



Tufts Center for the Study of Drug Development

# Impact REPORT

ANALYSIS AND INSIGHT INTO CRITICAL DRUG DEVELOPMENT ISSUES

## Maine enacts drug price controls; 16 other states taking similar action

*Maine becomes first state to attempt to establish price ceilings for prescription drugs*

- Gov. Angus King signed the “Maine Rx” bill into law in May after both houses of the Maine legislature overwhelmingly approved the legislation.
- In passing the bill, the Maine legislature issued a statement, saying, “Excessive pricing for prescription drugs threatens Maine’s ability to assist with the health care costs of Maine citizens...[and] hurts the ability of the Maine business community to provide health insurance coverage to Maine’s work force...”
- The law intends to reduce prescription drug prices for all eligible residents of the state without replacing or discouraging employer-based plans.
- It also requires Maine’s Commissioner of Human Services to adopt rules for setting, periodically reviewing, and phasing out maximum retail prices by July 1, 2002.
- It’s important to understand the significance of the Maine law, as another 16 states in the U.S. have already proposed, filed, or enacted price control bills. A number of states are expanding their state pharmaceutical assistance programs.

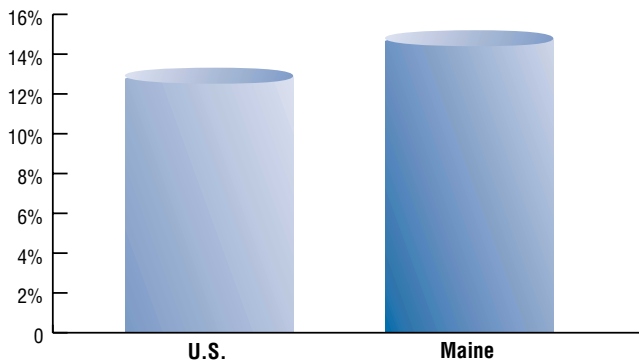
**M**aine made history this spring when it became the first U.S. state to enact a law which could establish maximum retail prices for prescription drugs for all state residents. Many more could follow, as similar legislation continues to be filed in statehouses throughout the country.

While U.S. spending on prescription drugs as a share of the total national health care bill has been rising for the last two decades, hospital expenditures have declined while spending on physician services has remained even. This suggests that the nation as a whole may be relying on prescription medicines to avoid more costly hospital stays.

Ultimately, the issue being debated is as much about access as it is about affordability. The fulcrum for balancing access with affordability is coverage. If third-party payors, including Medicare, insurance companies, and HMOs, can’t make prescription drugs available to all those who need them, then state legislatures will try to do it for them.

## Context for price controls: Health care consumes a large part of the economy

### Health Care Spending as Percentage of GDP

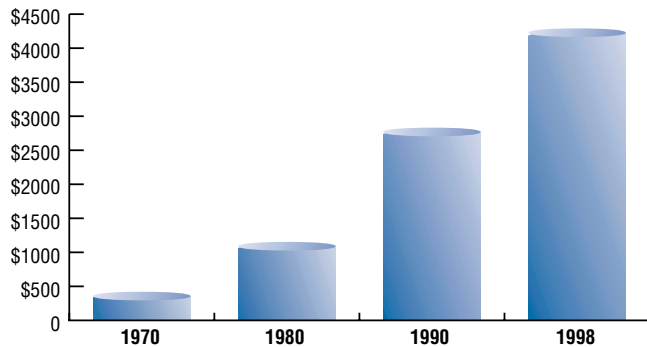


Source: Health Care Financing Administration, Maine Development Foundation

- Health care spending in the U.S. accounts for 12.9% of GDP. In Maine, the equivalent figure is 14.8%.
- Prescription drugs accounted for an estimated 10% of total health care spending in Maine in 1999.
- Today, about 325,000 Maine residents—or 26% of the state—lack a prescription drug benefit of any kind.
- A recent study by the pharmacy benefit manager Express Scripts indicates that the cost per prescription rose nationally 9.6% in 1999.

