STATE OF MAINE
114TH LEGISLATURE
FIRST REGULAR SESSION

COST CONTAINMENT FOR PRESCRIPTION DRUGS

A Report
of the
Joint Standing Committee on
Business Legislation

December 1989

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EXECUTIVE SUMMARY

Below is a list of the major questions posed to the Study Committee and the Committee's response:

Question: Are there any problems with safety in having prescriptions filled by mail?

Answer: The Committee found no evidence that there was any difference in safety between having a prescription filled by mail and through an in-state pharmacy.

Question: Is mail order a less expensive way for an employer to provide for the filling of prescriptions for maintenance drugs?

Answer:

1. Broadly speaking, the Committee was not able to answer this question. The Committee had neither time nor money to set up its own test design. It was, therefore, forced to rely on published sources, which were found to be sponsored by one interest group or the other and produced conflicting results. The Committee did determine that one reason this question may be unanswerable is that there are too many variables, prominent among them the details of the specific programs.

2. In terms of the Maine program specifically, the question is easier to answer, at least in the short run.

   The State experienced a 128% increase in benefits paid for prescriptions the first year of the mail program, compared to a year to year increase of approximately 65% the year before mail order. The second year of mail order gave an additional 44% increase, suggesting that the program may stabilize, but at the higher level.

   What is more difficult to answer is the why of this increase, which greatly exceeds the experience of any states or experts contacted. Is it solely due to increased awareness of the prescription benefits and the convenience of mail order or is it a better financial deal for employees and a worse one for the state through mail order?

   The Committee was unable to answer these questions from State data, but from review of the experience of other states and the opinions of consultants, it appears that the failure to

ask the employee to share the cost of mail order through a co-pay may have been a contributing factor to the substantial increase in employee claims coincident with the introduction of mail order.

Question: Should all pharmacies be entitled to participate in a 3rd party prescription drug program?

Answer:

1. The Committee determined that the cost containment benefits of such a program to employees and employers are sufficient as to justify a limited enrollment preferred provider program.

2. The Committee determined that the requirements for participation in the State's prescription card program were easily complied with and found no evidence of any significant number of pharmacies that had not elected to join the program.

3. The Committee determined that the next time the State bids its mail order prescription business there will be an opportunity for pharmacies to submit a bid that calls for filling these prescriptions at retail. However, it should be noted that under terms of the State's Medicaid contract, Medicaid would have to be offered the same terms as offered to the State employees' program.

Question: Should the co-pay for the mail portion of a 3rd party prescription drug program be the same as for the prescription card portion?

Answer:

1. Based on the specifications of the current State program and data from other states and consultants in the field, the Committee determined that mail order is currently a more cost effective way than the card for the State to reimburse for employee prescriptions.

2. As is the case in most states, Maine does not have detailed data on its major medical program, thus making a comparison with mail order difficult. Indications are beginning to emerge on a national basis that unless there is a significant mail order co-pay, it may not be as cost effective for the employer as first thought. However, the question of co-pay is subject to collective bargaining, so that the

Committee felt that it should not attempt to influence this issue. The Committee did feel that a mail order program has significant convenience advantages in a state like Maine and that some additional state expense is justified in order to provide this convenience.

LEGISLATIVE BACKGROUND

The origin of this study lies in a change in the State employee benefits program implemented in July, 1988 by which State employees were given two additional ways in which they could be reimbursed for their physicians' prescriptions; that is, through the mail at no cost or through the use of a plastic charge card with a cost of $5 for a branded drug and $3 for a generic drug. These provisions were added to the existing program which allowed submission of prescription expenses as part of the employee's major medical benefit which pays 80% of the cost after a $100 deductible is met.

The mail order portion of the contract for program services was awarded to Medco, a New Jersey firm, which resulted in Maine pharmacists losing that portion of the mail order business represented by their mark-up on prescription drugs, all of which are manufactured by out-of-state firms. In the fall of 1988 the Pharmacy Group of New England, consisting of independent Maine pharmacies plus Laverdieres, sued Medco, Blue Alliance, the Superintendent of Insurance, the Board of Pharmacy and the Employees Health Program. As summarized for the Committee by the Attorney General's Office, the key points alleged by the plaintiffs were as follows (Appendix R).

1. All pharmacies are entitled to participate in all aspects of any 3rd-party prescription drug program on the same basis. The assistant attorney general writing to the Committee, states that she feels current law was unclear on this point.

2. The State's 3rd party prescription act (See Appendix D) is preempted by the Employee Retirement Income Security Act (ERISA). The Attorney General's office indicated that they felt this to be a complex question. The plaintiff did not pursue the suit and it was dismissed.

As a further result of the concern generated by the loss of this business, two bills were introduced in the First Regular Session of the 114th Legislature. LD 1083 required that an organization selling drugs by mail would be required to maintain a facility in the State. LD 1311 required that there be a mail order co-payment equal to that required of pharmacy card purchases and that the employee card plan be open to all pharmacies.

Both these bills were eventually referred to the Committee on Business Legislation and that Committee elected to appoint a subcommittee (hereafter referred to as the Committee) to study between sessions the issues raised at the various public hearings by the proponents and opponents of these bills.

METHOD

The study committee heard from invited witnesses on August 28th, October 2nd and October 16th. A list of those witnesses is in Appendix F. In addition, the Committee held work sessions on October 30th and November 13th to arrive at its conclusions and recommendations. Members of the entire Business Legislation Committee were invited to the last session and three attended.

At the Committee's request, staff contacted many national organizations, universities and consultants. The Committee and its staff is appreciative of the willingness of these people to assist Maine in its study of these issues.

Staff also reviewed a large amount of secondary source data. The more pertinent articles are cited in the text and are included in a bibliography.

FINDINGS

BACKGROUND (Excerpted from Bibliography 1.)

A. History

The mail order prescription drug industry is not a new phenomenon. Formal organizations created for the purpose of distributing prescription legend pharmaceuticals to the general public have been in operation on a large scale since the 1960s. The largest entry in this market, the United States Veterans Administration, existed even before that. It dispenses prescriptions through the mails to more patients and at a greater volume than all of the rest of the industry combined. Excluding the Veterans Administration mail out services, the mail order prescription drug industry began with a number of small firms who advertised prescription services directly to the public through magazine advertisements where consumers were encouraged to send for catalogs and ordering information, etc. This branch of the pharmacy distribution system was vigorously opposed by virtually all organized pharmacy associations and nearly 20 years later, the Justice Department closed an ongoing antitrust investigation with the stipulation that national pharmacy organizations agree not to undertake activities to restrict or harm the mail order prescription drug industry. Given the negative image portrayed about mail order dispensing of drugs by the very powerful and well established pharmaceutical organizations as well as the mainstream of the profession, the original mail order pharmacies had a difficult time maintaining economic viability. In fact, there were a number of mergers and purchases with few of the original entities surviving today.

In addition to the Veterans Administration, the major organizations in the field include Retired Persons Services which provides mail order pharmaceuticals for the American Association of Retired Persons and a number of newer mail order pharmacy entities which contract with fiscal intermediaries, insurers, third-party payors and other facets of the insurance industry, rather than selling their services directly to the public. The major players in this arena would include Medco Cost Containment and Express Pharmacy Services, a subsidiary of Thrift Drug Stores which is owned by the J.C. Penney Company. Within the last several years, there has been a large increase in the number of additional entries into the mail order pharmaceutical industry. Baxter Laboratories as well as a growing number of chain pharmacies and other unrelated corporations have entered the field, generally through acquisitions.

It is estimated by the National Association of Mail Service Pharmacies that 68 million prescriptions were dispensed through mail service pharmacies in 1988. The Veterans Administration is thought to be responsible for 50 percent of these, with the American Association of Retired Persons the source for 12 percent and the other 38 percent of prescriptions accounted for by the for-profit companies.

Independently owned community pharmacies through the National Association of Retail Druggists (NARD), the trade group for independent pharmacy owners, have made efforts to restrict or ban the mail order pharmaceutical organizations. Legislation has been submitted as well as proposals for regulations within boards of pharmacy at the state level. Nevertheless, the industry appears to be thriving and growing based upon virtually any criteria or parameter.

B. Nationwide Practices

1. Regulation

A 1988 study by the National Association of Boards of Pharmacy indicates that 20 states regulate mail order pharmacy; two by rule and the rest by legislation. In the same year, the American Medical Association reported 9 states as regulating mail order by law. A compilation put together for the Committee by Nicholas Willard of the American Association of Retired People shows 13 states regulating mail order, 8 by registration and disclosure and 5 by licensure. Maine is currently in the process of completing a fairly typical registration and disclosure type regulation but is somewhat unusual in having so much of its substance in rules, not law.

2. Employee Benefit Programs

A survey conducted by the Director of the State employee benefit program reveals that 14 states have a mail order employee benefit, while 12 have a card plan. Interestingly, Maine is one of only 2 states that offer both plans.

A 1988 Survey by Foster Higgins Co. reveals the following:

	Mail Order Only	Card Only	Mail Order & Card
All Respondents			
New England	4%	15%	2%
Government	1	29	8
20,000-39,999 Employees	34	8	7

THE ISSUES

Essentially, two issues were presented to the Committee as regards mail order pharmacy; namely, is it safe, and is it any less costly. The Committee's attention was quite quickly drawn to the cost issue, as after considerable study, it was unable to develop any evidence that there was any difference in safety between prescriptions filled by mail and those filled at a pharmacy.

COST

Cost, however, proved to be a very difficult issue to resolve.

I. The Situation Nationally

One of the major problems confronted by the Committee is that virtually all studies of the cost of mail order pharmacy have been done by persons representing one or the other side of the issue, or sponsored by one side or the other. This includes the university based studies. It proved very hard to find an objective expert.

A great many of the national "studies" of mail order pharmacy have been merely a collection of anecdotes. There has been generally considered to be only three significant studies.

A. "Actuarial Study of Mail Order Drug Option Expense", Richard Sieber, Pharmaceutical Card System, Inc.

Pharmaceutical Card System, Inc. is a prescription drug claims processing organization. The results of this study have been attacked as biased against mail order. The study identifies two places where mail order offers an opportunity for cost saving. One is the cost of the drugs. According to the study there is virtually universal agreement that an increase in the use of generic drugs has the potential to lower the cost of the drug benefit. The other component is the dispensing fee. On the one hand, economics of scale and low operating costs offer the potential for cost savings. However, the Sieber study indicated that mail order expenses exceeded expected charges by 5%. He found a lowering of unit costs by 4% that was more than balanced by increased volumes of ingredients and days of fill of slightly over 9%. Sieber speculated that the greater volumes purchased represent an acceleration of plan sponsored costs, since there is prepurchase of future monthly refills and these increase exposure to the cost of spillage, wasteage and that patient noncompliance or physician modification of treatment would be very costly with such large quantities dispensed.

Because of attacks on the methodology of this study, PCS contracted with the actuarial firm of Towers, Perrin, Foster & Crosby to review the methodology. This firm concluded that the study must be interpreted with care and was principally useful in providing hypotheses for future research.

B. "The Economics of Mail Service Prescription Plans", Boston Consulting Group, July 1987.

This study was sponsored by Medco Containment Services, a firm which was estimated in 1988 to have about 60% of the business in the for-profit mail-service industry and is the contractor for the Maine State Employees Program. This study concluded that mail service has the potential of offering cost savings of 20-25%.

C. "A Case-Specific Experience Study of the Cost-Effectiveness of Mail Service Drug Option Plans", M.J. Barberi, M.D. Sydlaske and D. Wilson, Mercer-Meidinger-Hansen, Inc., New York, NY Sept. 1987.

This study was sponsored by Medco Containment Services. The study concluded that mail service reduced total gross cost and that increased drug utilization was not a significant factor. Gross savings were found to vary directly with the degree to which long-term maintenance medications are used by a group and the percentage of prescriptions for those medications filled through mail services.

Thus, for some time after the publication of these studies, the public was faced with a dilemma in attempting to resolve their conflicting findings. Several projects have developed as attempts to solve this dilemma.

(1) "Safety and Soundness Standards in the Mail Order Prescription Industry", The Subcommittee on Government Efficiency, Federalism and the District of Columbia of the Committee on Governmental Affairs of the United States Senate, Aug. 5-6, 1987.

This report contained 684 pages which appeared to result in a large enough document for anyone to read in it what they wished. It has been used principally by mail order opponents, but their arguments have been fairly successfully rebutted by proponents.

(2) "Mail-Service Pharmacy Evaluation", A. I. Wertheimer and R. Pialla, Department of Graduate Studies in Social and Administrative Pharmacy, University of Minnesota, March 1989.

This study was sponsored by the American Association of Retired Persons, which provides mail order pharmaceuticals to its members. The study does, however, read as being an objective study. The conclusions and recommendations are not particularly definitive but include the following points.

> **(a)** "It could be a reasonable approach to dispense drugs in quantities of at least 3 months and perhaps greater depending on the specific characteristics of the therapeutic category and the health and emotional status of the patient.
>
> **(b)** There is no recommendation whatsoever or any sympathy for the prescribing of large quantities of psychoactive drugs or other controlled substances which may be subject to abuse or addiction.
>
> **(c)** It would not be difficult to issue guidelines of recommendations for physicians as to when the larger quantities of drugs might be appropriate. These periods would be after the mean periods of time for expected patient dropouts due to tolerance or other problems which require the prescribing of a different product."

(3) A study of the possible impact of a mail order benefit on Medicare System costs. Health Care Finance Administration, Maryland, Approximate publication date January, 1990.

> The Medicare Catastrophic Coverage Act of 1988 mandated that the Health Care Finance Administration conduct a study of the impact that the institution of a mail order benefit would have on system and beneficiary costs. This report has been completed and is in the review process at HCFA. This process has been held up because of the possible repeal of the majority of the Catastrophic Coverage Act. Staff has been told that some version of the report should be available by January, 1990.

Staff spoke with several professors who had been involved in the contract to conduct the study. They indicated that no safety problems relative to mail order were encountered. Staff was further told that the unwillingness of mail order providers to provide detailed information prevented any primary research in the area of cost, and forced the researchers to rely on secondary data. They indicate that tentative conclusions are that they were unable to take a firm position on the cost issue.

Interestingly, the most definitive study, at least in terms of the Committee's needs, was not a nationwide one. It was "Mail Order Prescriptions", Joint Standing Committee, Michigan Legislature. The conclusions are in Appendix X. The following are the most pertinent of the findings:

(a) "Cost savings may be illusory to the payor of the benefit.

(b) Mail order appears to be a safe & convenient method of obtaining pharmaceuticals.

(c) Rapid growth indicates high consumer acceptability of mail order.

(d) A major objection to mail order is that it reduces patient/pharmacist communication. However, some people question how much interaction actually does take place."

The Maine Committee found no reason to disagree with these conclusions.

Michigan has gone very slowly in terms of implementing changes as a result of this study. In the first place, state action is limited by constitutional interstate commerce and ERISA preemption problems. In the second place, employee benefit programs are often beyond the province of legislative review and are also generally the result of collective bargaining. To date, the only action proposed by the Michigan Legislature is a letter to their plan's administrative body requesting them to closely monitor the program and develop an annual report.

II. The Situation in Maine

A. Program Cost

In July, 1987 Maine offered its state employees a mail order option to pay for their prescription drugs and in July, 1988 added a fixed pay card to the options available. For the year end 7/88 the expense of reimbursing employees for their drug expenses was 130% greater than the year end 7/87, while for the last year prior to the plan the yearly increase had been 65%. For year end 7/89 the increase was 231% greater than the base year of 7/87. Eighty-seven percent of the latter increase came from mail order and 27% from the card, while major medical had a reduction equal to 14% of the overall increase. Employee use practices in the latest quarter show 27% using mail order. Data was not available concerning the incidence of use of the card.

The program cost increases observed were of a magnitude far in excess of the experience of any out-of-state experts that Committee staff contacted. For example, the 1988 national survey by Foster Higgins (Appendix K) showed the average effect of a mail order or card program in government programs was 7.5% increase in expenses, while among those reporting an increase, the average was 21.9%. Also, Martin E. Segal Company's 1989 Survey of State Employee Health Benefit Plans shows for 1988 a yearly increase in the consumer price index medical component of 7% and an increase in the average total cost of state employee health plans of 20%. The magnitude of Maine's increase resulted in the Committee focusing its attention on trying to explain and deal with the increase. Since their interrelationship prevented doing otherwise, the Committee included the card plan in its efforts.

B. Committee Authority

It is desirable for the reader to keep in mind in reviewing the Committee's activities, as it was for the Committee in conducting them, the following statutory provision of 5 MRSA §285, sub-§2.

> "The provisions of these group insurance policy or policies shall be determined, insofar as the provisions are not inconsistent with terms and conditions contained in collective bargaining agreements, by the State Employee Health Commission."

The Health Commission is a 15 member labor management commission, with 10 of its members required to be picked on the basis of their membership in various bargaining units. A description of current membership is in Appendix N.

C. Reasons for Cost Increase

The Committee was not able from analysis of existing data to identify a reason for these increases. Part of the inability to do so was occasioned by the absence of detailed data on the major medical program, a lack which appears to be experienced in all states. Interestingly, a 1989 article in Pension World stated that major medical seems to be a more cost effective way than mail order of providing drug benefits. Further, in the November 20, 1989 issue of Business Week, Foster-Higgins, one of the leading researchers and consultants in health care issues, stated that about half the companies in their annual national survey found that preferred provider agreements, such as Maine has, had no appreciable effect on restraining health care cost. In the Foster-Higgins Survey previously cited, of all government respondents offering mail and/or card, 50% reported an increase in expenditures versus only 22% reporting a decrease. As indicated earlier in the report, the average increase was 22%. These commentaries highlighted the difficulty of managing a prescription program without adequate data. Because of the absence of detailed major medical information, the Employee Health Care Commission had little hard data on which to base its decision to go to mail order and to set goals for evaluating the results of this decision.

The Committee felt strongly that it is necessary for the Director of the State Employee Health Program and the Employee Health Care Commission to have and use data reports in order to manage the program, i.e. to set goals and objectives and then determine if they are being met. One of the often mentioned benefits of mail order and the card is the data that they generate to allow one to manage a program. It was the Committee's conclusion that the regular reports called for in the Medco bid response are adequate in this regard. (Appendix Q) (There is some question, however, as to whether the user profile data is being produced and, as noted previously, no data is produced on the instance of use of the card.) However, a 1988 magazine article (Biblio. 4) concluded that no mail service provider has a national, industry-specific base to which an employer can compare his data. The Committee found this to be true of Medco. Three examples of the problems inherent in the lack of nationwide data were the Committee's inability to evaluate the following potentially actionable statistics:

a. For the 3rd quarter 1989, nineteen percent of mail order drugs dispensed were for a brand drug when a generic was available, while the figure for the card was 25%.

b. Forty-five percent of retirees utilized mail order in year end June, 1989 versus 31% of active employees.

c. For year end June, 1989 forty-eight percent of prescriptions dispensed in the card program were for maintenance drugs.

The article found that venders have not really considered sophisticated management reporting systems. Medco was singled out as having the potential to provide these types of reports but needed client direction.

