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# Medicaid Drugs

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*The following commentary unites a collection of articles primarily concerned with prescription drug issues in Medicaid. It also features highlights from a piece outlining Australia's pharmaceutical delivery system. Specifically, in this issue, you will find comprehensive analyses of drug expenditure trends, issues regarding access to pharmaceuticals in Medicaid, and an evaluation of ongoing generic drug cost-containment programs.*

## INTRODUCTION

Rising pharmaceutical prices have been the subject of intense research and debate over the last several years as drug therapies play an ever-increasing role in our treatment of illness and disease. A significant proportion of expenditures incurred by Medicaid, the insurer of over 40 million medically and categorically needy persons, is devoted to paying for prescription drugs. Recently passed legislation, namely the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), will likely have a considerable impact on Medicaid expenditures, as Medicare will become the primary drug insurer for approximately 6 million beneficiaries eligible for both the Medicare and Medicaid Programs (known as dually eligible beneficiaries). The trends and analyses contained within include information on dually eligible beneficiaries, as well as all classes of Medicaid beneficiaries.

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## Background

Medicaid, the Nation's largest program that provides health care to the poor and near-poor, was created in 1965. It is jointly funded by the Federal Government, along with State governments, and is intended to assist people who meet certain eligibility criteria. Each State has its own guidelines that determine what medical services it covers, however, there are certain services that must be covered in order for States to receive Federal funds. One service that is not required of States is coverage for outpatient prescription drugs, yet every State has elected to provide such coverage for at least some of their beneficiaries.

Thinly-stretched State budgets, along with spiraling drug costs, have compelled States to implement certain cost-control mechanisms as they strive to balance the provision of quality health care with the need for fiscal restraint. Among the list of cost-control measures currently employed by many States are monthly utilization limits, automatic generic substitution, creation of maximum allowable cost (MAC) programs, and prior authorization requirements (National Pharmaceutical Council, 2002). Spending trends and the impacts some of these provisions have on State budgets and on Medicaid beneficiaries are scrutinized in this issue of the *Health Care Financing Review*.

## Trends in Costs

The contribution from Baugh, Pine, Blackwell, and Ciborowski is an examination of Medicaid prescription drug costs

throughout the decade of the 1990s. During that 10-year period, the authors report overall Medicaid spending increased considerably. Spending for drugs was no exception as it increased from \$4.4 billion in 1990 to \$20 billion in 2000. On a per recipient basis, spending soared from \$256 in 1990 to \$975 in 2000.

Among the disabled, Baugh et al. find that increases in drug spending averaged better than 20 percent for the period studied. In fact, this group had the highest Medicaid drug payments of any of the other eligibility groups including the aged, children, and adults. In 2000, drug spending for the disabled topped \$11.6 billion, which represented 58 percent of Medicaid's drug payments. That is up from 42 percent in 1990.

They also report that the number of Medicaid recipients increased by just under 2 percent per year throughout the 1990s. The largest group of medication recipients was children (8.3 million), more than double the number of adults receiving Medicaid drugs (4 million).

## **Cost Containment**

With Medicaid drug bills ascending at double-digit rates, cost control policies take on added importance. This issue features an analysis of potential cost containment strategies as they relate to generic drugs. The objective of Abramson, Harrington, Missmar, Li, and Mendelson was to characterize the MAC lists of five States and compare them to each other, as well as to drug prices that are regulated by the Federal Upper Limits (FUL) program. Both the MAC and the FUL programs contribute to savings garnered by Medicaid by encouraging pharmacies to dispense generic medications rather than brand-

name drugs. They also influence prices by limiting the reimbursements Medicaid can make for generic drugs.

Comparing MAC programs with one another, the researchers conclude there is a relatively high degree of variation in the breadth, depth, and price aggressiveness across these programs. Discussions with Medicaid officials indicate the reasons for these differences are the tedious nature of MAC list creation and administration, and State MAC programs frequently have trouble acquiring reliable drug pricing data.

From an administration perspective, the investigators recommend that States focus their MAC list efforts on those drugs with the highest sales volume. Moreover, States should ensure that their MAC lists contain as many forms and strengths for covered drugs as possible to reduce price variability within drug name. Finally, States should collaborate with each other on their MAC list operations.

To address the data acquisition problem, Abramson et al. recommend making reimbursement allowances to pharmacies in order to obtain accurate pricing data. Additionally, States should gather pricing information from alternative sources, as well as implement formal policies that require price disclosure.

