaches used to contain and manage drug costs in Connecticut and other states, while the fourth chapter presents the committee's specific findings and recommendations. The fifth chapter discusses a variety of issues related to increasing consumer access to prescription drugs.

The report also contains eight appendices. Appendices A, B, and C provide more detailed information about the major state programs briefly described in the main sections of the report. Appendix D provides background information about pharmacy benefit managers, while Appendix E summarizes information about pharmaceutical activities in other states. Appendix F presents information on the status of recent legislation affecting DSS pharmacy programs, and Appendix G provides a glossary of terms used in this report.

Agency Response

It is the policy of the Legislative Program Review and Investigations Committee to provide agencies subject to a study with an opportunity to review and comment on the recommendations prior to publication of the final report. Appendix H contains responses from the Department of Social Services and the Office of Policy and Management (OPM).

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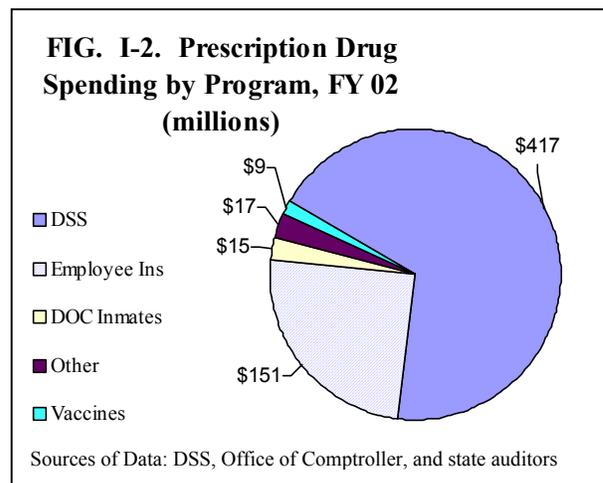
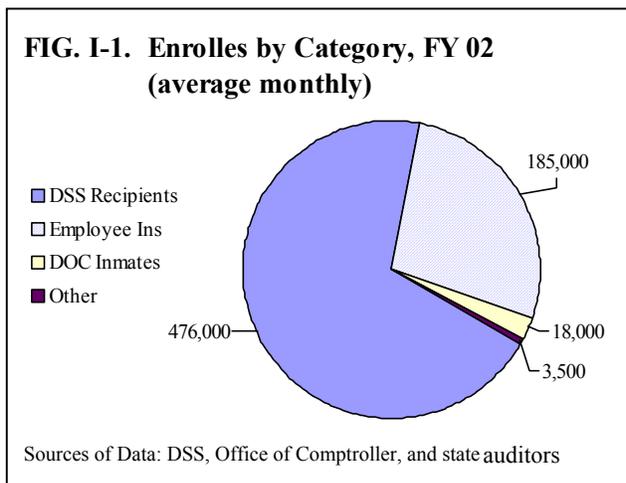
State Prescription Drug Programs

The state of Connecticut pays for some or all of the cost of prescription drugs for nearly 700,000 eligible state residents per month. The primary populations the state provides coverage for are:

- low-income children and adults as well as certain aged, blind, and disabled individuals enrolled in medical assistance programs (including long-term care);²
- state employees and retirees (and their dependents) covered by the state’s health insurance plan;
- inmates of state correctional facilities; and
- patients at state-run hospitals and health care facilities.

The state also buys pharmaceuticals for distribution through infirmaries operated by state higher education institutions and for public health programs such as vaccination clinics. Figure I-1 shows average monthly enrollment with the three largest programs broken out.³

Figure I-2 shows the distribution of state spending on prescription drugs by program area. Payments for state employees and retirees and the various programs operated by the Department of Social Services consumed 93 percent of the \$609 million spent in FY 02. (Chapter II contains information on expenditures by individual program.)

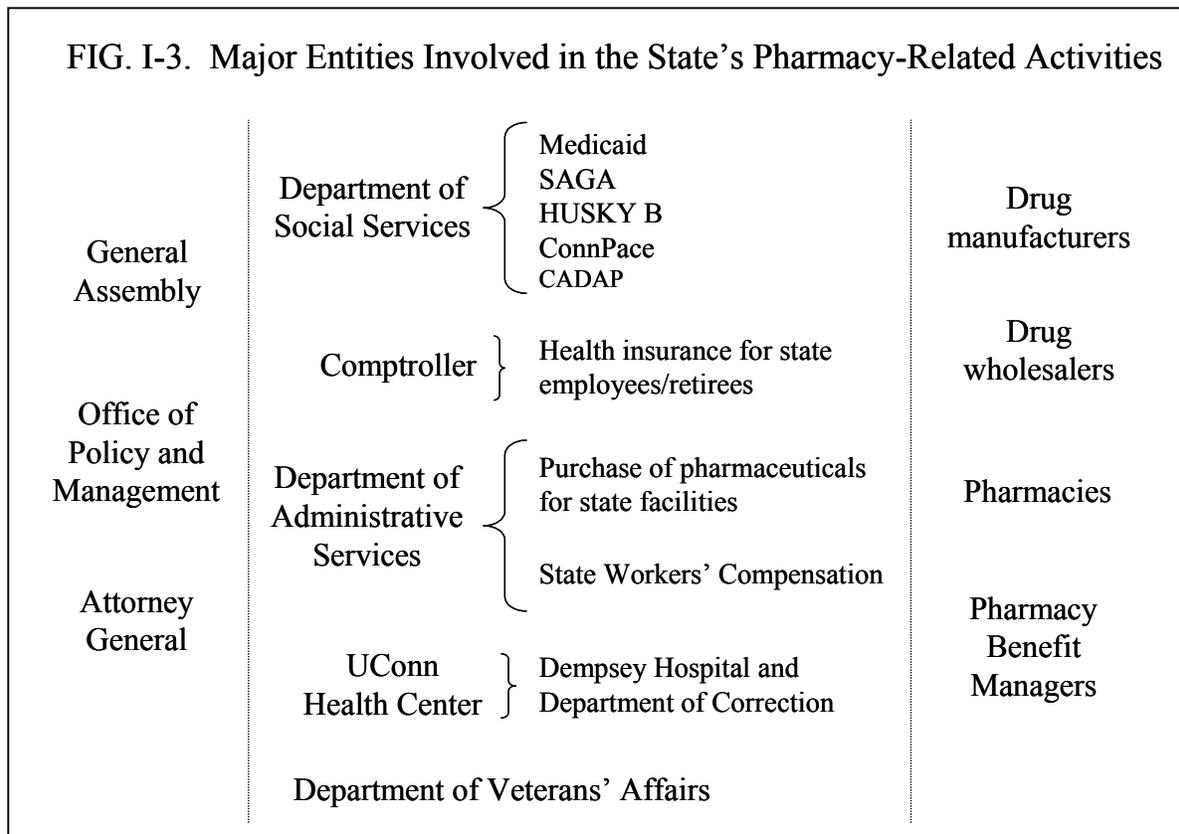


² DSS administers several programs targeted at low-income populations. These include: Medicaid fee-for-service, Medicaid Managed Care (HUSKY A), State Children’s Health Insurance Program (HUSKY B), Connecticut Pharmaceutical Assistance Contract for the Elderly and Disabled (ConnPACE), State Administered General Assistance (SAGA), and the Connecticut AIDS Drug Assistance Program (CADAP).

³ The “other” category includes estimates for state inpatient facilities based on bed occupancy rates. The figure does not include the number of individuals receiving vaccinations purchased by the Department of Public Health (DPH).

Key Participants In the Purchasing of Drugs For the State

Figure I-3 shows the range of entities with direct and indirect roles in the state’s activities related to the purchase of prescription drugs. A brief description of each is presented below.



The state entities listed on the left side of the figure have broad or multiple areas of involvement with pharmacy-related issues of concern to the state of Connecticut. The *General Assembly* establishes policies concerning eligibility for prescription drug benefits and appropriates funding to pay for services. It also sets statutory parameters for the operation of programs (e.g., the pharmacy dispensing fee for DSS programs). In general, the legislature has greater authority over programs that are solely state-funded, such as the state administered general assistance program, but it can make certain changes in federal entitlement programs if the federal rules give such discretion.

The *Office of Policy and Management* has an ongoing coordination role concerning expenditures through the state budget process. Staff have also been involved in efforts to coordinate the purchase of pharmaceuticals by state institutions and agencies.

The activities of the *Office of the Attorney General* are divided between the attorney general’s broad role as a consumer advocate and direct representation of state agencies on legal questions. In the latter instance, the office currently represents the Department of Social Services in a case alleging the prices some manufacturers charged DSS for drugs were inflated.

The state agencies listed in the center of Figure I-3 operate the major state programs that provide prescription drug services. Those agencies include:

- Department of Social Services - responsible for the operation of five federal and state medical assistance programs for state residents, which represent the state's largest category of spending on prescription drugs. These programs serve low income children and adults, with special programs serving the elderly and individuals with AIDS. (See Appendix A for a more detailed description of these programs.)
- Comptroller - primary agency overseeing pharmacy benefits for state workers and retirees, who together comprise the state's second largest expenditure category for prescription drugs. The Office of the Comptroller in consultation with the Health Care Cost Containment Committee, a group representing management and labor, selects the health carrier responsible for coverage of pharmacy services for enrollees. (See Appendix B for a more detailed description of the state employee health insurance program.)
- Department of Administrative Services (DAS) - oversees two types of programs. Agency purchasing staff coordinate contracts for the acquisition of pharmaceuticals dispensed at state facilities operated by agencies such as the Department of Mental Health and Addiction Services (DMHAS) and the Department of Mental Retardation (DMR). Other DAS staff oversee the workers' compensation program for state employees.
- University of Connecticut Health Center (UCHC) - purchases and dispenses drugs for patients of John Dempsey Hospital and, under a memorandum of understanding with the Department of Correction (DOC), provides the same services for inmates in all DOC facilities. (See Appendix C for more detailed descriptions of the drug purchasing processes DAS and UCHC use.)
- Department of Veterans' Affairs - not a large purchaser of drugs, but a noteworthy entity because it qualifies for special federal pricing that is lower than what any other state entity pays for pharmaceuticals.

Moving to the right column in Figure I-3, the entities listed are the major players in the pharmaceutical marketplace where drugs are produced and sold. Key participants include:

- Pharmaceutical manufacturers - sell pharmaceutical products primarily to drug wholesalers, but may sell to some large pharmacy chains. Each manufacturer establishes a baseline sale price. However, that price does not reflect rebates or volume discounts a wholesaler may receive.
- Drug wholesalers - purchase drugs from manufacturers and resell them to other institutional and retail pharmacies. There are fewer than 50 wholesalers in the United States, with the top five accounting for more than 90 percent of the wholesale drug market.⁴

⁴ California HealthCare Foundation, *Navigating the Pharmacy Benefits Marketplace*, January 2003, p.22.

- Pharmacies - The Department of Consumer Protection currently licenses 611 retail pharmacies in Connecticut and registers 235 mail-order pharmacies that are located outside of Connecticut.
 - Retail pharmacies buy drugs directly from wholesalers, join group purchasing organizations (GPOs) to increase their purchasing power, or, if large enough, purchase directly from pharmaceutical manufacturers. Individual pharmacies may receive discounts from wholesalers based on timely payment.
 - Mail-order pharmacies buy pharmaceuticals in large volumes and dispense them through automated processes. Most of the drugs dispensed are for patients with chronic conditions who take the same drug on a long-term basis (i.e., maintenance drugs).

- Pharmacy benefit managers - These organizations are private companies that manage drug benefits for some, but not all state programs. Currently, PBMs administer the health insurance drug benefit for state employees and some Medicaid recipients. The major functions of PBMs include:
 - negotiating discounts with manufacturers, wholesalers, and pharmacies;
 - maintaining drug formularies by overseeing the types of drugs prescribed and determining if there are less expensive alternatives that can be substituted;
 - acting as financial intermediaries between pharmacies and health plan sponsors (e.g., verifying customer eligibility, handling disputes, and paying claims);
 - operating drug utilization review (DUR) programs, including the capacity to generate comparative profiles of physician prescribing patterns or pharmacy dispensing;
 - purchasing and dispensing medications through mail-order companies they own; and
 - creating and maintaining pharmacy networks to ensure adequate geographic access.

PBMs receive a fee for the administrative tasks they perform. PBMs also use the buying power of their customers to negotiate discounts from drug companies. The profits made by PBMs primarily come from manufacturer discounts and rebates for specific drugs on preferred drug lists and through the operation of mail-order prescription drug companies. The retention by PBMs of some or all of the rebates from manufacturers has become increasingly controversial, with attorneys general in several states conducting investigations of this business practice.

In recent years, a number of states including Connecticut considered legislation regulating the business practices of PBMs. (Appendix D provides additional information regarding PBM regulation.)

State Prescription Drug Purchases

The state utilizes multiple approaches to procure the prescription drugs it provides program-eligible beneficiaries. The state also pays different prices for prescription drugs, depending on the program.

How Drug Prices Are Set

The “cost” of a drug reflects the expenses incurred to perform a number of tasks over a period of years. The major elements of that “cost” are:

- scientific research and testing to create a product that meets a specific medical need;
- ongoing manufacturing;
- product marketing through an international distribution system; and
- built-in sales profit.

At the same time there is rarely a single “price” for a drug. Rather, the amount charged will vary widely, depending on who is purchasing the product. This makes it difficult for a customer such as the state of Connecticut to:

- know exactly how a price was determined;
- evaluate the fairness of the price; or
- propose changes to reduce the price.

In addition, opportunities to “price shop” for alternative pharmaceuticals are much more limited than for choosing other consumer products. The typical prescription drug consumer has little flexibility to choose among different products because he or she must rely on a physician to decide which drug best treats a particular medical condition. Furthermore, insured consumers may be even more restricted because of the influence of pharmacy benefit managers who are managing drug choices through the use of preferred drug lists and prior authorization programs.

Common pricing measures. Figure II-1 shows a simplified pricing model reflecting how drug manufacturers set drug prices for the market. The manufacturer establishes two pricing measures.

The wholesale acquisition cost (WAC) is used as a baseline for sales to wholesalers before any rebates or discounts are applied. The average wholesale price (AWP) is the manufacturer’s suggested retail price (i.e., what the manufacturer recommends wholesalers use as the price to resell a drug to retail pharmacies).⁵ In reality, these pricing formulae are used as “list” prices and are discounted by varying amounts throughout the distribution chain.

⁵ Ibid., p.21.

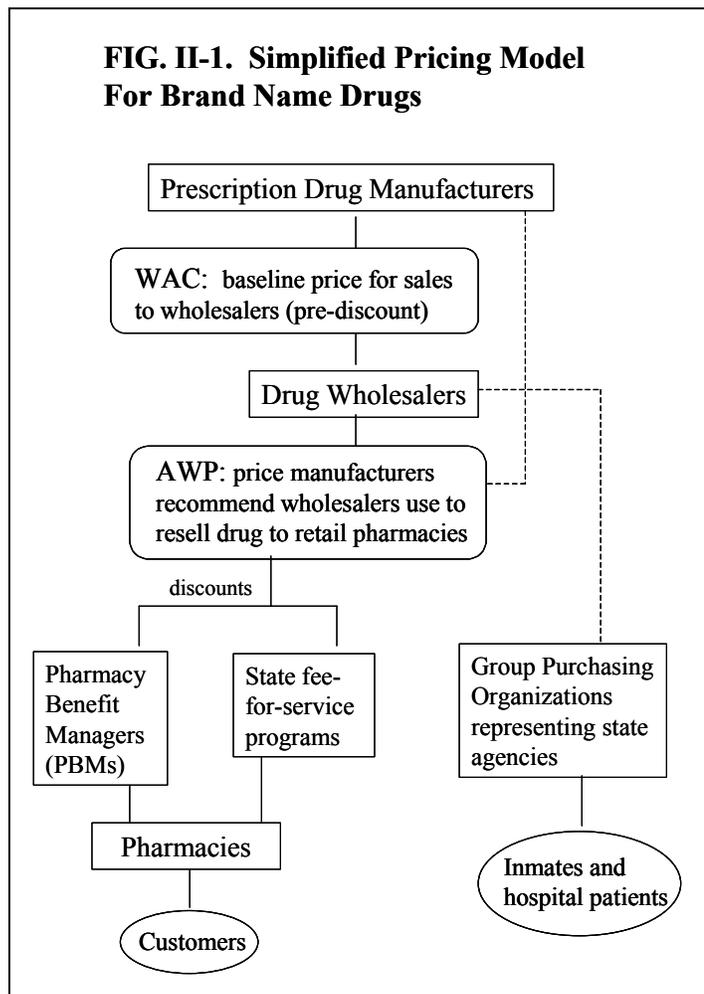
For generic drugs, a different pricing system is used. Private health plans and many government programs develop and reimburse pharmacies for generics based on Maximum Allowable Cost (MAC). This type of pricing system is used because there is a wide variance among the prices for identical (generic) drugs sold under different names or by different companies. MAC pricing programs establish the maximum allowed cost for each of these drugs. The pharmacy will be reimbursed the same amount regardless of which version of the drug it buys. The intent of this system is to encourage retail pharmacies to use the most cost-effective generic drug.⁶

Price negotiation. Pharmacy Benefit Managers use AWP pricing for brand name drugs as a starting point for developing drug payment contracts with retail pharmacies. This includes the PBMs overseeing the prescription drug programs for state employees and retirees, as well as DSS programs administered by managed care organizations (i.e., HUSKY A and HUSKY B).

For generic drugs, PBMs develop lists that specify MAC charges as the ceilings for the amount they will reimburse. The amount of the dispensing fee, which is paid for each prescription filled, is also part of the PBM negotiation process. Details of the financial arrangements PBMs make with drug companies and pharmacies are considered proprietary and are not subject to disclosure.

The Connecticut Department of Social Services, like its counterparts in other states, also uses AWP and MAC as pricing measures for its fee-for-service programs. However, instead of negotiating discounts using AWP, the DSS commissioner sets reimbursement rates plus a pharmacy dispensing fee using a percentage of the AWP for brand name drugs and generics not eligible for MAC list pricing.

Other pricing systems. In addition to the pricing systems described above, a number of other pricing formulae exist. Federal law guarantees substantial drug discounts to state Medicaid



⁶ Pharmacy Benefit Management Institute (www.pbmi.com).

programs, veterans’ homes, and specific public health entities that receive federal funding. Table II-1 shows the three that are of particular interest to the state of Connecticut.

Table II-1. Federal Prescription Drug Pricing Discounts		
<i>Federal Discount Program</i>	<i>Description</i>	<i>Who Benefits in Connecticut</i>
Medicaid Rebate Program	Drug manufacturers are required to pay state Medicaid agencies a quarterly rebate on brand name drugs and generic drugs based on federally defined formulae.	DSS receives rebates for all Medicaid fee-for-service programs. The state also requires rebates for ConnPACE, the State Administered General Assistance program, and the Connecticut AIDS Drug Assistance Program.
Federal Supply Schedule (FSS)	FSS is a schedule of contracts and prices for frequently-used supplies and services available for purchase by federal agencies.	Drugs for the Veterans’ Home and Hospital are purchased under federal contracts for veterans’ hospitals. No rebates are received because FSS rates are below those for Medicaid.
340B Price	Under the Public Health Service Act, federally qualified health centers (FQHCs) qualify for special price discounts. The amount of the discount is based on the Medicaid rebate formula, although covered entities may negotiate even lower prices.	There are only 13 FQHCs in Connecticut. They can access 340B pricing <i>only</i> for patients served by the centers. The state reimburses FQHCs for pharmaceuticals provided to patients enrolled in state programs. Drug manufacturers do not provide rebates for drugs purchased through a 340B pricing system.
Source of Data: Public Health Institute, <i>Pharmaceutical Discounts Under Federal Law: State Program Opportunities</i> (May 2001).		