The Committee was, therefore, forced to rely primarily on conjecture for trying to explain this large increase. It was generally felt that the reasons were (1) increased awareness of the prescription benefit (2) the convenience of the new options (3) the less expensive nature (to the employee) of the new options.

The only one of these that it is possible to analyze objectively from existing information is the third. Through the major medical program the employee was only reimbursed 80% and only after a $100 deductible was met. Mail order reimburses from the 1st dollar and covers the entire cost. The card plan reimburses from the 1st dollar and requires a co-pay of $3 for generic and $5 for branded drugs.

At the time the terms of the program were agreed upon, which is perhaps as long ago as three years, the terms in it were probably standard for what was then only an emerging health care option. Since that point, experience on a national basis has tended to result in the following trends:

(1) Institution of a co-pay into mail order programs. Medco has indicated that this ranges between $4 and $8 for their clients.

(2) In at least one incidence, elimination of the card plan. South Carolina eliminated the plan after only 9 months, when it was determined it was costing the state $10 million. South Carolina does not have mail order and will be reverting to major medical. According to South Carolina officials, a number of private companies are also abandoning the card plan.

(3) An increase in the average spread between the card co-pay for branded and generic drugs from $2 to $3.

(4) An increase in the branded co-pay of between $7 and $12 and the generic between $4 and $8, or introduction of a deductible.

D. Methods of reducing program costs

The Committee looked at a number of ways of reducing the costs of the program, a great many of which came from Appendix BB. Those national experts who are familiar with Maine's program felt that cost savings would be best generated by providing employee incentives or passing some costs onto the employee rather than focusing on the provider aspects of the program. For example, they feel the use of generic drugs in the Maine program is at a good level. These figures for the latest quarter are 38% generic for the card program and 33% for mail order. Supporting this point of view is that the latest quarterly Medco report indicates a client saving per mail order claim of $7.85 and an employee saving of $9.72. However, they also admitted that once the employee benefits of such a program are in place it is very difficult to change them. For example, The Federal Mediation and Conciliation Service estimates that 60% of the 85 strikes that it is mediating involve health benefits issues.

Among the cost cutting measures explored by the Committee were the following:

(1) Provider oriented

(a) Pharmacist

(i) Provide the pharmacist a generic dispensing incentive, e.g. a higher dispensing fee, probably between 50% and 100% higher. (Maine's current fee is $3.35).

(ii) Require that pharmacist substitute generic drugs when the doctor okays. (12 states, including New Jersey, do this. Most, however, give the purchaser an option.) (Maine now allows it.)

(iii) Require that the full cost savings of generic drugs be passed on. (14 states, including New Jersey, have this requirement.) (Maine requires only that the generic price be no higher than the brand name.)

(b) Physician

(i) Board developed guidelines to physicians as to when mail order quantities of drugs are appropriate.

(ii) Board developed drug prescribing protocols.

(iii) Physician incentive programs based on cost effectiveness in prescribing.

(c) Both

(i) Institute Board developed mandatory generic drug formulary. (24 states, including New Jersey, have some version of this.)

(2) Patient oriented

(a) Provide that a patient who requests a branded drug pay the difference between it and the generic.

(b) Introduce a co-pay or co-insurance into the mail order program but retain the incentive for it versus the card.

(c) Increase the spread between the card co-pays for branded and generic drugs.

To discuss some of the items individually:

(1) Plastic cards

As mentioned earlier, some employers have found the card to be expensive. A 1986 article (Biblio. 3) cited the following negative aspects of card programs, at least as of that date:

(a) Card plans typically include perverse features that, in effect, reward providers for high claims volume and for dispensing the highest cost brand-name drugs.

(b) The plans are inefficient because they provide little or no incentive for employees to be better or more informed purchasers. They also do nothing to encourage pharmacists to be more efficient purchasers of pharmaceuticals.

As indicated in the article, New York found the following experience with its card program:

(i) Too many brand-name drugs were prescribed and dispensed.

(ii) Dispensing fee costs were high. (However, they did not have a mail order option at that time.)

(iii) A generous ingredient cost formula was used to reimburse pharmacists.

One hundred percent of the average wholesale price was reimbursed, (as it is in Maine), while it is well known that pharmacists generally purchase drugs at less than average wholesale. A 1989 article in Pension World (Biblio. 6) states that pharmacists rarely pay more than 89% of the listed wholesale price of a drug. (Maine uses AWP minus 6% for branded and 20% for generic in its mail order program.)

(iv) Management reports were inadequate.

(v) Performance standard audits were inadequate.

Michigan has a yearly 3rd party audit of its plan and feels that it is one of the most important elements of its program. (See Appendix S). The Maine Study Committee felt that the internal Medco audits were adequate and nothing at this stage would justify the considerable additional expense of a 3rd party audit.

In a 1989 magazine article (Biblio. 7) James Manning, Senior Executive Vice President of Medco, is quoted as saying that they are seeing "a lot more employers that are more willing to put in restrictions on these plans, such as front end deductibles and co-pays. In the same article, Donald Dahler, President of PCS, Inc., the largest card program vender, states that more employers are interested in implementing annual deductibles in addition to co-payments under the card plan.

Finally, an article in the April, 1989 issue of Business and Health (Biblio. 2) quotes several consultants as stating that the high utilization and low generic substitution of card plans are calling them into question. Enrollees are found likely to purchase marginally useful drugs that they would not otherwise purchase. "Card plans make drugs much more accessible." Lastly, they state that the card plans often have negligible audit and utilization review components.

(2) Mail Order

An analysis of experience with prescription drug programs in the February, 1989 issue of Business Insurance (Biblio. 7) quoted Kris Gibney, President of the Prescription Service Division of Baxter Health Care Corp., perhaps Medco's major competitor, as stating that employers should be sure that mail order co-payments are high enough to share costs with employees. She recommends near $8, as that is about equal to 20% of the cost of the supply of the drug. An article in Pension World (Biblio. 6) states that with mail order plans most sponsors continue the per prescription deductible. However, the article states, there is a tendency to raise the deductible as the cost of drugs increase, so the same percentage of employee participation is maintained.

A study by the Rand Corporation (Biblio. 9), cited in a November 20, 1989 Business Week article, found that health costs dropped when participants were forced to pay higher deductibles and there appeared to be no differences in health between those who used the health services most and those who used it least.

(3) Formularies

An article in Forbes magazine for October 30, 1989 (Biblio. 5) states that some states are adopting "formularies," i.e. lists of drugs approved for reimbursement. Further, states are viewing these formularies as tools to get price breaks on drugs protected by patents.

(4) Generic Drugs

The latest Medco quarterly report indicates the following relative to savings on generic drugs:

	Amount Saved	Additional Amount That Could Be Saved
Mail Order	$177,279	$103,639
Card	90,558	63,740

In the previously cited Foster-Higgins National Survey, 44% of those offering a generic drug program of some sort reported that it resulted in a cost reduction, while only 4% reported an increase.

Relative to both these points, however, there are those experts that feel that Maine can not expect to greatly exceed its current generic level without initiating a much more controlled environment than the State's plan envisions.

RECOMMENDATIONS

1. To the extent that it is possible within the requirement that all collective bargaining units be represented, experience in some area that relates to the Commission's operation should be a criterion for selecting members of the State Employees Health Care Commission.

2. Third-party prescription drug programs that do not have open enrollment should be subject to the appropriate Preferred Provider Arrangement Act.

3. New providers of third-party prescription drug programs that will not have open enrollment should no longer be required to give notice to all pharmacies of the institution of the new program.

4. Pharmacists should be required to dispense generic drugs unless the doctor indicates that they should not be dispensed. The pharmacist should be required to pass on the entire cost saving incurred through the use of generic drugs. Purchasers should be given the option of refusing the generic, but only after the cost saving has been explained to them.

Currently, the pharmacist is allowed to dispense generic drugs and must charge a price no higher than that of the branded drug. They are not required to give the purchaser the option of refusal.

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#288LHS

APPENDIX A

STATE OF MAINE
ONE HUNDRED AND FOURTEENTH LEGISLATURE
COMMITTEE ON BUSINESS LEGISLATION

June 8, 1989

Rep. John L. Martin, Chairman
Legislative Council
State House Station #115
Augusta, ME 04333

Re: Request for study

Dear Chairman Martin:

The Committee on Business Legislation would like to request a study of third-party prescription programs. This request is in response to 2 bills which came before the committee in the last session: LD's 1083 and 1311. These bills presented complex and important subjects which the committee was not able to adequately deal with, particularly since the latter was rereferred to the committee quite late in the session.

The details concerning this study request are as follows:

I. Study subject & tasks

A. Subject of study

The subject of the study is third-party prescription programs and the use of mail order prescriptions in conjunction with them.

B. Specific questions to be examined

1. Should there be a change in the law relating to mail order prescriptions, in general, and particularly in conjunction with third-party prescription programs?

2. For which, if any, of the following reasons does fulfillment of a prescription by mail order constitute a threat to the citizens of Maine?

STATE HOUSE STATION 115, AUGUSTA, MAINE 04333 TELEPHONE: 207-289-1331

(a) Such a process might result in the demise of many retail pharmacies and, therefore, people living in small towns may be without a local pharmacy.

(b) The fact that mail order suppliers are generally large firms located out-of-state might result in the following problems:

1) prescriptions may be filled under laws less strict than Maine's.
2) their fulfillment will not be subject to Maine's disciplinary procedures.

(c) The fact that the prescription is filled by mail is more apt to result in misfilled prescriptions.

(d) The fact that the prescription is filled by mail may result in the loss of the following:

1) maintenance of, and reference to, the patient's profile by the pharmacist.
2) patient counseling by the pharmacist
3) the face-to-face evaluation of the patient by the pharmacist.
4) easy contact between pharmacist and doctor.

(e) The introduction of a mail order option will result in the consumer getting his drugs from 2 sources, which could result in taking drugs that should not be taken together. Several hypotheses need to be checked as to current patient behavior:

1) do patients get prescriptions from more than 1 doctor?
2) do patients have prescriptions filled at only 1 pharmacy?

3. Are Maine pharmacists providing consumer counseling and making reference to patient profiles? Are these important consumer benefits?

4. Would regulation of out-of-state mail order result in interstate commerce or other constitutional problems? Would it be preempted by the Employee Retirement Income Security Act of 1974 (ERISA)?

5. Does mail order represent a cost saving? To the patient? The employee? The insurer? Is this true if the same brand of drug is used? Is this true if the possible wasteage occasioned by the large quantities required by mail order programs is considered?

6. Should Maine require out-of-state pharmacies to verify the prescription and that a legitimate physician-patient relationship exists?

7. Does use of an out-of-state business by State agencies result in an unacceptable loss of income to Maine businesses and loss of tax dollars to the State.

8. Is the mail order firm that Maine does business with the best available in terms of safety? Price?

C. Specific tasks to be undertaken

1. Invite representatives of the following organizations to appear before the committee at informational sessions:

- State Employees' Health Commission
- Maine Pharmacy Association
- Board of Commissioners of Pharmacy
- Maine Employees' Association
- Blue Cross/Blue Shield
- Paid Prescriptions Programs, Inc.
- National Pharmacies, Inc.
- Maine State Employees' Health Insurance Program
- Board of Registration in Medicine
- Maine Medical Association

2. Since this is an issue in which most states are involved or concerned, contact the National Council of State Legislatures and the Council of State Governments for information.

3. Obtain information from national trade associations such as:

- The National Association of Mail Service Pharmacies
- National Association of Boards of Pharmacy
- American Pharmaceutical Association

4. Since a number of possible solutions to this problem lie in the federal area, keep up to date on the activities of the Food and Drug Administration.

5. Review consumer complaints received on prescription fulfillment with the following groups:

(a) In Maine, with the Attorney General, Pharmacy Association and the Pharmacy Board.

(b) In New Jersey, where Maine prescriptions are now filled, with similar groups.

(c) With similar groups in other states doing business with the firm with which Maine currently does business.

II. Appointment of members

The study shall be conducted by a subcommittee of 5 members of the Committee on Business Legislation chosen by the chairs of that committee. This selection is to be completed by July 1, 1989.

III. Convening of the study group

The Chair of the Legislative Council shall call the first meeting, which is to take place no later than August 1, 1989.

IV. Selection of chair

The Chairs of the Committee on Business Legislation are to select the chair of the study committee.

V. Staffing

Staffing and clerical assistance is to be provided by the Legislative Council.

VI. Compensation of members

All members are to receive legislative per diem and reimbursement for expenses.

VII. Report

The study group is to prepare a report and any supporting legislation that it feels necessary. This report is to be submitted to the Committee on Business Legislation by November 10, 1989. That committee is to present any recommended legislation, with a supporting study if it so desires, to the Legislature by December 1, 1989.

VIII. Administrative item

The Executive Director of the Legislative Council is to administer the committee's budget.

IX. Number of meetings

The study committee is to hold no more than 4 meetings, including those required for organization and for developing conclusions and recommendations. The study committee may hold an additional meeting with the full Committee on Business

Legislation to present its findings to that body. Permission for further additional meetings is to be requested of the Legislative Council.

This is a very important issue to our committee and we hope that the Council will act favorably on this request.

Sincerely,

Sen. John E. Baldacci
Senate Chair

Rep. Carol Allen
House Chair

APPENDIX B

114th MAINE LEGISLATURE

FIRST REGULAR SESSION - 1989

Legislative Document **No. 1083**

H.P. 771 House of Representatives, April 10, 1989

Reference to the Committee on Business Legislation suggested and ordered printed.

Ed Pert
EDWIN H. PERT, Clerk

Presented by Representative McCORMICK of Rockport.
Cosponsored by Senator DUTREMBLE of York, Representative PENDLETON of Scarborough and Representative SHELTRA of Biddeford.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-NINE

An Act to Regulate Out-of-state Mail Order Pharmacies to Ensure the Safety of Prescription Drugs.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 32 MRSA §13702, sub-§13, as enacted by PL 1987, c. 710, §5, is amended to read:

13. Mail order prescription pharmacy. A "mail order prescription pharmacy" means an entity that dispenses or distributes prescription medications by mail or carrier ~~from a facility not located in this State to a patient who resides in~~ Maine.

Sec. 2. 32 MRSA §13721, sub-§2, as enacted by PL 1987, c. 710, §5, is repealed.

Sec. 3. 32 MRSA §13751, sub-§5 is enacted to read:

5. Mail order prescription drug outlet. Each mail order prescription drug outlet dispensing or distributing prescription drugs to a patient who resides in the State shall have a facility located in the State from which those drugs are dispensed. The facility located in the State shall be regulated under all rules applicable to the State's drug outlets.

STATEMENT OF FACT

This bill amends the Maine Pharmacy Act to strengthen the protection of Maine consumers by requiring that out-of-state mail order prescription pharmacies dispensing to Maine residents comply with the same safety standards as Maine pharmacies. This result is accomplished by requiring out-of-state mail order prescription pharmacies to dispense prescription drugs from a facility located in Maine that is subject to all Maine pharmacy rules.

APPENDIX C

114th MAINE LEGISLATURE

FIRST REGULAR SESSION - 1989

Legislative Document **No. 1311**

H.P. 943 House of Representatives, April 24, 1989

Reference to the Committee on Human Resources suggested and ordered printed.

EDWIN H. PERT, Clerk

Presented by Representative HANDY of Lewiston.
Cosponsored by Senator DUTREMBLE of York, Representative JOSEPH of Waterville and Representative RUHLIN of Brewer.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-NINE

An Act to Amend the Third-party Prescription Program Act and Provide for Responsible Health Care Decisions.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 32 MRSA §13773, as enacted by PL 1987, c. 710, §5, is amended to read:

§13773. Notice; registration

No 3rd-party prescription program may be instituted in this State until written notice of the provisions of the program has been filed with the Superintendent of Insurance and given to all pharmacies which are located within the counties covered by the program at least 30 days prior to the commencement of the program. In the case of chain or branch pharmacies, the notice shall be given to the main office or headquarters. These pharmacies shall have 30 days from the date of notice to enroll in the program. The Superintendent of Insurance shall approve only those 3rd-party prescription programs that conform to the provisions of this Act.

Third-party prescription programs shall provide a method of registration by which any pharmacy may register to participate in the plan. The 3rd-party prescription program may exclude any pharmacy that has not registered.

Sec. 2. 32 MRSA §§13778 and 13779 are enacted to read:

§13778. Freedom of choice; nondiscrimination

Any person participating in a 3rd-party prescription program shall have the right to select a pharmacy.

1. Freedom of choice. All 3rd-party prescription programs in this State that provide coverage for prescription drugs or other pharmaceutical services shall provide each person benefiting from the coverage the freedom to choose a pharmacy. No 3rd-party prescription program in this State that provides prescription drugs or other pharmaceutical services may limit participation in the program to those pharmacies selected by a 3rd party.

2. Nondiscrimination. It shall be unlawful for an employer providing a 3rd-party prescription program in this State that offers prescription drugs or other pharmaceutical services to any employee or beneficiary to:

A. Require that the beneficiary obtain drugs from a mail order pharmacy as a condition of obtaining the employer's or 3rd-party prescription program administrator's payment for prescription drugs; and

B. Impose on an employee or beneficiary not utilizing a mail order pharmacy designated by the employer or 3rd-party

prescription program administrator a copayment fee or other condition not imposed on employees or beneficiaries utilizing the mail order pharmacy.

3. Reimbursement. This section shall not apply to any employer who offers as a part of a 3rd-party prescription program coverage to employees or beneficiaries that provides for reimbursement of an equal portion of the cost to the employee or the beneficiary for prescription drugs, regardless of the supplier, provided that the 3rd-party prescription program allows the employee or beneficiary the freedom to choose where the drugs are purchased.

§13779. Enforcement

The Superintendent of Insurance shall promulgate rules necessary to carry out the purposes of this Act.

This Act shall apply to all 3rd-party prescription programs providing prescription drugs or other pharmaceutical services in this State.

STATEMENT OF FACT

This bill changes the existing 3rd-party prescription program by prohibiting any 3rd-party prescription program from denying a person benefiting from the coverage the freedom to seek service from any pharmacy the person chooses.

As a health professional with a direct link to a patient, a pharmacist is in a position to supply an individual with important information for making responsible health decisions.

The 3rd-party prescription program shall provide a method of registration by which a pharmacy may register to participate in the plan.

This bill allows any pharmacy to participate in a 3rd-party prescription program as long as the pharmacy has registered with the Superintendent of Insurance.

APPENDIX D

REFERENCES TO MAINE LAW

5 MRSA §285	Responsibility for Group Health Insurance Management
5 MRSA §285-A	State Employee Health Commission
24 MRSA §2333	Nonprofit Service Organizations Preferred Provider Arrangement Act
32 MRSA §13702	Definition of Mail Order Pharmacy
32 MRSA §13751	Mail Order Registration
32 MRSA §13771	Third-Party Prescription Program Act

#325LHS

APPENDIX E

02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

392 BOARD OF COMMISSIONERS OF THE PROFESSION OF PHARMACY

CHAPTER 9 - OUT OF STATE MAIL ORDER DRUG COMPANIES

SUMMARY: This chapter outlines rules and regulations to be followed by Mail Order Drug Companies mailing to customers in the State of Maine.

