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Agency of Human Services

M E M O R A N D U M

TO: Rep. Martha Health, Chair, House Committee on Appropriations
Sen. Jane Kitchel, Chair, Senate Committee on Appropriations
Rep. Michael Fisher, Chair, House Committee on Health Care
Sen. Claire Ayer, Chair, Senate Committee on Health and Welfare

CC: Doug Racine, Secretary, Agency of Human Services

FROM: Mark Larson, Commissioner

DATE: April 1, 2013

RE: VPharm Program Analysis – Premium and Co-Payment Structure

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Pursuant to the requirements of Act 162, Section E.307.9 of the 2012 legislative session; please find attached the Department of Vermont Health Access (DVHA) review the VPHARM program beneficiary premium and co-payment structure as well as the current and anticipated pharmaceutical manufacturing rebate compliance and payments levels with DVHA’s recommendations regarding changes to the VPHARM program premium or co-payment structure.

Please do not hesitate to contact me if you have questions or would like additional information.

Report to
The Vermont Legislature

VPharm Program Analysis

In Accordance with
ACT 162, Section E.307.9

Submitted to: House and Senate Committees on Appropriations
House Committee on Health Care
Senate Committee on Health and Welfare

Submitted by: Mark Larson
Commissioner
Department of Vermont Health Access

Prepared by: Carrie Hathaway
Director of Financial Services

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Director of Pharmacy Services

Report Date: **April 1, 2013**

Department of Vermont Health Access

Legislative Authority

During the 2012 legislative session, the Vermont legislature enacted No. 162, An act relating to making appropriations for the support of government.

Section E.307.9 (a) of Act 162 of the 2011-2012 Legislative Session requires a report as follows:

Sec. E.307.9 VPHARM REVIEW

(a) The commissioner of Vermont health access shall review the VPHARM program beneficiary premium and co-payment structure as well as the current and anticipated pharmaceutical manufacturing rebate compliance and payments levels. The commissioner shall make recommendations to the house and senate committees on appropriations, the house committee on health care, and the senate committee on health and welfare by January 15, 2013 regarding changes to the VPHARM program premium or co-payment structure.

Executive Summary

Beneficiaries who are Medicare-eligible, enrolled in a Part D plan, and meet established eligibility requirements are eligible for Vermont's VPharm program. VPharm is a publicly-funded drug benefit program that provides "wrap" coverage of covered Part D drugs, and also provides coverage of many over-the-counter (OTC) drugs and diabetic supplies that are not defined as covered products under the Part D benefit. During last year's legislative session, there was discussion about the financial health of the VPharm program, and whether the program could be enhanced for beneficiaries by either lowering premiums or lowering co-pays for Vermont's VPharm-eligible elderly and disabled. Since there were also changes made during the last legislative session to the state rebate program which affected VPharm rebates, it was unclear what impact these changes would have on the program. A decision was made to complete an analysis that would assess these changes and provide recommendations to the aforementioned committees during the 2013 Legislative session.

DVHA does not recommend any changes to the VPharm program at this time. Our successful rebate programs have allowed the state to operate the pharmacy program with minimal costs to the state budget, offsetting some of the medical and drug premium assistance costs associated with operating the program. The new rebate methodology is significantly improving manufacturer compliance, but overall rebate assessments to individual manufacturers is less as a result of the rebate being based on the amount of the state's proportion of the claims payment. If a change was recommended to

decrease the amount of financial participation contributed by individuals, it would cause a general fund shortfall which would have to be addressed through some other mechanism. Currently individuals expend $3.2 million in order to benefit from $9.1 million in pharmacy and Part D premium coverage.

Description of VPharm Program

VPharm assists Vermonters who are enrolled in Medicare Part D with paying for prescription medicines. This includes people age 65 and older as well as people of all ages with disabilities up to 225% of the federal poverty level (FPL). VPharm eligibles pay a monthly premium that ranges from $15-$50 per month depending on their level of income and eligibility. This premium payment is inclusive of their Part D premium as well as their VPharm premium. VPharm consists of two types of coverage. The first is the "wrap" portion of the VPharm benefit which, for Part D covered drugs, pays for the co-pays, co-insurance, deductibles, and/or donut hole for which beneficiaries are responsible, and leaves the beneficiary with a small $1 or $2 co-pay depending on the cost of the drug. The non-"wrap" portion pays for OTC's and diabetic supplies that are not considered Part D covered drugs for which DVHA pays in full, leaving the beneficiary with a small $1 or $2 co-pay depending on the cost of the drug.