How the State Obtains Prescription Drugs

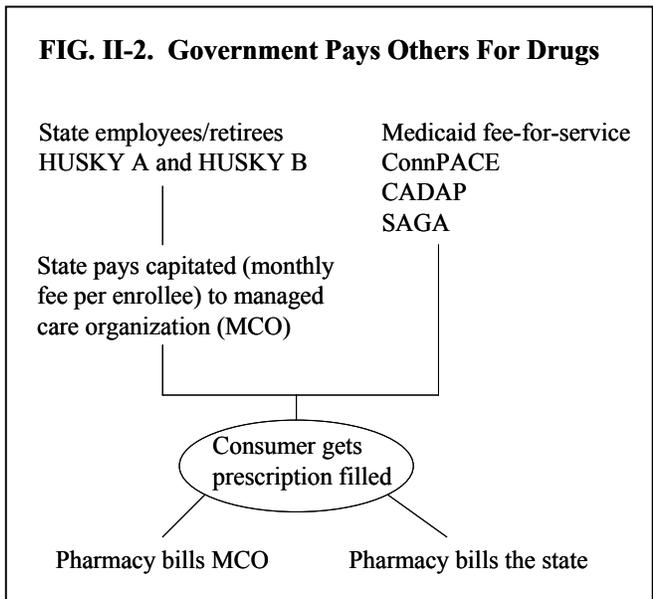
Prescriptions may be filled by community pharmacies, obtained through mail order companies, or prepared on-site at state facilities. The method used to pay for the drugs also varies. Figures II-2 and II-3 outline the key steps when the state pays other parties for drugs dispensed at pharmacies and when it buys drugs directly. Additional information about each approach is presented below.

Reimbursement model. When covered participants have their prescriptions filled by a community or mail-order pharmacy, the pharmacy is responsible for obtaining the drugs. After the prescription is filled, the pharmacist submits a claim for reimbursement.

As shown in Figure II-2, from the state’s perspective, there are two ways the pharmacy will get paid, and the method will depend on the state program in which the individual receiving the prescription is enrolled. State employees and retirees and HUSKY A and HUSKY B

programs operate under a *managed care model*. The state pays a capitated fee (i.e., a per-member-per month rate) to the managed care organization (MCO) to cover all health benefits for enrollees. When a claim is submitted, the MCO is responsible for payment, and no bill is sent to the state by either the pharmacy or the MCO.

Under all other major state programs that provide an out-patient pharmacy benefit, including drugs for aged, blind, and disabled Medicaid recipients, and ConnPACE, SAGA, and CADAP enrollees, the state is responsible for reimbursing pharmacies for prescriptions dispensed to cover enrollees. Under this model, commonly known as a *fee-for-service* (FFS) approach, the pharmacy determines eligibility for services, dispenses the prescription, and then bills the state for payment. The amount the state pays the pharmacy is set by the commissioner of DSS (within federal Medicaid parameters), based on a payment formula that takes into account the estimated acquisition cost of the drug and a dispensing fee.



Most outpatient pharmacy programs require the person getting the prescription filled to contribute toward the cost of the drugs at the time the prescription is picked up. This amount is referred to as the “co-pay.” State employees and retirees pay \$3 for generic prescriptions and \$6 for brand name drugs. A co-pay of \$1.50 is authorized for most social service recipients. However, participating pharmacies currently cannot refuse services to Medicaid recipients unwilling to contribute this payment. In such cases, the pharmacy must absorb that portion of the prescription cost. The co-pay for ConnPACE enrollees is \$16.25

The specific pharmacies a person can use to obtain prescription drugs paid for by the state depends on the program in which he or she is enrolled. However, the current networks of participating pharmacies in Connecticut for all of the programs are quite extensive.

Direct purchase model. Drugs purchased directly by the state may be:

- ordered, dispensed, and paid for by a specific state facility (e.g., Connecticut Valley Hospital); or
- ordered, prepared, and paid for by one state entity and then shipped to another state facility where they are given to the patient (e.g., the University of Connecticut Health Center for Department of Correction inmates).

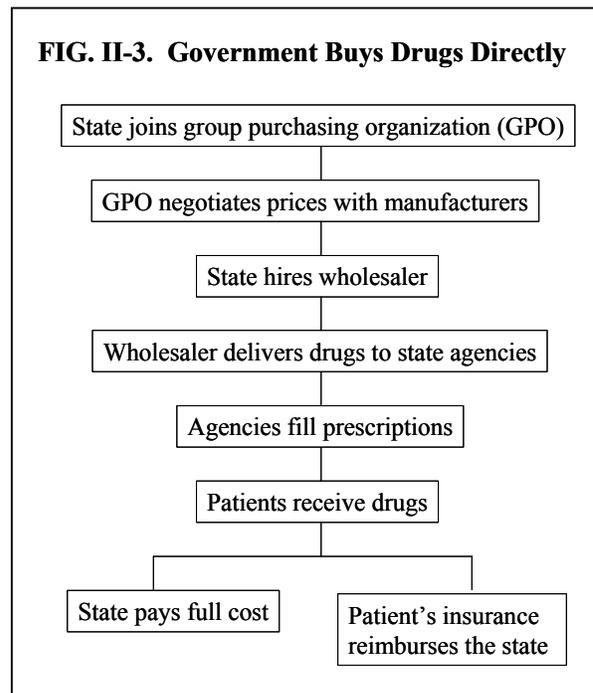
The state uses the same basic process to obtain pharmaceuticals that it uses to buy most other products. It seeks and reviews bids, selects one or more vendors, and signs a contract

specifying a price for the life of the contract. However, the process of purchasing prescription drugs varies with respect to how prices are set.

In the pharmaceutical marketplace, buyers (including the state of Connecticut) agree to a formula price that specifies any discounts or surcharges to be applied to the manufacturer's price at the time of purchase. In most cases, these adjustments are based on how quickly the buyer will pay for the drugs, but some types of buyers are eligible for discounts based on the quantity of drugs purchased.

As shown in Figure II-3, Connecticut like many public and private entities belongs to several group purchasing organizations. Group purchasing organizations combine the buying power of all enrollees in an effort to qualify for better drug prices.

Drugs to be dispensed on-site at state of Connecticut facilities are purchased from a variety of manufacturers using the services of a drug wholesaler under contract with the state. The wholesaler is paid for all drugs purchased within a set number of days before or after delivery, regardless of whether or not the drugs have been dispensed to any patients.



How Much the State Spends for Pharmaceuticals

The program review committee finds no central source of information exists regarding total state spending on prescription drugs. The committee developed a prescription drug expenditure profile for state FY 01, FY 02, and FY 03 by combining data provided by individual state agencies involved with state pharmaceutical programs, the Office of the State Comptroller, and an October 2002 report prepared by the state auditors.

State spending related to pharmaceuticals increased from approximately \$512 million in FY 01 to \$609 million in FY 02. By FY 03, expenditures totaled approximately \$719 million. Table II-2 presents state expenditures for prescription drugs for those three years by individual agency and program.

It is important to note the amounts for state employees and retirees and the HUSKY A and HUSKY B programs reflect claims paid on behalf of enrollees, rather than direct expenditures by the state. The state pays a per-member-per-month fee to managed care organizations to cover health benefits for these programs. As part of that fee, the MCO pays all eligible pharmacy claims. Paid pharmacy claims are included in the table as a proxy for the state expenditures, based on the assumption the pharmacy portion of the fee paid for health benefits generally is at least equal to total pharmacy claims.

<i>Agency</i>	<i>FY 01</i>	<i>FY 02</i>	<i>FY 03</i>	<i>% Change FY01-03</i>
Comptroller: State employees/retirees	\$123.6	\$151.0	\$171.0	38%
Department of Social Services ¹				
• Medicaid				
– HUSKY A	\$48.3	\$67.1	\$79.5	65%
– Fee for service	\$237.9	\$277.3	\$315.6	33%
• Husky B	not available	\$1.6	not available	-
• ConnPace	\$37.9	\$44.4	\$73.1	93%
• SAGA	\$19.3	\$19.2	\$24.1	25%
• CADAP	\$7.5	\$6.9	\$7.4	-1%
Department of Administrative Services:				
• State Workers' Compensation	\$0.9	\$0.9	\$1.3	44%
• DMHAS Inpatient	\$6.4	\$6.9	\$7.7	20%
• UCONN Infirmary	\$0.6	\$0.6	\$0.5	-17%
• DMR	\$0.5	\$0.4	\$0.5	0%
• Dept. of Children & Families	\$0.4	\$0.6	\$0.7	75%
UConn Health Center	\$8.5	\$7.3	\$25.4	24%
• DOC	\$12.0	\$14.7	combined	combined
Department of Public Health	\$7.0	\$8.5	\$7.9	13%
Department of Veterans' Affairs	\$0.9	\$1.1	\$1.2	33%
TOTAL	\$511.7	\$608.5	\$715.9	40%

¹DSS figures reflect drug manufacturer rebates received by the state for Medicaid fee-for-service, ConnPACE, SAGA, and CADAP.

Sources of Data: Legislative Office of Fiscal Analysis and governor's budgets, Office of Comptroller, DSS, DAS, and the state auditors.

The average cost per claim in FY 02 by program for the two state agencies with the highest pharmacy costs is shown in Table II-3. In DSS, the average cost per claim falls within the \$50 to \$52 range, except for HUSKY A and CADAP. Further exploration of the reasons for the lower cost per claim in the HUSKY A program is necessary, but could be attributed to factors including better prices negotiated by PBMs, more frequent use of generics, or lower cost drugs being purchased (such as inhalers for asthma). The high cost per claim for CADAP is most likely the result of the specialized drugs used to treat conditions associated with HIV and AIDS.

<i>Program</i>	<i>Total No. of Claims</i>	<i>Avg. Cost per Claim</i>
Comptroller: State employees/retirees health insurance	2,700,000 (est.)*	\$56 (est.)
Department of Social Services:		
• Medicaid Fee-for-service	5,421,444	\$51
• HUSKY A	1,728,851	\$39
• HUSKY B	n/a	n/a
• ConnPACE	874,486	\$51
• SAGA	374,508	\$51
• CADAP	36,057	\$192

* Data are from three health insurers. ConnectiCare covers July 2001 through June 2002, but the Anthem and Health Net information cover a reporting period of September 2001 through August 2002.

Sources of Data: Office of Comptroller and DSS.

Controlling Prescription Drug Costs

A major factor affecting state prescription drug expenditures is how the benefits of the various state programs are designed and managed. Eligibility criteria, the scope of services covered, cost-sharing requirements, utilization management strategies, and reimbursement formulae all impact program costs.

Cost Containment Strategies

A variety of options exist to reduce the volume and price of the pharmaceuticals purchased by the state. Table III-1 lists the major prescription drug cost containment strategies in place for each state program that buys directly or pays others for prescription drugs. The table also indicates whether an agency has been given statutory authority to implement a particular approach, but has not done so.

Connecticut state government is using a variety of approaches to curb drug spending. However, the program review committee finds the strategies listed in the table are not uniformly applied across all state agencies or even among different programs administered by the same agency. For example, while many health plans offered by private employers use PBMs to administer prescription drug costs and implement many of the other cost containment strategies shown in the table, only three programs provided by the state do so.

Managing utilization of drugs. Several strategies shown in Table III-1 focus on utilization management to control access to and the use of specific drugs. Many of these techniques are combined as a “package approach” to maximize savings. The major ones include:

- prior authorization - requires program recipients to receive approval from a program administrator before certain drugs will be dispensed. Such approval may be required for drugs that are costly, have a high potential for abuse, or when a physician specifies a generic drug cannot be substituted for a brand name drug.
- mandatory generic substitution - requires automatic dispensing of less expensive, chemically-equivalent generic drugs in place of brand name drugs, unless prescribed otherwise by a doctor.
- preferred drug lists (PDLs or formularies) - lists of prescription drugs considered the most effective and lowest cost for patient care. The lists are developed by health insurers and PBMs (usually through a pharmacy and therapeutics committee) and are subject to periodic review and modification by those entities. A “closed” formulary limits coverage to only the drugs on the list. An “open” formulary permits coverage for both formulary drugs (i.e., medications on the list) and non-formulary drugs (i.e., medications not on the list). However, program participants may have to pay a larger share of the cost of a non-formulary drug.

TABLE III-1. Common Cost Containment Strategies For Prescription Drug Programs

Strategy	Comptroller: State Employees/ Retirees	DSS: Medicaid fee-for- service, SAGA, ConnPace, and CADAP	DSS: HUSKY A and HUSKY B	DAS: Workers Comp	DAS: Purchasing for state agencies (e.g., DMHAS, DMR, and UConn-Storrs)	UConn Health Center for DOC Inmates	Dept. of Veterans' Affairs
Pharmacy Benefit Manager (PBM)	y	n	y	y	n/a	n/a	n/a
Utilization Management							
prior authorization	y	y ¹	y	n	n	y	y
mandatory generic substitution	y	y	y	n	n	y	y
preferred drug list (formulary)	y	y* ¹	y	n	n	y	y
drug utilization review	y	y	y	y	y	y	y
disease management	y	y*	y	n/a	n/a	n/a	n/a
Reducing Price							
co-pay	y	y ¹	y	n	n/a	y	n
rebates	n	y	n	n	y	y	n/a
mail order	y	y*	n	y	n/a	n/a	n/a
Key							
<i>y - yes</i>							
<i>y* - authority but not implemented</i>							
<i>n - no</i>							
<i>n/a - not applicable</i>							
¹ = does not apply to CADAP							
Source of Data: Program review committee staff analysis of agency provided data							

- drug utilization review - evaluates both patient use and physician behavior to examine whether the correct drug dosage was prescribed for a patient, the potential for adverse interactions with other drugs, and frequency of refills. Drug utilization reviews also screen physician prescribing patterns, look for submission of duplicate prescriptions by a patient, and pursue evidence of general fraud and abuse.
- disease management programs - target potential high users of services and monitor their medical care. These programs typically focus on beneficiaries with specific chronic conditions, such as hemophilia, diabetes, asthma, and congestive heart failure.

Reducing the price paid. Connecticut has also tried to directly control what it pays to purchase drugs. The approaches taken by the state to drive down drug costs include:

- increasing beneficiary co-pays;
- reducing dispensing fees paid to pharmacies;
- legislating the prescription payment rate by having the commissioner set the payment formula for DSS programs;
- obtaining rebates from pharmaceutical manufacturers;
- offering beneficiaries use of mail-order pharmacies; and
- implementing drug return programs in institutional settings so unused drugs can be repackaged rather than destroyed.

Another approach Connecticut is looking at involves a multi-state consortium. Connecticut is a member of the National Legislative Association on Prescription Drug Prices (NLAPDP), which is currently looking at pooling the purchasing power of nine states and the District of Columbia to obtain better prices from drug manufacturers.⁷ Another element of this effort is exploring the establishment of a nonprofit PBM to obtain lower drug prices and higher manufacturer rebates for participating members.

Other strategies not used in Connecticut programs. There are a number of other strategies used by private health insurers and other states that have not been adopted by any of Connecticut's programs. These include:

- imposing more stringent recipient cost-sharing by adopting:
 - multi-tiered co-pays so program recipients pay the lowest co-pay for generic drugs and the highest co-pay for non-formulary brand name drugs;
 - co-insurance requirements so beneficiaries pay a fixed percent of prescription drug costs; and
 - deductibles so consumers pay a specified amount annually before prescription drug coverage is activated.

⁷ The association includes representation from all of the New England states, as well as Hawaii, New York, Pennsylvania, and the District of Columbia.

- taking advantage of bulk purchasing opportunities, which combine drug purchases from multiple programs to obtain volume discounts and larger rebates; and
- adopting “fail first” or “step therapy” policies that require practitioners to demonstrate an older, less expensive drug within a certain therapeutic class has failed for an individual before a newer, more expensive medication is prescribed.

Appendix E describes several efforts undertaken in other states that are of interest in Connecticut. In particular, innovative approaches to contain prescription drug costs and expand access in the states of Florida, Maine, Michigan, New Hampshire, and Vermont are described.

Factors That Might Constrain Changing the System

The Office of the Attorney General, advocates of social service recipients, and industry representatives have expressed serious concerns about many of the cost containment strategies that involve utilization management. Specifically, these groups oppose prior authorization and preferred drug lists for drug-assistance type programs because they believe such tactics impede consumer access to the most appropriate medicines.

Several programs operated by the state also have restrictions that limit the state’s ability to contain prescription drug costs. An example of this concerns the use of co-pays, which determine the share of the cost of each prescription borne by the person receiving the drugs.

Federal and state laws govern the design and administration of the Medicaid program operated by DSS. Before the department can change certain program elements, such as increasing recipient co-pays or implementing a preferred drug list, DSS must file a plan amendment with the Centers for Medicare and Medicaid Services (CMS). Further, even when approval is granted and the state sets up a co-payment schedule, program participants cannot be denied prescriptions if they tell a pharmacist they are unable to make the co-payment.

Similarly, provisions of the health insurance programs for most state employees and retirees cannot be changed without agreement by the State Employees Bargaining Agent Coalition (SEBAC). The state’s “June 1997 Agreement 5” (as amended in July 1999) with SEBAC governs all components of the health insurance program through June 30, 2017. The agreement governing prescription benefits for state workers specifies plan participants can only be required to pay \$3 and \$6 for generic and brand name drugs respectively for the life of the agreement. Connecticut cannot change these amounts without approval from other parties.

Findings and Recommendations

In FY 03, the state spent about \$719 million on pharmaceuticals. The program review committee is proposing a variety of actions to reduce the cost of prescription drugs paid for by the state. Some involve the quantity of drugs purchased; others target the price paid. In general, the opportunities for savings presented in this chapter fall within three categories:

- greater scrutiny of specific drugs prescribed (e.g., add prior authorization, mandatory generic substitution, preferred drug lists, and drug utilization review requirements to more programs);
- enhanced monitoring (e.g., routinely confirm billed prices are correct and all available discounts and rebates are received); and
- increased bulk purchasing (e.g., consolidate more state purchases and expand the use of mail order).

The recommendations are aimed at containing state expenditures and improving management of drug purchasing activities by state agencies. The program review committee's proposals to modify the state's current system of providing prescription drug services are grouped separately for each major program area.

Department of Social Services Programs

The Department of Social Services operates six programs that provide a pharmacy benefit. In total, the department spent \$500 million on prescription drugs for its program recipients in FY 03 -- more money than any other state agency and a 20 percent increase over the previous year. In FY 02, there were about 476,000 eligible program recipients, although it is important to note not all clients actually access the pharmacy benefit.

Since the 2000 legislative sessions, the Connecticut General Assembly has enacted a wide array of mandates aimed at containing the spiraling cost of prescription drugs within the Department of Social Services. All of the mandates target prescription drug expenditures related to DSS programs reimbursed on a fee-for-service basis (Medicaid fee-for-service, ConnPACE, SAGA, and CADAP) versus those under a managed care reimbursement approach (HUSKY A and HUSKY B). See Appendix F for a detailed summary of the implementation status of the prescription drug cost containment legislation enacted by the legislature since 2000.

Although the November 2003 adoption of a Medicare prescription drug benefit by Congress will have a major impact on DSS programs, the program review committee believes the findings and recommendations contained in this report remain valid. Most importantly, many DSS program recipients will not be eligible for Medicare prescription drug benefits and will continue to rely on DSS to pay for their prescription drugs.