As conditions of licensure, the out-of-state mail order drug outlet must comply with the following:

1. Be licensed and in good standing in the state of residence.

2. Apply for a license annually with the State of Maine and pay the required fee which should not exceed $200. Such application will include the following information:

   a. Name and address of the owner, partners or corporation and its officers.

   b. Name, address, state of residence license number, DEA license number and telephone number of the division or drug outlet serving Maine residents.

   c. Name, address and telephone number of the pharmacist responsible for licensure of the division or drug outlet serving Maine residents.

   d. Copy of the current year's inspection report(s).

3. Supply, upon request, all information needed by the Maine Commission of Pharmacy to carry out the Commission's responsibilities under the statutes and rules pertaining to out of state mail order drug outlets.

4. Provide a toll-free telephone number to enable communication between a Maine patient and a pharmacist at the drug outlet who has access to the patient's records. The toll-free number will appear on all prescription labels. Access to a pharmacist will be available for a minimum of 40 hours per week.

5. Be aware that the Commission may enter into an agreement with the State of residence for the purpose of having reciprocal inspections performed.

The Commission may initiate disciplinary action when:

1. A violation of the Maine rules pertaining to out of state mail order drug outlets has occurred.

2. A violation affecting a Maine citizen has occurred and the state of residence has not resolved the issue within 45 days from the date the violation was reported.

3. An emergency arises that would constitute an immediate threat to the health of Maine citizens.

APPENDIX F

MAIL ORDER PRESCRIPTION STUDY

AGENDA

August 28, 1989
1:00 to 4:30 P.M.
Room 437

1:00	Chairman Baldacci	Introductory Remarks
1:15	Rep. McCormick	Sponsor of LD 1083
1:30	Rep. Handy	Sponsor of LD 1311
1:45	Jo Gill	Executive Director Maine State Employees Health Insurance Program
2:15	John Knox	Committee Policy Analyst
2:30	Break	
2:45	Ann Robinson	Representing Mail Order Pharmacies
3:00	Stanley Stewart	Executive Director Maine Pharmacy Association
3:15	Denise Doyon	Chairman Board of Pharmacy
3:30	Committee	Discussion of Content & Time of Future Meetings

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Mail Order Pharmacy Study
Preliminary Agenda
October 2, 1989
Room 437

1:00	Sen. Baldacci	Introductory remarks
Invited Speakers		
1:15	Stephen Laverdiere Samuel Dahlquist	President Director of Pharmacy Laverdiere's Drug Store
1:30	Kathleen Bishop	Director, Employee Benefits Central Maine Power Company
1:45	Second major private employer (to be selected)	
Financial Data Requested by Committee		
2:00	Jo Gill	Executive Director Maine State Employees Health Insurance Program
2:15	Ann Robinson (Robert Marotta, Regulatory Counsel, Medco available for questions.)	Representing Medco
2:30	Break	
2:45	Stanley Stewart	Executive Director Maine Pharmacy Association
Persons Requesting to Speak		
3:00	Jadine O'Brien	Blue Cross/Blue Shield
3:15	Carl Leinonen	Maine State Employees Assoc.
3:30	Charles Sherburne	American Federation of State, County and Municipal Employees
3:45	Discussion & plans for next meeting	Committee

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MAIL ORDER PHARMACY

AGENDA

October 16, 1989

Room 437

1:00 p.m.	Senator Baldacci	Introductory remarks
1:15 p.m.	Jeffrey Robertson	Administrative Director, Pharmacy Group of New England
1:30 p.m.	Frank Johnson	Management Chair Maine Employees Health Commission
1:45 p.m.	John Veader	Labor Chair Maine Employees Health Commission
2:00 p.m.	Jo Gill	Executive Director Maine State Employees Health Insurance Program
2:15 p.m.	Committee	Discussion of findings and development of conclusions

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APPENDIX G

spectrum

Pharmaceuticals
Products and Technologies

Rapid Growth for Mail-Order Drug Dispensing

Marcia D. Codling
Health Industries Management Section

The rapid expansion of the mail-order drug industry over the next five years will reshape the retail drug business. This growth will contribute to changes in the drug distribution network, creating risks for wholesalers and drugstores and mainly opportunities for manufacturers.

Summary

Mail-order sales of prescription pharmaceuticals grew 50%/year from less than $100 million in 1981 to $750 million in 1986. We estimate that mail-order sales will increase 30%/year through 1991, reaching $2.8 billion, or 10% of the total U.S. market.

Price and convenience are the major forces behind the growth of mail-order dispensing. Mail-order firms can save customers 5-40% on their drug costs through volume purchasing, generic substitution, automated dispensing, and multimonth supplies. The convenience of at-home shopping and large supplies is especially valued by older Americans.

The mail-order industry has more than two dozen participants, which we group into four categories: nonprofit organizations, for-profit health care companies, chain drugstores, and companies from allied businesses.

The growth of mail-order sales will contribute to broader changes in drug distribution. The power of buying groups and purchasing agents will grow. Manufacturers will sell directly to large mail-order dispensers, buying groups, and repackagers that serve dispensing physicians. By 1995 alternative dispensing will be a major challenge to traditional distributors, and drugstores will account for only 60% of the U.S. dispensing market, down from 80% in 1985.

Market Size and Growth

Sales of prescription drugs through the mail in the United States have expanded rapidly in recent years. From less than $100 million in 1981, U.S. mail-order drug sales grew 50%/year to an estimated $750 million in 1986. Although mail-order dispensing now accounts for less than 4% of the $21-billion U.S. prescription pharmaceuticals market, we believe it will grow 30%/year over the next five years, commanding a 10% share of the $28.5-billion market by 1991. Drugs provided through mail order are almost exclusively for chronic therapy, a category that accounts for about 70% of all prescription pharmaceutical sales in the United States.

Forces Fueling Growth

The most important forces behind the growth of mail-order dispensing are price and convenience.

Price. Mail-order firms save customers, whether individual consumers or corporate benefit plans, 5-40% on their drug costs. These savings are possible because mail-order firms can:

- Make large purchases;
- Aggressively substitute generic drugs;
- Dispense 90-day or even 180-day supplies to patients (as opposed to 30-day or smaller supplies in most drugstores); and
- Centralize dispensing to achieve economies of scale.

Table 1 shows, using a hypothetical but realistic example, how a mail-order service can lower the cost of drugs to both a corporate benefit program and the employees it serves through lower fees and ingredient costs.

Convenience. Mail-order also offers convenience in the form of at-home shopping and large supplies; prescriptions may be filled only three or four times a

Table 1

Cost Comparison of Drug Benefit Programs (dollars per 90-day supply)

	Major Medical	Card Program	Mail-Order
Ingredient Cost	15.00	15.00	13.50
Dispensing Fee	9.75	9.00	1.45
Claim Processing Fee	5.00	1.95	—
Total	**29.75**	**25.95**	**14.95**
Copayment	(9.00)	(9.00)	(3.00)
Net Cost to Employer	20.75	16.95	11.95

Note: Major medical and card program costs based on three 30-day prescriptions; mail-order costs based on one 90-day prescription.

Source: Arthur D. Little, Inc., estimates.

year rather than each month. Convenience is an especially great concern for the growing number of older Americans, who make up about 12% of the U.S. population but consume about 30% of its prescribed pharmaceuticals. Many older persons have limited mobility and take one or more maintenance drugs.

Participants

The industry already has more than two dozen participants, which we can group into four main categories (Table 2). The largest group (in terms of mail-order volume) consists of two nonprofit organizations: the Veterans Administration (which has provided veterans with free drugs through the mail for decades and is really outside the industry) and the American Association of Retired Persons (AARP). Between 10% and 15% of the AARP's 24 million members use its mail-order drug service, which has been administered by Retired Persons Services since the early 1960s.

The for-profit health care companies in the mail-order drug business include Medco Containment Services (the largest in the group), Health Care Services, Baxter Travenol Laboratories, MediRx America, American Prescription Plan, and roughly half a dozen others. A third major group, chain drugstores, recently entered this promising growth area, led by Walgreen and Thrift Drug's Express Pharmacy

Table 2

Selected Participants in Mail-Order Dispensing by Category, 1986

Nonprofit Organizations
Retired Persons Services (American Association of Retired Persons)
Veterans Administration

Health Care Companies
American Medical International
America's Pharmacy (Caremark)[1]
American Prescription Plan (Medivix)
Health Care Services
Medco Containment Services (Porex Technologies)
MediRx America
Preferred Prescription Service (Baxter Travenol Laboratories)

Drugstore Chains
Action Mail Order Drug (LaVerdiere's)
Express Pharmacy Services (Thrift Drug/J.C. Penney)
Walgreen

Others
ArcVentures (Rush Presbyterian-St. Luke's Medical Center of Chicago)
Blue Cross/Blue Shield
Capital Area Community Health Plan
Mature Outlook (Sears, Roebuck)

1. On April 2, 1987, Caremark agreed to sell America's Pharmacy to Newport Pharmaceuticals International for $12 million.

Source: Arthur D. Little, Inc.

Services (J.C. Penney). Because the large chains are familiar with drug retailing and consumer marketing, we expect them to become significant mail-order dispensers by the early 1990s. For chains that already provide drugs as part of third-party plans, mail-order is simply a new delivery channel.

The last group of participants consists of companies from several allied businesses. They include Blue Cross/Blue Shield, which offers mail-order dispensing to federal employees; ArcVentures, a for-profit subsidiary of Rush Presbyterian-St. Luke's Medical Center of Chicago; and Capital Area Community Health Plan, a small New York health maintenance organization. Sears, Roebuck, which has sold home health care equipment through the mail for over 50 years, now offers mail-order drugs through its Mature

Outlook program for older persons; Walgreen holds the dispensing contract. Size should give several of these large entrants an advantage, especially when they sell to corporate clients who choose to add mail-order drug dispensing to their employee health plans.

The six largest industry participants accounted for about two-thirds of prescriptions filled by mail-order in 1986 (Table 3). Their major customers have been benefit programs offered by large employers, state governments, and unions.

Market Impact

The growth of mail-order drug sales that we foresee will coincide with and contribute to broader changes in the drug distribution network. Figure 1 shows our view of the structure of that network in the United States in 1975, 1985, and 1995. In the 1975 network, most drugs (over 80% in recent years) went through wholesalers to hospitals and drugstores. Manufacturers promoted their products mainly to the physician.

By 1985 important alternative channels had emerged within the drug distribution network. Wholesalers remained the largest buyers of drugs from the manufacturer, but buying groups and purchasing agents representing hospitals, health maintenance organizations, or large group practices were important decision makers as well. Manufacturers promoted and in some cases sold directly to these new participants in the network. Also, mail-order services and physicians had become significant dispensers of drugs to consumers, while alternative sites served a greater share of the population.

We expect that by 1995 alternative dispensing will be a major challenge to traditional distributors. Manufacturers will sell directly to large mail-order dispensers, buying groups, and repackagers that serve dispensing physicians. We estimate that in 1995 drugstores will account for only 60% of the U.S. drug-dispensing market, down from 85% in 1975 and 80% in 1985.

Table 3

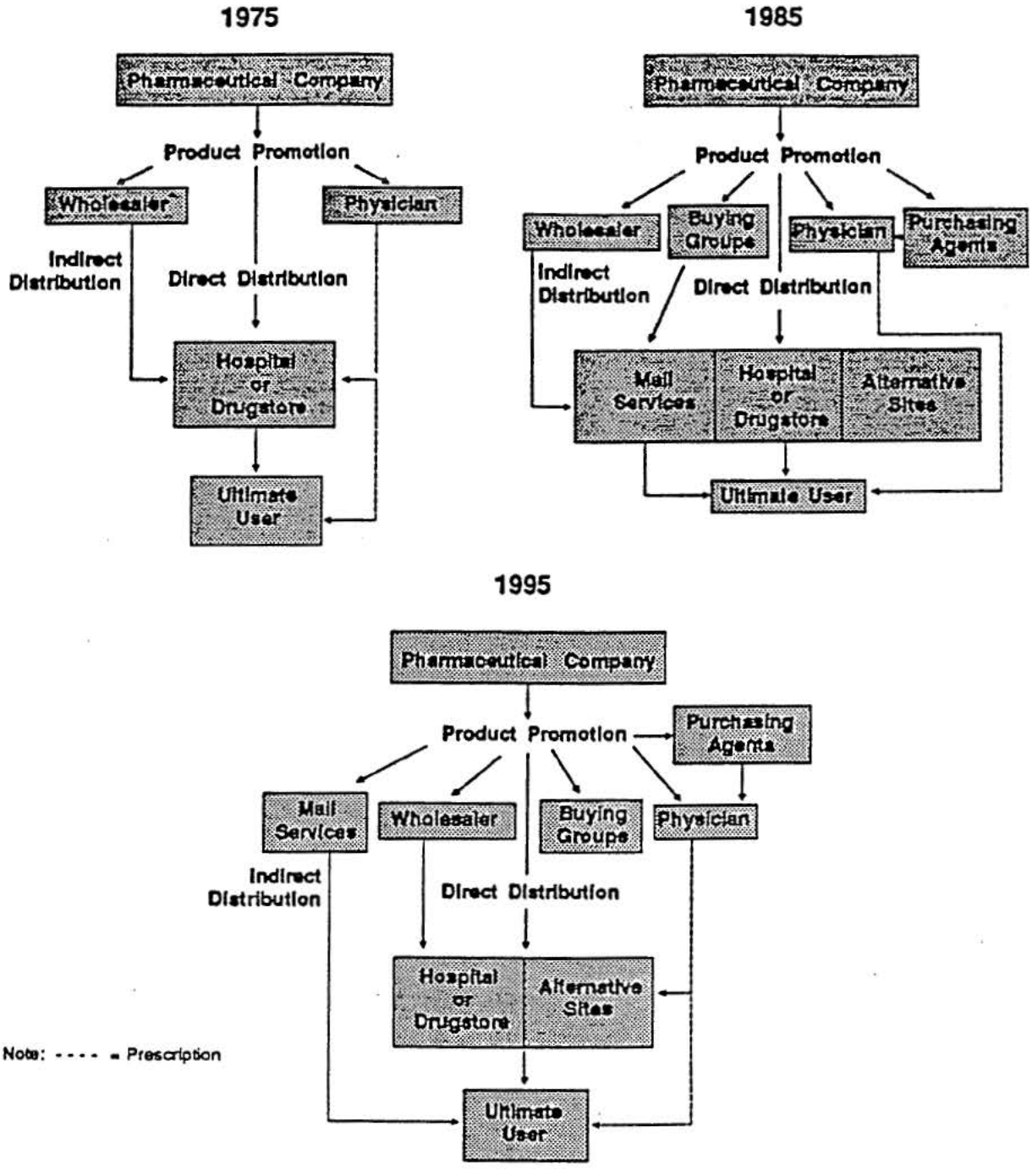
Major Participants in Mail-Order Dispensing, 1986

Participants	Number of Prescriptions (MM)	Major Customers
Veterans Administration	20	U.S. veterans
Retired Persons Services (American Association of Retired Persons)	8	AARP members
Medco Containment Services (Porex Technologies)	6	Alcoa, General Motors, Occidental Petroleum, United Technologies, International Ladies Garment Workers Union, Public Employees Retirement System of Ohio, State Teachers Retirement System of Ohio
Health Care Services	1.5	Ford, Goodyear, Pennsylvania state employees
Express Pharmacy Services (Thrift Drug/J.C. Penney)	1	Chevron, General Motors, Pitney Bowes, Rockwell
Preferred Prescription Service (Baxter Travenol Laboratories)	1	Ameritech, Amoco, Bell Atlantic, Southland, Texaco, Texas Instrument

Source: Arthur D. Little, Inc., estimates.

Figure 1

The U.S. Drug Distribution Network



Note: - - - - = Prescription

Source: Arthur D. Little, Inc.

Manufacturers

The rapid growth of mail-order drug dispensing will not have a profound effect on the large pharmaceutical companies. Nevertheless, the trend may increase the impact of generic substitution, and many companies will concede some margin in order to negotiate volume purchases from the largest mail-order services. A few manufacturers may enter the business as part of overall strategies aimed at taking advantage of likely changes in the drug distribution network.

Wholesalers

Despite their sophisticated distribution systems, the major wholesalers are unlikely to join the mail-order business themselves in the next five years. To do so would harm their relations with the retail pharmacies that account for much of their sales. Instead, the major distributors will supply the mail-order firms, treating them as an alternative delivery channel. Those firms that supply mainly independent community pharmacies will lose business as their customers do. Eventually, however, some wholesalers will integrate forward by launching or acquiring mail-order drug dispensers.

Drugstores

Mail-order dispensing clearly threatens the community drugstore's prescription pharmaceutical sales. Moreover, since the pharmacy often serves as a draw while high-margin over-the-counter drugs and general merchandise provide most of the profits, losing prescription sales has a multiplied effect.

So far, community pharmacies have responded to this competitive threat by maintaining that mail-order dispensing endangers patients and reduces the quality of care. Pharmacist organizations have sought to publicize the negative aspects of mail-order dispensing. Table 4 shows community pharmacists' major criticisms of the mail-order industry and the mail-order industry's responses.

Pharmacist organizations are lobbying state pharmacy boards and legislatures to ban or control mail-order firms. Some states do not permit mail-order firms within their borders, although the firms can still

Table 4

Pros and Cons of Mail-Order Dispensing

Criticism	Defense
Eliminates interaction with pharmacist, who explains use of drug, checks for side effects, and ensures customer is not taking medication that might react with prescription.	Real patient counseling in drugstores is rare; FDA study found only 19% of consumers cited pharmacists as main source of drug information.
Faceless dispensing leads to more mistakes.	No studies compare error rates of mail-order and community pharmacies; Medco, the largest for-profit mail-order pharmacy, claims an error rate of under 1% with highly automated dispensing.
Drugs can be stolen, tampered with, or damaged by extreme temperatures during shipping.	Packages are insulated and unmarked; temperature damage is a problem faced and largely solved by the entire pharmaceutical industry.
Cost savings may be illusory; a 1986 study concluded that although unit costs were lower with mail-order, overall costs were higher owing to waste associated with multi-month supplies.	Study dealt with small sample and specific contract and is therefore of limited value; some firms are reining in multi-month supply practice.

Source: Arthur D. Little, Inc.

send drugs into these states. Attorneys general in several states have also ruled that out-of-state mail-order firms must be licensed in the state if they ship products to state residents. So far, no state board of pharmacy has filed suit to test such a ruling. The Federal Trade Commission is monitoring the situation and is likely to oppose such state regulation on the grounds that it illegally restrains interstate commerce. A test case may be brought in Arkansas in 1987. Even if such laws are upheld, enforcing them will probably prove impractical.

The mail-order drug industry is responding to legitimate demands for cost control and convenience. Its success signals that the bases of competition in retail pharmacy are changing. Walgreen, Thrift Drug/J.C. Penney, and LaVerdiere's have already entered the mail-order business, as have a handful of independent drugstores. We expect that more community pharmacies will do the same. Entering the mail-order drug business may be an especially workable approach for networks of small chains and independent drugstores. Both chain and independent drugstores are likely to seek mail-order drug dispensing contracts with managed-care systems such as health maintenance organizations and preferred provider organizations.