## Fast rising spending on health care is straining business and personal pocketbooks

### U.S. Per-Capita Health Care Spending (Current dollars)

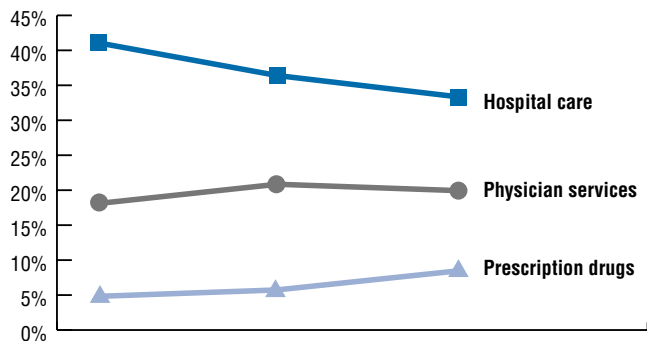


Source: Health Care Financing Administration

- In 1999, per-capita health care spending in Maine reached \$3,911, slightly below the U.S. average.
- Today, 57% of Maine businesses offer health insurance plans to their employees, compared to 52% for U.S. businesses as a whole.
- Maine recently filed a waiver request with the U.S. Department of Health and Human Services to allow it to use Medicaid funds to extend prescription coverage for disabled adults and elderly over 62 years of age with income up to 185% of the federal poverty level.

## Is the U.S. relying on prescription drugs as a way to reduce more costly hospitalization?

### Drug Spending Rises as Hospital Costs Drop (Share of total U.S. health care spending)



Source: Health Care Financing Administration

- U.S. spending on prescription drugs during the last two decades rose from under 5% to nearly 8% of the national health care bill.
- At the same time, hospital spending dropped from 37% to 33% of total health care spending.
- Physician services remained fairly constant at around 20%.
- While Congress is embroiled in debate over various bills focusing on prescription drug pricing, the response from the states has been more immediate. (See summary on page 3.)

## Drug price legislation has been finding a welcome reception in statehouses across the U.S.

- Although the “Maine Rx” law is the most comprehensive prescription drug price control bill to be signed into law by a U.S. governor, as of July 3, 2000, price control bills have been proposed, filed, or enacted in 16 other states.
- The National Conference of State Legislatures’ Health Care Program reports that at least 28 states have considered or are considering prescription drug cost-related legislation this year.

### *State Legislatures Considering Prescription Drug Price Control Legislation*

State	Bill	Description	Status
Arizona	HB2719	Establish maximum prescription drug prices based on Federal Supply Schedule (FSS) prices.	Filed 2/8/00
California	SB393	Establish maximum prescription drug prices for Medicare beneficiaries based on Medicaid prices.	Signed into law 10/10/99
Colorado	SB143	Establish maximum prescription drug prices for Medicare beneficiaries based on Medicaid prices.	Not yet filed
Connecticut	S.246 H.5736	Allow Medicare beneficiaries to purchase prescription drugs at Medicaid prices.	Not yet filed
Florida	S940	Establish prescription drug pricing program for Medicare beneficiaries based on Medicaid prices.	Signed into law 6/8/00
Illinois	H3036 S1403 H3361	Establish prescription drug pricing for seniors according to FSS prices.	Passed House 3/1/00
Massachusetts	H4900	Establish bulk purchasing of prescription drugs for Medicare and Medicaid beneficiaries, state workers, as well as under- and uninsured.	Signed into law 11/16/99
Maine	S1026 LD2599	Establish discounted (prescription drug) prices for all Maine residents without pharmaceutical coverage.	Signed into law 5/11/00
Michigan	HB 5922	Establish directly negotiated prescription drug prices with drug manufacturers to get bulk discount for all uninsured residents.	Filed 6/21/00
Minnesota	SF2376 HF3444	Entitle Medicare beneficiaries to Medicaid discounts.	Filed 2/1/00
New Hampshire	S225	Establish discount prescription drug program for low-income residents.	Not yet filed
New Jersey	A231	Establish directly negotiated prescription drug prices with drug manufacturers (“best” price or lowest price offered to any purchaser).	Not yet filed
New York	S6068 A9786	Establish directly negotiated prescription drug prices with drug manufacturers (“best” price or lowest price offered to any purchaser).	Filed 1999
Pennsylvania	H2254	Establish that all Pennsylvania public programs pay FSS prices for prescription drugs.	Filed 2/10/00
Vermont	H193	Prohibit price discrimination.	Filed 1999
Washington	HB 2361	Establish drug manufacturer rebate program.	Filed 2000
Wisconsin	S335	Establish prescription drug discount program for low to middle-income seniors and certain Medicare beneficiaries.	Filed 1/21/00