Preliminary estimates produced by the Legislative Office of Fiscal Analysis (OFA), using October 2003 data, indicate approximately 20 percent of the 393,000 current DSS Medicaid recipients would qualify for prescription drug coverage under Medicare. While the committee recognizes these recipients are some of the most costly in terms of drug utilization, DSS will still be responsible for prescription drug expenditures incurred by over 300,000 Medicaid clients, as well as paying for services for recipients of SAGA, HUSKY B, and CADAP. Thus, state prescription drug cost containment efforts are still needed.

Implementation Status of Legislative Mandates Enacted Since 2000

The program review committee finds the Department of Social Services has made significant progress, particularly in the last year, in implementing many of the pharmacy cost containment provisions mandated by the legislature. The committee recognizes DSS was required to implement a large number of legislative mandates, involving considerable staff resources and major programmatic changes. Some of the key mandates implemented by the department over the last year include:

- a prior authorization program;
- maximum allowable cost pricing for certain generic drugs;
- introduction and then an increase in the prescription drug co-payment for recipients of Medicaid fee-for-service and SAGA (from \$1.00 to \$1.50), and an increase in the co-pay for ConnPACE recipients (to \$16.25);
- an increase in the ConnPACE annual application fee from \$25 to \$30;
- reduction of pharmacy dispensing fees from \$4.10 to \$3.30; and
- introduction of 340B pricing at Federally Qualified Health Centers.

Overall, DSS estimates implementation of these and other cost containment initiatives (described in Appendix F) saved the state almost \$8 million in FY 03. The department projects savings will increase to \$23 million in FY 04 once the strategies have been operational for a full year. Introduction of MAC pricing for generic drugs has had the biggest cost impact, with 74 percent of the projected savings in FY 04 resulting from this initiative.

However, the committee finds a preferred drug list -- a key cost containment mandate and one that could generate significant savings -- has not been implemented. Before a preferred drug list can even be adopted, the governor must complete appointments to the legislatively created and federally required Pharmaceutical and Therapeutics Committee, and the committee must be convened.

The Connecticut General Assembly established an 11-member Pharmaceutical and Therapeutics Committee under P.A. 02-2, May 9 Special Session. The committee was charged with establishing a preferred drug list for DSS fee-for-service pharmacy programs. Subsequent legislation modified that requirement to make the Department of Social Services, in conjunction with the committee, responsible for adopting the list. On two occasions, the legislature directed the executive branch to convene the Pharmaceutical and Therapeutics Committee by a specific date, but both dates have passed without a meeting. The initial reason for the delay was the need

to have an operational prior authorization program. However, this occurred on July 17, 2003, and the committee is still not in place.

A preferred drug list specifies the prescription medications the state will cover without prior authorization (i.e., a determination that a drug not on the list is medically necessary). The PDL generally is reviewed quarterly for inclusion of new pharmaceutical products or changes in accepted clinical practice standards. Preferred drug lists have been used in state employee health plans and private commercial plans, as well as in Medicaid managed care, for several years. Thirty-three states have enacted legislation to establish preferred drug lists for their state Medicaid fee-for-service programs as a way to contain prescription drug costs.

Under the Medicaid program, the federal government allows the development of preferred drug lists, but certain restrictions apply:

- the formulary must be developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the governor of the state or the state's drug use review board; and
- the formulary must include the covered outpatient drugs of any manufacturer who has entered into and complies with a Medicaid rebate agreement. A covered outpatient drug may be excluded with respect to a specific disease or condition for an identified population only if, based on the drug's labeling, the excluded drug does not have a significant, clinically meaningful therapeutic advantage (in terms of safety, effectiveness, or clinical outcome) over other drugs included in the formulary, and there is a written explanation (available to the public) of the basis for the exclusion.

Federal statutes (i.e., the Omnibus Budget Reconciliation Act of 1990) require drug manufacturers to enter into national rebate agreements with the U.S. Department of Health and Human Services for states that receive federal funding for drugs dispensed to Medicaid patients. States establish PDLs for their Medicaid programs to obtain additional rebates from drug manufacturers above and beyond those required by federal law. Most states that operate a PDL receive supplemental rebates through negotiations with pharmaceutical manufacturers and wholesalers that want their products to be included on the PDL and available to Medicaid recipients without having to obtain prior authorization. States with PDLs have used their bargaining power to obtain supplemental rebates to reduce expenditures for prescription drugs. The larger the rebate negotiated by the state, the greater the savings to the state for the drugs it covers.

With almost 500,000 enrollees and expenditures of a half billion dollars annually for prescription drugs, DSS has significant bargaining power to obtain additional rebates by essentially guaranteeing manufacturers and wholesalers a large volume of sales. However, the department must have a preferred drug list in place to accomplish this. Therefore, the program review committee recommends:

The Department of Social Services shall convene the Pharmaceutical and Therapeutics Committee by January 1, 2004. If the committee has not met by that date, the authority to

appoint the Pharmaceutical and Therapeutics Committee shall be transferred to the Drug Utilization Review Board within the Department of Social Services. The department shall report monthly in writing to the committees of cognizance over human services and appropriations and the Program Review and Investigations Committee on the status of the Pharmaceutical and Therapeutics Committee. Such reports shall begin January 1, 2004, and continue until a preferred drug list is established.

Several states have already established comprehensive preferred drug lists. Michigan developed a list in less than a year, and it contains over 40 classes of drugs. Legislation in Connecticut, first enacted during the 2002 session and amended the following year, limits the preferred drug list to three classes of drugs for FY 04. While the committee believes this provides the Pharmacy and Therapeutics Committee with a starting point, a more comprehensive list is necessary for FY 05 if significant cost savings are to be generated. Therefore, the program review committee recommends:

The Department of Social Services, in conjunction with the Pharmaceutical and Therapeutics Committee, shall develop a comprehensive preferred drug list for FY 05.

The program review committee believes the state could have achieved significant cost savings in the DSS pharmacy programs if a preferred drug list had been in place and supplemental rebates negotiated. Expanding the preferred drug list to include more eligible drugs will significantly increase savings. Indeed, in anticipation of the PDL being established, the legislature budgeted \$12.5 million in savings for FY 04 based on the limited list being in place by November 2003.

Pharmacy Carve-Out

As described in Chapter Two, DSS pays for prescription drugs for its program recipients in two ways. First, the HUSKY A and HUSKY B programs follow a managed care model of reimbursement -- the department contracts with four managed care organizations that are responsible for providing all health benefits, including pharmacy benefits, to eligible recipients for a per-member-per-month fee. Three of the four MCOs contract with a pharmacy benefit manager to administer the pharmacy benefit portion of the program. Although DSS knows the total amount of the capitated rate the state pays each MCO, the portion of the rate allocated for pharmacy benefits is not known by DSS, nor is the amount of any rebates retained by the PBM for having a preferred drug list.

Pharmacy claims in the HUSKY A program grew from \$67.1 million in FY 02 to \$79.5 million in FY 03, an increase of 19 percent. Similar information on the HUSKY B program was not readily available. Since these programs operate under a managed care model, the department does not conduct day-to-day analysis of drug utilization and cost. Similar to state employees' health insurance, management of drug utilization and cost data are the responsibility of the MCO (and the PBM). Therefore, DSS is concerned with overall increases in the capitated rate, rather than the individual components.

Conversely, under the DSS pharmacy fee-for-service programs, pharmacies provide drugs to eligible clients, and DSS reimburses the pharmacy based on a specific formula. In FY

02, Connecticut received about \$89 million in drug manufacturer rebates for prescription drugs reimbursed under the fee-for-service approach. The department actively manages its fee-for-service pharmacy programs and is either directly responsible for performing functions similar to those performed by a PBM or oversees contractors who perform them. With the exception of negotiating supplemental rebates, the major components needed to manage the prescription drug benefit for all DSS program recipients are already operating (i.e., a claims reimbursement system, drug utilization review, and prior authorization processes).

In summary, the program review committee finds:

- The administration of the pharmacy benefit for HUSKY A and HUSKY B involves four separate managed care organizations and three separate PBMs, each with its own formulary.
- DSS has no input into the selection of the PBM for each plan.
- The federal government does not require, and the state does not receive, drug manufacturer rebates for drugs provided to Medicaid recipients who are under managed care plans.
- The PBMs do not disclose rebates or additional discounts they may receive from drug manufacturers, and these do not have to be passed through to DSS.
- The department could maximize its power to negotiate supplemental rebates from drug manufacturers by developing a uniform, expanded preferred drug list common to all programs under DSS.

Therefore, the program review committee recommends:

The Department of Social Services shall carve out pharmacy benefits from the HUSKY A and HUSKY B programs and consolidate the administration of all pharmacy benefit programs within the department.

C.G.S. Sec. 17b-274e shall be amended to require DSS, in conjunction with the Pharmaceutical and Therapeutics Committee, to develop a single preferred drug list common to all DSS pharmacy programs.

DSS shall contract with an organization having expertise in negotiating supplemental rebate agreements with drug manufacturers in order to obtain supplemental rebates on behalf of the state of Connecticut once the preferred drug list is established.

On July 1, 2003, administration of pharmacy benefits for state employees and retirees changed to a single PBM. According to staff in the Office of the Comptroller, a single company was chosen to reduce costs through volume purchasing. Although the state employees' pharmacy benefit is managed by a PBM, the Department of Social Services could manage its own programs, if it contracted with an organization experienced in negotiating supplemental rebates, since all of the other pharmacy management components are already in place.

Other Cost Saving Initiatives

Generic drug pricing. During the 2002 May Special Session, the legislature required the Department of Social Services to establish a maximum allowable cost for certain multi-source generic drugs dispensed under pharmacy programs reimbursed on a fee-for-service basis. MAC pricing is a cost containment strategy that promotes the purchase and use of the most cost-effective product when a drug is available from multiple sources. Chemically equivalent generic drugs are typically available from a variety of manufacturers or wholesalers at, in many cases, variable prices. MAC pricing establishes a ceiling price for selected generic drugs, thereby determining the maximum the department will reimburse a pharmacy.

The department uses the following criteria to determine which drugs are subject to state MAC pricing:

- must be a multi-source product (at least three suppliers of the generic product are available);
- cannot be on the Federal Upper Limit list; and
- must be in an oral dosage form (including tablets, capsules, and liquids).

Establishing MAC pricing lists encourages pharmacies to dispense the least costly generic available in order to maximize their own profits, while at the same time ensuring the state pays for the lowest cost generic available. The department has about 350 drugs on its MAC pricing list.

Some states, including Georgia, Maryland, and Oklahoma, have expanded their MAC lists to include up to 850 drugs. States that have considerably more drugs on their MAC lists do not have the three supplier limit found in Connecticut. Many require that only two suppliers offer similar products, which allows for more generic drugs to be subject to MAC pricing.

Implementation of MAC pricing in Connecticut began in January 2003. Reports provided by DSS projected cost savings of \$8 million for the first three quarters of the calendar year. The committee believes additional cost savings would result if Connecticut modified its MAC list criteria. Therefore, the committee recommends:

The Department of Social Services should amend its criteria for MAC pricing to require the availability of at least two, instead of three, suppliers of a generic product.

Nursing home drug return program. The nursing home drug return program began as a pilot program in January 1998. Public Act 00-2, May Special Session, expanded the program and required mandatory implementation. The program's objective is to reduce overall pharmacy expenditures by allowing the return of unused patient medications being dispensed in long-term care facilities, as well as to reduce waste.

Each long-term care facility is required to have procedures for the return of unused drug products to the pharmacy from which such drug products were purchased. The act requires the

pharmacy to reimburse DSS for the price of the drug less a restocking fee for drugs dispensed to a Medicaid resident but not used.⁸ The drugs must be:

- prescription drugs but not controlled substances;
- sealed in individually packaged units;
- returned to the pharmacy during the recommended shelf life of the product and determined to be of acceptable integrity by a licensed pharmacist;
- in single-dose sealed containers approved by the federal Food and Drug Administration (FDA), if they are oral or parenteral products;
- in units-of-use FDA-approved containers, if they are topical or inhalant drug products; and
- in multiple-dose sealed FDA-approved containers from which no doses have been withdrawn, if they are parenteral medications.

The act prohibits returning drugs originally dispensed in a bulk-dispensing container.

In 2002, the legislature enacted Public Act 02-1, which allows DSS to impose a \$30,000 penalty on any long-term care facility that fails to comply with the provisions of the nursing home drug return program. Based on DSS data, the committee finds:

- Since its inception, the drug return program has produced overall cost savings of \$1.4 million, with the greatest savings occurring in FY 03.
- Almost 28 percent (72 out of 260 nursing homes) have not returned any of the prescription drugs on the list and thus, are not in compliance with the law.
- To date, no penalties have been assessed against homes that have not complied with the law.

The department sent a letter to each of the homes in September 2003 reiterating the mandated legislation and asking them to outline the actions they have taken to comply with the statute. Responses were received from 62 facilities, and DSS is in the process of following up with homes that did not respond.

According to department staff, one reason certain nursing homes are not complying with the program is because the pharmacies from which they receive prescription drugs for residents do not package the drugs in a manner that would allow for their return. The committee believes the department may not have assessed any penalties because the amount of the fine is so high. In the opinion of the committee, the department may find a more realistic fine easier to impose. Therefore, the program review committee recommends:

C.G.S. Sec. 17b-363a shall be amended to require pharmacies providing prescription drugs to nursing home Medicaid clients to dispense prescription drugs covered by the nursing

⁸ Pharmacies that fill prescriptions for Medicaid residents in long-term care facilities receive the full DSS dispensing fee of \$3.30 per prescription because federal Medicaid law prohibits charging this population prescription co-pays. DSS only pays pharmacies in the community a \$1.80 dispensing fee for prescriptions dispensed to most Medicaid recipients because the remaining \$1.50 is in the form of a client co-pay.

home drug return program in appropriate packaging so any unused drugs can be returned.

C.G.S. Sec. 17b-363a(g) shall be amended so that the list of drugs to be returned will include, BUT NOT BE LIMITED TO, the 50 drugs with the highest average wholesale price that meet the requirements for the program.

C.G.S. Sec. 17b-363a(f) shall be amended to lower the fine for any long-term care facility that violates or fails to comply with the program to \$1,000 for each incidence of noncompliance.

ConnPACE pharmacy expenditures. The ConnPACE program is a state-funded program to assist in providing prescription drug benefits to Connecticut's senior and disabled citizens. It began as a pilot program in April 1986 and became permanent in 1987. The legislature made several changes to the ConnPACE program during the 2003 legislative sessions including:

- imposition of a \$100,000 asset test for unmarried ConnPACE recipients and \$125,000 limit for married recipients;
- adoption of an asset recovery requirement on the estates of ConnPACE recipients; and
- an increase in the ConnPACE co-pay to \$16.25.

Expenditures for ConnPACE grew from \$44.4 million in FY 02 to \$73 million in FY 03, an increase of 64 percent, although the number of individuals enrolled in the program grew only 12 percent. (Drug manufacturer rebates are reflected for both years.) Although program costs are escalating rapidly, the impact of the new Medicare prescription drug benefit just enacted by Congress will have major implications for the ConnPACE program. These changes, as well as those enacted by the Connecticut General Assembly in the 2003 session, need to be assessed before additional cost-saving mandates are imposed on the program.

However, the committee also believes that incentives to increase the use of generic drugs should be built into the ConnPACE program, similar to those existing in the private sector. Although the ConnPACE program already requires automatic substitution of a generic drug for a brand name drug, unless the practitioner obtains prior authorization, there is concern some patients may pressure their practitioner to write such a prescription. The committee believes a two-tiered co-pay should be adopted so the lower price the department pays for generic drugs is reflected in the amounts ConnPACE recipients pay. This would allow recipients to benefit from the lower cost of the drug and encourage the use of generics by this population.

The department also has the authority to implement a voluntary mail-order program for all of its pharmacy programs, but has not moved forward with putting any mail-order programs into effect. The committee believes this option may be a great convenience for persons with disabilities and the elderly, who may have limited access to community pharmacies. Although a mail-order program may not generate large cost savings, it would be beneficial for program recipients who are housebound.

Therefore, the program review committee recommends:

Under the ConnPACE program, the co-pay for generic drugs shall be \$10, and the co-pay for brand name drugs shall be \$16.25.

The Department of Social Services should implement a mail order option for the ConnPACE program.

Long-term care and improved drug utilization review. Prescription drugs are used to treat most chronic conditions, and the elderly take numerous medications -- particularly residents of nursing homes. Even though payments for prescription drugs in nursing homes constitute a significant portion of total Medicaid spending in Connecticut, DSS had to generate special reports to tabulate such expenses when program review requested that data.

State expenditures for prescription drugs in nursing homes totaled \$80.7 million in 2002, an increase of 14 percent over the previous year. This represents about 29 percent of all pharmacy expenditures for Medicaid fee-for-service recipients.

Federal law requires all states to have drug utilization review processes for outpatient drugs to ensure that prescriptions paid for under Medicaid are appropriate, medically necessary, and not likely to result in adverse medical outcomes. While the federal government cannot extend similar requirements to nursing home residents, states are permitted to do so. Most states, including Connecticut, include nursing homes in their DUR programs. *However, the program review committee finds DSS does not specifically analyze prescription drug use in nursing homes.* The committee believes analysis of utilization patterns and drug costs within individual nursing homes, as well as among all nursing homes, could produce useful information for the department. Examining these patterns separately, rather than as part of the overall Medicaid account, could be beneficial for the department in helping establish specific cost containment strategies for this very frail population. The program review committee recommends:

The Department of Social Services should analyze prescription drug costs and utilization for Medicaid long-term care residents independent of expenditures for prescription drugs dispensed to program recipients in the community. As part of that analysis, the department should compare drug utilization and cost trends among nursing homes, examine generic versus brand name drug use, and evaluate practitioners' prescribing patterns. Based on the analysis, by January 1, 2005, the department shall recommend ways to reduce prescription drug costs in nursing homes to the legislative committees of cognizance for human services and appropriations.

The 340B drug pricing program. Section 340B of the federal Public Health Service Act requires drug manufacturers to enter into agreements with the Department of Health and Human Services to provide outpatient drugs to covered entities at discounted prices. Federally Qualified Health Centers are specifically included under the federal law as entities eligible to purchase drugs at discounted prices. Generally, these prices are at least as low as the prices paid by state Medicaid agencies. In order to receive the discounted pricing, an FQHC must adhere to certain requirements. It must be the purchaser and owner of the covered drugs, and the drugs can only be dispensed to patients of the health center.

Most FQHCs with their own licensed, in-house pharmacies purchase drugs at these discounted prices. Other FQHCs that do not operate in-house pharmacies purchase drugs at these prices through contractual agreements, which they developed with retail pharmacies that meet certain federal "contracted pharmacy guidelines."

The Hill Health Center in New Haven, a Federally Qualified Health Center, recently re-started its pharmacy and is receiving 340B pricing for its patients. The Department of Social Services reimburses Hill Health for patients in DSS programs. Instead of a dispensing fee, the department pays an \$8 administrative fee plus the 340B price for the drug. Because this is a new initiative, the program review committee believes DSS should continue to evaluate drug prices under this program and compare them to prescription drug reimbursements provided under its other programs. The department should calculate cost savings before it expands the program to other geographic areas. Therefore, the program review committee recommends:

DSS should evaluate the results of the 340B pricing program and compare it to the reimbursement provided under its other pharmacy programs to determine if it should be extended to other geographic areas of the state.

Health Insurance for State Employees and Retirees

Approximately 136,000 individuals are covered by the state of Connecticut's health insurance program for state employees, retirees, and dependents. In FY 03, prescription drug claims paid on behalf of enrollees totaled \$171 million.