Community pharmacists can match many of the features mail-order companies offer while differentiating themselves by providing a measure of personal service. The California Pharmacists Association, for example, has begun to sell pharmacy service contracts to major employers. These contracts feature aggressive substitution of generic for brand-name drugs and allow larger supplies of certain medications to be dispensed. Unlike mail-order arrangements, however, they feature personal service to customers.

About the Author

Marcia D. Codling is a member of the Health Industries Management Section of Arthur D. Little, Inc. Her consulting assignments focus on business strategies for over-the-counter drugs, generic drugs, and nutritional supplements, as well as for prescription drug markets in developing countries. Ms. Codling holds degrees in pharmacy, hospital administration, and business management.

APPENDIX H

MAIL ORDER PHARMACY

National Association of Boards of Pharmacy
1300 Higgins Road, Suite 103
Park Ridge, Illinois 60068

	Regulate	Source	Agency	Activity to Regulate
Alabama	Yes	Leg.	Board	
Alaska	No			No
Arizona	No			
Arkansas	Yes	Leg & Bds	Board	
California	Yes	Leg	Board	
Colorado	No			No
Connecticut	No			No
Delaware	Yes			Yes, may be revised
Dist. of Col.	No			No
Florida	Yes	Leg.	Board	
Georgia	Yes		Board	
Hawaii	No			No
Idaho	No			Yes, leg. considered
Illinois	Yes	Leg.	Board	Yes
Indiana	No			Yes, Board discussions
Iowa	No			No, out of state Yes, in state
Kansas	Yes	Leg.	Board & AG's office	
Kentucky	No			Yes, proposed to leg. '90
Louisiana	Yes 1/89	Rule	Board	
Maine	Yes	Leg.	Board	
Maryland	No			No
Massachusetts	Yes	Rule	Board	
Michigan	No			Yes
Minnesota	Yes	Leg & Rule	Bd.	
Mississippi	No			No
Missouri	No			No
Montana	No			Yes
Nebraska	Yes	Leg.	Board	
Nevada	Yes*	Leg	Board	* under gen'l licensing
New Hampshire	No			No
New Jersey	No			Bd. has proposed
New Mexico	No			Yes
New York	No			No
North Carolina	Yes	Leg.	Board	
North Dakota	Yes	Leg.	Board	
Ohio	No			No
Oklahama	No			
Oregon	No			No, Proposing Leg.
Pennsylvania	No			Yes, will discuss when reg. are revised
Puerto Rico	*			
Rhode Island	No			Yes
South Carolina	No			No
South Dakota	No			No
Tennessee	Yes	Leg.	Board	
Texas	Yes	Leg.	Board	

	Regulate	Source	Agency	Activity to Regulate
Utah	Yes	Leg		
Vermont	No			No
Virginia	No			No
Washington	No			Yes, Bd. consid. leg.
West Virginia	No			No
Wisconsin	Yes	Leg.	Board	Yes
Wyoming	No			Yes
Virgin Islands	*			

* indicates that messages or survey were not returned

APPENDIX I

State Health Legislation Report

Vol. 16, No. 3
August 1988

- PADS II

Multiple Prescription Programs

Mail Service Pharmacies

Public Affairs Group
Division of Legislative Activities
Department of State Legislation
American Medical Association
535 N. Dearborn Street
Chicago, Illinois 60610

Each prescription form must be serially numbered and in triplicate, with the original copy labeled "Copy I," the duplicate copy labeled "Copy 2," and the triplicate copy labeled "Copy 3." The prescribing practitioner shall sign Copies I and 2 of the form and give them to the person authorized to receive the prescription and retain Copy 3 of the form for his records for a period of not less than two years from the date the prescription is written.

Each dispensing pharmacist shall retain Copy 2 with the records of the pharmacy for a period of not less than two years and sign Copy I and send it to the Department within 30 days from the date the prescription is filled. [Tex. Rev. Civ. Stat. Ann. art. 4476-I5, §3.09]

MAIL SERVICE PHARMACIES

Mail service pharmacy (MSP) is a form of pharmacy practice that dispenses prescription drugs by mail. Currently, regulations of MSP differ widely from state to state. A pharmacist in any state can dispense a prescription written by a physician in any other state and the pharmacist is regulated under the laws of the state in which the pharmacist/pharmacy is licensed. In addition, some states have recently passed legislation regulating out-of-state mail service pharmacies that provide prescription drugs to residents within the state. State laws regulating out-of-state mail service pharmacies are summarized below.

Alabama (1966)

Every mail-order house which dispenses drugs or medicines through the United States mail or otherwise from any point outside of the state of Alabama to any point within the state of Alabama shall obtain a permit from the state Board of Pharmacy as a condition precedent to being qualified and authorized to transact such business in the state of Alabama. [Ala. Code §34-23-31]

Arkansas (I983)

Any pharmacy operating outside the state which ships, mails or delivers in any manner a dispensed legend drug into Arkansas shall hold a pharmacy license issued by the Arkansas State Board of Pharmacy, and that part of the pharmacy operation dispensing the prescription for an Arkansas resident shall abide by Arkansas law and regulations of the Board. [Ark. Stat. Ann §17-91-401]

California (1968)

No out-of-state pharmacy doing business in this state which has not obtained a certificate, license, permit, registration, or exemption from the Pharmacy Board and which sells or distributes drugs in California, shall conduct the business of selling or distributing drugs in the state without obtaining an out-of-state drug distributor's license from the Board. [Cal. Bus & Prof. Code §4084.6]

Florida (1986)

Any pharmacy which is located outside the state and which ships, mails, or delivers a dispensed medicinal drug into Florida shall be considered a nonresident special pharmacy and shall disclose to the Board of Pharmacy the following information:

1) That it is licensed in the state in which the dispensing facility is located;

2) The location, names, and titles of all principal corporate officers and all pharmacists who are dispensing medicinal drugs to Florida residents;

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3) That is complies with all lawful directions and request for information from the boards of pharmacy of all states in which it is licensed, except that it shall respond directly to all communications from the Florida board concerning emergency circumstances arising from errors in the dispensing of medicinal drugs to Florida residents;

4) That it maintains its records of medicinal drugs dispensed to Florida patients so that the records are readily retrievable from the records of other medicinal drugs dispensed;

5) That is cooperates with the Florida Board of Pharmacy in providing information to the board of pharmacy of the state where it is licensed concerning matters related to the dispensing of drugs to Florida residents; and

6) That during its regular hours of operation but not less than six days per week, for a minimum of 40 hours per week, a toll-free telephone service shall be provided to facilitate communication between patients of this state and a pharmacist at the pharmacy who has access to the patient's records. This toll-free number must be disclosed on the label affixed to each container of dispensed medicinal drugs.

A nonresident special pharmacy which complies with the above requirements shall not be required to obtain a pharmacy permit from the Board. [Fla. Stat. §465.0156]

Louisiana (1985)

No out-of-state pharmacy shall do business in the state until it has been issued a pharmacy permit by the Board of Pharmacy. [La. Rev. Stat. Ann. §1184]

Minnesota (1988)

Pharmacies located outside the state that regularly dispense medications for Minnesota residents and mail, ship, or deliver prescription medications into the state must register annually with the Board of Pharmacy. "Nonresident special pharmacy" registration shall be granted by the board upon certification by the pharmacy:

1) That it is licensed in the state where the dispensing facility is located;

2) The location, names, and titles of all principal corporate officers and all pharmacists dispensing to residents of Minnesota;

3) That it complies with all lawful directions and requests for information from the boards of pharmacy of all states in which it is licensed or registered and it shall respond directly to all communications from the Board concerning emergency circumstances arising from the dispensing of drugs to residents of Minnesota;

4) That it maintains records of drugs dispensed to residents of the state so that they are readily retrievable;

5) That it cooperates in providing information to the board of pharmacy of the state in which it is licensed concerning matters related to the dispensing of drugs to residents of Minnesota; and

6) That during its regular hours of operation, but not less than six days per week, for a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate communication between patients in Minnesota and a pharmacist at the pharmacy who has access to the patient's records. The toll-free number must be disclosed on the label affixed to each container of drugs dispensed to residents of Minnesota. [Minn. Stat. §151.19]

Nebraska (1988)

No person outside of the state shall ship, mail or in any manner deliver dispensed prescription drugs into Nebraska unless such person:

1) Is licensed as a pharmacist in the United States;

2) Has filed with the Department of Health evidence of a pharmacy license or permit issued by, and valid in, the state in which such prescription drugs will be shipped, mailed, or otherwise delivered;

3) Is located and operating in a state in which the requirements and qualifications for obtaining and maintaining a pharmacy license or permit are considered by the Department of Health, with the approval of the Board of Examiners in Pharmacy, to be substantially equivalent to the requirements contained in the pharmacy practice act; and

4) Has designated the Secretary of State as the agent for service of process in Nebraska.

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The Department of Health, upon the recommendations of The Board of Examiners in Pharmacy, shall notify the Attorney General of any possible violations of the Mail Service Prescription Drug Act. If the Attorney General has reason to believe that an out-of-state person is operating in violation of the Act he shall enjoin such person from further delivering prescription drugs in Nebraska. [L.B. 350]

North Dakota (1987)

Any pharmacy operating outside the state which ships, mails, or delivers in any manner a dispensed prescription drug or legend drug into North Dakota shall obtain and hold a pharmacy permit issued by the North Dakota State Board of Pharmacy and that part of the pharmacy operation dispensing the prescription for a North Dakota resident shall abide by state laws and rules of the Board. [N.D. Cent. Code §43-15-34.1]

Utah (1988)

The Division of Occupational and Professional Licensing shall, with the collaboration of the State Board of Pharmacy, examine, inspect, and investigate all applications and all applicants for licensure as out of state mail service pharmacies and grant certificates of licensure to all applicants whom it judges to be properly qualified.

Upon a finding by the Division that an out-of-state mail service pharmacy meets the requirements for licensure, the Division shall issue a license. Each out-of-state mail service pharmacy shall be licensed if it:

1) Ships, mails, or delivers any legend drug to any resident within the state;

2) Provides information to a resident of the state on drugs or devices; or

3) Counsels pharmacy patients in the state concerning adverse and therapeutic effects of drugs.

Each out-of-state mail service pharmacy shall be licensed in good standing by the state in which its dispensing facilities are located and shall comply with all applicable laws, regulations, and standards of such state and the United States as a condition precedent to obtaining and maintaining a license in Utah.

Each applicant for a license as an out-of-state mail service pharmacy shall:

1) Submit an application;

2) Pay a fee;

3) Submit satisfactory evidence that the physical facilities, records, and operations of the out-of-state mail service pharmacy are in accordance with the laws and regulations of the state in which the facilities are located;

4) Submit evidence of licensure in good standing issued by the state in which the pharmacy is located;

5) Submit certification that it will cooperate with all lawful requests and directors from the regulatory board or licensing authority of its state of domicile relating to the shipment, mailing, or delivery of dispensed legend drugs to Utah residents;

6) Submit quarterly reports, by the pharmacist-in-charge; concerning each prescription for a controlled substance shipped, mailed or delivered to a Utah resident, including the,

(i) patient name;
(ii) practitioner name;
(iii) prescription number;

(iv) date of prescription;
(v) name of drug; and
(vi) strength and quantity of dosage; and

7) If the information required in subsection (6) cannot be provided, submit to on-site inspection of the pharmacy's records.

Each out-of-state mail service pharmacy shall identify to the board a pharmacist licensed by the state in which the pharmacy is located who shall serve as pharmacist-in-charge.

Each out-of-state mail service pharmacy dispensing a substituted drug product into the state shall notify the patient of the substitution either by telephone or in writing. Each out-of-state mail service pharmacy shall comply with the state statutory requirements with respect to drugs which may be substituted, including labeling and record keeping, when dispensing substituted drug products. [Utah Code Ann. §§58-17-12; -15]

APPENDIX J

July 1989

Jurisdictions where Legislative or Regulatory Attempts Have Been Made to License (L), Require Disclosure (RD) or Ban (B) Out-of-State Mail Service Pharmacies (date and result). States for which an Attorney General's opinion exists are underlined.

Alabama (R)	(1975, Enacted)*
Arkansas (L)	(1983, Enacted)*
Arizona (L)	(1987, failed)
California (L)	(1986, failed)
(L)	(1987, failed)
(RD)	(1988, Enacted)*
Florida (RD)	(1986, Enacted)
(R)	(1989, Enacted)
Georgia (L)	(1986, failed)
Idaho (RD)	(1989, Enacted)*
Illinois (L)(enabling)	(1988, enacted unopposed)*
Kentucky (L)	(1986, failed)
Louisiana (L)	(1985, Enacted)*
Maine (L)	(1986, failed)
(RD)	(1988, Enacted)*
Maryland (L)	(1986, defeated)
Minnesota (L)	(1987, died)
(RD)	(1988, Enacted HF 752)*
Mississippi (L)	(1986, vetoed, unconstitutional)
Missouri (L)	(1987, died)
	(1988, died)
Nebraska (L)	(1986, failed)
	(1987, failed)
	(1988, Enacted)*
New Jersey (L)	(1986, failed)
(L)	(1987, withdrawn)
New York (L)	(1986, failed)
(L)	(1989, pending)

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North Dakota (L)	(1987, Enacted)*
Oklahoma (L)	(1989, died)
Oregon (L)	(1987, failed)
(RD)	(1989, pending)**
Puerto Rico (L)	(1986, failed)
Rhode Island (L)	(1986, failed) (1987, failed) (1988, failed) (1989, pending)
South Carolina (B)	(1986, failed) (1989, died)
Tennessee (L)	(1987, withdrawn)*
Texas (L)	(1986, died)
(L)	(1987, pending)*
Utah (RD)	(1988, Enacted)*
Washington (B)	(1987, failed)
(RD)	(1989, died)**
West Virginia (L)	(1986, failed) (1987, failed)
Wisconsin (RD)	(1988, died)
Wyoming (L)	(1987, failed)
(RD)	(1989, Enacted)**

Notes:

* **Alabama:** Originally enacted in 1975, the Alabama act has been substantially modified. The Alabama AG struck down the provision requiring an out-of-state licensee to have an Alabama licensed pharmacist on staff and the Alabama Board has deleted the provision requiring compliance with Alabama code from the rules. Today, the act is merely a registration and disclosure document. To our knowledge, no major mail service pharmacy has registered and there has been no attempt to enforce the law.

* Arkansas: Enforcement case in Arkansas state court removed to federal district court for decision.

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* California: Legislation supported by the AARP Pharmacy Service and the Board of Pharmacy. Disclosure bill with complaint referral mechanism.

* Florida: 1989 amendmments impose Florida's negative formulary for drug substitution on non-resident pharmacies as well as provide for a non-resident pharmacy permit.

* Idaho: Supported by the AARP Pharmacy Service and Board of Pharmacy, bill was based on California statute.

* Illinois: Enabling bill with major compliance goal being out-of-state operations fulfilling IL Schedule II TripScript program.

* Louisiana: Licensure and full compliance statute; final regs promulgated 12/88 and enforcement letter distributed to some mail service operations.

* Maine: Bill establishes out-of-state drug outlet license but fails to provide relevant compliance guidelines. However, regs adopted for promulgation by ME Board are similar to California Statute.

* Minnesota: Bill supported by AARP Pharmacy Service and State Board of Pharmacy (similar to California SB.2213).

* Nebraska: Provides for licensure for pharmacies located in states where professional standards are not substantially equivalent. No regs issued.

* North Dakota: Licensure and full compliance statute with no enforcement to date. Regs adopted February 1988.

* Tennessee has a 1987 AGs opinion stating that authority for licensing out-of-state pharmacies exists in the current statute. Licensure demands have been transmitted but no enforcement actions have been taken.

* Texas: Board adopted licensure and regulatory requirements in August 1987; however, AG opinion is that Board does not have statutory authority to license pharmacies located in other states.

* Utah: Bill supported by AARP Pharmacy Service and Board of Pharmacy. Disclosure with requirement for quarterly controlled substance report.

* Wyoming: Bill supported by AARP Pharmacy Service and Board of Pharmacy is based on the California Disclosure Statute.

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** Oregon and Washington considered bills modeled on the California and Utah disclosure statutes which were agreed to by the state pharmacists association(s), the state board(s) and mail service pharmacy representatives. However, the bills were not enacted.

** Ohio Attorney General William Brown opined in 1982 that regulating out-of-state mail service pharmacies violated the Commerce Clause of the U.S. Constitution.

Prepared by: Nicholas Willard
AARP Pharmacy Service
8/15/89

APPENDIX K

HEALTH CARE BENEFITS SURVEY 1988

TABLES OF SURVEY RESPONSES

Foster Higgins

A. Foster Higgins & Co., Inc. is a consulting subsidiary of Johnson & Higgins

PLAN DESIGN

Type of plan

	Percentage of respondents describing largest plan as:				
	Comprehensive major medical	Basic plan (no major medical)	Basic plan plus major medical	Other	Offer HMO only
ALL RESPONDING EMPLOYERS	60%	1%	34%	3%	2%
BY REGION					
PACIFIC	63%	1%	29%	2%	5%
MOUNTAIN	67	—	24	4	5
NORTH CENTRAL	60	1	32	4	4
SOUTH CENTRAL	68	1	29	1	1
NEW ENGLAND	56	1	40	4	—
MID-ATLANTIC	45	—	53	2	—
SOUTH ATLANTIC	61	1	33	3	2
BY INDUSTRY					
CONSUMER PRODUCTS	61	—	36	4	—
MANUFACTURING	59	1	37	2	1
MINING/CONSTRUCTION	56	3	38	—	3
ENERGY/PETROLEUM	79	3	18	—	—
WHOLESALE/RETAIL TRADE	68	1	28	3	—
TECHNICAL/PROFESSIONAL SERVICES	71	1	24	1	3
UTILITIES	53	—	42	5	—
TRANSPORTATION SERVICES	67	—	21	8	4
HEALTH SERVICES	41	3	43	7	6
FINANCIAL SERVICES	72	1	25	2	—
COMMUNICATIONS	60	—	36	4	—
GOVERNMENT	53	—	39	3	4
EDUCATION	57	—	41	3	—
INSURANCE	55	1	31	8	5
OTHER	59	—	34	3	4
BY TOTAL NUMBER OF EMPLOYEES					
UNDER 500	58	1	34	3	5
500–999	56	2	34	6	2
1000–2499	58	1	37	2	1
2500–4999	61	1	35	3	1
5000–9999	58	2	35	4	2
10000–19999	69	1	28	1	1
20000–39999	71	—	27	2	—
40000 OR MORE	67	—	30	3	—

N = 1613

1 Offer mail-order and/or card prescription drug program

2 Cost impact

For respondents with either program, total drug costs for 1987:

