

Prescription drugs play an important role in today's health care. Nationwide, more and more people rely on prescription drugs to maintain and improve their health. For Medicaid beneficiaries, many of whom are unable to pay for their medications, coverage for prescription drugs is especially important.

Prescription drugs are not a required benefit under federal Medicaid rules. However, state Medicaid programs recognize the importance of this benefit. In fact, even though states do not have to cover prescription drugs for any Medicaid population, all states and the District of Columbia cover prescription drugs for at least some categories of Medicaid beneficiaries.

States have been battling prescription drug costs for more than a decade. In 1990, in response to then rapidly rising Medicaid prescription drug costs, Congress established the Medicaid prescription drug rebate program. Under the rebate law, Medicaid programs that cover prescription drugs must cover any drug<sup>1</sup> produced by manufacturers that agree to pay rebates to the states. These requirements do not apply to states that include payments for prescription drug coverage in the payment to managed care plans.<sup>2</sup> Further modifications made to this law in 1993 permitted states to use formularies<sup>3</sup> as a means of establishing a list of preferred drugs. Drugs that are excluded from the formulary must be available to beneficiaries, although they can be subject to a prior authorization process. (For a discussion of prior authorization, see page 3, "Efforts to Change Provider Prescribing Behavior.")

Too often efforts to reduce Medicaid spending result in a reduction in the benefits covered or the amount of care received. However, states can make changes to their prescription drug programs that have the potential to achieve savings and, if the appropriate protections are in place, to do so without any adverse effects on beneficiaries. The trick is identifying which cost containment approaches will reduce costs without harming beneficiaries.

### **Why Do States Want to Cut Prescription Drug Spending?** \_\_\_\_\_

Today, prescription drug coverage is an important part of the Medicaid program. In 1998, 19.3 million Medicaid beneficiaries received prescription drugs, making drugs the most commonly used Medicaid service.<sup>4</sup> Spending on prescription drugs is the fastest growing area of Medicaid spending, increasing by 18.1 percent from 1997 to 2000. As a result, prescription drugs are consuming an ever larger share of Medicaid dollars. In 2000, the Medicaid program spent \$16.6 billion on prescription drugs (federal and state dollars combined).<sup>5</sup> Despite this rapid increase, prescription drugs consume only 8.2 percent of all Medicaid dollars, a relatively small share of overall Medicaid spending.<sup>6</sup>

Increased spending on prescription drugs for the Medicaid population, as with the privately-insured population, is being driven by three factors: 1) more drugs are being prescribed; 2) newer, more costly brand-name drugs are being substituted for older, lower-cost drugs; and 3) prices for prescription

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drugs are rising rapidly. Factors such as direct-to-consumer advertising also play a role in driving up the cost of drugs for the Medicaid program.

As states seek to control their spending on Medicaid, the prescription drug benefit is likely to be a target for cuts because it is one of the fastest growing components.

## States Efforts to Control Medicaid Prescription Drug Spending

States have used a variety of approaches to control spending on prescription drugs. In general, these approaches can be divided into two categories: those that are designed to change beneficiary behavior, and those designed to change providers' prescribing behavior.

### ✘ Efforts to Change Consumer Behavior

Since a prescription written by a licensed provider is required before a beneficiary can obtain a prescription medication, those efforts that target providers' prescribing behavior seem to make more sense than those that seek to change beneficiary behavior. In fact, it is impossible for a Medicaid beneficiary to obtain a prescription and have it paid for by Medicaid unless a provider first writes the prescription. Nevertheless, state efforts to change consumer behavior are among the most popular.