The state operates the health insurance program using a managed care model with the state paying a capitated fee to an insurance carrier for each enrollee. Program participants select their coverage from a variety of health plans offered by three different carriers. Since July 1, 2003, a single pharmacy benefit manager -- Anthem Prescription Management, a subsidiary of Anthem, Inc. -- has been responsible for prescription drug coverage for all enrollees. A specified portion of the monthly capitated fee is earmarked for pharmacy services, and all of that money is paid to Anthem, Inc.

Although the single PBM model had been in use since July 1, 2003, the program review committee found the contract covering the services of the pharmacy benefit manager still had not been signed as of December 2003, nor had a date been scheduled for it to be signed.

The request for proposals (RFP) issued in November 2002 to select the PBM listed performance measures the state wanted the successful bidder to perform. For example, generic substitution was to occur at least 35 percent of the time, mail order service had to be 99.9 percent accurate with a turnaround of two business days, and savings of 3 to 5 percent were to result from drug utilization review efforts. Periodic reports on claims activity and savings were also specified. Staff in the Office of the Comptroller indicated achieving objectives listed in the RFP will be pursued in the future, but compliance is not currently mandated.

The program review committee is concerned performance measures were not clearly established before commencement of the new contract period. Furthermore, health insurers already achieved several of the performance measures listed in the RFP. For example, 38

percent of all prescriptions dispensed in FY 02 were for generic drugs, a rate higher than the goal in the RFP. Given that the generic dispensing rate that year for all DSS programs (except ConnPACE) was almost 45 percent (before mandatory generic substitution and prior authorization requirements were in place), the measure in the RFP seems inadequate.

Although all of the state employee health plans have prior authorization programs, preferred drug lists, and drug utilization review processes, there is little independent analysis by the comptroller's office of drug utilization patterns or drug costs. For example, during FY 02, the three insurers paid different prices (even within their own plans) for some of the same drugs. When asked to explain such variations, the comptroller's staff said managing drug costs and utilization were the responsibility of the PBM. The committee believes it is important for the state to be aware of plan elements, such as the prices a PBM negotiates, because the state ultimately pays the bill for any lost savings in the form of higher monthly fees.

Since the contract covering the services of the PBM has not been signed, the program review committee recommends:

The contract between the state of Connecticut and Anthem Inc. for pharmacy benefit management services should incorporate pharmacy-related performance objectives with valid, quantifiable goals and require submission of periodic reports analyzing prescription drug usage by enrollees and the results of individual cost-saving measures.

Another problem with the current pharmacy benefit system is the lack of incentives for enrollees to use mail order, switch to generic drugs, or continue using the same drug when it becomes available over-the-counter rather than by prescription. Under the two-tier co-pay system in effect until 2017, enrollees pay \$3 for a generic drug and \$6 for a brand name drug. Private employers, other states, and even the Connecticut Teachers' Retirement System require more stringent cost-sharing. The most commonly used strategies are:

- three-tiered co-pays so program recipients pay the lowest amount for generic drugs, a somewhat higher fee for brand name drugs for which no generic is available, and the highest fee for non-formulary drugs (e.g., brand name drugs for which a less costly alternative is available);
- co-insurance requirements where beneficiaries pay a fixed portion of the cost of a drug (e.g., 10 percent for generic and 25 percent for brand name); and
- deductibles that must be paid each year before any prescription drug coverage begins (e.g., the enrollee pays the first \$250 - \$1,000 in prescription costs).

The Kaiser Family Foundation's 2003 Employer Health Benefits Survey found co-pays nationally averaged \$9 for generic drugs, \$19 for brand name drugs, and \$29 for non-preferred drugs.⁹ In addition, two-thirds of the survey respondents used three-tier systems.

⁹ Kaiser Family Foundation/Health Research and Educational Trust *2003 Annual Employer Health Benefits Survey*, Section 9: Prescription Drug and Mental Health Benefits, November 2003.

Government workers in other states also have much higher co-pays than Connecticut state employees. In Arkansas, employee co-pays under the three-tier system are \$10, \$25, and \$50, while in Idaho, the rates are \$12, \$18, and \$40.¹⁰

In light of these trends, it is not unreasonable for the state of Connecticut to require beneficiaries to pay a larger share of the cost of prescription drugs. Unfortunately, the state is limited in its ability to change the agreement governing health insurance. When contract negotiations do occur in the future, the state should discuss changing the pharmacy benefit. The program review committee recommends:

the state should renegotiate the SEBAC agreement governing prescription drug benefits for state employees and retirees to:

- increase prescription drug co-pay rates;
- establish a three-tier system of co-payment; and
- include an inflation adjustment for any long-term co-pay rates.

Direct Purchase of Pharmaceuticals

The state spent \$44 million in FY 03 on the direct purchase of prescription drugs. These pharmaceuticals are dispensed within state facilities (e.g., hospitals and prisons) and through public health programs (e.g., vaccination clinics). *The program review committee finds no single agency is responsible for buying these pharmaceuticals, monitoring wholesaler compliance with state contracts, or aggregating information about the state's purchases of drugs.*

The Department of Administrative Services, in its role as the state's general purchasing agency, negotiates and signs many of the contracts used to buy pharmaceuticals. However, once DAS negotiates and signs the contract, its involvement with prescription drug purchases is limited. The state facility needing drugs deals directly with the authorized wholesaler to order items, and that facility also pays the bill.

The largest users of DAS pharmaceutical contracts are the Department of Public Health and the Department of Mental Health and Addiction Services. In FY 03, DPH made approximately 18 percent of the state's direct purchases, primarily for vaccines. The combined purchases of eight DMHAS locations represented 17 percent of the total.

The University of Connecticut Health Center makes its own arrangements to purchase pharmaceuticals. In FY 03, UCHC spent \$25 million on the direct purchase of drugs, or 57 percent of the state's total. UCHC is a member of a university hospital consortium eligible to buy drugs at prices below those obtained by the group purchasing organization to which DAS belongs. UCHC buys drugs for patients of John Dempsey Hospital and Department of Correction inmates (under a memorandum of understanding between UCHC and DOC). Slightly more than half of the health center's pharmaceutical expenditures are for DOC inmates.

¹⁰ www.accessarkansas.org/dfa/ebd and State of Idaho - Module 1 FY 2003 Policy

Contract Management

Contract management involves ongoing monitoring of vendor compliance with contract provisions, including verification that goods and services are billed at the correct prices. *The program review committee finds the state agencies involved in the purchase of prescription drugs have a limited understanding of how the pricing system for pharmaceuticals works and do not independently confirm the state is being billed correctly for the drugs it buys.*

Prices. Unlike most commodities that the state buys at fixed prices, prescription drugs are based on negotiated formulae that vary across programs and over time. Prices are often discounted based on a matrix that weighs the quantity of drugs purchased and the speed of payment. As a result, the purchasing process for pharmaceuticals is more complex and requires greater scrutiny to confirm products were supplied in accordance with the terms of the contract.

In October 2002, a state auditors' performance audit of statewide pharmaceutical purchasing raised concerns about the possibility the state was paying more for prescription drugs than appropriate. The report found agencies were satisfied the prices charged were accurate "based on inquiries with the consortiums and wholesaler price lists they receive."¹¹ The auditors recommended agencies establish policies to verify prices independently, and DAS agreed with the need to address the issue.

However, as of the fall of 2003, DAS was still relying on the group purchasing organization it belongs to (and the wholesaler it buys from) for confirmation the state has been receiving the prices that its contracts call for. In addition, DAS assumes the agencies buying the drugs are checking the accuracy of prices and paying within the time frame required to receive discounts.

The program review committee found there was no written documentation of the discount the state was receiving in 2003 under the primary pharmaceutical contract negotiated by DAS. The contract¹² had been amended nine times since November 2000 to change suppliers and available products as well as extend its duration. A June 2002 addendum listed 10 state entities and the discounts they were eligible for based on timeliness of payment. (Rates ranged from 0.29 percent to 0.88 percent, with one entity subject to a surcharge of 0.49 percent for an extended payment period.)

In June 2003, DAS told program review staff the state actually had been receiving a single discount of 0.24 percent, but the rate had just increased to 1.47 percent. As of mid-December 2003, no contract addendum describing the new discount had been filed.¹³

Rebates. A related component of drug pricing is the availability of financial rebates from manufacturers for certain drug purchases. The state should be eligible to receive some

¹¹ State of Connecticut Auditors of Public Accounts, *Performance Audit: Statewide Pharmaceutical Purchasing, Inventory, Delivery and Use* (October 23, 2002), pg. 24.

¹² Contract Award No. RFP001-A-12-0553-C (Core-CT No. 01PSX0189)

¹³ On December 29, 2003, DAS and Cardinal Health signed Supplement 10 to contract No. 01PSX0189, extending the length of the contract by five months and describing new pricing discounts. According to DAS, the discount rate in effect as of January 2004 is cost minus 1.25 percent.

rebates under the DAS pharmaceutical contracts. *The program review committee finds neither DAS nor the wholesaler who fills most of the orders for the state -- Cardinal Health -- is able to provide information about the amount of rebates the state has received in recent years, let alone what it may have been entitled to.*

An August 2003 e-mail from a representative of Cardinal Health said:

.... we are unable to identify which credits that have come from manufacturers through Cardinal are for Rebates. Manufacturers send us many credits on a daily basis and they do not identify exactly what the credit was for. In other words the manufacturer credit we pass through to your [the state of Connecticut] accounts may be for expired drug returns, rebates, or for other reasons.¹⁴

This situation continues despite a finding in the October 2002 state auditors' report that the rebates received by state agencies that purchased pharmaceuticals directly were "minimal" and procedures for recovery "haphazard." The report also noted: "There are no formal policies or procedures in place to ensure that rebates are appropriately recouped."¹⁵ It recommended policies and procedures be adopted to ensure rebates are recouped, and DAS concurred.

Payments. One factor affecting the price the state pays for prescription drugs is how quickly payments are made to the wholesaler. *The program review committee finds the late payment of bills by one facility within the Department of Mental Health and Addiction Services caused the wholesaler to threaten to end discounts for all state entities purchasing drugs under the primary DAS pharmaceutical contract.*

DMHAS indicated the delay was caused by insufficient funds in the account used to pay for drugs during a transition period when the state changed from a different system of accounts. Program review is concerned the department did not seem to understand how the actions of one facility could affect the state's overall expenses. It is vital agencies unable to pay their pharmaceutical bills on time bring the problem to the attention of OPM.

Proposed actions. To ensure Connecticut receives the prescription drugs it orders at contracted prices, all state agencies buying pharmaceuticals need to perform some basic oversight tasks. Specifically, the program review committee recommends:

On an ongoing basis, all state entities that purchase pharmaceuticals should verify the prices charged reflect the state's discount rate, monitor the availability and receipt of applicable rebates, and confirm the wholesaler has been paid by the required date. The commissioner of any agency with multiple facilities making prescription drug purchases should ensure all locations comply with these requirements and should investigate the possibility of coordinating purchases among two or more locations.

Annually, on or before October 15, each state agency that directly purchases pharmaceuticals shall report to OPM how much the agency spent on prescription drugs the previous fiscal year and the amount received back in rebates or credits from

¹⁴ August 26, 2003, e-mail correspondence from John Martins, Cardinal Health, to program review committee staff.

¹⁵ Connecticut Auditors of Public Accounts, pp. 17-19.

manufacturers, wholesalers, or any group purchasing organizations to which the state belongs. Agencies with multiple institutions purchasing drugs shall provide the information by individual location.

The program review committee believes it is important to have information about the state's drug purchases available to budget and policy makers. Having the data available at a single location -- the Office of Policy and Management -- will make it more accessible.

Cost Saving Opportunities

The amount of money the state spends on direct-purchase pharmaceuticals is determined in large part by the particular drugs prescribed for patients in state facilities. Implementing strategies that examine which drugs are used can help reduce costs. Some state institutions already require drug utilization reviews and prior authorization, but only a few have formal policies. The program review committee recommends:

All state agencies that provide pharmaceuticals directly to patients should develop written policies regarding generic drug substitution and prior authorization for use within individual facilities.

Psychotropic drugs and several other classes of medications are often excluded from substitution provisions because of concerns about the potential for adverse side effects if the drug a person has been taking successfully is replaced. In keeping with the requirements of C.G.S. Sec. 38a-476b, the availability of psychotropic drugs would not be affected by implementation of this recommendation. However, developing a uniform policy throughout an agency for other classes of drugs will ensure all patients receive equal treatment and that the most cost-effective drug is dispensed.

The program review committee also recommends:

All state agencies that provide pharmaceuticals directly to patients shall establish drug return programs for at least the top 50 drugs with the highest average wholesale price, with provisions comparable to the requirements specified in C.G.S. Sec. 18-81q for the existing drug return program used at correctional facilities.

Returning unused drugs to the wholesaler for credit is another potential cost-saving measure. While there are limitations on the scope of what can be returned, the value of such an effort is demonstrated by the experience of the UConn Health Center. The state auditors' October 2002 report described problems UCHC was experiencing as it began implementing a program to recycle drugs returned from DOC facilities. At that time, annual savings were estimated at \$200,000. In fact, the program saved \$588,000 in FY 03.

The program review committee further recommends:

All state agencies that provide pharmaceuticals directly to patients should evaluate the eligibility of all patients for federally supported assistance programs and identify opportunities to use beneficial pricing formulae (e.g., 340B) to obtain pharmaceuticals.

The state participates in a number of federally funded programs that help enrollees obtain prescription drugs. The potential exists that some patients in state institutions are eligible for enrollment, but not aware of it. To ensure the state takes full advantage of these opportunities, procedures should be in place to routinely screen patients for eligibility.

Finally, the program review committee recommends:

All state agencies that provide pharmaceuticals directly to patients should investigate the value of purchasing larger quantities (e.g., 100 capsules versus 50 capsules) of routinely dispensed drugs.

Like many other products, prescription drugs may be available in larger packages that are cheaper on a per unit basis. Agencies that routinely dispense high volumes of specific drugs should identify those that are available at a cheaper price when purchased in a large package and determine whether it would be cost-effective to purchase the larger packages.

Group purchasing organizations. The Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP) is a group purchasing organization created by the state of Minnesota. The goal is to give government-based healthcare facilities a combined purchasing power that enables them to receive the best prices for pharmaceuticals and related supplies. Entities from 40 states are members, but no Connecticut agencies belong. There is no fee to join, and expenses are incurred only if purchases are made. In addition, entities that buy more than \$7,500 a year are eligible for credits, which averaged 0.65 percent of annual purchases the past five years.¹⁶

Because DAS does not know how much the state receives in credits and rebates through the group purchasing organization it currently belongs to, the value of joining MMCAP is unclear. DAS did compare MMCAP prices with those paid by Connecticut Valley Hospital (CVH) between May and October 2002. Unfortunately, the analysis did not fully take into consideration discounts and rebates received by either MMCAP or Connecticut.

Of the 31 drugs examined, the list price for Connecticut was cheaper in 18 instances, while MMCAP had lower prices for 13 drugs. In some cases, the price CVH was actually charged was lower than the list price (apparently reflecting the contractual discount). When that price was used, MMCAP still had lower prices for the same 13 drugs, but the amount of the savings narrowed. The differences between Connecticut and MMCAP prices varied considerably, with some less than a dollar per package. However, in one case even the discounted Connecticut price was 56 percent higher than the MMCAP price, a difference worth nearly \$14,000 during the time period examined.

Since the state would not be required to use MMCAP exclusively to purchase drugs, if there is a potential for the state to save money by joining an additional group purchasing organization, the state should take advantage of the opportunity. The program review committee recommends:

On behalf of the state of Connecticut, the Department of Administrative Services should pursue membership in the Minnesota Multi-State Contracting Alliance for Pharmacy and

¹⁶ www.mmcap.org

other similar purchasing organizations to determine whether the state can obtain better prices for pharmaceuticals. The cost-benefit analysis should take into consideration timely payment discounts, volume rebates, and other credits.

Single Purchasing Authority

The October 2002 report from the state auditors discussed the potential for significant savings from consolidating pharmacy services into one facility and/or purchasing dispensed prescription drugs from local pharmacies.¹⁷ Since that time, representatives of DAS and UCHC have met several times to discuss how such an arrangement would work. A staff person from OPM was involved in the early discussions, but that person's departure from OPM ended the agency's presence at meetings. Representatives of DMHAS have also been involved.

The UConn Health Center is eligible for lower prices than DAS due to the teaching hospital attached to the center and the fact it pre-pays its drug purchases. As a result, most consolidation discussions focus on the feasibility of UCHC purchasing drugs for all state entities currently buying drugs under DAS contracts. Issues that need to be resolved include whether:

- UCHC can use its hospital discount rate to buy drugs for other state entities;
- money is available to pre-pay the additional drug purchases;
- UCHC will take physical possession of all the drugs ordered (and if so, whether it has space available to store the additional drugs); and
- the amount of money saved will be sufficient (after all staffing and transportation expenses are calculated) to make the change worthwhile.

Consolidating all state agency purchasing through a single source such as the UConn Health Center would result in a greater number of purchases by one entity. However, it does not guarantee larger discounts, more opportunities for rebates, or a more coherent purchasing strategy will occur. For example, unless there are similarities in many of the particular drugs each facility uses, the thresholds needed to get larger discounts or rebates on specific drugs will not be reached. In addition, the cost-saving strategies described earlier still need to be implemented.

Originally, the program review committee expected to propose consolidating all pharmaceutical purchases under one agency. Having a single entity in a position to examine trends, question expenditures, and determine if there are better ways of doing things makes sense. However, the committee is not convinced any of the state agencies involved in the purchase of prescription drugs is ready to take on this responsibility immediately. A major concern is the lack of comprehensive knowledge about how the drug purchasing marketplace operates and the effect that has on the state's ability to get the best prices.

The program review committee believes the agencies currently involved in the system first need to compile data regarding the scope and expenses of existing operations, analyze the state's requirements for specific prescription drugs, and examine other group purchasing

¹⁷ Connecticut Auditors of Public Accounts, pg. 13.

opportunities, such as MMCAP. When these tasks have been accomplished, the framework for a successful consolidation will be clearer.

Putting pressure on the time table for data collection and analysis is the fact several key pharmaceutical contracts will expire soon. The UCHC contract expires next spring, while the primary DAS contract expires May 2004, although the latter can be extended through December 2004. Therefore, the program review committee recommends:

The Department of Administrative Services and the UConn Health Center should continue meeting and develop a joint proposal for consolidation of the state's direct purchases of pharmaceuticals to occur on or before January 1, 2005. The proposal and a summary of the factors on which it is based should be submitted to OPM by March 31, 2004, for a review of the feasibility of the plan. At a minimum, the proposal should be based on:

- **an analysis of the range of prices the state currently pays for its most frequently used drugs;**
- **a projection of the costs and savings likely to result from consolidation;**
- **an understanding of how authority for comprehensive drug purchasing would be transferred from DAS to UCHC; and**
- **a review of alternative cost-saving strategies, including the feasibility of having additional small facilities obtain prescription drugs from local pharmacies rather than through direct purchase.**

Since OPM was involved in the initial discussions between DAS and UCHC, the program review committee believes it would be appropriate for OPM to review the consolidation proposal before implementation begins. The recommended time table is compressed to reflect the need for the state to take action before new contracts have to be signed.

Access

Despite all of the prescription drug programs described in this report, there are still people in Connecticut who have difficulty paying for the prescriptions they need. Some are workers who do not receive employer-sponsored health benefits, but earn too much money to qualify for state medical assistance programs. (About 10 percent of the state's population were uninsured in 2002.¹⁸) Others have limited prescription drug coverage or are dealing with a catastrophic illness and have considerable medication needs. Ironically, uninsured people also may pay higher prices for drugs since discounts negotiated by PBMs or governmental agencies would not apply to their purchases.