	Percent of respondents
Decreased	22%
Increased	42
Stayed the same	36

Average change in costs: +5.4

	Percentage of respondents offering:		
	Mail-order program only	Card program only	Mail-order and card program
ALL RESPONDING EMPLOYERS	8%	18%	7%
BY REGION			
PACIFIC	10%	13%	9%
MOUNTAIN	4	28	3
NORTH CENTRAL	8	23	9
SOUTH CENTRAL	8	14	3
NEW ENGLAND	4	15	2
MID-ATLANTIC	11	8	13
SOUTH ATLANTIC	7	21	4
BY INDUSTRY			
CONSUMER PRODUCTS	14	7	11
MANUFACTURING	10	10	10
MINING/CONSTRUCTION	13	6	3
ENERGY/PETROLEUM	15	6	3
WHOLESALE/RETAIL TRADE	9	13	1
TECHNICAL/PROFESSIONAL SERVICES	5	21	3
UTILITIES	21	24	14
TRANSPORTATION SERVICES	17	22	4
HEALTH SERVICES	5	27	3
FINANCIAL SERVICES	6	14	2
COMMUNICATIONS	32	—	8
GOVERNMENT	1	29	8
EDUCATION	5	24	5
INSURANCE	11	30	8
OTHER	7	9	7
BY TOTAL NUMBER OF EMPLOYEES			
UNDER 500	4	23	5
500–999	6	17	6
1000–2499	5	15	5
2500–4999	8	16	11
5000–9999	9	10	12
10000–19999	24	17	3
20000–39999	34	8	7
40000 OR MORE	24	10	26

N = 1595

	1 Percentage of respondents offering generic drug program	2 Of those, percentage of respondents offering reduction in drug co-pay as incentive
ALL RESPONDING EMPLOYERS	30%	61%
BY REGION		
PACIFIC	33%	59%
MOUNTAIN	36	74
NORTH CENTRAL	33	49
SOUTH CENTRAL	32	68
NEW ENGLAND	24	64
MID-ATLANTIC	23	57
SOUTH ATLANTIC	30	71
BY INDUSTRY		
CONSUMER PRODUCTS	33	67
MANUFACTURING	29	61
MINING CONSTRUCTION	16	50
ENERGY PETROLEUM	35	64
WHOLESALE RETAIL TRADE	32	52
TECHNICAL PROFESSIONAL SERVICES	21	68
UTILITIES	37	80
TRANSPORTATION SERVICES	35	63
HEALTH SERVICES	41	41
FINANCIAL SERVICES	20	57
COMMUNICATIONS	28	57
GOVERNMENT	16	68
EDUCATION	32	36
INSURANCE	45	67
OTHER	25	47
BY TOTAL NUMBER OF EMPLOYEES		
UNDER 500	26	61
500-999	31	54
1000-2499	31	64
2500-4999	38	66
5000-9999	31	43
10000-19999	30	65
20000-39999	33	68
40000 OR MORE	53	70
	N = 1556	**N = 454**

1 Offer generic drug program

2 Offer incentive

3 Cost impact

For respondents with program, total drug costs of 1987:

	Percent of respondents
Decreased	**44%**
Increased	**4**
Stayed the same	**52**

Average change in costs: −3.4%

	Percentage of respondents offering dental coverage:		
	As part of medical plan	As freestanding plan	Total
ALL RESPONDING EMPLOYERS	25%	54%	79%
BY REGION			
PACIFIC	30%	66%	96%
MOUNTAIN	38	58	95
NORTH CENTRAL	24	56	79
SOUTH CENTRAL	22	48	69
NEW ENGLAND	15	58	73
MID-ATLANTIC	20	55	75
SOUTH ATLANTIC	27	47	74
BY INDUSTRY			
CONSUMER PRODUCTS	11	71	82
MANUFACTURING	20	57	77
MINING CONSTRUCTION	25	66	91
ENERGY PETROLEUM	30	64	94
WHOLESALE RETAIL TRADE	38	47	85
TECHNICAL PROFESSIONAL SERVICES	38	30	68
UTILITIES	17	68	85
TRANSPORTATION SERVICES	36	55	91
HEALTH SERVICES	18	66	84
FINANCIAL SERVICES	24	62	86
COMMUNICATIONS	40	52	92
GOVERNMENT	18	53	71
EDUCATION	18	63	82
INSURANCE	22	64	86
OTHER	31	46	78
BY TOTAL NUMBER OF EMPLOYEES			
UNDER 500	27	39	66
500-999	30	53	84
1000-2499	24	63	87
2500-4999	25	63	88
5000-9999	23	65	88
10000-19999	22	70	92
20000-39999	22	71	93
40000 OR MORE	5	75	80
N= 1595			

Offer dental coverage

APPENDIX L

John R. McKernan, Jr.
Governor

Jo A. Gill
Executive Director

Department of Administration
STATE EMPLOYEE HEALTH INSURANCE PROGRAM
Telephone (207) 289-6780
or toll free
1-800-422-4503

To: John B. Knox, Analyst
Office of Policy and Legal Analysis

From: Jo A. Gill, Executive Director
Maine State Employees Health Insurance Program
Department of Administration

Re: State Mail Service Contracts

Date: August 7, 1989

We have recently contacted other State Health Insurance Programs to determine the prescription drug alternatives available to other public sector employees.

The following States provide Mail Service Prescription coverage to their participants:

State of California
State of Florida
State of Hawaii
State of Maine
Commonwealth of Massachusetts
State of Michigan
State of Nevada
State of New Jersey
State of New York
State of Ohio
Commonwealth of Pennsylvania
State of Texas
State of Virginia
State of Washington

Additionally, a number of States utilize card systems, similar to those provided by PAID Prescriptions. They include:

State of Iowa
State of Kansas
State of Kentucky
State of Maine
State of Michigan

State House Station 114, Augusta, Maine 04333 — *Offices Located at* 219 Capitol Street, Augusta

State of Maryland
State of Minnesota
State of North Dakota
State of Oklahoma
State of Oregon
State of South Carolina
State of Utah

In conversations with representatives of the Public Sector programs, our personnel discovered a fair amount of activity in the prescription drug benefit area. Many states are exploring alternatives including establishment of Preferred Provider Networks, Health Maintenance Organizations, Mail Service, Card Systems and redesigning benefits to require separate higher deductibles.

Please let me know if you have any questions.

APPENDIX M

COMPARISON OF PHARMACEUTICAL LAWS OF MAINE & NEW JERSEY

1. Maine requires 1,500 hours of practical experience for a license while New Jersey requires 1,000.

2. Maine will not license foreign educated. New Jersey will.

3. Maine requires only a pharmacy license. New Jersey also requires a license to manufacture and to wholesale pharmaceuticals.

4. New Jersey has a model food and drug act and a controlled substance act. Maine has neither.

5. Maine had "dependent" prescribing authority for physicians' assistants, and nurse practitioners, New Jersey does not.

6. Maine does not require computerized storage of prescription records. New Jersey does.

7. New Jersey restricts sale of syringe/needles to pharmacies, Maine does not.

8. New Jersey has a penalty for sale of OTC look-alikes. Maine does not.

9. There are a number of differences between the two States regarding generic drugs.

   a. New Jersey utilizes a formulary (a State list) for approved generic drugs. Maine does not.

   b. New Jersey has a 2-line Rx format requiring physician's signature on the appropriate line as a means of indicating whether or not a generic may be substituted. Maine accomplishes this through checking a box. (If checked, a generic can not be substituted).

   c. Maine allows the substitution of generic drugs. New Jersey requires it.

   d. New Jersey requires that the full cost saving of the generic drug be passed to the consumer. Maine requires only that the generic drug price be no higher than the price of the brand name drug.

SOURCE: Prepared by John Knox, Committee Staff, from
Survey of Pharmacy Law
The National Association of Boards of Pharmacy,
1988-89

Revised October 12, 1989 to reflect corrections provided by Denise Doyen, Chairman, Maine Pharmacy Board

#173LHS

APPENDIX N

State Employee Health Commission

Labor

Alan Carr, State Police Trooper
Donna Doore, State Archives
Phil Goggins, Retiree
Loni Messore, Court System
Paul Perry, Law Enforcement, Dept. of Conservation
Brad Ronco, Health Planning Office, Dept. of Human Services
John Veader, Dept. of Inland Fisheries & Wildlife
Tom Wellman, Adjuster Officer, Dept. of Labor (Formerly with Dept. of Human Services working on claims of the disabled)
Charles Sherburne

Management

Steve Leech, Court System
Jo Gill
Alicia Hanson, Bureau of Employee Relations
Frank Johnson, Bureau of State Employee Health
Jonathan Lepoff, Bureau of Labor Standards
Randy Schwartz, Director, Div. of Health Promotion and Education, Dept. of Human Services

APPENDIX O

John R. McKernan, Jr.
Governor

Jo A. Gill
Executive Director

Department of Administration
STATE EMPLOYEE HEALTH INSURANCE PROGRAM
Telephone (207) 289-6780
or toll free
1-800-422-4503

Availability of Prescription Benefit Reimbursement: History and Competitive Bidding

In 1962, the Maine State Employees Association, holder of health insurance policies for State government employees, announced the inclusion of a major medical plan which provided coverage for prescription drugs.

The major medical program continued with some changes in the total dollar maximum and changes in insurance carriers, but the coverage for prescription drugs remained intact.

In 1968, as the State began to share in a greater share of employee health insurance premium, the Board of Trustees was established to oversee the health insurance plan. As responsibilities associated with the health insurance program administration increased, an Executive Director was hired to supervise the administration of the program.

Beginning in 1985, the State began exploring health care cost containment with a group convened by Commissioner Michael Petit at the request of Governor Brennan. This followed informal meetings among individuals who were becoming increasingly concerned about the direction of health care. From these discussions, and as a result of collective bargaining, the Labor Management Committee on Employee Health was developed in 1986. In 1988, the 113th Legislature enacted a measure replacing the Board of Trustees with the State Employee Health Commission.

State House Station 114, Augusta, Maine 04333 — *Offices Located at* 219 Capitol Street, Augusta

One of the first areas of concern addressed by the Labor Management Committee in 1986, was that of prescription drug costs. Clearly, prescription costs were increasing and becoming a growing portion of the major medical experience. With this growth came questions about the appropriateness of the costs and the fact that providers fees could vary, greatly.

As a result of the prescription drug issue being reviewed, Prudential, our former major medical carrier, provided suggestions of alternatives used by other employers. Prudential was using National Pharmacies, Inc. (subsidiary of Medco) as a source of providing mail service prescriptions to other clients. The Board of Trustees concurred with the Labor Management Committee and a voluntary mail service prescription drug program was introduced on a pilot basis to our participants in August, 1987.

In 1988, having six months experience with the prescription drug program, the Labor Management Committee with the Board of Trustees agreed to continue a mail service prescription program. In January, 1988, by issuance of a Request for Proposal, bids were invited for hospitalization, medical/surgical, major medical, managed care and prescription drugs.

Advertisements for the Request for Proposals were placed in the Kennebec Journal, Maine Sunday Telegram, Boston Globe and Wall Street Journal. Proposals were sent to over seventy prospective insurance company, managed care and pharmacy bidders including America's Pharmacy, Baxter-Travenol, CVS, Employee Pharmaceutical, EPI of Florida, Express Pharmacy Services, Home Shopping Pharmacy, LaVerdiere's, Medco, Medi-RX America, Partridge Pharmacy, Pharmacy Group of New England, Prescription Plan Service, Presque Isle Pharmacy, Stokeld Health Services and Wellby Drug.

The bids were open on February 5, 1988. In addition to bids for health insurance and managed care, we received pharmacy bids from America's Pharmacy, Baxter-Travenol, Employee Pharmaceutical, Inc., Express Pharmacy, Home Shopping Pharmacy, Medco, Pharmacy Group of New England, Prescription Plan Service, Stokeld-Accuscript, Wellby-Hannaford Brothers.

With the Labor Management Committee and the Board of Trustees, the bids were reviewed using the criteria included in the Request for Proposals. Following the review, the Labor Management Committee interviewed five submittors. They included Express Pharmacy (division of J.C. Penney), Home Shopping Pharmacy, Medco, Wellby (division of Hannaford Brothers) and Pharmacy Group of New England.

The interviews were scheduled on February 24th and 25th. Each pharmacy submittor was provided twenty-five to thirty minutes to present information. The balance of the time was provided for committee members to ask questions of the submittors.

Following a subsequent review of the criteria, it was agreed by the Labor Management Committee and Board of Trustees that Medco be selected to provide the prescription mail service program. The program remained voluntary.

Discussions ensued with Blue Alliance, the underwriter and health insurance carrier selected to provide the major medical benefits. Steps were taken so that the administrative issues were addressed, such as eligibility maintenance, claims payments and other accounting procedures. Blue Alliance and Medco entered an agreement that clarified issues pertinent to their administration of the plan and administration of other plans entering such an arrangement.

In summary, the mail service program through National Pharmacies, Inc. (Medco) and the acute need program through PAID Prescriptions were introduced to participants as voluntary alternatives to the traditional method of obtaining prescription medications with a managed care component included.

A = RESPONSIVENESS TO THESE SPECIFICATIONS -- 20 POINTS
B = PROPOSED COST (RETENTION, RESERVES, MAXIMUM EXPOSURE) -- 40 POINTS
C = EXPECTED QUALITY OF SERVICE, BASED ON DEMONSTRATED QUALIFICATIONS TO INSURE/ADMINISTER PLANS OF COMPARABLE SIZE/DEMOGRAPHICS, DATA CAPTURE AND REPORTING CAPABILITIES AND FINANCIAL RELIABILITY -- 20 POINTS
D = EXPECTED RESPONSIVENESS TO STATE'S/EMPLOYEES' NEEDS, INCLUDING LOCATION OF CLAIM AND SERVICE OFFICES -- 20 POINTS

NAME OF BIDDER	A (20 PTS.)	B (40 PTS.)	C (20 PTS.)	D (20 PTS.)	Total	Comments
America's Pharmacy	20	18 (6.21)	20	18*	76	*Des Moines, Iowa
Baxter Travenol	20	25 (5.55)	15	20	80	
EPI	18*	22 (5.61)	15	15**	70	*bill to state **reports
Express Pharmacy	20	30 (4.79)	20	20	90	
Home Shopping Pharmacy	20	40 (3.61)	0*	0*	60	*only HSN as client no group experience on which to base bid
Medco	20	35* (4.02)	20	20	95 *generic	*inflation guarantee substitution guarantee *generic savings guarantee
Pharmacy Group of NE	15*	1 (7.86)	10**	20	46	**no group experience **new working organization *proposal for all RX's no audit trails
PPS	10	5 (7.76)	10	15	40	
Stokeld Health Services	20	13 (6.38)	15	15	63	
Wellby	15*	9 (7.59)	10**	20	54	*all RX's **no group experience **reports **no audit trails

APPENDIX P

John R. McKernan, Jr.
Governor

Jo A. Gill
Executive Director

Department of Administration
STATE EMPLOYEE HEALTH INSURANCE PROGRAM
Telephone (207) 289-6780
or toll free
1-800-422-4503

Structure of Prescription Drug Benefits:
Choices

MAJOR MEDICAL DESCRIPTION

Since 1982, prescription drug benefits have been part of the Major Medical Program offered to State of Maine employees and retirees.

In order to obtain the major medical benefit, a participant takes a prescription to a pharmacy of his or her choice. The pharmacist dispenses the medication. Payment is made for the medication by the participant and a receipt is requested and retained by the participant.

A major medical claim is filed by the participant for expenses including office calls, prescription drugs, durable medical equipment, physical therapy, skilled nursing care and remaining balances on Blue Shield claims. Generally, participants are encouraged to file claims, annually, although a participant may file more frequently.

To file a claim, the participant must complete a major medical claim form by including his or her name, address, phone number, policy numbers, ailment and signature. Copies of itemized bills or receipts should be attached to the claim form and the claim should be mailed to the insurance company.

Payment is made to the participant, directly.

State House Station 114, Augusta, Maine 04333 — *Offices Located at* 219 Capitol Street, Augusta

The major medical alternative existed as the only option until August, 1987, when a voluntary mail service program was added as a second option.

MAIL SERVICE PRESCRIPTION PROGRAM DESCRIPTION

Mail Service provides maintenance medication, prescriptions that must be taken on a long term basis. To utilize mail service, the participant must mail the prescription to the mail service pharmacy in a special National Pharmacies, Inc., envelope. The prescription is dispensed and mailed to the participant.

On a monthly basis, National Pharmacies, Inc., bills the insurance company underwriting the prescription benefit. The insurance company pays the amount due to National Pharmacies, Inc. and charges it back to the State Employee Health Insurance Program claims experience.

ACUTE NEED PRESCRIPTION PROGRAM

A third option, a plastic card for acute need medication was added to the program in June, 1988. The plastic card entitles participants to utilize a local participating pharmacy for an acute prescription need.

The Acute Need Prescription Program may be utilized when a participant has an immediate need for a short term medication. To qualify as an Acute Need Prescription, there is a limitation of a 21 day supply with one refill. Prescriptions not meeting that category, must be dispensed locally and the expense must be filed with major medical or the prescription may be dispensed through mail service.

To use the plastic card, a participant should take the prescription to a pharmacy and show their plastic identification card. The pharmacist will dispense the medication, take an impression of the card on a claim form and complete the form. The participant must sign the form and pay the pharmacist $3 for generic medication or $5 for brand name medication.

The pharmacist submits the claim form to PAID Prescriptions requesting payment for the Average Wholesale Price plus dispensing fee minus the $3 or $5 copayment. PAID Prescriptions reimburses the pharmacy.

Monthly, PAID Prescriptions bills the major medical insurance carrier for the claims paid by PAID for State of Maine participants. The major medical insurance company reimburses PAID Prescriptions.

APPENDIX Q

Medco's Management Information System which is currently being provided to the State is structured on a two-tiered system to maximize responsiveness and detail to the client. The first tier of data support consists of state-of-the-art core reports which are routinely provided to the client on a quarterly basis. These reports, which are detailed below, represent a concise consolidation of Medco's extensive data base capabilities and are produced in a simple, readable format. John Kleshinski and Cathy Bruno will continue to personally deliver and discuss the content of each report quarterly. These reports include the following:

- EXECUTIVE SUMMARY REPORTS

  Serving as a quarterly summary of all mail service prescription activity, this report provides the client with a "snap shot" of number of prescriptions filled, associated costs, a brand versus generic total cost and overall utilization comparison, and a summary of prescription activity by member, spouse, and dependent.

- UTILIZATION SUMMARY BY LOCATION

  This management tool allows the client to analyze and compare utilization trends, cost differences, and generic/brand prescribing patterns among multiple enrollee-location sites. The client maintains the flexibility of determining and defining the various enrollee sites that would be used for this and other location-specific reports.

- ACTUAL AND POTENTIAL GENERIC SAVINGS REPORT (BY LOCATION)

  This report points out the actual dollar savings accrued by the client based upon the prescribing of generic drugs. Also detailed in this report is an analysis of brand drug costs compared to substitute generic drug costs and the dollar savings that would have been realized by the client if generic drugs were prescribed when applicable.

- USER PROFILE

  The User Profile report depicts the prescription utilization by demographic categories, including age grouping, male/female comparison, and member/spouse/dependent child summary data. This report is available by enrollee - location site.

Additional core reports are also available at the State's option, but again at no additional cost. Ms. Bruno would be glad to further discuss content of these optional reports. These reports include the following:

- BRAND DRUG UTILIZATION BY ENROLLEE

  Incorporated in this report is a listing by location of enrollees who receive brand drugs when generic substitute medications are available. This report also details the potential dollar savings accruable by enrollee if appropriate generic drugs were substituted for the actual brand drugs received.