- **Requiring Cost-Sharing:** Medicaid has strict cost-sharing requirements for prescription drugs. As with any cost-sharing applied to a Medicaid service, the amount of the cost-sharing for drugs must be nominal. As of October 2001, 28 states and the District of Columbia had some cost-sharing requirement for prescription drugs, ranging from \$0.50 to \$3.00 per prescription.<sup>7</sup>

States typically have a range of cost-sharing amounts depending on the type of drug dispensed, whether it is a brand-name or a generic, or the cost of the drug dispensed (i.e., \$1 for drugs under \$10; \$2 for drugs costing \$10 to \$25; and \$3 for drugs over \$50 dollars). One state, Utah, which has a copay of \$1 per prescription, limits the amount of cost-sharing a beneficiary must pay out-of-pocket for prescription medications to \$5 per month.

Although, by law, Medicaid beneficiaries cannot be denied service if they are unable to pay the cost-sharing,<sup>8</sup> the existence of a copay requirement may be sufficient to discourage beneficiaries from filling prescriptions.

Given the nominal nature of cost-sharing under the Medicaid program, it is unclear how substantial the savings would be from adding or increasing cost-sharing requirements. Rather, new or higher cost-sharing may do more to increase costs by discouraging beneficiaries from filling needed prescriptions, resulting in more costly care in the long term. This is especially true for beneficiaries with chronic conditions, who may rely on multiple prescriptions. In addition, cost-sharing requirements often result in a reduction in provider reimbursement because care cannot be denied if beneficiaries are unable to pay.

#### Fight Efforts to Increase Copays Beyond Normal Levels

Although current cost-sharing must be nominal, new waiver options may afford states the opportunity to increase cost-sharing above the existing levels specified in law. Advocates should fight efforts by states to increase copay requirements beyond nominal levels, since higher copays are likely to pose a major barrier to Medicaid beneficiaries' receiving care. It is also important that beneficiaries know their rights; in this case, that means they can get their prescription even if they cannot pay the copay amount.

■ **Establishing limits on how much and how often beneficiaries can fill prescriptions:**

Many states have established limits in an effort to control prescription drug use and costs. While limits may offer modest savings to states' Medicaid budgets, some of these efforts may have harmful effects on beneficiaries' health. The most arbitrary of these is the use of an overall limit on the number of prescriptions that can be filled each month. These per-month limits on prescriptions hurt Medicaid beneficiaries with chronic and disabling conditions, who rely most on prescription drugs to maintain their health.

Other efforts to control costs through limits curb the number of refills permitted be-

fore a new prescription must be written or limit the amount of medication dispensed per prescription to 30 or 90 days in an effort to avoid wasting medication.

**Make Sure Your State Has Clear Process for iMedical Necessityi Exemption**

If your state is looking to cap the number of prescription drugs a beneficiary can have covered during a specific period, it is important that the state have a clear process for the beneficiary to get an exemption due to medical necessity. In addition, pharmacists and physicians need to be educated about the process. Beneficiaries need to be made aware of their rights under current law to have drugs that are medically necessary covered by Medicaid, even if they exceed the monthly limit.

☒ **Efforts to Change Provider Prescribing Behavior**

Health care providers are essential to the prescribing process. Not only are they required to write the prescription, but they also have the most knowledge of the patient's condition. At the same time, providers may lack the necessary information on the cost of specific prescription drugs and are often unaware of the availability of generics. Health care providers are also the target of direct marketing efforts conducted by sales representatives for the manufacturers and other marketing efforts by drug manufacturers. Consequently, policies that aim to change providers' prescribing behavior have the most potential for offering substantial savings to state Medicaid programs without compromising the health care of the beneficiary.

■ **Increased Use of Generics:** Generic drugs have the same active ingredient as brand-name drugs but are generally available at significantly lower cost. Generic drugs are roughly half the price of brand-name drugs in the first year after entering the market.<sup>9</sup> Today, generic drugs constitute roughly 20 percent of total Medicaid spending on drugs.<sup>10</sup> States can reduce their prescription drug expenditures by substituting generic drugs for brand-name drugs when generic drugs are available.

Sixteen states currently require generic substitution of drugs prescribed for Medicaid beneficiaries, with seven of these states allowing the physician to override dispensing of the generic in writing.<sup>11</sup> States have used other efforts to increase the use of generic drugs. These efforts include establishing differential copay amounts between generic and brand-name drugs. Other methods for increasing the use of generic drugs focus on payment to the pharmacist. Six states require prior authorization for brand-name drugs when a generic equivalent is available.