An important reason to increase consumer access to prescription drugs is to offset other health-related expenses. To the extent a drug makes it possible for someone to avoid surgery or the onset of another illness requiring more intensive medical intervention, the difference between the price of the prescription and the other procedure is a savings. Likewise, access to a needed prescription drug may make it possible for someone to hold a job or live independently, thereby enhancing the quality of the person's life.

Connecticut, like many other states, is searching for new ways to assist individuals with inadequate prescription drug benefits, particularly without adding to the dollars the state already spends on pharmaceuticals. Commonly used approaches include helping individuals access private assistance programs or requiring they be charged in accordance with the price schedules negotiated for one of the state's medical assistance programs.

Existing Programs

Most of Connecticut's efforts to expand prescription drug coverage have targeted the elderly. In 1986, Connecticut began operating the ConnPACE program, the prescription drug benefit program for seniors and persons with disabilities who meet certain income and asset guidelines. In FY 03, the program provided benefits to about 54,000 recipients and expended \$73 million. As noted earlier, it is unclear how the ConnPACE program will be modified to complement the new Medicare prescription drug benefit package.

Two separate state legislative efforts to expand drug coverage to the elderly and persons with disabilities in recent years involved expanding the ConnPACE program. Specifically, legislation enacted in 2000 and 2001 directed the Department of Social Services to:

- *submit a plan to establish a ConnPACE Part B for elderly and disabled people who do not qualify for regular ConnPACE, which would give a drug discount to certain seniors and disabled people who do not qualify for Medicaid or ConnPACE. It would not cover people who are not seniors or disabled. The plan has varying scenarios with income limits of 235 percent,*

¹⁸ U.S. Bureau of Labor Statistics and Bureau of the Census, *Table HI06. Health Insurance Coverage Status by State for All People: 2002* (revised September 11, 2003).

300 percent, or 400 percent of the federal poverty level. DSS submitted a plan to the appropriations, human services, and public health committees, but no action was taken on it.

- *seek a federal Medicaid waiver to obtain federal funds to cover seniors enrolled in the state-only ConnPACE subsidy program.* If federal approval is obtained, eligibility will be extended to 300 percent of the federal poverty level. Although DSS submitted the waiver to the Centers for Medicare and Medicaid, no action has been taken by CMS.

Legislation during the 2003 session focused on enhancing the availability of drug pricing information so that consumers could make informed and cost-effective choices. None of the proposed bills was adopted, but the two major proposals would have established:

- *an Affordable Prescription Drug Board within DSS.* The board would be responsible for distributing to the state's pharmacies a list of the range of drug prices for the 50 highest volume drugs sold under the ConnPACE program. The bill required DSS to post this information on its website and the commissioner to submit an annual report to the board and the General Assembly detailing state options for lowering drug prices in the state.
- *a Prescription Drug Consumer Information Board.* The board would be required to obtain the drug prices for 50 ConnPACE drugs with the highest sales volume and compare them to other prices including wholesale, Canadian wholesale, the federal supply schedule, in-state retail, and other governmental agencies. The board would distribute the information to all retail pharmacies, and DSS would post the information on its website.

Other states. According to the National Conference of State Legislatures (NCSL), at least 38 states have established or authorized some type of program to provide pharmaceutical assistance, primarily to low-income elderly or persons with disabilities who do not qualify for Medicaid.¹⁹ Most programs use state dollars to subsidize a portion of the cost, but others use discounts or bulk purchasing approaches. Given the scope of the recently adopted prescription drug benefit under Medicare, these states will also need to evaluate how the new law will impact their state pharmaceutical assistance programs. However, as of November 1, 2003:

- 35 states have legislatively created programs, while three are by executive branch action only;
- 29 state programs are operational;
- 30 states provide for a direct subsidy using state funds; and
- 20 states offer a discount only program, although a majority of those states also have a separate subsidy program.

Nongovernmental efforts. A number of privately sponsored prescription drug assistance programs open to Connecticut residents of all ages also exist. Retail pharmacy chains,

¹⁹ www.ncsl.org/programs/health/drugaid.htm

consumer groups, and drug manufacturers offer discount cards. Enrollees usually pay a monthly fee in return for a percentage off their prescriptions (and in many cases, other health-related products and services as well). Some of these programs do have minimum age requirements.

Most pharmaceutical manufacturers also operate programs that provide free or low cost drugs.²⁰ Each manufacturer establishes its own rules, but typically these programs serve patients who meet specific qualifications related to income and type of illness.

In the past, most manufacturers required a person's physician to submit the request for pharmaceuticals and documentation of income eligibility. The drugs were sent to the doctor's office or the person's home, depending on the manufacturer. If an individual needed drugs made by more than one company or received prescriptions from multiple doctors, separate applications were submitted.

Now efforts are being made to streamline the application process and reduce the paperwork for doctors' offices. Several organizations offer services that allow use of one application to request all of the pharmaceuticals for which a person might be eligible.

The Pharmaceutical Research and Manufacturers of America (PhRMA), which represents 48 research-based pharmaceutical and biotechnology companies, has an interactive program on its web site that provides comprehensive information about programs sponsored by all of its members.²¹ PhRMA also is looking at the possibility of making software available to states to help expedite applications from needy patients.

The Robert Wood Johnson Foundation offers a web based program to help physicians and other health care providers find information about patient assistance programs. The database can be searched by drug company, by the brand or generic name of a drug, or by drug class.²²

Private consultants are also getting involved in this area, offering to help government agencies enroll individuals who may be eligible for manufacturers' programs. The person seeking assistance fills out an application, and the consultant matches the person with the appropriate programs. The consultant typically charges the government an initial set-up fee per enrollee plus a monthly charge per prescription. These efforts generally focus on identifying individuals who can be moved off government prescription drug assistance programs because any difference between what the state spent before and the cost for the consultant would represent a savings to the state.

Helping individuals obtain pharmacy benefits, particularly from a non-government source, assists the patients and reduces expenses for the state. Although the DSS website already offers a link to a group that helps people enroll in privately funded programs for a one-time \$5 fee per prescription, additional efforts to expand awareness of these opportunities should be pursued.

²⁰ Manufacturers have provided free drugs through physicians' offices since the 1950s. Manufacturers that currently operate such programs are eligible for federal tax credits.

²¹ www.helpingpatients.org

²² www.rxassist.org

The program review committee recommends:

The Department of Social Services should publicize private, low- and no-cost prescription drug assistance programs more widely. In particular, any person who applies to a state medical assistance program and is deemed ineligible should be provided with information about opportunities to obtain prescription drugs directly from manufacturers.

Drug Importation

The number of U.S. residents buying prescription drugs outside the country is growing. A September 2003 poll found 7 percent of adults surveyed nationally said they bought prescription drugs from another country, up from 5 percent of respondents in November 2002.²³ Canada and Mexico are the two most common sources, but drugs purchased through the internet may come from countries all over the world.

A recent memo prepared by the Connecticut Office of Legislative Research (OLR) summarized the legal issues related to importation of prescription drugs into the United States.²⁴ The memo noted federal law strictly limits the types of drugs that can be imported into the United States in an effort to ensure the U.S. drug supply is safe and effective. The U.S. Food and Drug Administration, concerned about safety risks associated with drug importation, has warned it cannot assure the public that drugs delivered from a foreign country are the same product approved for sale in the U.S. The FDA also indicated states that plan to import prescription drugs are responsible for ensuring that only FDA-approved drugs meeting all regulatory standards and labeling requirements are imported. It added that the ability of a state to do this is extremely unlikely, which would mean a state importation program would violate the law. The FDA expressed the belief that state laws legalizing importation are preempted by federal law.

Despite this stance, local and state governments continue turning to Canada to cut their drug costs. Nearby, Springfield, Massachusetts recently started obtaining some prescription drugs for employees through a Canadian mail order company. Minnesota is planning a website to help state residents contact Canadian pharmacies that meet state quality standards. Meanwhile the governor of Illinois recently released a study that looked at the feasibility of obtaining prescription drugs from Canadian pharmacies for state employees and retirees.²⁵ The report found the state employee drug plan would save money by obtaining drugs from Canada. To minimize the impact on pharmacies in Illinois that would lose business, the report suggested using a model that pays pharmacists to manage the drug therapies of plan participants.

U.S. drug manufacturers are also taking action, but in a different direction. Several have notified Canadian wholesalers, distributors, and pharmacists that shipments will be stopped unless they agree not to export the products to the U.S. or sell them to pharmacies that do so.

²³ Wall Street Journal Online/Harris Interactive Health-Care Poll, on-line poll conducted September 16-18, 2003, with results published October 9, 2003.

²⁴ OLR Research Report 2003-R-0713, *Prescription Drug Importation*, (October 7, 2003).

²⁵ Illinois Department of Central Management Services, *Report on Feasibility of Employees and Retirees Safely and Effectively Purchasing Prescription Drugs From Canadian Pharmacies*, October 27, 2003.

A key reason the prices of drugs sold in Canada are lower is that they are controlled by the government. Depending on whether a drug is new to the market or has been available for some time, the price will be based on competing products, the median of prices charged in seven European countries, or adjusted for inflation. The manufacturer sets the initial price of a drug, but a government review board checks prices twice a year to be sure they conform with the requirements of the law.²⁶

While prices are lower in Canada for many popular drugs, the full range of drugs available in the U.S. is not available in Canada. Furthermore, prices are not lower for all drugs, especially generics. This has been attributed to the fact generic drug makers are less likely to enter markets that restrict the prices of brand name drugs because the narrower price difference between the two products makes the generic less attractive to consumers.²⁷

New Medicare Legislation

Until recently, Medicare provided extremely limited outpatient prescription drug benefits, primarily for injectable drugs administered by licensed medical practitioners and certain cancer drugs. The new Medicare legislation passed by Congress at the end of November adds comprehensive prescription drug benefits to the program. Effective April 2004, Medicare recipients will be eligible for discount cards, estimated to save recipients 15 to 25 percent per prescription.

Beginning in 2006, the new law covers recipients who pay a monthly premium, meet an annual deductible, and pay a co-pay per prescription. The amount Medicare will pay depends on a person's annual drug expenditures and income level. As mentioned earlier, approximately 84,000 people in Connecticut who currently receive prescription drug benefits through Medicaid will be eligible for the Medicare prescription drug program. Analysis of the details of the voluminous Medicare bill and the effect of the program changes on Connecticut residents and state expenses will be continuing.

²⁶ Patricia Barry, "Why Drugs Cost Less Up North," AARP Bulletin (June 2003), p.8.

²⁷ Ira Carnahan, "The Cheap Drugs Myth," *Forbes* (February 3, 2003).

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Pharmaceutical Programs Administered by the Department of Social Services

The Department of Social Services administers several programs that provide a pharmacy benefit and spends more than any other state agency on prescription drugs. The programs are intended to serve low-income children and adults, aged, blind, and disabled persons living in the community, and long-term care residents who meet certain income eligibility guidelines.

Table A-1 lists all of the DSS programs that provide a pharmacy benefit. For each, the table shows total program expenditures, the amount expended for pharmacy services, and average monthly enrollment during FY 02. It should be noted the state receives 50 percent federal reimbursement for Medicaid and 65 percent for SCHIP, while most of CADAP is funded through a federal grant. Furthermore, for three of the programs -- Medicaid, SAGA, and Husky B -- pharmacy services are provided as part of a larger health care package.

Table A-1. DSS Programs with a Pharmacy Benefit, FY 02			
<i>Program</i>	<i>Total Expenditures (millions)</i>	<i>Pharmacy Expenditures (millions)</i>	<i>Average Monthly Enrollment</i>
Medicaid			
• Managed Care (HUSKY A)	\$429.7	\$67.1	262,956
• Fee-for-Service	\$2,117.4	\$277.3	124,533
ConnPACE	\$44.4	\$44.4	48,138*
SAGA	\$88.7	\$19.2	29,752
CADAP	\$6.9	\$6.9	1,524
HUSKY B (part of SCHIP)	\$17.7	\$1.6	10,503
Total	\$2,704.8	\$416.5	
*Enrollment as of June 30, 2002			
Drug manufacturer's rebates are reflected in totals.			
Sources of Data: Office of Fiscal Analysis and governor's budgets, OFA spreadsheets, and DSS reports			

DSS Administration of Pharmacy Benefits

Although each DSS program targets a different population with different eligibility criteria, the department administers these programs in one of two ways:

- HUSKY A and HUSKY B operate similar to private managed care plans. DSS contracts with managed care organizations on a prepaid, capitated risk basis to provide a comprehensive set of services to enrollees, including pharmacy services. The HUSKY A program operates under a Medicaid

waiver that allows services to be more restrictive than under the regular Medicaid program. The MCOs have implemented a variety of cost containment strategies, including formularies, prior authorization, and drug utilization review programs.

- Medicaid fee-for-service, ConnPACE, SAGA, and CADAP recipients receive services on a fee-for-service basis. This type of payment system operates as a vendor payment program. Pharmacies bill the department for pharmaceutical services provided to recipients and are reimbursed based on a payment formula approved by the DSS commissioner. The department contracts with a private company to pay claims. Another contractor is responsible for conducting drug utilization reviews and operating the newly implemented prior authorization program.

A brief description of each program within DSS is provided below, along with pharmaceutical expenditures, caseload, and utilization data.

HUSKY A and HUSKY B

The HUSKY A program serves poor, non-disabled adults and children; HUSKY B serves only low-income children. For both programs enrollment in managed care type health plans is mandatory. Connecticut contracts with four MCOs to administer health benefits under the HUSKY A program, while three participate in the HUSKY B program. In turn, each MCO subcontracts with a pharmacy benefit manager to oversee the pharmacy benefit. Because DSS does not pay expenditures under these programs, claims paid by the MCO are presented below rather than DSS expenditure data.

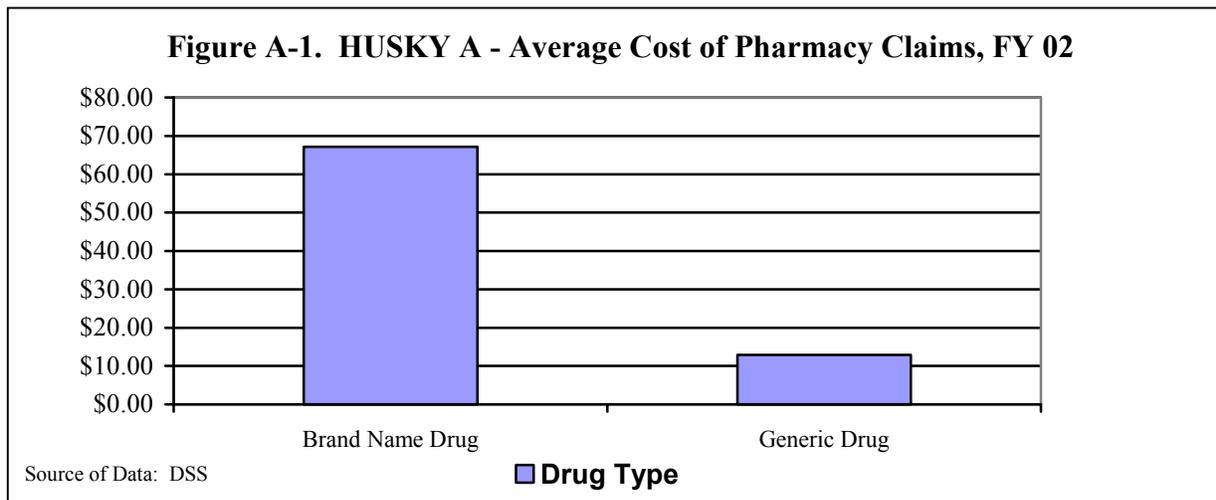
Program statistics. In FY 02, average monthly enrollment in HUSKY A was 262,956 and in HUSKY B was 10,503. Pharmacy claims comprised about 16 percent of total claims for HUSKY A and about 8 percent for HUSKY B.

Since HUSKY A comprises the bulk of program costs, the following analysis describes that program. Based on program data for FY 01 and FY 02, the committee found:

- paid pharmacy claims increased 39 percent (from \$48.3 million to \$67.1 million), while total health care claims increased only 24 percent;
- the number of distinct enrollees increased 12 percent (from 302,883 to 337,883);
- the number of clients that used the pharmacy benefit increased 17 percent (from 54,780 to 63,924 recipients);
- the actual number of claims paid grew 19 percent (from 1,456,273 to 1,726,566); and
- the average cost of a claim grew from \$33.17 to \$38.83, an increase of 17 percent.

The growth in the HUSKY A program can be attributed to several factors, including higher costs-per-prescription, higher utilization-per-recipient, and higher caseloads.

Use of generic drugs. A common strategy to contain pharmacy costs is to require mandatory substitution of generic drugs if such a drug is available and the doctor does not require a specific brand name drug be dispensed. Both HUSKY A and HUSKY B data show generic drugs account for only about half of the total number of claims processed. However, as Figure A-1 shows, the average cost for a brand name drug under HUSKY A is much higher (\$67.20 per claim) than the average cost of \$12.90 for a generic drug.



Medicaid Fee-for-Service, ConnPACE, SAGA, and CADAP

There are four other distinct prescription drug programs within DSS: 1) prescription drugs provided as part of the state’s medical assistance program (Medicaid) for aged, blind and disabled clients, including eligible recipients in long-term care facilities; 2) the Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program; 3) prescriptions provided to those receiving general assistance (i.e., SAGA)²⁸; and 4) the Connecticut Aids Drug Assistance Program that covers eligible recipients who are HIV-positive or have AIDS.

Reimbursement. As noted previously, pharmacy benefits under these programs are paid on a fee-for-service basis. Instead of a single capitated rate paid to MCOs as in Husky A and Husky B, DSS expenditures for outpatient prescription drugs include three components:

- drug estimated acquisition cost, which is typically expressed as average wholesale pricing minus a specified percentage for brand name drugs and generics not eligible for maximum allowable cost price lists;
- a pharmacy dispensing fee; and
- rebates from drug manufacturers that reduce the department’s gross expenditures. (Rebates are based on a formula that takes into account the purchase volume of brand name drugs.)

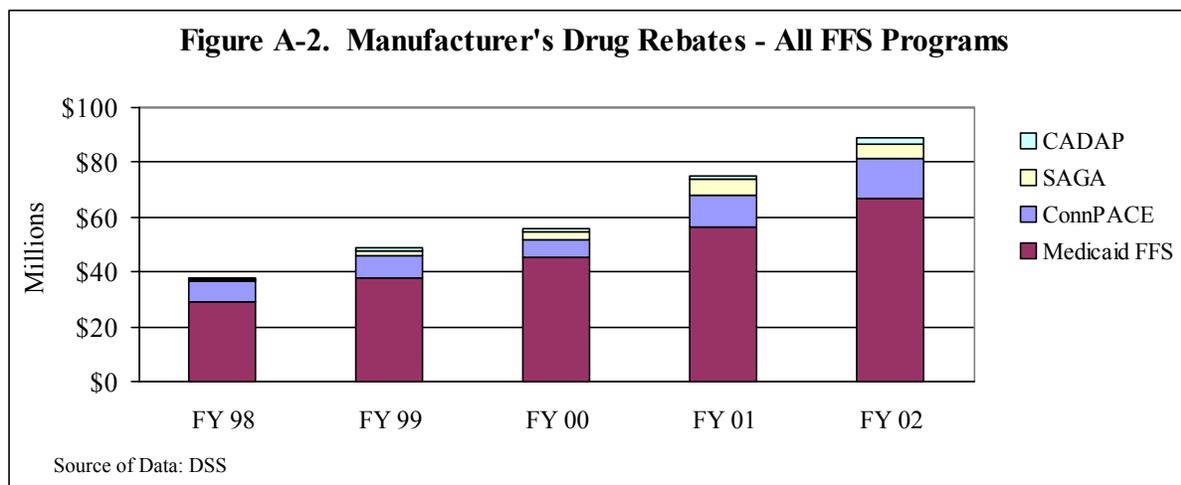
²⁸ Major changes to the SAGA program were enacted in P.A. 03-3. This program will no longer be reimbursed on a fee-for-service basis, but rather the state will pay federally qualified health centers a specific rate to provide care. FQHCs can access special low prescription drug prices under federal law.