- WHOLESALE INGREDIENT COST DATA REPORT

  Enrollee and dependent ingredient costs are displayed in this report for male and female users in pre-determined age grouping categories. This analysis further breaks out ingredient cost data for retired enrollees and their dependents by separate age groupings.

- CLAIM UTILIZATION DATA SUMMARY

  This is a two-part report which provides a) enrollee utilization data and b) dependent utilization data. Each report separates active enrollees from retirees and shows by male/female age groupings the actual number of mail service prescriptions and the average days-supply.

Sample standard and optional reports are included in the Exhibits section.

APPENDIX R

STATE OF MAINE
Office of the Attorney General

Inter-Office Memorandum

August 16, 1989

TO *Crombie J.D. Garrett, Deputy Attorney General*
FROM *Linda M. Pistner, Assistant Attorney General*
SUBJECT *Third Party Prescription Drug Programs*

This will summarize my understanding of the legal issues which have been raised concerning the Third Party Prescription Program Act, 32 M.R.S.A. §§13771-13777. These comments are provided for whatever benefit they may be to the office's response to the study being conducted in this area by the Joint Standing Committee on Business Legislation. My information comes from the handling of the litigation in this area (Pharmacy Group of New England, et al. versus Paid Prescription Programs, Inc., et al.) and through some limited involvement with review and comment on proposed legislation in this area during the last legislative session.

A variety of issues were raised in the litigation, several of which were simple compliance problems. For example, the Paid Prescriptions, Inc. program did not provide timely written notice of the provisions of the program through a filing with the Superintendent of Insurance, nor it did give such notice to all pharmacies located in counties covered by the program at least 30 days prior to commencement, both as required by §13773. An argument was raised by Paid in its defense that the statute is somewhat ambiguous about who has the responsibility of making this filing. Although clarity on this point might be useful, it is fairly obvious that the only entity in a position to give notice of the terms of the program is the program provider itself.

A somewhat more significant issue concerned the fact that Paid's affiliate, National Pharmacy, Inc., was providing mail order services under the program without benefit of a registration from the Commission of Pharmacy as required by 32 M.R.S.A. §13751. Although National had not applied for registration at the time of the commencement of the litigation, had it so applied it would have learned that the Commission of Pharmacy had not adopted rules required to establish the criteria necessary for such registration. Due to a major recodification of its statutes, the Commission of Pharmacy had a large number of rulemaking responsibilities to fulfill, which situation was aggravated by the fact that the new pharmacy act was enacted on an emergency basis allowing no lead time for proposal and promulgation of rules. This issue was resolved by the Commission's agreement to prioritize the adoption of rules concerning registration for mail order facilities, and National's agreement to submit a request for an interim license to cover that period until such time as the rules were adopted. Because I do not have continuing responsibility for the Commission of Pharmacy, and the litigation was terminated by a voluntary dismissal, I don't know whether further issues were encountered as to the substance of these proposed rules during that process.

Crombie J.D. Garrett
Deputy Attorney General
August 16, 1989
II.

The key issue raised by the litigation, and one which resurfaced in connection with legislative proposals presented last session, concerned the terms upon which pharmacists were entitled to participate in a third party prescription drug program. Based upon the requirement in §13773 that written notice of all provisions of the program be given to all pharmacies in the service area prior to commencement of the program, together with the language in §13776 requiring that any change in a contract offered to one pharmacy be offered to all State pharmacies participating, the Pharmacy Group of New England argued that all pharmacies were entitled by statute to participate in any third party prescription drug program on the same basis in all aspects of the program. This controversy was generated by the two-tier Paid program, under which retail pharmacies were reimbursed for filling acute or short-term prescriptions with a modest co-pay provision, but long term or maintenance drug prescriptions could be filled through a mail order program by National with either no co-pay or a one dollar co-payment. Paid and National argued that the statute did not prohibit this two-tier arrangement, and did not require access to the maintenance or long term drug program on the part of all retail pharmacies otherwise participating in the program.

The Third Party Prescription Program Act is not clear on the issue of the terms of participation. The Pharmacy Group of New England suggested that this question could be addressed by rulemaking on the part of the Commission of Pharmacy. My advice to the Commission at that time was that the lack of clarity in the statute created doubt as to their ability to adopt a rule specifying a requirement one way or another on this issue.

Another issue common to both the litigation and the legislative debate was the extent of possible ERISA preemption. In the litigation, Paid and National were prepared to argue that the State statute is preempted in its entirety under ERISA by virtue of the fact that prescription drug programs are sold directly by the provider to employers. Similar statutes have been determined, by trial courts or opinions of state attorneys general, to be ERISA preempt, but in virtually all cases the degree of regulation attempted by the programs was substantially greater than that found in the current Maine statute. The extent to which the Maine statute could be expanded in its regulatory impact without prompting preemption is a complex question.

A final issue which has been raised most directly in a legislative forum is whether or not a mail order facility can be required by statute to maintain a retail pharmacy in the State for purposes of filling prescriptions for Maine residents. It has been argued that public health and safety require regulation to this degree; conversely, it has been argued that such a requirement is purely anticompetitive. The legal concerns which I have with respect to this proposal are twofold. First, due to the burdensome nature of such a requirement, it would have to be demonstrated that specific health and safety

goals cannot be met in a less restrictive fashion in order for such a statute to be determined a proper exercise of the police power. Further, the burden on interstate commerce of such a requirement is fairly obvious, thus raising question as to its constitutionality on that ground.

One final note concerns the split regulatory responsibility under the current Maine law for the Third Party Prescription Program Act. There does not appear to be any need for the third party prescription program filings to be made with the Superintendent of Insurance, particularly in light of the lack of specificity in the statute as to the contents of such a filing and the fact that the remainder of the law is subject to the jurisdiction of the Commission of Pharmacy. Were there to be established regulatory requirements concerning rates under these programs which would require expertise of the Bureau of Insurance, a different situation could result, but rate regulation is precisely the type of change that would likely provoke ERISA preemption. Certain of the problems encountered in the litigation would have been avoided had the regulatory responsibility for the entire program rested with the Commission of Pharmacy.

I trust this is somewhat helpful in explaining the issues, although I am aware that it raises more questions than it answers.

LMP/jet

cc: John Knox
Legislative Analyst
Office of Policy and Legal Analysis

APPENDIX S

I. EXECUTIVE SUMMARY

INTRODUCTION

The Michigan Department of Civil Service (MDCS) has contracted with Baxter Healthcare Corporation to provide administrative services for a mail order prescription program for qualified State employees and retirees. The terms of the contract stipulate the timing and exact detail of various administrative tasks associated with the program. Included in the contract is a third party audit program. TPF&C was retained to conduct this audit for Fiscal Year (FY) 1988, which included claims paid from October 1987 through September 1988.

The audit, which focused on nine specific administrative tasks, utilized a random sample of 130 claims to test adherence to contractual provisions. The tasks included:

- Timely dispensing of prescriptions
- Prevention of duplicate fillings
- Adherence to Ingredient Cost Formulas
- Appropriate calculations of discount rates
- Proper dispensing of prescriptions
- Appropriate dispensing of generic drugs
- Appropriateness of refills
- Adherence to plan design regarding covered drugs
- Eligibility control.

TPF&C conducted the audit in May of 1989.

APPENDIX T

APPENDIX T

Maine State Health Insurance Program

Prescription Drug Summary

	5/86–4/87	5/86–7/86	5/87–7/87	8/86–7/87	8/87–7/88	8/88–7/89
Major Medical						
Total Expense	$1,400,000	$ 260,000	$ 350,000	$1,479,000	$1,474,000	$1,006,000
$ change vs. yr. ago	+560,000		90,000	N/A	-5,000	-468,000
% change vs. yr. ago	+63		+29%		-1	-32
% vs. base year	N/A		+29%		-1	-32
Mail Order						
Total Expense		N/A	N/A	N/A	$1,901,689	$2,958,117
$ change vs. yr. ago					N/A	1,056,478
% change vs. yr. ago					N/A	+56%
% change vs. base year (Major Medical)					+29	+100
Card						
Total Expense		N/A	N/A	N/A	$ 22,704	$ 932,612
$ change vs. yr. ago					N/A	909,978
% vs. base year (Major Medical)					N/A	+37
Major Medical & Mail Order						
Total Expense		N/A	N/A	$1,479,000	$3,375,689	$3,964,117
$ change vs. yr. ago				N/A	1,896,689	588,478
% change vs. yr. ago					+128%	+17
$ change vs. base year					1,896,689	2,485,117
% change vs. base year					+128%	+168
Major Medical & Card						
Total Expense		N/A	N/A	$1,479,000	$1,496,704	$1,938,612
$ change vs. yr. ago				N/A	17,774	441,978
% change vs. yr. ago					+1%	+30
$ change vs. base year					17,774	459,612
% change vs. base year					+1%	+31
Major Medical, Mail Order & Card						
Total Expense		N/A	N/A	$1,479,000	$3,398,383	$4,896,729
$ change vs. yr. ago				N/A	1,919,373	1,498,376
% change vs. yr. ago					+130%	+44
$ change vs. base year					1,919,373	3,417,729
% change vs. base year					+130%	+231
As % Total Expense						
Major Medical				100%	43	21
Mail Order					56%	60
Card					1%	19
As % of Total Increase vs. Base Year						
Major Medical					-1%	-14
Mail Order					+99%	+87
Card					+2%	+27

APPENDIX U

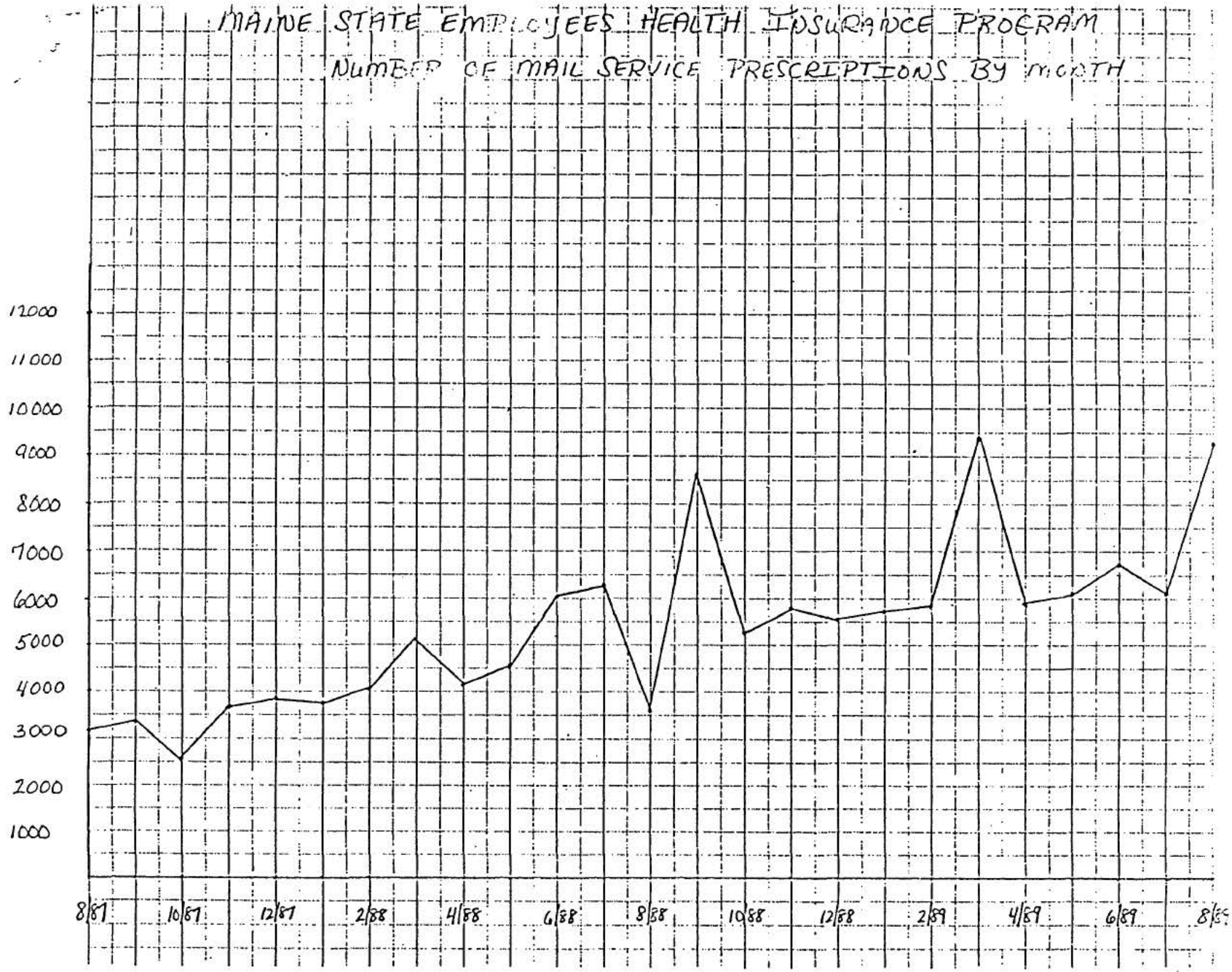
MAINE STATE HEALTH INSURANCE PROGRAM
PRESCRIPTION DRUGS

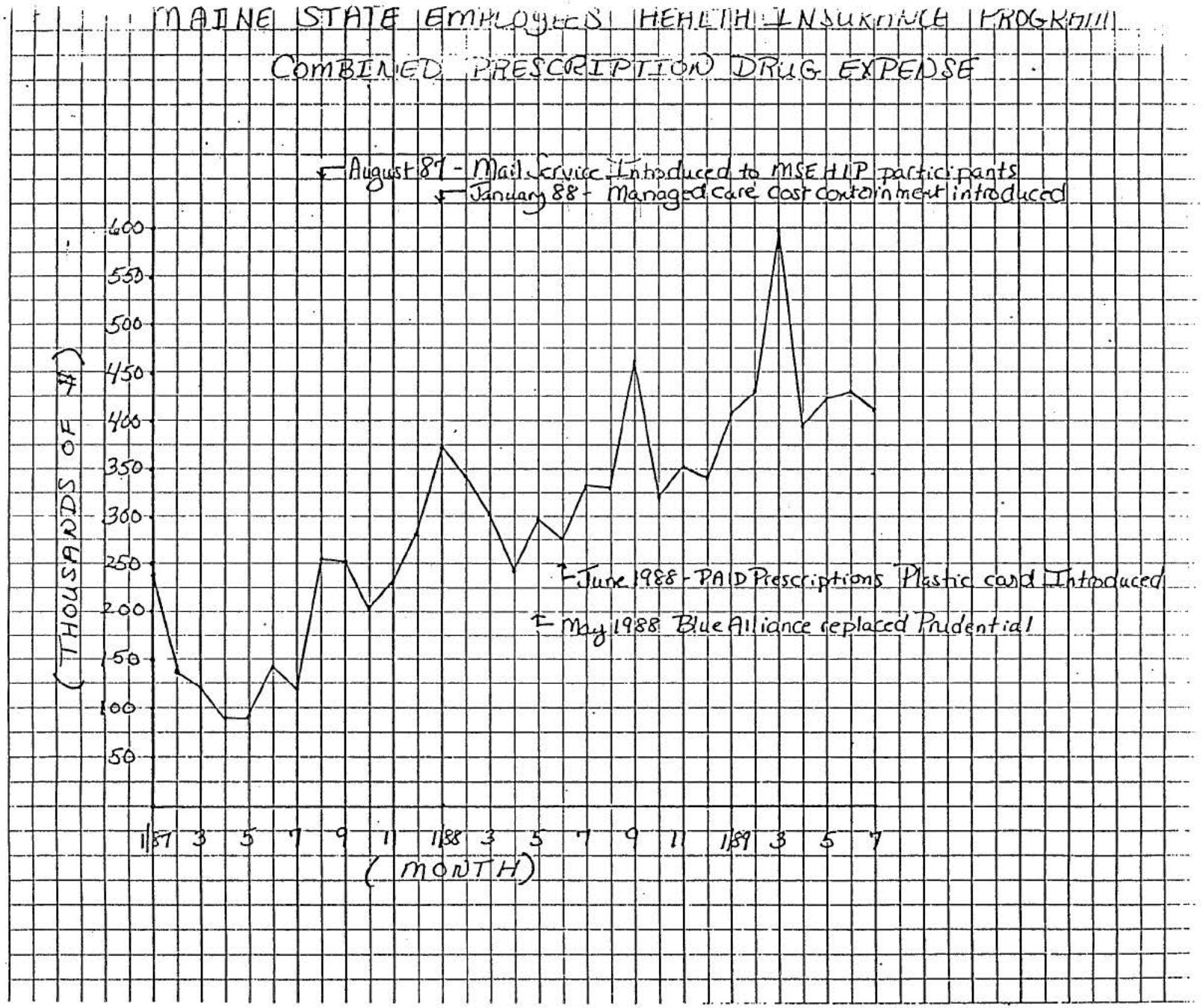
Monthly Trend

8/87 8/88	$255,037 $237,531	$237,531/$255,037 = .93%
9/87 9/8	$252,035 $467,044	$467,044/$252,035 = 185%
10/87 10/88	$206,799 $323,897	$323,897/$206,799 = 157%
11/87 11/88	$231,960 $350,940	$350,940/$231,960 = 151%
12/87 12/88	$282,599 $346,505	$346,505/$282,599 = 123%
1/88 1/89	$372,258 $781,144	$781,144/$372,258 = 210%
2/88 2/89	$341,358 $430,532	$430,532/$341,358 = 126%
3/88 3/89	$300,616 $598,473	$598,473/$300,616 = 199%
4/88 4/89	$244,082 $393,175	$393,175/$244,082 = 161%
5/88 5/89	$297,364 $424,400	$424,400/$297,364 = 143%
6/88 6/89	$276,599 $429,140	$429,140/$276,599 = 155%
7/88 7/89	$337,786 $412,218	$412,218/$337,786 = 122%

#286LHS

APPENDIX V


MAINE STATE EMPLOYEES HEALTH INSURANCE PROGRAM
NUMBER OF MAIL SERVICE PRESCRIPTIONS BY MONTH
12000
11000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
8/87
10/87
12/87
2/88
4/88
6/88
8/88
10/88
12/88
2/89
4/89
6/89


MAINE STATE EMPLOYEES HEALTH INSURANCE PROGRAM
COMBINED PRESCRIPTION DRUG EXPENSE
August 87 - Mail Service Introduced to MSEHIP participants
January 88 - Managed care cost containment introduced
June 1988 - PAID Prescriptions Plastic card Introduced
May 1988 Blue Alliance replaced Prudential
(THOUSANDS OF $)
600
550
500
450
400
350
300
250
200
150
100
50
1|87 3 5 7 9 11 1|88 3 5 7 9 11 1|89 3 5 7
(MONTH)

APPENDIX W

MAINE STATE HEALTH INSURANCE PROGRAM APPENDIX W

MAIL ORDER AND CARD SUMMARY

	3rd Qtr. 1988	4th Qtr. 1988	1st Qtr. 1989	2nd Qtr. 1989	3rd Qtr. 1989	Year-End June 30, 1989 Active	Retired	
Mail Order								
Brand Only Available	47%	46%	47%	48%	48%	50%	44%	
Brand Dispensed	20	21	20	19	19	19	20	
Generic Dispensed	33	33	33	33	33	30	35	
% Maintenance of of Total								89%
Card								
Brand Only Available	39	36	34	35	37	34	41	
Brand Dispensed	26	27	27	27	25	27	26	
Generic Dispensed	34	37	39	38	38	39	34	
% Maintenance of of Total								58
% Utilizing Mail Service	17.8	23.2	24.2	26.5	26.7	31	45	
Average Cost	36.97	37.70	39.95	4.42	43.54	39.86	38.88	
Average Units	125.8	125.4	129.5	126.9	128.5	121.6	131.9	
Average Days' Supply	67.7	67.3	68.1	68.4	68.0	66.3	69.7	
Prescription Per Card	3.0	3.8	3.4	3.7	3.6	8.6	13.9	
Mail Service as % All Claims	53.2	52.7	45.2	42.8	44.0	38.8	61.7	

SOURCE: Various Medco Reports

#326LHS

APPENDIX X

V. POSSIBLE LEGISLATIVE OPTIONS

1. That the Legislature direct the State Department of Civil Service to closely monitor the mail service prescription program and develop an annual report. The report should include, but not be limited to, detailing utilization patterns by age and drug type, average cost per prescription; savings to the state and individuals; use of generics; complaints; assurance of quality of drug dispensing; the increase of employee awareness of the expense of prescription drugs and availability of high quality generic substitutes; and results of monitoring for inappropriate or abusive drug utilization.