In comparing MAC to FUL lists, the authors also report that State MAC lists typically contain more drugs and assign lower prices to those medications. This finding is attributable to MAC programs usually having a greater degree of latitude on issues of quantity and price.

The researchers include several observations in their analysis regarding FULs drugs. For instance, FULs drugs account for almost two-thirds of total nationwide generic drug sales. Also, some State MAC lists include medications also found on FULs lists, but FUL prices are considerably higher.

## Access Effects

Removing barriers to drug treatment is likely to have certain “access effects” such as increasing the number of patients on a particular drug, or changing the characteristics of the treated population. To examine this, and other issues related to drug access, McCombs, Mulani, and Gibson analyzed the various impacts of offering open access to second-generation antipsychotics in the California Medicaid Program (Medi-Cal).

They found a substantial increase in the likelihood that a patient in the Medi-Cal program would start antipsychotic drug therapy without having a mental health condition diagnosed in the previous 6 months when there was open access to such therapy (38.4 percent closed access; 51.7 percent open access). Moreover, the authors found a sizable increase in the number of episodes initiated per month once open access was granted to the second-generation antipsychotics. For patients restarting therapy (with the newly approved medications), this effect appeared to be temporary as the rate of restart episodes eventually fell below the levels observed prior to open access. Similar results were observed for patients who switched to the newer medicines without a break from their usual medicine, and for those who augmented their original therapy with the newer drugs.

With respect to changing characteristics of the treatment population, McCombs et al. note that, although the average age in the open access period was slightly higher compared to the mean age for the closed access period (44.8 years closed; 45.1 years open access), the proportion of patients with an episode of therapy under age 25 nearly doubled from 7.7 to 12.4 percent.

Similarly, although less dramatic, was an increase in the proportion of beneficiaries age 65 or over (15.8 percent closed; 18.4 percent open).

The authors conclude that while the average monthly cost of treating patients taking antipsychotics increased across all service types and the persistence on the initial drug use declined under open access, reductions in the future use of nursing home care and psychiatric hospitalizations helped to offset these higher costs.

## Drugs Abroad

Questions related to drug prices and their availability are pondered worldwide (Danzon and Furukawa, 2003). This issue features an article by Duckett on Australia’s Pharmaceutical Benefit Scheme (PBS), one branch of that country’s universal health insurance arrangement.

Growing from a list of 139 “life saving and disease preventing” drugs in 1939, Duckett reports that in 2003, the PBS covered over 600 generic products marketed as 2,602 different brands. Frequently, gaining access to the drugs on the list requires contact with the administering agency of the PBS and the Health Insurance Commission. There are also times when the medical practitioner is required to certify the presence of certain indications to justify the need for a medication.

Duckett states when a pharmaceutical is listed on the PBS under several different brand names, pharmacists are permitted to dispense “generically” identical forms of the drug. As a rule, the PBS will only pay for the least expensive version of that drug while the consumer must pay any additional costs associated with obtaining a specific branded drug.

His commentary indicates expenditures on pharmaceuticals have been growing faster than Australia's overall economy in recent years. Moreover, prescription drug expenditures are the fastest growing segment of that country's health care bill, averaging 15 to 20 percent growth per year.

In general, the Australian blueprint for providing pharmaceuticals performs well with respect to several criteria including equity and efficiency. From an equity perspective, the PBS helps to minimize financial barriers to drugs through low copays for Australians age 65 or over. He cites a study that showed just 2 percent of Australia's aged population reported not filling a prescription due to cost.

From an efficiency point of view, the PBS is successful due, in part, to its requirement that all new drugs face a rigorous cost-effectiveness test prior to being listed on the PBS. Some argue that by passing this test, any added expenditures to the program are likely offset by savings in other sectors of health care or by increases in productivity.

## Highlights

The Medicaid highlights by Tepper and Lied provide a somewhat different perspective on drug spending increases.

Tepper and Lied illustrate that FFS drug expenditures, as a percent of FFS total expenditures, climbed to over 11 percent in 2001. That compares to a rate of about 6 percent in 1985. At the State level in 2001, California led all others with approximately \$3.1 billion in total drug spending, followed by New York with \$2.9 billion. New Jersey led all States in prescriptions per beneficiary with 33, despite being ninth in the Nation on total drug spending (\$0.64 billion).

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