There are three levels of VPharm benefits, depending on the eligibility of the individual. VPharm 1 is the most generous and covers the cost-share of all Part D covered drugs in addition to OTC's and diabetic supplies. VPharm 2 and 3 cover only maintenance drugs

covered by Part D, a limited list of OTC's, and diabetic supplies. The chart below summarizes the VPharm benefit levels:

DVHA Pharmacy Programs that "Wrap" Part D Plans

Plan	Benefit	Potential Beneficiaries	Income Limit	Monthly Premium	Beneficiary Copayment/Coinsurance
100% LIS-eligible VPharm Members (can be VPharm 1, 2 or 3)	1) PDP copayments of no greater than $6.60 should be billed to VPharm. Claims greater than this amount will be rejected. 2) Coverage of defined drugs in classes that are excluded from Medicare Part D coverage. (Note: 100% LIS-eligible VPharm members do not have a PDP deductible, donut hole or coinsurance.)	Aged or disabled with Medicare D pharmacy coverage. Requires that Medicare has deemed members eligible for subsidy.	See below: Members can fall into any of the FPL categories listed below for VPharm members.	$15/$20/$50 depending on VPharm plan.	Part D copayment of =/< $6.60 should be billed to VPharm. Patient is responsible for $1 or $2 of the Part D copayment, depending on the cost of the drug.
VPharm 1	1) Payment of the PDP premium not covered by the Low Income Subsidy (LIS) and cost-sharing for drugs covered by beneficiary's PDP and not covered by the LIS (copayment, deductible, coinsurance and "donut hole"), and 2) coverage of defined drugs in classes that are excluded from Medicare Part D coverage.	Aged or disabled with Medicare D pharmacy coverage. No resource limit.	</= 150% of the FPL	$15 per person	Part D copayment/coinsurance should be billed to VPharm. Patient is responsible for $1 or $2 of the Part D copayment, depending on the cost of the drug.
VPharm 2	1) Payment of the PDP premium and cost-sharing for maintenance drugs covered by beneficiary's PDP (copayment, deductible, coinsurance and "donut hole"), and 2) coverage of defined maintenance drugs in classes that are excluded from Medicare Part D coverage.	Aged or disabled with Medicare D pharmacy coverage. No resource limit.	>150% but </= 175% of the FPL	$20 per person	Part D copayment/coinsurance for maintenance drugs should be billed to VPharm. Patient is responsible for $1 or $2 of the Part D copayment, depending on the cost of the drug.
VPharm 3	1) Payment of the PDP premium and cost-sharing for maintenance drugs covered by a beneficiary's PDP (copayment, deductible, coinsurance and "donut hole"), and 2) coverage of defined maintenance drugs in classes excluded from Medicare Part D coverage.	Aged or disabled with Medicare D pharmacy coverage. No resource limit.	>175% but </= 225% of the FPL	$50 per person	

VPharm Over-The-Counter (OTC) Pharmacy Coverage	
VPharm 1 (100% State funded for deductible, coverage gap, coinsurance and copayments)	1. Manufacturer rebate required. 2. OTC coverage limited to those drugs that are not covered by PDP. A prescription is required, and the drug must be part of the medical treatment for a specific current health problem. There is no coverage for OTC proton pump inhibitors.

	3. Prior authorization and other limitations of the Preferred Drug list (PDL) may apply. 4. Coverage is limited to generic drug formulations except as specified in the PDL
VPharm 2 & 3 (100% State funded for deductible, coverage gap coinsurance and copayments)	1. Maintenance drug coverage only. 2. Manufacturer rebate required. 3. OTC coverage limited to diabetic supplies, loratadine, cetirizine and non-steroidal anti-inflammatory analgesics (NSAIDS) when not covered by PDP. A prescription is required, and the drug must be part of the medical treatment for a specific current health problem. 4. Prior authorization and other limitations of the Preferred Drug list (PDL) may apply. 5. Coverage is limited to generic drug formulations.

VPharm Rebate Governance

The 'wrap" portion of the VPharm program is defined as a State Pharmaceutical Assistance Program (SPAP) and is completely funded by state dollars, therefore it is governed by our State-only rebate program. Up until the changes implemented on **July 1, 2012**, the level of state rebate was defined as at least as much as the full amount of a "Medicaid-level" rebate DVHA collects on its federally-funded programs. The specific language follows:

Prior to July 1, 2012

33 V.S.A. § 1901 – Administration of program

(a)(4) A manufacturer of pharmaceuticals purchased by individuals receiving state pharmaceutical assistance in programs administered under this chapter shall pay to the department of Vermont health access, as the secretary's designee, a rebate on all pharmaceuticals for which state-only funds are expended in an amount at least as favorable as the rebates provided under 42 U.S.C. section 1396r-8 paid to the department in connection with Medicaid and programs funded under the Global Commitment to Health Medicaid Section 1115 waiver.

33 V.S.A. § 2073- VPharm assistance program

(f) A manufacturer of pharmaceuticals purchased by individuals receiving assistance from VPharm established under this section shall pay to DVHA, as required by section

1901 of this title, a rebate on all pharmaceuticals for which state-only funds are expended in an amount at least as favorable as the rebate paid to DVHA in connection with the Medicaid program.