Dispensing fees. Dispensing fees reimburse pharmacies a set fee for each prescription filled. The federal Centers for Medicare and Medicaid Services require dispensing fees to be “reasonable” but do not specify an amount. DSS pays \$3.30 per prescription, and the fee is the same for ConnPACE, SAGA, CADAP and Medicaid fee-for-service.

Drug rebates. The Medicaid Drug Rebate Program, enacted as part of the Omnibus Budget Reconciliation Act of 1990, requires drug manufacturers to sign a rebate agreement with the federal government in order to receive payment for outpatient prescription drugs provided to Medicaid fee-for-service beneficiaries. In exchange, states must provide coverage for all Food and Drug Administration approved prescription drug products manufactured by a company that has signed a drug rebate agreement. In Connecticut, as in many other states, rebate requirements have been extended to include state-funded pharmacy programs. Thus, drug manufacturers also provide supplemental rebates for ConnPACE, SAGA, and CADAP under the same rebate formula.²⁹

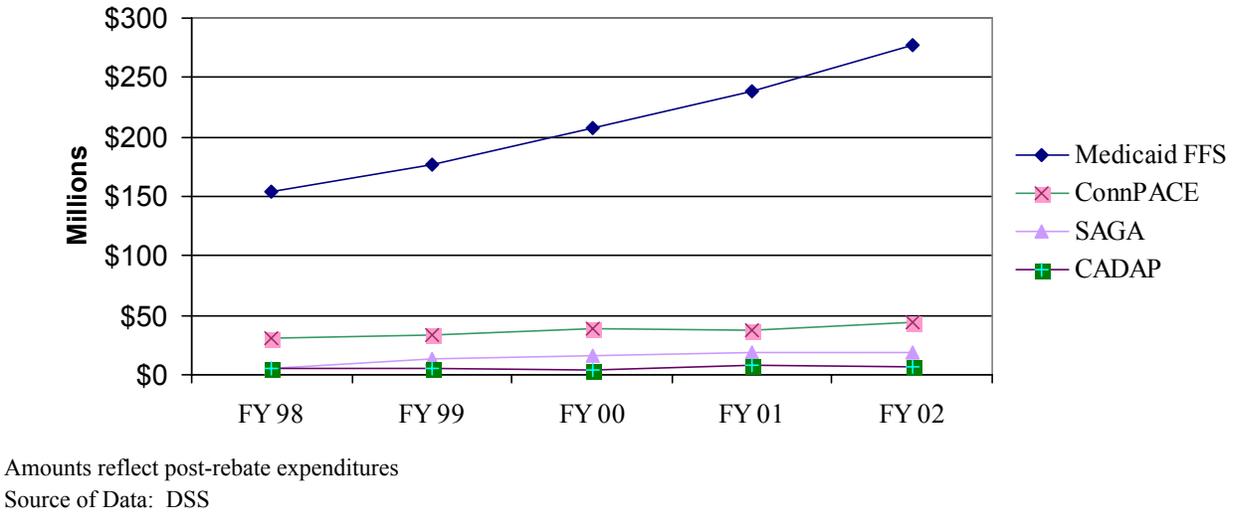
Figure A-2 shows the drug rebates received for each program over a five-year period. Rebates totaled \$38 million in FY 98 and grew to almost \$89 million by FY 02, an increase of 134 percent. The largest rebates were received for the Medicaid program (about 75 percent of total rebates received in FY 02).

Pharmacy expenditures. Figure A-3 shows prescription drug expenditures for the four programs paid for under a fee-for-service approach. Expenditures for Medicaid recipients comprise the vast majority of all pharmacy expenditures – increasing from \$154 million in FY 98 to \$277 million in FY 02. The cost of drugs for long-term care residents, currently about \$75 million, is included in the Medicaid FFS amounts. The nursing home population resides in a limited number of facilities, is heavily financed and regulated by the state, and is served by a small number of large wholesale-type pharmacies making frequent deliveries.



²⁹ Federal law does not require rebates for Medicaid programs under managed care type health plans.

**Figure A-3. Pharmacy Expenditures for FFS Programs
FY 98 - FY 02**



The use of generics versus brand name drugs under these programs varies. Overall, FY 02 data show about 70 percent of all claims under ConnPACE are for brand name drugs, accounting for about 86 percent of total program costs. The other programs had brand name claims of 56 to 57 percent.

Appendix B

Pharmacy Benefits Under the State Employee Health Insurance Program

The state of Connecticut offers its workers and retirees comprehensive health insurance that includes a prescription drug benefit. Program participants choose among a range of plans offered by three health insurers. Each type of plan provides similar core benefits, but the network of service providers, the level of direct access to those providers, and the share of the monthly cost of the plan paid by participants vary.

The plans all operate under a managed care model with the state paying a capitated fee (i.e., a specified amount per member per month). Almost 184,000 people (employees, retirees, and dependents) are enrolled under the state's health insurance program. Seventy percent are in plans offered by Anthem Blue Cross and Blue Shield, one-quarter are under Health Net, and the remainder are covered by ConnectiCare.

Effective July 1, 2003, the state separated out prescription drug coverage and selected Anthem Blue Cross and Blue Shield, which operates its own pharmacy benefit manager, to administer the pharmacy component of the health insurance program. Now, regardless of the plan or provider chosen by an enrollee for other health services, all members receive prescription drug benefits through Anthem Prescription Management.

Table B-1 summarizes enrollment by health insurer at the close of FY 03. The distribution of enrollees who are active employees versus retirees is important because older individuals are more likely to have greater health and prescription drug needs. Although enrollees switch their primary health care coverage to Medicare when they reach 65, prescription drug benefits have not been available under Medicare so enrollees continued to obtain pharmacy benefits through the state health insurance plan. Legislation adopted by Congress in November 2003 adds prescription drug coverage for Medicare recipients. However, although some discounts will be available to recipients in 2004, most benefits will not take effect until 2006.

TABLE B-1. Health Plan Enrollment By Insurer, June 30, 2003				
<i>Carrier</i>	<i>Active Employees</i>	<i>Non-Medicare Retirees</i>	<i>Medicare Retirees</i>	<i>Total</i>
Anthem Blue Cross Blue Shield	87,647	15,397	26,500	129,544
Health Net	39,098	3,406	1,943	44,447
ConnectiCare	9,344	137	182	9,663
Total	136,089	18,940	28,625	183,654
Source of Data: Office of Comptroller.				

Member Profile

The program review committee obtained detailed demographic data about members of the state employee health insurance program enrolled during the fall of 2002.³⁰ Figure B-1 indicates the proportion of members who are subscribers versus those who are covered adult dependents or children. The dominant category for both Anthem and Health Net is subscribers -- approximately half of their members fall in that category. The distribution under ConnectiCare is more even, with similar proportions of subscribers and children (38 and 42 percent respectively).

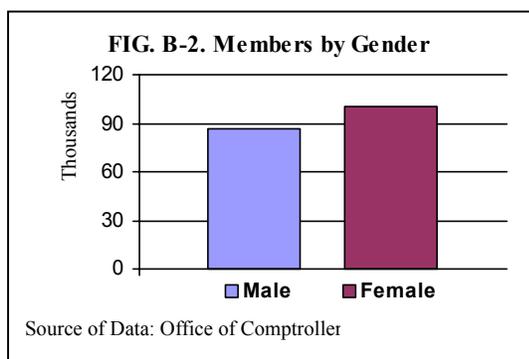
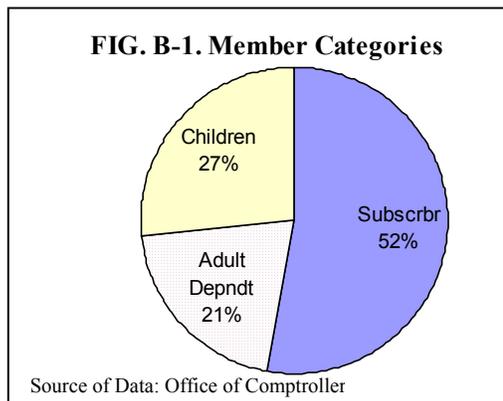
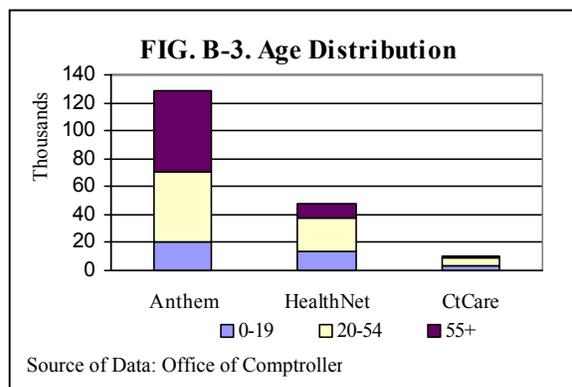


Figure B-2 presents information about the gender of program participants. Fifty-four percent of all enrollees are female, with the proportion nearly the same for each carrier. (The rate ranged from 52 percent to 54 percent.)

Figure B-3 provides data about the ages of program participants. This characteristic varied the most among the memberships of the individual health plan carriers. The largest age group overall

was “20 to 54” at 43 percent of all enrollees. This group was the predominant one for ConnectiCare and Health Net, while Anthem had more members in the “55+” group (45 percent). That older group in turn made up only 8 percent of the ConnectiCare membership.³¹



Expenditures

In FY 02, the state spent \$579 million on health insurance premiums for state employees and retirees. Determining the specific portion of that cost attributable to prescription drugs is problematic. Until the current fiscal year, the state paid each health plan carrier a single monthly fee per member for all health benefits including prescription drugs. No information was compiled about the portion of the overall fee attributable to pharmacy services. The new health insurance contract includes a separate prescription drug component handled completely by Anthem, which should provide better data about the state’s costs for prescription drugs.

³⁰ Data were provided by the individual health insurance carriers through the Office of the State Comptroller, which is responsible for administration of the program. Anthem data are from September 2002, Health Net from October 15, 2002, and ConnectiCare from November 1, 2002.

³¹ One reason Anthem has such a large number of older enrollees is the requirement that individuals who retired prior to 1997 must enroll with Anthem in order to receive free health insurance coverage from the state.

Under both the bundled and separate fee approaches, the insurer is responsible for paying for prescriptions dispensed to health plan members minus any required co-pay. (Under the state's current labor agreement, health plan members pay \$3 for generic drugs and \$6 for brand name drugs.) Depending on the particular product, the PBM also may receive rebates from manufacturers based on the volume of drugs purchased.

Historic data on pharmacy claims (i.e., the retail cost of the prescription drugs dispensed to enrolled members) are available. As a result, claims paid are often used as a proxy for the minimum cost to the state for prescription drugs under capitated health plans.

Prescription drug claims increased from \$149 million in FY 02 to \$171 million in FY 03. However, they continued to represent 29 percent of all health claims for both years.

Figure B-4 displays the annual pharmacy cost per member from FY 00 through FY 03, grouped by member type. The figure also shows the overall average for all members combined.

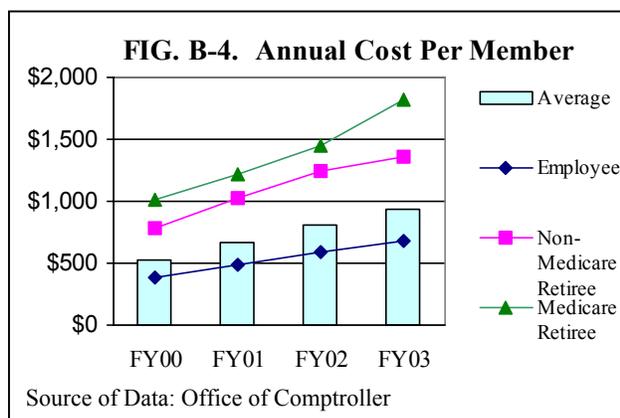


Table B-2 presents information about the volume of prescription claims received by each plan during a twelve-month period from late 2001 through mid 2002. The table also displays the number of brand name versus generic drugs as well as the number of prescriptions dispensed from retail versus mail order pharmacies. The use of generic drugs ranged from 37 percent (Anthem) to 43 percent (ConnectiCare). Mail-order purchases totaled 1 percent or less for all three carriers.

TABLE B-2. Volume of Prescriptions Dispensed, 2001-2002

<i>Carrier</i>	<i>Total Number of Scripts</i>	<i>No. of Brand Name</i>	<i>No. of Generic</i>	<i>No. of Retail</i>	<i>No. of Mail Order</i>
Anthem (09/01-08/02)	1,951,037	1,224,034	727,003	1,940,202	10,835
Health Net (09/01-08/02)	656,627	398,083	258,544	649,707	6,920
ConnectiCare (07/01-06/02)	75,216	42,689	32,527	74,536	680

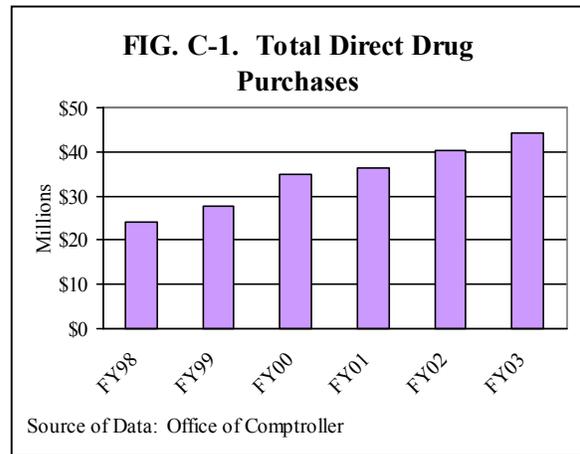
Sources of Data: Individual health insurance carriers through the Office of the State Comptroller.

Claims experience is important to both the state and health insurers. Cost drives the price an insurance carrier will charge the state for coverage. At the same time, details of what and how much were paid for a service can provide valuable information about usage patterns. This information can highlight opportunities for cost containment and better health care management.

State Contracting for the Purchase of Pharmaceuticals

In FY 03, the state of Connecticut spent approximately \$44 million for the prescription drugs it bought directly for distribution to patients in state clinics and residential facilities (e.g., hospitals and correctional institutions) and public health programs (e.g., vaccinations).³² This was a 10 percent increase over the previous year and an 83 percent increase since FY 98. Figure C-1 shows total annual purchases during this period.

The state uses multiple approaches to purchase prescription drugs directly. The Department of Administrative Services and the University of Connecticut Health Center both buy drugs through the same wholesaler, but the terms of their agreements differ, as described below.



The Connecticut Department of Veterans' Affairs receives prescription drugs through a contract set up by the federal government for the military. The department pays special, low prices for the pharmaceuticals it purchases for the state veterans' home. These prices are among the lowest available to any buyer in the country.

The Department of Public Health also has access to special federal pricing. The department is eligible to buy vaccines under contracts the Centers for Disease Control and Prevention has with various drug manufacturers. It is charged according to the federal pricing schedule.

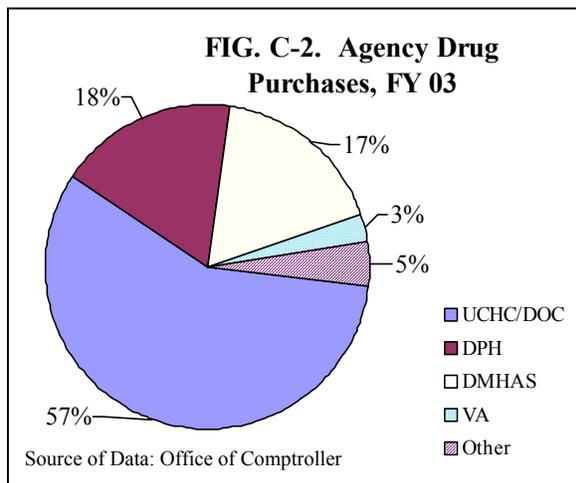


Figure C-2 shows a breakdown of purchases in FY 03 by agency. Those spending the most were the UConn Health Center including purchases for the Department of Correction, DPH, and the Department of Mental Health and Addiction Services. The "other" category includes the Department of Children and Families, the Department of Mental Retardation, and the infirmary at the University of Connecticut's main campus in Storrs.

³² Other related costs not reflected in that number are the salaries and fringe benefits for the pharmacy staff who dispense the drugs. Information in the State Auditors' October 2002 report, *Performance Audit Statewide Pharmaceutical Purchasing, Inventory, Delivery and Use* indicated such costs totaled at least \$6.6 million in FY 02.

Department of Administrative Services

The Department of Administrative Services signs a majority of the contracts the state uses to buy pharmaceuticals. However, each state entity needing covered products deals directly with the authorized drug wholesaler and buys the quantity needed.

At any given time, there are at least a half dozen active DAS contracts for pharmaceutical products. Many are for specialized drugs (such as vaccines that can only be obtained from limited sources) or for blood plasma and laboratory supplies. Only three of the eight contracts currently in effect directly involve obtaining a diverse range of prescription drugs or pharmacy services for clients of state facilities.

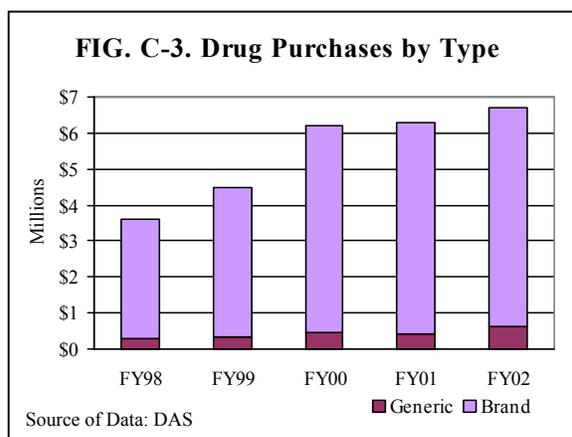
The largest contract (Core-CT No. 01PSX0189) covers the purchase of generic and brand name drugs by state facilities to be dispensed to patients on-site. The primary agency using the contract is the Department of Mental Health and Addiction Services, with purchases made by the individual facilities, not the central office. The current contract runs from January 1, 2001, through May 31, 2004.³³

Although the wholesaler coordinates the purchase of drugs from a variety of manufacturers under this contract, the state is a member of a group purchasing organization that actually negotiates the prices of the individual drugs. DAS relies on the group purchasing organization to obtain the best prices possible and provide the wholesaler with a list of the negotiated prices. Using a matrix that considers purchasing volume and timely payment, the wholesaler subtracts a specified percentage from the contract cost. Late payments can result in a surcharge.

Figure C-3 summarizes purchases under this contract, noting the proportion of generic and brand name drugs. Between FY 98 and FY 02, overall spending increased 85 percent -- growing from \$3.6 million to \$6.7 million.

Spending on generics doubled during that period, but it still comprised only 10 percent of the total. This is at least partly because DMHAS made nearly all of the purchases, and generic substitutions are less common for psychotropic medications than for other therapeutic classes of prescription drugs.