2. That the Legislature consider legislation similar to Louisiana's which requires that out-of-state pharmacies hold a Michigan Pharmacy License to dispense within our borders.

A major drawback to this approach is the difficulty of determining how the state Board would identify which MOPs were doing business in Michigan. Information obtained through "the grapevine" or accidentally is not a very efficient approach.

A second issue to be resolved with this type of legislation would be how the Board would handle the cost of inspections. Can they pass on the presumably higher cost to the out-of-state pharmacy?

Third, who or what would be licensed? The pharmacy or the pharmacist or both? Alabama adopted legislation which licenses out-of-state pharmacies and at least one full-time pharmacist in each firm.

3. The Legislature could consider a bill similar to a 1987 Arkansas law which makes it unlawful for any employer providing pharmacy services to employees to require they obtain drugs from an out-of-state pharmacy as a condition of obtaining the employer's coverage or to impose a copayment or other condition not imposed upon employees utilizing the designated out-of-state mail order pharmacy.

This is primarily designed to prohibit the "economic incentive" which public and private employers are beginning to offer in their health care plans as an incentive to consumers to utilize the MOP and as a way of passing on the anticipated savings. The major effect would be to protect the community pharmacy from the competition, probably a questionable policy objective for the state government.

Furthermore, a new federal government program run by Aetna specifies that enrollees must purchase certain long-term drugs through the mail order service to receive coverage for them. Expenses for these drugs are not subject to the normal deductible and there is no copay on other drugs purchased through the MOP.

In view of the fact that the federal government has already offered this type of a plan to their employees, it makes it less likely that legislation of this type would survive a federal court challenge, should one be brought.

4. Legislatively allow the state Board of Pharmacy to provide a review of those mail order pharmacies which voluntarily submit. Such review could determine whether or not the pharmacy had minimum standards in place to assure a certain quality of dispensing practices. For example: only pharmacists interpreting the prescription and dispensing the drugs; and a computer system which could maintain sophisticated patient profiles and automatically do drug screening. The Board could then publicize a list of those firms whose practices had been reviewed and/or audited and make the information available to consumers considering using a mail order plan.

5. Direct the state Board of Pharmacy to undertake programs to provide consumer education on the pros and cons of the various drug dispensing practices and the consumer's responsibility to know what drugs they are taking and report accurately to their physician and pharmacist.

6. Repeal Michigan's prohibition against delivering drugs by mail. This would give community pharmacies in Michigan a better ability to compete with the chains and out-of-state mail order pharmacies by allowing them to also deliver drugs by mail. It would also allow the Legislature to establish regulations for pharmacies engaged in mail delivery of drugs which could then be applied "even handedly" to companies both in and out of the state, making constitutional problems with such regulation less likely.

The Michigan Pharmacists Association is already on record as opposing this type of legislation because of their health and safety concerns regarding mail order delivery of pharmaceuticals.

SOURCE: Mail Order Prescriptions, A Report of the Joint Standing Committee, Michigan Senate, Nov., 1989

APPENDIX Y

HARMON CROPSEY
21ST DISTRICT
P.O. BOX 30036
LANSING, MICHIGAN 48909-7536
(517) 373-7946
(616) 423-7763

THE SENATE
LANSING, MICHIGAN

COMMITTEES
LOCAL GOVERNMENT AND VETERANS, CHAIRMAN
EDUCATION AND MENTAL HEALTH, VICE CHAIRMAN
AGRICULTURE AND FORESTRY
HUMAN RESOURCES AND SENIOR CITIZENS

July 25, 1989

Mr. John Knox
Office of Policy Analysis
State House Station #13
Augusta, Maine 04333

Dear Mr. Knox:

It was a surprise to talk with you the other day. I had no idea the work of the committee had rippling effects outside of Michigan.

Enclosed are two bills that the Senator had drafted in response to the report. The first bill has "01010'89 a Draft 1" on the bottom left corner. This bill would require our Department of Civil Service to begin collecting data on the various aspects of mail-order drugs. The second bill (01010'89 b Draft 1) would require the State Board of Pharmacy to conduct normal procedural evaluation of the dispensing practices of the contracted pharmacy.

We are waiting for other bills to be drafted that would make it possible to compile further data about these businesses. As I mentioned, we are having constitutional conflicts. Because prescriptions may not be shipped within our borders by a resident company, these bills would allow participation by an out-of-state company. Therefore, we would have to trust them to comply with our laws. Another obstacle is the independent status of our Civil Service Department, which has legislative immunity. There again, we must rely on them to comply.

We have strong groups lobbying for the removal of the in-state shipping ban on prescription drugs as well as for out-of-state compliance with state law. However, these areas would not address the possible health problems with mail order drugs. For that reason, we will work to gather as much information as possible before 1990.

I would like to know the conclusions your committee reached. Since I am unfamiliar with Maine laws, I am curious as to how you will handle, or have already dealt with, the conflicts we have encountered.

Thank you for calling; I hope this information is helpful. If you have any further questions, please feel free to call.

Sincerely,

Matthew G. Hare

Matthew G. Hare
Legislative Aide

APPENDIX Z

GARY J. SEKULSKI
SENIOR VICE PRESIDENT
MARKETING & PRODUCT DEVELOPMENT

October 26, 1989

Mr. John B. Knox
Legislative Analyst
State of Maine
Office of Policy and Legal Analysis
Room 101/107/135
State House Station 13
Augusta, Maine 04333

Dear Mr. Knox:

I was pleased I could be of assistance to the Subcommittee at the October 16, 1989 hearing. When we talked at that time, you asked me to informally respond to the following:

1. Is the State of Maine's prescription drug program experiencing cost increases similar to other programs?

2. What do you anticipate future cost increase trends to be?

3. Is the copayment structure for the State of Maine in line with the copayments of other clients?

4. Do you have any industry articles concerning prescription drug prices?

As you know, we have provided documentation that the plan design Medco promotes and which the State of Maine has adopted is cost effective in relation to retail programs. As far as the "increase" in prescription drug program costs are concerned, however, the State of Maine's experience is similar to other programs in both the public and private sectors regardless of the nature of the provider, i.e., mail service pharmacy, retail pharmacy, or an integration of both. For example, in comparing 1989 experience to 1988 experience, cost increases in prescription drug programs range from 15.4% to 26.7% with Medco's experience, on the average, being at the low end of this range.

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It is also interesting to note that these cost increases are comprised of:

1. Inflation or pure price increases from manufacturers.

2. Changes in drug mix.

3. The introduction of new drug therapies.

4. Increased utilization.

If industry trends are correct, we anticipate Medco to be at the low end of the range in the future.

As far as copayment structures are concerned, there is a definite move by plan sponsors to higher copayments. The following is representative of some of the more recent changes in copayment.

	BRAND/CARD	GENERIC/CARD	MAIL SERVICE
1.	$7	$4	$4
2.	8	5	5
3.	10	7	7
4.	12	8	8

Lastly, it is my understanding that you have already been provided with industry articles concerning prescription drug prices.

If I can be of further assistance, please let me know.

Very truly yours,

Gary J. Sekulski
Senior Vice President
Marketing & Product Development

CC: Severin Beliveau, Esq.

GJS/vw:2228;6

APPENDIX AA

The Reimbursement Update

Incorporated

November 8, 1989

John Knox
Office of Policy and Legal Analysis
State House, Room 101/107
Station 13
Augusta, ME 04333

Re: State of Maine Employee Drug Benefits

Dear John:

As we discussed on the telephone today, my analysis of the information available to me at this time indicates that provider reimbursement is not the problem area in the explosive growth of benefit expenses for the State of Maine Employee Benefits program. I would need additional information on the actual number of covered beneficiaries (lives) and the PAID/MEDCO management information system (MIS) reports to perform a more complete analysis of the **utilization** component.

In other words, of the two major areas that affect drug benefit costs, price and utilization, the latter is the problem area which requires attention. The most obvious "fix" for this problem would involve adoption of the two-tier copayment structure into the mail-order portion of the benefit. This change would reduce the cost of the drug benefit by at least 15%, but savings could be as much as 30%. With the MIS/utilization reports an accurate count of eligible beneficiaries, I could calculate a precise savings projection.

I look forward to hearing from you again.

Sincerely,

Fred

Frederic R. Curtiss, Ph.D., R.Ph., CEBS
President

355 Oak Trail Drive
Double Oak, Tx 75067
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APPENDIX BB

6.

Fall 1988

GHAA JOURNAL/97
v9no1 pp 97-104

Cost and Use Management in Prescription Drug Benefits

Frederic R. Curtiss, Ph.D.; Michael J. Tichon, J.D.

INTRODUCTION

Use management (UM) is the 1988 version of use review (UR) or the managed health care equivalent of UR programs conducted by traditional insurers. Rather than focusing on retrospective review of use data, and perhaps retroactive denial of provider payments, UM is characterized by three additional components. First, concurrent review occurs coincidentally with the delivery of services. Second, prospective review focuses on establishing delivery protocols that specify minimum and often maximum limits and standards of care. Third, UM involves true management of use, in contrast to the mere review of use data.

Prescription drug use has many facets. Aggregate drug use might be described in terms of the absolute number of prescriptions dispensed per person over a given period of time. For HMOs and other managed health care plans, this measure of drug use is commonly expressed as the number of prescriptions per (covered) member per month, or X prescriptions per member per month. Alternately, the same measure might be expressed in terms of X prescriptions per member per year. However, other measures of drug use are also important. Two other notable measures of drug use are (1) the percentage of generic or multiple-source, prescription drugs dispensed to all covered members and (2) the percentage of nonformulary (formulary: a list of drugs that have been defined as safe and effective) drugs prescribed and dispensed.

There are three managers of drug use. The physician prescribes a drug after evaluating the patient's condition. The patient (member) may also influence drug use by participating with the physician in drug product selection (DPS) and in the decision of whether to have the prescription filled at the pharmacy. The patient may further influence the selection of a particular prescription drug through consultation with the pharmacist, the third influential factor in drug use. For example, as a matter of concurrent review, the pharmacist may judge the prescribed drug to be medically unnecessary, inappropriate, or in conflict with the patient's diagnosis, coincident drug therapy, or other idiosyncratic factors. The pharmacist may also play a role in the DPS by selecting the manufacturer of a drug that is available from more than one manufacturer or labeler.

It is useful to place drug UM in the context of all available cost management tools and to define some of the design features of prescription drug plans.

Managing Total Costs

Managing total costs in prescription drug plans has been described in detail previously by Curtiss, including explanation of efforts to control (1) the average cost per prescription, (2) the number of prescriptions dispensed, and (3) administrative expenses.[1] Drug UR and UM are necessary components of total cost management in prescription drug benefits.

In understanding the effective cost management of pharmacy services, it is helpful to think of the cost management tools in terms of a hierarchy of intervention ordered by the degree of effect on the enrollee. The first level is virtually unnoticeable to the member and has to do with increasing the efficiency in claims processing and benefit administration. The use of an efficient pharmacy third party administrator (TPA) can reduce the total per claim cost to a small fraction of the cost of drug claims administered through an indemnity carrier; It may be as little as 40¢ to 45¢ per claim, including the production of periodic management information system (MIS) and data management reports. When data entry is performed by pharmacists at the time of service, electronic claims submission can reduce this average cost per claim even further. This administrative cost compares with indemnity claims administrative costs of as much as $6.50 per drug claim.

The second level of cost management includes production of useful MIS and data management reports, including drug UR exception screens to identify high-cost users for case management and to profile high-volume and high-cost prescribers. Drug UR screen parameters may include specifications of a threshold or trigger number of prescriptions per patient per quarter, use of more than three different prescribers (physicians) in the same quarter, use of two or more drugs within the same therapeutic class, concurrent use of therapeutically conflicting drugs, etc.

Prescribers can be profiled according to the frequency of prescribing within an individual therapeutic class and rank ordered by frequency of prescriptions, total cost of prescriptions, or the average cost per prescription. Particularly useful are drug UR prescriber profiles that list all physicians within a given medical specialty by the relative frequency of prescribing of generic drugs versus trade name and single-source drugs. Other MIS and data management reports are pharmacy profiles that show current period and year-to-date totals of prescription volume, average prescription cost, and the total average use per member for the entire plan. Meaningful MIS reports and drug UR exception reports, constructed from valid and reliable data, are essential to effective retrospective drug UM.

The third cost management tool involves the use of drug UR committees, comprised of physicians and pharmacists, to evaluate the drug UR exception reports. High-use prescribers might be contacted by telephone, by letter, or by personal interview when review indicates that prescribing practices could be improved.

The fourth and fifth cost management tools are also outgrowths of the drug UR committee process. Physician incentive payments, an increasingly common feature in managed health care programs, can be structured from MIS data that ranks each physician according to relative cost-effectiveness in prescribing. Initially,

physicians are profiled against their peers, in the same medical specialty, according to measures such as percentage of generic drugs prescribed. Obviously, comprehensive claims administration and MIS reporting are necessary to implement this cost containment tool, an important element of concurrent drug UM.

Fifth, drug prescribing protocols can be designed and communicated to participating physicians. For example, Drug Y should be prescribed for Diagnosis X only after a trial has been conducted with Drug Z. Drug prescribing protocols are the foundation of prospective drug UM.

The sixth cost containment feature of any well-managed prescription drug benefit involves on-site pharmacy audits. Provider audits are a valuable deterrent to fraud; equally important, when they are conducted by an objective third party, they help to ensure quality of care by assessing pharmacists' dispensing practices against state dispensing regulations and professional practice standards. The identification of pharmacies for on-site audits can be achieved through the use of MIS exception reporting based on parameters such as high volume, high cost per prescription, and a high proportion of dispensing within certain drug classes such as controlled substances.

The seventh cost management tool is not evident to the member and affects the pharmacist. A generic dispensing incentive involves paying the pharmacist a differential dispensing fee that encourages the use of a lower cost but equally effective generic drug. For example, trade name drugs may be reimbursed based on a product cost plus a dispensing fee, while generic drugs would be reimbursed to the pharmacist at the product cost but with a higher dispensing fee (e.g., 50 percent-100 percent higher). A pharmacy generic dispensing incentive encourages active pharmacist involvement in concurrent drug UM.

The first seven cost containment tools are virtually invisible to the member. The eighth tool, however, begins to bring the member into the cost management program. High-cost drug use that is found to be not medically necessary by the drug UR committees can be managed on a case-by-case basis to ensure the appropriateness of multiple-drug use. Such case management might be appropriate for multiple-high-cost drug use in a patient with several concomitant chronic diseases such as congestive heart failure, diabetes, and hypertension. Separately, high-cost drug use that is determined not to be medically necessary or of questionable necessity or to involve drug abuse can be managed through the ninth tool, assignment of the member to a clinical pharmacy case manager. This cost management device is effective because it positions UR at the time of service (i.e., concurrent UR) and prevents the member from using multiple pharmacies and multiple prescribers in an effort to disguise the drug abuse.

The tenth cost management tool, a drug formulary, is potentially the most significant factor in reducing the total cost of the drug benefit. While a voluntary drug formulary would be invisible to the member, it is also ineffective in reducing drug costs. A mandatory drug formulary, in concert with a physician or patient financial incentive and/or disincentive, is necessary to reduce significantly the average cost per prescription.

A mandatory generic drug formulary is more apparent to the enrollee and is more effective in reducing the drug cost per prescription. This eleventh cost management device requires some form of member financial responsibility when either the member or the prescriber insists on the trade name product of a generic drug. Importantly, the member is not denied the drug benefit but, rather, pays the price difference in the product cost between the generic drug and the trade name drug, plus the applicable copayment amount. The mandatory generic drug formulary is implemented with one copayment amount, for example, $2 per prescription.

As with all drug formularies, it is the responsibility of the formulary committee, comprised of physicians and pharmacy clinicians, to indicate those drugs that should not be substituted for therapeutic reasons. (Note that this list of nonsubstitutable drugs totals no more than five to 10 specific drugs and is often referred to as a negative formulary. Two common examples are digoxin and phenytoin.)

The twelfth cost management tool, the therapeutic drug formulary, is even more progressive and is still more evident to the member. This drug formulary is developed by a panel of experts who evaluate each therapeutic class to select safe and cost-effective drugs. While the development of a therapeutic drug formulary typically involves sophisticated analyses of pharmacokinetics,[3] general rules in these therapeutic deliberations include two basic questions: (1) Do the drugs selected in a given therapeutic class cover all medical conditions for which the class of drugs might be prescribed? (2) Does each drug selected in a given therapeutic class have a benefit to risk ratio such that the drug would be acceptable for prescribing to a family member or a friend? A well-designed therapeutic formulary would contain fewer than 400-500 drugs, including all dosage forms and strengths of the same drug.

A therapeutic drug formulary serves as a guide to rational drug prescribing as well as a cost management tool. The therapeutic drug formulary can produce savings in average drug cost per prescription when it is implemented with member financial responsibility, as discussed earlier, or alternately, the two-tier copayment method creates a sufficient member financial incentive to increase the use of generic prescription drugs and thereby produce savings. That is, the copayment for generic drugs might be $2, while the copayment for trade name and nonformulary drugs might be $5.

The thirteenth method, the mandatory collection of copayment from the member, is important as a deterrent to unnecessary drug use. Coupons or other discounts to the copayment amount encourage unnecessary drug use. Participating pharmacies should be required to collect the appropriate copayment amount from the member at the time of service to ensure that drugs are used judiciously.

The fourteenth method uses "starter," or trial dose, protocols for certain expensive drugs. This method reduces waste caused when new prescriptions produce an adverse reaction or prove to be unacceptable for use in a given patient. Drugs that are candidates for trial dose protocols include certain high-cost antihypertensive drugs, some anti-inflammatory drugs, and the new

antiulcer agents, all dispensed in a maximum initial quantity, for example, a seven-day supply.