In most cases, substituting a generic for a brand-name drug makes a great deal of sense. The beneficiary gets a drug that works, and the Medicaid program pays less than it would for a brand-name drug. However, in some cases, the generic may not be appropriate because the patient has an adverse reaction to one of the inactive ingredients, or it does not work for that specific patient.

- **Requiring Prior Authorization:** Prior authorization is increasingly common in Medicaid prescription drug programs. While the Medicaid rebate law prohibits states from excluding coverage of most drugs among participating manufacturers, the law does permit states to establish prior authorization requirements. If a state places a drug on the prior authorization list, before that drug is dispensed, the physician will be contacted to see if a lower-cost alternative would be equally appropriate. Resolution must be provided within 24 hours. During this time the drug is not dispensed; however, in the case of an emergency, the beneficiary must be provided with a 72-hour supply of the drug the physician prescribed.<sup>12</sup> If the physician does not agree to a preferred drug, the prescription must be filled with the original drug prescribed by the physician. As of October 2001, 36 states used prior authorization for some categories of drugs.
- **“Fail First” Requirements:** Some states are using “fail first” requirements, which are similar to prior authorization. Fail first requirements are used when there are multiple drugs available for treatment of a specific condition (i.e., gastrointestinal disease or arthritis). Fail first requirements require use and failure of one drug, typically the oldest, least costly drug, before a newer, more costly drug will be covered.

### **Make Sure Beneficiaries Can Get Brand-Name Drugs If They Need Them**

If your state is looking to increase the use of generic drugs, it is important to make sure that there are adequate provisions for Medicaid beneficiaries to get brand-name drugs if the physician says it is medically necessary. Generic substitution rules vary from state-to-state. It is important to understand your state’s laws on generic substitution.

### **Prior Authorization and “Fail First” Requirements: Beneficiaries, Physicians, and Pharmacists Need to be Informed**

**Prior Authorization:** If your state is looking to add or increase prior authorization, it is important to make sure that beneficiaries know they have the right to a 24-hour response and a right to a 72-hour supply in an emergency. In addition, it is important that states have qualified staff providing prior authorization. Physicians and pharmacists also need to be part of the process. They will need easy access to the list of drugs requiring prior authorization.

**“Fail First” Requirements:** If your state is considering establishing fail first requirements for certain drugs, it is important that drugs in this category also be available through prior authorization. If fail first requirements are established for a drug, it is important to know what the drug protocol is for the condition treated by that drug. Much like prior authorization, physicians and pharmacists need access to this information.

To protect beneficiaries, fail first requirements should rely on protocols for treatment of specific conditions. In Medicaid, physicians who object to the use of the first round drug can usually get the prescribed drug covered by going through the prior authorization process. At least 12 states have fail first requirements for some categories of drugs.

## Other Mechanisms for Controlling Costs

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At least three states (Florida, Maine, and Michigan) have negotiated supplemental rebates with drug manufacturers. Although these programs are in varying stages of implementation, all three rely on prior authorization as the primary hook for receiving higher rebates from drug manufacturers. In exchange for the increased rebate amount, the state typically will place that manufacturer's drugs on a list of preferred drugs. Those manufacturers choosing not to participate may have their drugs placed on a prior authorization list. (For a fuller discussion of the Florida program, see the Florida case study in this kit.)

States should also consider negotiating better prices for drugs with the pharmacies. There are two different components to the pharmacy payment for prescription drugs: 1) the pharmacy payment for the cost of the drug, and 2) the fee paid to the pharmacy for preparing and dispensing the drug. The dispensing fee is typi-

cally a small component of the total cost of the prescription. A recent survey found that 39 states had dispensing fees under \$6.00.<sup>13</sup> As a result, in most states, reducing the dispensing fee is not likely to generate significant savings.