Table C-1 breaks down the FY 02 data from Figure C-3 by location and drug type. The facilities purchasing the largest quantities of prescription drugs are those operating residential programs. Indeed, most state-run outpatient programs provide clients with prescriptions to be



³³ The state has had similar, multi-year contracts since at least the early 1990s. The current contract originally ran from January 1, 2001 through December 31, 2002. During 2002, it was extended for an additional 12 months, and at the end of 2003, it was extended for five more months.

filled at local pharmacies. If those clients are on Medicaid, their pharmacy expenditures will be reflected in data reported by the Department of Social Services.

TABLE C-1. Contract Payments for Pharmaceuticals, State FY 02.

<i>Location</i>	<i>Generic</i>	<i>Brand Name</i>	<i>TOTAL</i>
Bridgeport Mental Health	\$72,299	\$1,030,544	\$1,102,843
Cedarcree Hospital	\$53,250	\$777,179	\$830,429
Connecticut Mental Health Center	\$113,495	\$1,061,887	\$1,175,382
Blue Hills Hospital	\$20,207	\$123,064	\$143,271
Connecticut Valley Hospital	\$308,373	\$2,682,540	\$2,990,913
UConn Infirmary (Storrs)	\$51,516	\$355,922	\$407,438
Southeastern Mental Health	\$601	\$2,470	\$3,071
Capital Region Mental Health	\$8,320	\$35,158	\$43,478
TOTAL	\$628,061	\$6,068,764	\$6,696,825

Source of Data: Department of Administrative Services.

The other two DAS contracts of interest cover comprehensive pharmaceutical services. Under both contracts, the state of Connecticut designates a pharmacy in the vicinity of specific state facilities to dispense, deliver, and monitor prescriptions for residents or clients at those locations. This approach is used because these facilities have limited or no pharmacists on-site.

One contract (Core-CT No. 99PSX0046) covers several DMHAS facilities in the southwestern corner of Connecticut as well as the Southbury Training School, operated by the Department of Mental Retardation. The total estimated value of the contract, which runs from October 1999 to April 2004, is \$2.5 million.

The other contract (Core-CT No. 03PSX0142) covers two facilities operated by the Department of Children and Families -- Riverview Hospital in Middletown and High Meadows in Hamden. The contract runs from July 2003 through June 2006, with an option for a three-year extension. The estimated value of the contract during the initial three-year period is \$2.4 million.

University of Connecticut Health Center

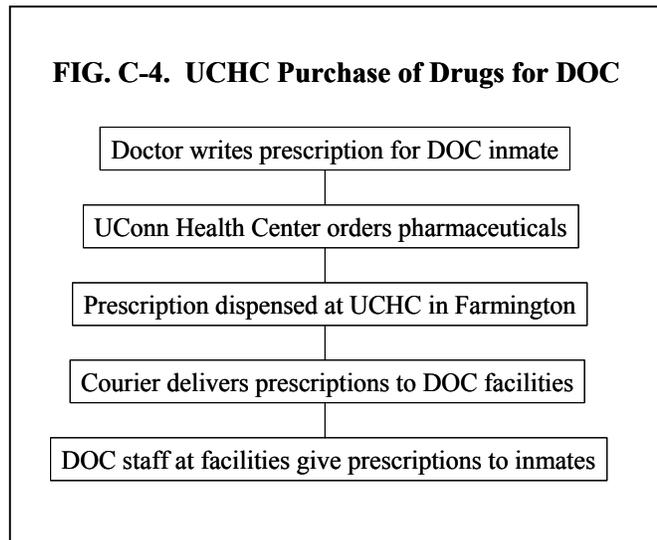
The University of Connecticut Health Center purchases pharmaceuticals for two populations -- patients of John Dempsey Hospital and Department of Correction inmates. The latter is part of a comprehensive program of health services provided through a memorandum of understanding between UCHC and DOC. The UConn Health Center buys drugs from the same wholesaler as DAS. However, because of the health center's status as a teaching hospital, its membership in a different group purchasing organization, and the fact it pre-pays its purchases, the health center pays lower prices.³⁴

³⁴ Manufacturers price according to the buyer's "class of trade." For example, teaching hospitals are eligible for discounts not available to other entities such as retail community pharmacies.

The health center is a member of University HealthSystem Consortium (UHC), a nationwide alliance of academic health centers. One of the benefits of membership is access to shared purchasing programs. A supply company set up by UHC obtains bids for a variety of clinical supplies, including prescription drugs. Using those prices, the wholesaler charges UHC members according to a matrix that takes into consideration the volume of drugs purchased and the timeliness of payments. Typically, the price the UConn Health Center pays is less than the wholesale acquisition cost. As a member of UHC, the health center also shares in rebates and dividends distributed by the consortium.

The UConn Health Center uses the same system to purchase prescription drugs for Department of Correction inmates. UCHC buys the drugs under its existing group purchasing arrangement. As shown in Figure C-4, the wholesaler delivers the drugs to the health center in Farmington, pharmacists on staff fill the prescriptions for the inmates, and a courier service delivers them to each facility where they are distributed.

Because doses must be packaged for daily (or in some cases weekly) distribution rather than the 30 to 90 day supply a retail customer typically receives, a large volume of individual packaging is required. To help expedite dispensing, an automated robotic system assists the pharmacists.



In FY 02, UCHC spent \$7.3 million on drugs for patients of the hospital. However, the state receives reimbursement for much of this expense. When the hospital bills a patient or his or her health insurer for services provided, a portion of the charge is for the prescription drugs dispensed during the patient's stay.

The cost of prescription drugs for DOC inmates in FY 02 was \$14.7 million. The state received only a small amount of reimbursement against this expense.

The ability to recycle unused drugs provides another opportunity for the state to save money. For example, DOC inmates cannot be forced to take the drugs prescribed for them. If an inmate refuses a prescription, since late 2002 a program has been in place to either return the drugs to the UCHC inventory or back to the wholesaler. In FY 03, the health center saved about \$600,000 through such efforts.

Pharmacy Benefit Managers

Pharmacy benefit managers are private companies that administer and manage prescription drug programs for a variety of organizations, including the state of Connecticut's health insurance plan for state employees/retirees and certain recipients of DSS programs. A PBM can be an independent company or a subsidiary of a drug manufacturer, retail pharmacy chain or health insurance company. The major functions of PBMs include:

- negotiating discounts with manufacturers, wholesalers, and pharmacies;
- managing drug formularies by overseeing the types of drugs that are prescribed and determining if there are less expensive alternatives that can be substituted;
- acting as financial intermediaries between pharmacies and health plan sponsors (e.g., verifying customer eligibility, handling disputes, and paying claims);
- operating drug utilization review programs, including the capacity to generate comparative profiles of physician prescribing patterns or pharmacy dispensing;
- purchasing and dispensing medications through mail-order companies they own; and
- creating and maintaining pharmacy networks to ensure adequate geographic access.

PBMs earn most of their revenues in three ways: 1) receiving a fee for the administrative tasks they perform; 2) negotiating discounts and rebates from drug manufacturers by including a company's drugs on a preferred drug list and obtaining a greater market share for the company's drug; and 3) through the operation of mail-order prescription drug companies.

During the program review study, several issues were raised by a variety of advocacy groups and the media concerning the business practices of pharmacy benefit managers nationwide. Specifically, demands for greater transparency in the financial relationships between PBMs and drug manufacturers prompted several states to propose bills regulating PBM activities. Although resolution of this topic is beyond the scope of the current study, this section contains background information about PBM regulation and actions taken in other states.

Proponents of PBM Regulation

The development and management of preferred drug lists by PBMs has become a central issue for those arguing for PBM regulation. The retention by PBMs of some or all of the rebates they obtain from manufacturers has become increasingly controversial, with the federal government as well as attorneys general in several states conducting investigations of this business practice. Other major PBM practices of concern are:

- establishing preferred drug lists that are based on the amount of manufacturer rebates received rather than clinical effectiveness;
- the propriety of the close relationships between many PBM companies and the pharmaceutical industry;
- lack of disclosure regarding contractual relationships with drug manufacturers; and
- marketing practices including collection and sale of patient information to help drug companies increase sales.

State actions. In recent years, a number of states (including Connecticut) considered legislation regulating the business practices of PBMs. Georgia was the first state to enact legislation regulating the practices of pharmacy benefit managers. The law, adopted in 2002, required every PBM providing services in Georgia be licensed as a pharmacy. During the 2003 legislative session, 22 other states proposed bills concerning PBM regulation, but only Maine passed comprehensive legislation, which requires:

- payments to a PBM based on the volume of certain drugs dispensed or as a result of the savings from the substitution of drugs be passed on to the covered entity;³⁵
- disclosure of financial terms between a PBM and a manufacturer to the covered entity; and
- consultation with and agreement by a prescriber before a PBM can switch the prescription drug to be dispensed to a covered individual.

The Maine law also prohibits contractual terms inconsistent with a PBM's fiduciary duty and forbids agreements to waive provisions of the law. It creates an enforcement mechanism under the Maine Unfair Trade Practices Act for violations, with fines of not more than \$10,000.

The Connecticut Insurance and Real Estate Committee heard testimony during the 2003 legislative session on a raised bill that would have required PBMs be licensed by the Departments of Insurance and Consumer Protection, report on certain business practices, and specify reimbursement levels for retail pharmacies. The bill was later amended to have the Department of Insurance, in consultation with the Commission on Pharmacy, study pharmacy benefit management plans to determine whether further regulation of such plans is needed on an annual basis and if so, the type of regulation required. The General Assembly took no action on the bill before the end of the session.

Development of nonprofit PBM. The National Legislative Association on Prescription Drug Prices has endorsed formation of an independent, non-profit Pharmacy Benefit Administrator (PBA) to provide quality and accessible health care services. The mission would be to transfer savings directly to the payer. The association, which began as a New England only

³⁵ Maine defines a covered entity as “a non-profit hospital or medical service organization, insurer, health coverage plan or health maintenance organization licensed pursuant to Title 24 or 24-A; a health program administered by the department or the State in the capacity of provider of health coverage; or an employer, labor union or other group of persons.”

organization, now has nine states and the District of Columbia as members. Increasingly, however, the group appears to be addressing broader prescription drug issues rather than moving toward direct operation of a non-profit PBA.

The association has established model legislation, part of which contains optional language for Pharmacy Benefit Manager Disclosure Rules. The model language would prohibit a state commissioner from entering into a contract with a pharmacy benefit manager unless the PBM has agreed to disclose any agreement the PBM has:

- with a pharmaceutical manufacturer that favors the manufacturer's products over a competitor's products or switches the drug prescribed by the patient's health care provider with a drug agreed to by the PBM and the manufacturer;
- with a pharmaceutical manufacturer to share manufacturer rebates and discounts with the PBM or to pay "soft money" or other economic benefits to the PBM;
- to share revenue with a mail order or internet pharmacy company;
- to sell prescription drug data concerning beneficiaries or data concerning the prescribing practices of health care providers; or
- with a pharmaceutical manufacturer, with a mail order or internet pharmacy, or wholesale and retail pharmacies affecting the financial or medical interests of beneficiaries.

Further, under the model legislation, a state commissioner cannot enter into a contract with a PBM that has entered into an agreement or engaged in the practices listed above, unless the commissioner determines the agreement or practice furthers the financial interests of the state and does not adversely affect the financial or medical interests of beneficiaries.

National Association of Insurance Commissioners (NAIC). The National Association of Insurance Commissioners has also developed a model act for state-level regulation of pharmacy benefit managers. The act, entitled "Health Carrier Prescription Drug Benefit Management Act," applies to all health carriers that provide benefits for outpatient prescription drugs.

The model act establishes requirements for the development of formularies and other pharmacy benefit management procedures, including the type of information that must be considered by health carriers making formulary decisions and establishing pharmacy benefit management procedures. The act requires health carriers to provide practitioners, pharmacies, and covered individuals with information regarding current formularies. It also requires health carriers to provide notice of certain changes and establish requirements for a medical-exceptions process for practitioners and patients to request coverage for drugs not on a preferred drug list.

Opponents of PBM Regulation

Representatives of pharmacy benefit management companies maintain that current federal and state laws are sufficient to regulate PBM activities. In terms of regulation by state departments of insurance, the industry contends PBMs do not accept underwriting risk and,

therefore, should not be licensed. Health insurers (or employers, if self-insured), not the PBM, are responsible for solvency risk.

Opponents of regulation believe PBMs should be governed in accordance with the functions performed (e.g., as drug utilization review companies or pharmacies) rather than as stand-alone entities. They believe regulating PBMs as a separate entity rather than focusing on the individual services performed is duplicative. Specifically, they argue PBM functions such as drug utilization reviews and mail service pharmacies are already regulated at the state level. Finally, they charge that regulation would raise operating costs for PBMs and diminish their ability to pass on cost-savings to their customers.

Future Action

Statutory regulation of pharmacy benefit managers will affect more than just the state prescription drug programs covered by the program review committee's current study of pharmacy benefits. Since the second part of the committee's study will examine various aspects of pharmacy regulation, further assessment of the advantages and disadvantages of PBM regulation will be considered as part of that review.

Other States

In response to budget pressures, almost all states are addressing the cost of prescription drugs. Legislative proposals are aimed at lowering the cost of the drugs states purchase for Medicaid, state employee health insurance programs, the criminal justice system, and other pharmaceutical assistance programs. According to the National Conference of State Legislatures, 49 states sought to create, expand, or substantially change state pharmaceutical programs and policies in 2003.³⁶ Additional proposed legislation affected pharmaceutical marketing or advertising. Proposed changes focused on three broad areas:

- Using some state funds to assist or subsidize the cost of pharmaceuticals for elders, low-income residents, or others. Most use state money to pay for a portion of the cost of pharmaceuticals for eligible residents who meet age and income criteria. Some states have established cost-sharing features including co-payments, annual enrollment fees, and monthly limits. Other states are experimenting with broader discount programs aimed at assisting people lacking private insurance or even the general consuming public.
- Achieving new discounts or reduced prices for eligible residents through state law, or by combining "bulk" purchases among programs, agencies, or states.
- Changing pharmaceutical purchasing policies related to the use of generics, implementing preferred drug lists, increasing cost-sharing and co-payments, negotiating supplemental rebates, and joining purchasing cooperatives.

Connecticut's Office of Legislative of Research has issued several reports on other states' efforts to reduce drug costs and increase access for the uninsured. The descriptions below summarize information contained in OLR Reports on Florida, Maine, and Vermont.³⁷ These three states have been aggressive in dealing with rising drug costs.

Florida

Disease management (DM) is a fairly new approach that seeks to improve patient care and outcomes and reduce health care costs by concentrating services on people with chronic conditions. Such people often receive care from multiple providers, do not follow treatment and medication regimens, experience preventable complications, and have a high use of costly services. Disease management offers an integrated approach to chronic disease treatment that features case management, patient and physician education, and patient monitoring. A growing number of states are developing or using disease management with their Medicaid clients.

³⁶ www.ncsl.gov

³⁷ Office of Legislative Research reports, 2003-R-0068 and 2003-R-0097 (Florida), 2003-R-0096 (Maine), and 2003-R-0029 (Vermont).

Florida, the first state to implement a disease management program, adopted legislation approving such programs beginning in 1997. Legislation has targeted DM programs to certain Medicaid recipients with asthma, diabetes, HIV/AIDS, hemophilia, hypertension, heart disease, cancer, sickle cell anemia, or end-stage renal disease. Potential DM candidates are identified through paid claims. Patients are notified of their eligibility and are advised of the additional care management benefits they can obtain. Providers also may refer patients who are not already enrolled but might benefit from a program.

In 2002, the Florida legislature adopted a Medicaid preferred drug list and a prior authorization law. The law requires supplemental rebates be negotiated with drug manufacturers that want their products considered for the list. (Under this type of arrangement, physicians who want to prescribe a drug that is not on the list must first obtain authorization from a state contractor.) The law does allow drug companies to provide services such as DM in lieu of supplemental cash rebates. Currently, three drug companies have opted to provide a DM program.

Florida enacted the DM initiative in order to save money. Early reports show mixed results with some stating the state is not reaping expected savings, while others proclaim the programs a success. Florida and some other states have opted for imposing "guarantees" on contractors to ensure at least minimal savings are achieved.

States are eligible to receive federal Medicaid matching funds when they run DM programs. Depending on the type of program, the funds are considered reimbursements, either for direct services rendered or for administrative costs.

The number of states with operational or proposed Medicaid DM programs rose from 11 in FY 02 to 21 in FY 03, most likely because of added pressure states are under to reduce Medicaid costs during the current economic downturn.

Maine

The Maine legislature originally enacted a pharmaceutical access program called "Maine Rx" that provided discounts on drug purchases to residents without public or private prescription drug insurance coverage. The law directed the human services commissioner to negotiate rebates with manufacturers and use those rebates to reimburse pharmacies that discount drugs for program participants. In the negotiations, the commissioner is required to consider Medicaid rebate agreements and use his or her best effort to obtain the same rebates for Maine Rx. While manufacturers' participation is voluntary, drugs produced by those that do not provide rebates are subject to prior authorization for Medicaid coverage, and the manufacturers' names will be made public. Thus, the program ties Medicaid coverage for a manufacturer's products to its willingness to pay rebates on those drugs for non-Medicaid participants.

Effective July 1, 2003, the commissioner is authorized to set maximum retail prices for all prescription drugs sold in Maine, if the prices paid for the most commonly prescribed drugs under Maine Rx are not reasonably comparable to the prices paid under Medicaid. It also makes it "illegal profiteering" for a drug manufacturer to charge a price that is "unconscionable" or that

produces an "unjust or unreasonable profit. Illegal profiteering subjects a manufacturer to a civil penalty.

The Maine Rx program was challenged by the drug industry and arguments ultimately were presented before the U.S. Supreme Court. Although the court upheld the Maine program, the possibility of future challenges to certain program components exist. In the 2003 legislative session, the legislature adopted the "Maine Rx Plus" program that supplements the Maine Rx program. The Maine Rx Plus program contains many of the same provisions as the original, but has different eligibility requirements, pricing, and rebate arrangements.

Maine also adopted legislation to regulate the practices of pharmacy benefit managers to ensure full disclosure of contracted activities, including contractual financial terms that apply between a PBM and a drug manufacturer. It also requires the benefits of special drug pricing deals negotiated by these companies be passed through to consumers and not simply used as company profits. It also clarifies that violations of law regarding these issues are violations of the Maine Unfair Trade Practices Act, enforceable by private action or by the attorney general.

With the attention paid to the Maine Rx case and the subsequent ruling by the U.S. Supreme Court, similar legislation has been introduced across the country. At least 19 states -- Colorado, Florida, Georgia, Illinois, Indiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New York, Ohio, Rhode Island, Tennessee, Texas, Vermont, and West Virginia -- have introduced legislation modeled after the Maine Rx program or particular elements of the program.

Vermont

Vermont passed legislation in 2002 that creates a "pharmacy best practices and cost control program" designed to lower prescription drug prices for Vermont residents through a variety of approaches. The law requires the state to buy drugs for state-sponsored pharmaceutical and health assistance programs from a preferred drug list. The law directs the state to: (1) encourage private health plans to participate and use drugs on the preferred list; and (2) negotiate supplemental rebates from drug manufacturers in addition to the rebates they now provide under Medicaid. The state will also be able to negotiate supplemental rebates on behalf of private sector health plans that want to participate as well as for public employee health benefit plans and other public assistance programs.

The new program will use a prior authorization process with special provisions for emergency situations. Prior authorization does not apply to drugs prescribed for the treatment of severe and persistent mental illness.