This required manufacturers to pay a full rebate based on utilization in the VPharm program, even though we were wrapping the Part D benefit. Many manufacturers were opposed to paying a full rebate on drugs for which DVHA was only paying a portion of the claim. For example, a prescription for 100 tablets that costs $100 and for which Part D pays $80, leaves the member with a $20 co-pay. The manufacturer was obligated to pay 100% of the Medicaid-level rebate based on 100 tablets of utilization. In some cases, the rebate assessed could exceed the $20 amount paid on the claim by DVHA. This was not felt to be an equitable allocation of rebates and caused non-payment issues by some manufacturers. In order to provide a more reasonable rebate calculation and improve on-time rebate collections, the legislation was modified to apply a rebate on all pharmaceutical claims for which state-only funds are expended in an amount that is in proportion to the state share of the total cost of the claim. In the example above, after July 1st, 2012 if the full Medicaid rebate was $35, the manufacturer would be obligated to pay 19.54% of $35, or $6.49 on a $20 payment. The specific language follows:

After July 1st, 2012

33 V.S.A. § 1901 – Administration of program
(a)(4) A manufacturer of pharmaceuticals purchased by individuals receiving state pharmaceutical assistance in programs administered under this chapter shall pay to the department of Vermont health access, as the secretary's designee, a rebate on all

pharmaceutical claims for which state-only funds are expended in an amount that is in proportion to the state share of the total cost of the claim, as calculated annually on an aggregate basis, and based on the full Medicaid rebate amount as provided for in Section 1927(a) through (c) of the federal Social Security Act, 42 U.S.C. Section 1396r-8.

33 V.S.A. § 2073- VPharm assistance program

(f) A manufacturer of pharmaceuticals purchased by individuals receiving assistance from VPharm established under this section shall pay to DVHA, as required by section 1901 of this title, a rebate on all pharmaceutical claims for which state-only funds are expended in an amount that is in proportion to the state share of the total cost of the claim, as calculated annually on an aggregate basis, and based on the full Medicaid rebate amount as provided for in Section 1927(a) through (c) of the federal Social Security Act, 42 U.S.C. Section 1396r-8.

Rebate Collections

Since the implementation of this change, there has been a positive movement by manufacturers to pay past due balances and stay current with rebate collections. For rebate calendar year 2011, there were 290 manufacturers whose products were reimbursed under the wrap portion of the VPharm benefit. Of that, 30% of manufacturers paid the amounts due in 2011, while the majority did not comply under the previous rebate calculation methodology. As of the date of this letter 204 manufacturers or 70%, have remitted to the State the invoiced amounts for calendar

year 2012. Efforts are underway to achieve a higher compliance rate and DVHA is in the process of working with an additional 17 manufacturers to collect amounts due.

Financial Analysis

SFY '14 Approp.	VPharm1	VPharm2	VPharm3	TOTAL VPHARM	
Pharmacy	1,792,974	2,770,457	2,871,025	7,434,456	
Co-Pays Paid by the Beneficiary	*263,614*	*216,528*	*230,658*	*710,800*	
PDP Premium	306,490	744,311	726,585	1,777,386	
Current-Year Drug Rebates	(1,079,728)	(1,760,786)	(1,823,532)	(4,664,046)	*
Supplemental Drug Rebates	(16,706)	(2,633)	(3,022)	(22,361)	
TPL	(29,859)	(39,314)	(1,370)	(70,543)	
TOTAL CURRENT-YEAR PHARMACY COSTS	1,236,785	1,928,563	2,000,344	5,165,692	
Beneficiary Premiums	(1,410,820)	(668,757)	(1,164,498)	(3,244,075)	
Beneficiary Co-Pays	(263,614)	(216,528)	(230,658)	(710,800)	
TOTAL CURRENT YEAR NET PHARMACY COSTS	(437,649)	1,043,278	605,188	1,210,817	
Medical Benefit Covered	1,483,116	17,989	12,575	1,513,680	
Cost Settlements	1,267	13	0	1,280	
Buy-In Benefit Covered	5,632,490	195,395	103,430	5,931,315	
TOTAL CURRENT YEAR VPHARM PROGRAM	6,679,224	1,256,675	721,193	8,657,092	
State Funds For Current Year Pharmacy Only	*83,119*	*987,222*	*1,198,815*	*2,269,156*	
State Funds For Current Year Pharmacy Excl. Rebates	*1,088,952*	*2,736,360*	*3,008,978*	*6,834,290*	
State Funds for Current Year Total Program	*3,203,484*	*1,084,027*	*1,257,416*	*5,544,927*	
*note: SFY '14 appropriated includes an additional $3.2 million of one-time prior-year rebate collections.					

Recommendations

DVHA does not recommend any changes to the VPharm program at this time. Our successful rebate programs have allowed the state to operate the pharmacy program with minimal costs to the state budget, offsetting some of the medical and drug premium assistance costs associated with operating the program. The new rebate methodology is significantly improving manufacturer compliance, but overall rebate assessments to individual manufacturers is less as a result of the rebate being based on the amount of the state's proportion of the claims payment. If a change was recommended to decrease the amount of financial participation contributed by individuals, it would cause a general fund shortfall which would have to be addressed through some other mechanism. Currently individuals expend $3.2 million in order to benefit from $9.1 million in pharmacy and Part D premium coverage.