States also establish the payment to the pharmacy for the cost of the drug. These payments are usually based on a discount off of the average wholesale price (AWP). In a survey of 44 states, payments to pharmacies ranged from AWP minus 4 percent to AWP minus 15.1 percent. However, most states have similar payment rates. Thirty-four of those 44 states have payment rates between AWP minus 9 percent and AWP minus 12 percent.<sup>14</sup> While there may be room for some states to negotiate a greater discount on the price they pay pharmacists for drugs, as with any provider payment issue, the state's need for savings and beneficiaries' ability to obtain services must be balanced.

## Are These Efforts Worth It?

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Given the important role prescription drugs play in the lives of Medicaid beneficiaries, ensuring appropriate access to prescription drugs is essential. Some of the approaches states are using to control prescription drug spending may cause financial hardship for Medicaid beneficiaries, create significant barriers to getting necessary prescription drugs, and ultimately lead to more costly health care. Advocates seeking to minimize the effects of Medicaid budget cuts on prescription drug coverage should consider those approaches that seek to shift provider prescribing. Efforts to influence providers' prescribing behavior (with the appropriate beneficiary protections) and negotiating supplemental rebates are likely to yield greater savings for states without compromising beneficiaries' access to needed medications.

## Endnotes

<sup>1</sup> With the exception of the drugs in the following eight categories: (1) anorexia, weight loss, or weight gain drugs; (2) fertility drugs; (3) cosmetic or hair growth drugs; (4) drugs for symptomatic relief of coughs and colds; (5) smoking cessation drugs; (6) prescription vitamins and mineral products (other than prenatal vitamins and fluoride preparations); (7) barbiturates; and (8) benzodiazepines.

<sup>2</sup> Omnibus Budget Reconciliation Act (OBRA) of 1990. This law excludes prescription drug coverage that is part of Medicaid managed care plans. Medicaid managed care plans are not eligible for the Medicaid prescription drug rebate program. However, they are permitted to use formularies and other cost containment mechanisms. The fact that beneficiaries are in Medicaid managed care plans does not mean that their prescription drug coverage is “managed” by the plans. Many states keep payments for prescription drugs separate from general payments to managed care plans in order to get the rebate dollars.

<sup>3</sup> A formulary is usually a list of drugs covered by a health plan or pharmacy assistance program. In the case of Medicaid, since state Medicaid programs cannot exclude most drugs from coverage, a formulary serves as a list of preferred drugs. Drugs that are not on a state’s Medicaid formulary generally are available if prior authorization is granted.

<sup>4</sup> Department of Health and Human Services, Health Care Financing Administration, *A Profile of Medicaid: Chartbook 2000* (Washington: Department Health and Human Services, September 2000).

<sup>5</sup> B. Bruen, *States Strive to Limit Medicaid Expenditures for Prescribed Drugs* (Washington: Kaiser Commission on Medicaid and the Uninsured, February 2002).

<sup>6</sup> Renee Schwalberg, Hillary Bellamy, Mary Griffin, Chris Miller, Susan Schreiber Williams, and Linda Elam, *Medicaid Outpatient Prescription Drug Benefits: Findings From A National Survey of Selected Case Study Highlights* (Washington: Kaiser Commission on Medicaid and the Uninsured, October 2001).

<sup>7</sup> Ibid.

<sup>8</sup> 42 U.S.C. 1396 o(e).

<sup>9</sup> Congressional Budget Office, *How Increased Competition from Generic Drugs Has Affected Prices and Returns in the Pharmaceutical Industry* (Washington: Congressional Budget Office, July 1998).

<sup>10</sup> Unpublished data from the National Association of Chain Drug Stores.

<sup>11</sup> Renee Schwalberg, op cit.

<sup>12</sup> 42 U.S.C. 1396r-8.

<sup>13</sup> Renee Schawlberg., op cit.

<sup>14</sup> Andy Schneider and Linda Elam, *Medicaid: Purchasing Prescription Drugs* (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2002).