Source: Tufts Center for the Study of Drug Development

## What the Maine Prescription Drug Price Reduction Act provides

- **It reduces prescription drug prices for all eligible residents of the state without the intent to replace or discourage employer-based plans.**
  - The state will act as a pharmacy benefit manager (PBM) and negotiate manufacturer rebates and pharmacy discounts for all Maine residents determined eligible for the program.
  - Manufacturers or labelers who sell prescription drugs in Maine through the state's elderly low-cost drug program or any publicly supported pharmaceutical assistance program must enter into a rebate agreement with the state.
  - The amount of the rebate will be negotiated by the Commissioner of the Department of Human Services initially at a level equal to or greater than that of the Medicaid Rebate Program, and by October 1, 2001 to the level of any rebate provided to the Federal government.
  - Any retail pharmacy that sells prescription drugs covered by a rebate agreement must, in turn, sell those drugs to the holders of Maine Rx cards at discount prices plus professional fees (initially \$3 per prescription) set by the Department of Human Services. Names of manufacturers and labelers who do not enter into rebate agreements will be made available to the public and their drugs will also be subject to prior authorization restrictions when dispensed through the state Medicaid Program.
- **It establishes a 12-member Prescription Drug Advisory Commission, consisting of six public members, of whom two must be senior citizen advocates, plus two pharmacists, two prescribers, and two state officials.**
  - The Commission advises the Commissioner of Human Services on access to prescription drugs, pricing and affordability information, as well as the need for and procedures to be used in establishing maximum retail prices for prescription drugs.
  - The Act requires the Commissioner to adopt rules for setting, periodically reviewing, and phasing out maximum retail prices by July 1, 2002.
  - By January 5, 2003, the Commissioner must determine if the prices being paid for one or more drugs under the Maine Rx Program are reasonably comparable to the lowest cost paid in the state by any large purchaser. If they are not, then maximum retail prices for any or all prescription drugs sold in the state must take effect July 1, 2003.
- **The new law prohibits profiteering in prescription drugs by manufacturers, distributors and labelers.**
  - Profiteering is defined as: 1) exacting or demanding unconscionable prices; 2) exacting or demanding prices or terms that result in unjust or unreasonable profits; 3) discriminating unreasonably against anyone trading in prescription drugs in the state; and 4) placing retaliatory limits on access to drugs in the state.
  - Profiteering may be punishable under the Maine Unfair Trade Practices Act and may result in awards of treble damages, attorney's fees, punitive damages, and costs.

### Tufts Center for the Study of Drug Development

Tufts University  
192 South Street, Suite 550  
Boston, MA 02111 USA

**Tel** 617-636-2170  
**Fax** 617-636-2425  
**Email** [tufts\\_csdd@infonet.tufts.edu](mailto:tufts_csdd@infonet.tufts.edu)  
**Web** <http://www.tufts.edu/med/research/csdd>

© 2000 Tufts Center for the Study of Drug Development. All rights reserved.