Another approach is the method of channeling members to preferred providers in a pharmacy network. Channeling permits price negotiations with pharmacy providers to establish prospective prices for pharmacy services. The PPO network also permits the imposition of controls such as on-site provider audits, when specified in provider participation agreements. Member channeling involves the fundamental PPO features of price discounts and UR in return for increased volume for participating providers. The structure and function of pharmacy PPO networks has been described in detail in other work.[2]

The sixteenth cost management device, member assignment to one pharmacy, is the most significant, the most progressive, and perhaps the most intrusive on members. However, member assignment achieves several objectives. The pharmacy can receive a designated prepaid amount (capitation rate) per assigned member per month, with appropriate stop-loss provisions to guard against adverse selection and small numbers of assigned members.

Concurrent drug UM occurs at a maximum level of incidence because the pharmacist has a financial incentive to ensure proper, appropriate, and medically necessary drug use.

This contrasts sharply with fee-for-service incentives inherent in all other reimbursement alternatives. Therefore, member assignment to one pharmacy permits the implementation of the capitation method of provider reimbursement. While progressive, and perhaps somewhat intrusive on members, assignment to a primary pharmacy provider is similar to member assignment to a primary care physician--the so-called gatekeeper model of medical care delivery.

Drug Use Management Results

The effectiveness of drug UM is directly proportional to the degree to which all three parties of influence are brought into the design and operation of the prescription drug program. Preliminary data from the prescription drug benefit programs managed by Health Care Pharmacy Providers, Inc. lend some insight into the effectiveness of drug UM efforts. (Only preliminary data are presently available from HCPP, due to the age of the company; it only had 3 - 4 months of experience in most of the drug benefit plans.)

A prescription plan of 95,000 members with a single copayment of $2 per prescription achieved a generic use rate of 21 percent with only a pharmacist incentive, manifested as a 113 percent higher dispensing fee for generic versus name and single source drugs. In this plan, the physician was free to prescribe as he or she desired, and the member had no reason to be cost conscious because only a single copayment amount ($2 per prescription) was involved. This 21 percent generic use rate compares with an average rate of approximately 15 percent in the general population.

Another HMO drug benefit plan managed by HCPP had more than 135,000 members, a fixed $3 copayment amount, no financial incentive for the pharmacist, and no incentive and/or disincentive for the prescriber. However, the member was responsible for

the difference in drug cost, at the time of service, when either the member or the prescriber insisted on a trade name drug when a generic equivalent drug was available. The generic use rate was 35 percent.

A third plan had an incentive for pharmacists in the form of a higher dispensing fee, as well as a higher product cost margin for generic drugs, a fixed copayment of $3, and a voluntary generic drug formulary. Otherwise there was no prescriber incentives and/or disincentives. Members were responsible for the product cost difference when the member insisted on receiving a trade name drug. The generic use rate was 40 percent.

A fourth plan involved all three parties of influence in the selection of cost-effective drugs. The pharmacist received an incentive in the form of a higher dispensing fee and higher product cost margin when dispensing generic drugs. The member paid either a $2 copayment for a generic drug or a $5 copayment for a trade name drug. The member was also responsible for the product cost difference when he or she insisted on a trade name drug. Finally, the prescriber (physician) had a financial disincentive for requesting a trade name drug; if the prescriber insisted on a trade name drug when a generic equivalent was available, the prescriber was billed directly for the product cost difference. The generic use rate was 45 percent, and surprisingly, there was virtually no incidence of physician insistence on trade name products.

DISCUSSION

These drug benefits design features and drug UM are supplemented by retrospective drug UR activities. Retrospective drug UR can only become part of drug UM in the presence of the following four elements. First, the input data used to produce the drug exception and MIS reports must be reliable and valid. While seemingly simple, the capture of valid and reliable data requires imposing rigorous prepayment edicts and a continuous provider education process regarding data collection and data entry.

The second requisite element in bringing retrospective drug UR into drug UM is the design of practical and reasonable comparisons among prescribers. The credibility of drug UM can be destroyed by failing to observe factors such as physician medical specialty and other relevant physician characteristics in the design of drug UR reports.

The third element in effective retrospective drug UR involves the construction of measures that truly assess prescribing performance. One such measure is the ratio of generic drugs prescribed to total drugs prescribed by medical specialty. A second set of measures report the same statistic categorized by therapeutic drug class (e.g., antibiotics).

The fourth element in effective retrospective drug UR is the use of physician prescribing profiles to identify outlier prescribers (e.g., in the upper decile) for communication and follow-up. This communication may involve letters, telephone contact, periodic group meetings, and personal visits by a representative of the drug UR committee.

CONCLUSION

Active involvement of the member, the physician (or prescriber), and the pharmacist in the review and evaluation of patient drug therapies will enhance patient safety and improve quality of care. But, do the sixteen cost management tools described in this paper, including all of the drug UM activities, really produce any savings? One thing is certain, total spending in a prescription drug benefit is likely not to decrease if use controls are not implemented coincident to fee-for-service discounts. As emphasized by health care economists, all of the recent emphasis on health care cost containment (in managed health care) has not yet produced savings in total spending. In terms of both per capita spending (in constant dollars) and as a percentage of total U.S. production consumed by health care services, more will be spent this year than last year.

Pharmacists do not directly influence demand for prescription drugs and pharmacy services, but pharmacists can affect drug use through the methods described here, including monitoring of physician prescribing and patient drug use and ensuring medical necessity and appropriateness of drug therapy. A pharmacy PPO that only talks about drug UR and perhaps generates tables of drug use data in the name of drug UR will produce no savings for its clients. The most effective drug UR and drug UM occurs at the time of service, in the pharmacy, when it is conducted by the dispensing pharmacist. Drug UM is optimally effective when it involves all three parties that influence drug use: the member, the physician, and the pharmacist. The design of the drug benefit to include financial incentives for all three parties has the effect of moving drug UR to drug UM.

The ultimate model of UM and total cost management in prescription drug programs involves the following features:

- Member assignment to a pharmacy and/or pharmacist;
- A member incentive in the form of either a two-tier copayment (e.g., $2 versus $5 or $3 versus $7) or coinsurance (e.g., 20 percent of the prescription price) paid at the time of service;
- A therapeutic drug formulary with sharing of the financial penalty for nonformulary drug use by the prescriber and the member;
- On-site provider audits to ensure program integrity and provider compliance with professional practice standards and state regulations;
- Development and communication of prescribing protocols (i.e., prospective drug UM);
- Action-oriented follow-up of cases identified in drug UR exception reports, including all three parties of influence (member, physician, and pharmacist); and
- Strict insistence on valid and reliable drug claims data, including accurate identification of drug, quantity dispensed, patient, pharmacist, and prescriber or primary care physician.

REFERENCES

1. Curtiss, Frederic R. "Methods of Providing Prescription Drug Benefits in Health Plans." *American J of Hospital Pharmacy* 43 (Oct. 1986).

2.Curtiss, Frederic R. "Pharmacy Preferred Provider Organizations." *American Journal of Hospital Pharmacy* 44 (Aug. 1987).

3. **Pharmacodynamics:** refers to the interaction of drugs in animal systems and helps to explain differences in therapeutic effect among seemingly similar chemicals. **Pharmacokinetics:** considerations of absorption, distribution, metabolism, and excretion properties of specific drugs and chemicals form the basis of the field of pharmacokinetics. These considerations are important in the development of drug formularies.

This paper was presented at the 1988 Group Health Institute, Chicago, Ill.

THE AUTHORS

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APPENDIX CC

MAIL ORDER PHARMACY COMMITTEE
SOME RECOMMENDATION POSSIBILITIES

(Revised 11/9/89)

I. Changes in Law

A. Amend Third-party Prescription Program Act. (Ref. A)

1. Make it clear that the provider is the party required to file notice of the plan's provisions and that the filing is to be with the Board not the Superintendent of Insurance. (Attorney General's letter)

2. Require that preferred provider 3rd-party prescription drug programs be administered in accordance with the Non-profit Service Organizations' Preferred Provider Arrangement Act. (Blue Cross letter)

3. Eliminate the requirement that individual pharmacies be notified of the institution of a 3rd-party prescription program. (Blue Cross letter)

4. Eliminate the provision that the contract may not be changed unilaterally and that any change must be offered to all pharmacies. (Blue Cross letter)

B. Place portions of the proposed new rules into law. (Ref. I and J) (Currently 13 states regulate mail order pharmacy, 8 by registration and disclosure and 5 by licensure. Those regulating by licensure have not tried to enforce the legislation because of fears of challenge under interstate commerce. Maine's current law is rather innocuous, but adoption of currently proposed rules would result in Maine falling into the registration and disclosure category. Maine, however, would be unique in accomplishing this somewhat far reaching result through rules, not through law.)

C. To assure the requisite experience, have the 15 members of the Commission appointed from the following departments in consultation with the directors of those departments (Ref. H):

Dept. of Administration		3
Bureau of Veterans Services		1
Health Care Finance Comm.		1
Retirement System		1
Attorney General		1
Professional & Financial Reg.		2
Mental Health	1	
Dept. of Labor	1	

Health Policy Adv. Council	1
Bureau of Elderly	1
Human Services	3

and require that they have skills related to the activities of the Commission. Unions would continue to have appointing authority, but within the confines of this requirement.

II. Other Study Recommendations

A. Management Control

1. Program Director & Commission to obtain and analyze data required to evaluate the various prescription drug programs. (Ref. C and D) This data should include:

a. Number of persons enrolled in the health care program.

b. Number submitting claims for prescription reimbursement.

c. Number & dollar value of claims submitted for reimbursement.

d. How this was divided between generic and branded drugs.

e. Average size of claims.

f. Dollar amount of all claims submitted by an average claimant in a year.

g. The mix between acute and maintenance drugs.

(Michigan is making this a letter request, not a law.)

2. Require that development of requests for proposals be subject to the steps of the Administrative Procedures Act.

3. Require that all requests for prescription reimbursement proposals, including major medical, include the costs of providing the data indicated in 1. preceding. Require that all requests for major medical proposals include a cost for making available cost data on each major reimbursement component, i.e. hospital room & board, diagnostic, doctor visits, emergency room, in-patient and ambulatory surgery, professional services & doctor visits by specialty.

4. Employ a consultant who can design and analyze a management information system and data management reports for the total employee health care program. The purpose will be to:

a. To compare the Maine program with that in other states. The consultant should be required to have normative data for that comparison.

b. To assist in fine-tuning the objectives for the pharmaceutical reimbursement program.

c. To assist

(1) in selecting and revising the program's components, e.g. major medical, card plan, mail order; and

(2) in determining and revising the appropriate co-pay, co-insurance and deductibles so that the program meets its objectives.

d. To compare the costs of the pharmaceutical program with costs of other aspects of the health care program as enumerated in 2. preceding.

5. Require that suppliers be subject to a yearly audit by professional auditors covering the following topics (Michigan does this): (Ref. F)

- Timely dispensing of prescriptions
- Prevention of duplicate fillings
- Adherence to Ingredient Cost Formulas
- Appropriate calculations of discount rates
- Proper dispensing of prescriptions
- Appropriate dispensing of generic drugs
- Appropriateness of refills
- Adherence to plan design regarding covered drugs
- Eligibility control

B. Cost Saving Measures

1. Provider oriented

a. Pharmacist

(1) Provide the pharmacist a generic dispensing incentive, e.g. a higher dispensing fee. (Ref. C)

(2) Require that pharmacist substitute generic drugs when doctor okays. (12 states, including New Jersey, do this.) (Maine now allows it.)

(3) Require that the full cost savings of generic drugs be passed on. (14 states, including New Jersey, have this requirement.) (Maine requires only that the generic price be no higher than the brand name.)

b. Physician

(1) Board developed guidelines to physicians as to when mail order quantities of drugs are appropriate.

(2) Board developed drug prescribing protocols.

(3) Physician incentive programs based on cost effectiveness in prescribing. (Ref. C)

c. Both

(1) Institute Board developed mandatory generic drug formulary. (24 states, including New Jersey, have some version of this.) (Ref. C)

2. Patient oriented

a. Provide that a patient who requests a branded drug pay the difference between it and the generic. (Ref. C)

b. Introduce a co-pay or co-insurance into the mail order program but retain the incentive for it versus the card, (assuming that analysis shows mail order to be the more cost effective.)

c. Increase the spread between the card co-pays for branded and generic drugs.

d. Eliminate weight reduction drugs from the program.

C. Items Favoring Maine Based Mail Order Firms.

1. Require that the State or the University System provide or fund training, counseling and advice to Maine firms new to mail order.

2. Require that the contract be rebid no more frequently than yearly, upon receipt of an unsolicited superior bid by any supplier. An individual supplier could not submit such a bid any more frequently than every 5 years.

3. Require that the contract be given to a Maine firm whose experience is satisfactory and whose cost is within 5% of the lowest bidder, or require that geographic accessability and familiarity with Maine practices and the Maine medical and pharmaceutical community be considered in the award of the bid; or that a company with limited experience can be given added experience points if they agree to retain a consultant with the requisite experience. (Ref. E)

4. Require that the State supplier maintain a facility in Maine. (This is a limited version of Rep. McCormick's bill. It is currently the procedure in New York.) (Ref. G)

D. Safety

Eliminate from the mail order program, or restrict the quantities of, psychoactive drugs or other controlled substances which may be subject to abuse or adiction.

#234LHS

APPENDIX DD

Submitted by the 3rd-Party Prescription Program Study Committee Pursuant to Joint Rule 19

JBK/BUS
LR #2656
Doc #302LHS pg. 5
Nov. 17, 1989

SECOND REGULAR SESSION

ONE HUNDRED AND FOURTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY

AN ACT to Require that Relevant Experience Be a Consideration in Selecting Members of the State Employee Health Commission.

Be it enacted by the People of the State of Maine as follows:

5 MRSA §285-A sub-§2 is amended as follows:

2. Membership. The State Employee Health Commission shall consist of 15 labor and management members as follows:

A. One labor member from each bargaining unit recognized under Title 26, chapter 9-B appointed by the employee organization certified to represent the unit;

B. One labor member from the largest bargaining unit recognized under Title 26, chapter 14, appointed by the employee organization authorized to represent the unit;

C. One labor member appointed by the retiree chapters of the Maine State Employees Association;

D. Four management members appointed by the Commissioner of Administration;

E. One management member appointed by the Court Administrators; and

F. The Director of State Employee Health, ex officio.

All appointed or elected members shall serve at the pleasure of their appointing or electing authorities. Insofar as possible within the provisions of paragraphs A-F, persons appointed after September 1, 1990, shall have experience that is related to the responsibilities of the Commission.

STATEMENT OF FACT

This bill requires that new appointees to the State Employee Health Commission have experience that is relevant to the responsibility of that Commission, to the extent that this is possible within the provisions of the current law which requires representation from each State employee bargaining unit.

The Health Commission serves as trustee of the State Employees Accident and Health Insurance Program and advises the program director on health insurance issues and other issues concerning health and wellness.

Submitted by the 3rd-Party Prescription Program Study Committee Pursuant to Joint Rule 19

JBK/BUS
LR #3401
Doc #302LHS
Nov. 17, 1989

SECOND REGULAR SESSION

ONE HUNDRED AND FOURTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY

AN ACT to Require that Pharmacists Dispense Generic Drugs When Allowed by the Physician

Be it enacted by the People of the State of Maine as follows:

32 MRSA §13781 is amended as follows:

§13781. Generic and therapeutically equivalent substitution

Every written prescription issued by a practitioner in this State shall contain in the lower right-hand corner of the prescription form a box at least 1/2 inch by 1/2 inch. The following words must appear to the left of this box: "Any drug which is the generic therapeutic equivalent of the drug specified above in this prescription may be dispensed, provided that no check mark () has been handwritten in the box in the lower right-hand corner."

Any pharmacist receiving a prescription in which no handwritten check mark () is found in the box provided ~~may~~ shall, unless the purchaser requests otherwise under the procedures of this section, substitute a generic and therapeutically equivalent drug for the drug specified on the prescription, provided that the substituted drug is distributed

by a business entity doing business in the United States which is subject to suit and the service of legal process in the United States and that the price of the substituted drug does not exceed the price of the drug specified by the practitioner. The pharmacist shall pass on to the consumer all savings resulting from this substitution by charging no more than the regular and customary price of that pharmacy for the drug substituted.

Any pharmacist who substitutes a generic and therapeutically equivalent drug under this section shall inform the person to whom the drug is dispensed of the substitution. Any pharmacist who intends to substitute a generic drug shall notify the person presenting the prescription of the substitution and shall inform the person presenting the prescription that the person may refuse the substitution. If the person refuses the substitution, the pharmacist shall notify the person of the retail price difference between the brand name drug and the drug substituted for it and again give the purchaser the opportunity to accept the generic substitution. When any substitution is made under this section, the pharmacist shall cause the name of the generic and therapeutically equivalent drug, the name or abbreviation of the drug manufacturer or distributor of that substitute drug and all other information as required by section 13794 to appear on the container label of the drug dispensed.

This section does not apply to prescriptions ordered by practitioners for patients in hospitals when those prescriptions are filled by a hospital pharmacy or in any institution where a formulary system is established.

STATEMENT OF FACT

This bill requires that the pharmacist substitute a generic drug for a branded drug when such substitution is authorized by the physician. Upon being shown the cost saving, the purchaser has the option of refusing the substitution. Currently, such substitution by the pharmacist is allowed but not required. There is currently no provision for the purchaser to refuse the substitution. The bill requires that the full saving from this substitution be passed on to the consumer. Current law only requires that the generic drug be no more expensive to the consumer than the branded drug.

Submitted by the 3rd-Party Prescription Program Study Committee Pursuant to Joint Rule 19

JBK/BUS
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SECOND REGULAR SESSION

ONE HUNDRED AND FOURTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY

AN ACT to Require that Certain 3rd-Party Prescription Drug Programs be Subject to the Provisions of the Appropriate Preferred Provider Arrangement Act.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 32 MRSA §13772-A, is enacted to read:

§13772-A. Preferred Provider Programs.

Any third-party prescription program shall be administered in accordance with and subject to the limitations of the Non-profit Service Organizations Preferred Provider Arrangement Act of 1986, Title 24, chapter 19, subchapter II or the Preferred Provider Arrangement Act of 1986, Title 24-A, chapter 32.

Sec. 2. 32 MRSA §13773, as enacted by P.L. 1987, c. 710, section 5, is amended to read:

§13773. Notice.

No 3rd-party prescription program may be instituted in this State until the program provider has filed written notice of the provisions of the program ~~has been filed~~ with the ~~Superintendent of Insurance~~ Board of Pharmacy ~~and given to all pharmacies which are located within the counties covered by the program at least 30 days prior to the commencement of the program. In the case of chain or branch pharmacies, the notice shall be given to the main office or headquarters. These pharmacies shall have 30 days from the date of notice to enroll in the program.~~

STATEMENT OF FACT

This bill accomplishes the following:

1. Requires that 3rd-party prescription drug programs be subject to the provisions of one or the other of two Preferred Provider Arrangement Acts.

2. Makes it clear that it is the program provider who is obliged to file the notice of the provisions of a new 3rd-party prescription drug program and changes the recipient of the filing from the Superintendent of Insurance to the Board of Pharmacy.

3. Eliminates the provision that all pharmacies must be notified of a new 3rd-party prescription program.