The law also addresses pharmaceutical marketing by requiring all drug companies marketing drugs in Vermont to disclose gifts, fees and payments, and other economic benefits they provide to health care providers. Such disclosure must be made annually to the Vermont Board of Pharmacy. The act also created the Healthy Vermonters program, a pharmacy discount plan with liberal eligibility guidelines.

APPENDIX F. Status of Legislation Regarding DSS Pharmacy Programs.

<i>Public Act</i>	<i>Legislative Mandate for Department of Social Services</i>
P.A. 00-2, June Special Session (SS)	<i>Adopt plan for prior authorization for prescription drugs dispensed to recipients of the Medicaid fee-for-service program, ConnPACE, and SAGA for initial prescriptions: 1) costing \$500 or more for a 30-day supply or any early refill request, and 2) brand name drugs for which chemically-equivalent substitutes are available; submit plan to Human Services, Public Health, and Appropriations committees (amended by P.A. 02-7, May SS)</i>
	<i>Establish schedule of maximum oral dosage amounts</i>
	<i>Establish ConnPACE Part B for elderly and disabled people who do not qualify for regular ConnPACE (DSS submitted plan but plan was not adopted by legislature)</i>
	<i>Reimburse actual acquisition cost plus 8 percent for Factor VIII drugs (which treat Hemophilia A) and allow designation of specific suppliers from which pharmacists must order these drugs</i>
	<i>Establish nursing home drug return program requiring long-term care facilities return certain unused prescription drugs to pharmacies and permits DSS to pay pharmacies a restocking fee</i>
	<i>Require rebates for generic drugs in the General Assistance (GA) and ConnPACE programs to be at least as high as, instead of the same as, Medicaid rebates</i>
	<i>Study, in consultation with the Pharmacy Review Panel, the feasibility of additional pharmacy efficiencies in the Medicaid, GA, SAGA, and ConnPACE programs</i>
	<i>Require automatic generic substitution by extending the requirement practitioners prescribing brand name drugs for GA, ConnPACE, and SAGA specify why the brand name drug is medically necessary</i>
	<i>Develop plan to increase cost-effectiveness or access to particular drugs through designating specific suppliers</i>
	<i>Add two members to the DSS pharmacy review panel</i>
	<i>Develop plan for disbursing to pharmacists any “excess” savings resulting from pharmacy initiatives</i>
<i>Permit drug wholesalers and manufacturers to sell directly to skilled nursing facilities that have on-site pharmacists</i>	
P.A. 01-2	<i>Seek federal Medicaid waiver to obtain federal funds to cover seniors enrolled in the state-only ConnPACE subsidy program -- if federal approval obtained, eligibility will be extended to 300% of federal poverty level</i>
P.A. 01-9	<i>Make information about pharmaceutical company drug programs available to elderly and disabled within available appropriation</i>
P.A. 02-1, May 9 SS	<i>Establish payment ceilings, known as maximum allowable costs for generic prescription drugs under pharmacy fee-for-service programs and require annual review and update</i>
	<i>Reduce pharmacies’ dispensing fee from \$4.10 to \$3.85 as of September 1, 2002</i>
	<i>Fine long-term care facilities that violate the requirements of the nursing home drug return program \$30,000 for each incident of noncompliance</i>

APPENDIX F. Status of Legislation Regarding DSS Pharmacy Programs.

<i>Public Act</i>	<i>Legislative Mandate for Department of Social Services</i>
P.A. 02-1, May 9 SS (cont'd)	Establish preferred drug list for DSS fee-for-service programs
	Establish 11-member Pharmaceutical and Therapeutics Committee appointed by the governor and charged with developing a preferred drug list; authorize committee to review all drugs on list annually, recommending drugs to be added or removed from the list -- drugs not on the list are subject to prior authorization
	Provide for supplemental manufacturers' rebates and give manufacturers that provide such rebates the opportunity to present evidence in support of their including products on the preferred drug list; also provide that the PDL may be used separately from supplemental rebates, if there is no legal authority for such state-based rebates
	Allow DSS commissioner to implement pharmaceutical purchasing initiative by contracting with an established entity for the lowest pricing available for fee-for-service programs
	Allow DSS commissioner to establish a voluntary mail-order option for maintenance prescription drugs for fee-for-service programs
P.A. 02-7, May 9 SS	<i>Increase ConnPACE co-pays per prescription for new applicants from \$12 to \$15 (those in the program continue to pay \$12 and so do lower-income new applicants)</i>
	<i>Implement previously approved prior authorization plan for prescription drugs with addition that prior approval be required for any initial maintenance drug prescription for which there is a chemically equivalent generic substitution and the prescription is for less than a 15-day supply (Excludes atypical antipsychotic drugs)</i>
	<i>Implement and maintain procedure to review and update the maximum allowable cost [for generic drugs] list at least annually, and report annually to the Appropriations Committee on activities</i>
	<i>Eliminate 50 cent generic incentive dispensing fee paid to pharmacies</i>
	Report annually on the status of the pharmaceutical purchasing initiative to the Appropriations Committee
P.A. 03-2	<i>Implement \$1 prescription drug co-pay for Medicaid, SAGA, and CADAP recipients</i>
	<i>Increases ConnPACE co-pay to \$16.25</i>
	<i>Reduce pharmacies' dispensing fee from \$3.85 to \$3.60 effective February 15, 2003</i>
	Require Pharmaceutical and Therapeutics Committee to convene on or before March 31, 2003
	Amend requirement Pharmaceutical and Therapeutics Committee adopt a preferred drug list, and instead require DSS, in consultation with the Pharmaceutical and Therapeutics Committee, to adopt a PDL on or before July 31, 2003
Require DSS instead of Pharmaceutical and Therapeutics Committee review and update preferred drug list annually	

APPENDIX F. Status of Legislation Regarding DSS Pharmacy Programs.

<i>Public Act</i>	<i>Legislative Mandate for Department of Social Services</i>
P.A. 03-116	Require DSS commissioner to update and expand by June 30, 2003, and annually thereafter, the list of drugs included in the nursing home drug return program
P.A. 03-3, June 30 SS	Reduce pharmacies' dispensing fee from \$3.60 to \$ 3.30 under Medicaid fee-for-service, ConnPACE, SAGA and CADAP starting October 1, 2003
	Increase prescription drug co-payment for SAGA recipients from \$1.00 to \$1.50
	Impose asset test on ConnPACE recipients
	Implement asset recovery requirement on estates of ConnPACE recipients
	Require pharmacy services be provided to SAGA recipients through Federally Qualified Health Centers and increase co-pays from \$1.00 to \$1.50
	Require FQHCs to enroll in the federal Office of Pharmacy Affairs Section 340B drug discount program to provide pharmacy services to SAGA recipients -- FQHCs permitted to establish on-site pharmacy or contract with a commercial pharmacy to provide these services
	Allow the state to provide enhanced dispensing fee to a pharmacy enrolled in the federal 340B drug discount program or a pharmacy under contract to provide services under that program.
	Require DSS to submit a Medicaid state plan amendment to allow pharmacies to refuse to fill Medicaid prescriptions for "beneficiaries who demonstrate a documented and continuous failure to pay co-payments in spite of their ability to make these payments," described as unpaid for six prescriptions or six months
	Require pharmacists to fill prescriptions using the most cost-efficient dosage under FFS programs
	Require pharmacists to dispense a brand name drug if it is less costly than the generic equivalent
	Increase membership on Medicaid Pharmaceutical and Therapeutics Committee from 11 to 14 members
Specify preferred drug list applies to Medicaid, ConnPACE, and SAGA and is limited to three classes of drugs; require DSS commissioner to notify Human Services and Appropriations Committees of drug classes by January 1, 2004	
P.A. 03-1, Sept. 8 SS	Increase prescription drug co-pays for Medicaid, SAGA, and CADAP recipients from \$1.00 to \$1.50 by October 1, 2003

NOTE: As of December 2003, only items in ***bold, italic*** have been implemented.

Appendix G – Glossary of Terms

<i>Term</i>	<i>Definition</i>
<i>Average wholesale price (AWP)</i>	The average list price a manufacturer suggests wholesalers charge pharmacies. AWP is referred to as a “sticker price” because it is not the actual price large purchasers normally pay. AWP information is publicly available.
<i>Capitated Rate</i>	A method of paying health care providers or insurers in which a fixed amount is paid per enrollee to cover a defined set of services over a specified period, regardless of actual services provided.
<i>Connecticut AIDS Drug Assistance Program (CADAP)</i>	This program, administered by the Connecticut Department of Social Services, pays for drugs determined by the U.S. Food and Drug Administration to prolong the life of people with AIDS or HIV infection.
<i>Connecticut Pharmaceutical Assistance Contract for the Elderly and Disabled (ConnPACE)</i>	ConnPACE is a Connecticut prescription drug payment assistance program for people age 65+ with low and moderate incomes, and people with disabilities age 18+ not eligible for other low-income medical assistance programs.
<i>Disease Management (DM) Program</i>	Seeks to improve patient care and outcomes and reduce health care costs by concentrating services on people with chronic conditions. DM offers an integrated approach to chronic disease treatment that features case management, patient and physician education, and patient monitoring.
<i>Dispensing Fee</i>	The charge for the professional services, including overhead expenses and profit, provided by the pharmacist when dispensing a prescription. Medicaid and most insured prescription programs include dispensing fees as part of the pharmacy payment for prescriptions.
<i>Drug Utilization Review (DUR)</i>	Evaluates both patient use and physician behavior and generally examines whether the correct drug dosage was prescribed for a patient, the potential for adverse interactions with other drugs, and frequency of refills. Drug utilization reviews also screen physician prescribing patterns, look for submission of duplicate prescriptions by a patient, and pursue evidence of general fraud and abuse.

Appendix G – Glossary of Terms

<i>Term</i>	<i>Definition</i>
<i>Federal Supply Schedule (FSS)</i>	A list of prices available to all federal purchasers for prescription drugs. FSS prices are negotiated by the federal government and are intended to equal or better the prices manufacturers charge their “most-favored” nonfederal customers under comparable terms and conditions. Because terms and conditions can vary by drug and vendor, the most-favored customer price may not be the lowest price in the market. FSS prices are publicly available. Federal Departments of Veterans’ Affairs, Defense, and Public Health Service and the Coast Guard have the right to use FSS to purchase their pharmaceuticals, but they often get prices below the FSS on brand name drugs because those drugs are subject to a maximum statutory price called the <i>federal ceiling price</i> .
<i>Formulary</i>	A list of preferred drug products that typically limits the number of drugs available within a specific therapeutic class for purposes of drug purchasing, dispensing, and reimbursement.
<i>Federal Upper Limit (FUL)</i>	The maximum allowable reimbursement for certain generic drugs established and published by the Centers for Medicare and Medicaid Services on the FUL list.
<i>Managed Care Organization (MCO)</i>	A health insurer that offers health plans that control or coordinate the use of health services by its enrolled members in order to contain health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.
<i>Mandatory Generic Substitution</i>	A program management strategy that requires an individual to automatically receive a generic medication, if a generic equivalent is available.
<i>Maximum Allowable Cost (MAC)</i>	A maximum reimbursement price for generic drugs developed by government and private companies to place controls on price.
<i>Medicaid Fee-for-Service</i>	The state’s program for low-income aged, blind, and disabled persons, including long-term care residents. Reimbursement is on a fee-for-service (FFS) basis (i.e., a claim is submitted to the state and paid by the state after services are provided).

Appendix G – Glossary of Terms

<i>Term</i>	<i>Definition</i>
<i>Medicaid Managed Care (HUSKY A)</i>	The state’s medical assistance program targeted at low-income children and certain adults. The Medicaid managed care program is administered by the Department of Social Services, which pays managed care organizations a per-member-per-month fee to operate the program including payment of all health care claims.
<i>Medicaid Rebate program</i>	Under federal law, drug manufacturers must sign agreements guaranteeing rebates in order to receive payment for outpatient prescription drugs provided to Medicaid fee-for-service beneficiaries.
<i>Pharmacy Benefit Manager (PBM)</i>	An entity that specializes in providing administrative and management services to reduce the cost of pharmacy benefits. PBMs process and analyze prescription claims for pharmacy benefit and coverage programs. PBM services may include: contracting with a network of pharmacies; establishing payment levels for provider pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs. Many PBMs also operate mail order pharmacies or have arrangements to offer prescriptions through mail order pharmacies.
<i>Pharmacy and Therapeutics Committee</i>	A team of community based physicians who discuss drug classes and determine the preferred drug from a clinical perspective.
<i>Preferred Drug</i>	A prescription drug that is favored over other products within the same drug class. A Pharmacy and Therapeutics Committee selects the specific drug and then negotiation occurs between the entity purchasing the drug and the drug manufacturer regarding the amount the drug will be discounted if it is placed on the preferred drug list (PDL).
<i>Prior Authorization</i>	A system under which members must receive approval before prescriptions can be dispensed. Typically used for brand name drugs when equivalent generics are available.
<i>Retail Price</i>	The price charged by retail pharmacies to individuals without insurance (i.e., “cash-paying” customers).

Appendix G – Glossary of Terms

<i>Term</i>	<i>Definition</i>
<i>State Administered General Assistance (SAGA) Medical</i>	SAGA provides medical assistance to low-income persons who do not qualify or who are awaiting an eligibility determination for other state or federal programs. Eligibility is based on income and assets.
<i>State Children’s Health Insurance Program (SCHIP) also known as HUSKY B</i>	SCHIP is administered by the Department of Social Services. Health benefits are available to children whose parent’s income levels are too high to qualify for HUSKY A (Medicaid managed care).
<i>340B Drug Pricing Program</i>	The 340B Drug Pricing Program was established in response to the passage of Section 340B of U.S. Public Law 102-585, the Veterans Health Care Act of 1992. The law limits the cost of drugs for federal purchasers and certain grantees of federal agencies, including health care facilities certified by the U.S. Department of Health and Human Services as "covered entities." Federally Qualified Health Centers (FQHCs) are considered a “covered entity.” Entities that participate in this program may achieve significant savings on pharmaceuticals.
<i>Wholesale Acquisition Cost (WAC)</i>	The price paid by a wholesaler for drugs purchased from the manufacturer of a drug. Publicly disclosed WAC amounts may not reflect all available discounts.

APPENDIX H
AGENCY RESPONSES



STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

January 21, 2004

Patricia A. Wilson-Coker, JD, MSW
COMMISSIONER

Carrie Vibert, Acting Director
Legislative Program Review &
Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

TELEPHONE:
(860) 424-5908

TDD/TTY:
1-800-842-4524

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(860) 424-5129

Dear Ms. Vibert:

I want to thank you for the opportunity to comment on the Legislative Program Review & Investigations Committee's final report on Pharmacy Benefits and Regulations. The Department of Social Services has been looking forward to the final staff findings and recommendations.

At the outset, I want to commend the highly professional Committee staff that prepared the documents. I am not aware of a more comprehensive compilation of the myriad pharmacy programs now operating across many agencies in our state. I believe this very good staff work will serve as an important decision-making tool for not only the Committee, but also the full General Assembly and the Executive Branch as we continue to seek more efficient and cost-effective means to deliver comprehensive pharmacy benefits to the populations we serve.

A host of initiatives have been implemented by the Department to achieve cost savings, however, instituting these changes was not and is not a painless task. Whether it's clients, providers or advocates, any change being considered or made, needs to be done with great care. Although we may firmly believe in the principles of personal responsibility and reasonable cost sharing for these costly benefits, we also must acknowledge the potential negative impact they may have on the actual purchasing ability and utilization of essential medications. We move forward slowly and cautiously when we implement any changes to ensure we address the needs and concerns of everyone.

As we move further into the world of cost containment, administration of a smoothly running prior authorization system is critical for such initiatives as a preferred drug list. In addition, the establishment of a Pharmaceutical and Therapeutics Committee (P&T Committee) is a critical part of the establishment of a sound and clinically appropriate preferred drug list. Appointments to the P&T Committee have been made and P&T Committee members have been officially notified of their appointments. Since the work of this committee is critical to a number of the Department's health care efforts, it is the Department's intent to hold an introductory meeting with the Committee as soon as possible. A meeting date has been tentatively scheduled for February 10th. As mandated by Public Act 03-3 of the June 2003 Special Session, the first class of drugs added to the Preferred Drug List will be Proton Pump Inhibitors (PPI's). Recommendations for two additional classes of drugs will be one of the first priorities of the P&T Committee.

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Additional cost saving measures authorized by the legislature are in various stages of implementation. The Department is researching the array of state options for implementing disease state management programs; we have been working with the long-term care pharmacies to adjust/modify the list of drugs for return; we are analyzing the effects of the Medicare prescription drug benefits which will hopefully present an opportunity to shift some of the costs we incur for clients in our ConnPACE program to the federal government and we continue to analyze our prior authorization process to further align ourselves with accepted private industry practices.

There are opportunities before us. The report as submitted provides baseline information, as well as information regarding tools utilized by other states. We are committed to maintaining access to a credible drug benefit for the clients we serve and we must make every effort to control the growth while monitoring their health outcomes. We look forward to working with the committee and we once again, thank you for the opportunity to comment on the report.

Sincerely,

A handwritten signature in black ink, appearing to read 'Patricia A. Wilson-Coker', written over a faint circular stamp or watermark.

Patricia A. Wilson-Coker
Commissioner

cc: Michael P. Starkowski, Deputy Commissioner
Claudette Beaulieu, Deputy Commissioner
David Parrella, Director, Medical Care Administration
Marcia Mains, Director, Medical Operations
Evelyn Dudley, Manager, Pharmacy Programs



STATE OF CONNECTICUT
OFFICE OF POLICY AND MANAGEMENT

January 28, 2004

Carrie Vibert, Acting Director
Legislative Program Review &
Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

Dear Ms. Vibert:

Thank you for the opportunity to comment on the Legislative Program Review and Investigation Committee's draft final report on *Pharmacy Benefits and Regulation*. As I said in my comments at the hearing in September on the draft report, your staff should be commended for an excellent report that provides a useful framework for many of the issues affecting pharmacy expenditures.

While many of the recommendations in the report are useful, I would like to respond to implicit and explicit characterizations that the Administration has done little in this area. Pharmacy expenditures are a large portion of the state's budget, and we have paid a great deal of attention to cost containment, as evidenced by the numerous budget initiatives proposed over the course of this Administration. Many of the recommendations contained in your report have been proposed at one time or another, which underscores the sometimes controversial nature of modifying programs that affect some of our most vulnerable populations. Efforts underway or in place include: preferred drug list, prior authorization, generic substitution, disease management, co-pays, MAC pricing, and maximizing rebates.

There are a couple of specific comments I would offer in response to the report. First, all appointments to the Pharmaceutical and Therapeutics Committee have been made, and the committee will begin to meet within the next month. Second, the recommendations regarding DAS's role in contracting for pharmacy products used by a variety of agencies (including DMHAS, DVA, UConn Health Center, and DPH) will be addressed to some degree by our Spend Management ("Buy Smart") initiative. Under this initiative, state agency purchasing volume will be leveraged for reduced prices on wholesale and direct drug purchases, and there may be opportunities to implement increased discounts, direct negotiations with manufacturers, and potentially even a preferred drug list.

Again, thank you for the opportunity to comment on your report, and I look forward to working with the legislature on reducing health care expenditures while at the same time preserving access to important drug benefits and ensuring positive health outcomes.

Sincerely,

A handwritten signature in black ink, appearing to read "Marc S. Ryan", with a long, sweeping flourish extending to the right.

Marc S. Ryan
Secretary

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www.opm.state.ct.us