VERMONT

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Agency of Human Services

MEMORANDUM

TO: Rep. Ann Pugh, Co-Chair, Health Access Oversight Committee
Sen. Jane Kitchel, Co-Chair, Health Access Oversight Committee

CC: Robert D. Hofmann, Secretary, Agency of Human Services
Susan W. Besio, PhD, Director

FROM: Cynthia D. LaWare, OVHA Pharmacy Director

DATE: October 30, 2009

RE: Enclosed study on the promotion of generics in Medicaid

Per Special Session 2009 Act 1, Section E.309.4:

> (a) The office of Vermont health access shall determine the impacts of modifying the co-payment structure in Medicaid and VPharm from a three-tiered structure which varies depending on the cost of the drug to a two-tiered structure with a higher co-payment for a brand-name drug than for a generic drug. The office shall analyze the impacts of changing the fee structure on spending in the Medicaid and VPharm programs, on patient utilization of generic drugs and brand-name drugs, and on any access issues.

The enclosed report analyzes the current pharmacy copayment structures of $1, $2 and $3 for Medicaid and $1 and $2 for VHAP, VHAP Pharmacy, VScript and VPharm, depending on the cost of the drug, to a structure based on brand/generic classification.

The analysis demonstrates that OVHA would not realize additional savings from the migration to a brand/generic co-pay structure. Further, OVHA would, in fact, see a reduction in savings of $250,269 per year. This can be partially attributed to the loss of the three-tier structure ($1,$2,$3) for Medicaid that currently exists. Currently, OVHA aggressively promotes generics in its Preferred Drug List and requires that generics be dispensed when available. Per state law, claims for brand drugs that have generic alternatives will reject at the pharmacy, and substitution is required unless the physician certifies through the use of a "Dispense As Written" designation that the brand is medically necessary.

Further, in select situations, the State prefers the brand drug over the generic alternative when it is determined to be more cost effective to the State net of all rebates and discounts. In those situations, claims for the generic reject and the pharmacy is required to dispense the brand.

In summary, the OVHA is currently aggressively managing and mandating generic utilization whenever it is more cost-effective to the State, so moving to a Brand-Generic co-pay would not further encourage the use of generics beyond what is already required. The OVHA feels that a co-pay based on the calculated cost of the claim is a more suitable application of cost share by maximizing savings to the State.

Please let me know if further analysis is required.