
Overview of Selected Cost Containment Strategies for Medicaid Prescription Drug Spending*

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Abstract:

In North Carolina, Medicaid spending on outpatient prescription drugs has increased an average of 21% each year for the past eight years. Like other states, North Carolina has implemented numerous strategies over the years to contain these costs. This brief reviews Medicaid prescription drug spending and cost containment strategies in general. It then offers an overview of a handful of relatively large scale strategies that other states have implemented in recent years. It highlights states' use of preferred drug lists, supplemental rebates and multistate purchasing pools.

Prescription drug spending in the United States has been rising steadily for years – increasing at double digit rates from 1996-2004. National spending quadrupled between 1990 and 2002.¹ These trends are expected to continue well into the foreseeable future. On a national level, outpatient prescription drug spending overall is expected to increase 11.4% in 2005 and 11.6% in 2006.² State Medicaid programs, like other health care payers, are struggling to develop mechanisms that effectively control their prescription drug spending. Every state – including North Carolina – has implemented numerous strategies to control spending. Following the background on prescription drug spending and cost containment measures, this brief highlights

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several emerging strategies that North Carolina has not yet implemented and, by way of example, will discuss Florida's experience with those strategies.

How Much Does North Carolina Medicaid Spend on Outpatient Prescription Drugs?

Taking into account projected spending for 2005, North Carolina Medicaid spending for prescription drugs has increased on average 21% each year for the past eight years. Prescription drugs accounted for about 11% of total Medicaid expenditures in 1998, but are expected to make up over 20% of total spending in 2005. (See Table 1.)

SFY	Prescription Drugs Paid	% of Medicaid Total Expenditure	% Increase of Prescription Drug	Medicaid Total Expenditure
1998	455,381,447	10.85%		4,197,522,724
1999	557,772,671	12.94%	22.48%	4,311,798,597
2000	754,505,194	15.73%	35.27%	4,796,682,219
2001	927,240,693	16.96%	22.89%	5,468,556,418
2002	1,056,158,750	17.10%	13.90%	6,175,910,221
2003	1,203,630,913	18.27%	13.96%	6,586,787,583
2004	1,470,328,522	19.95%	22.16%	7,369,370,752
2005	1,729,324,900	20.57%	17.61%	8,406,324,580
Note: Compiled by the NC Department of Health and Human Services, Division of Medical Assistance. SFY 2005 expenditures are based on 2005-07 ESTIMATES				

How Will the New Medicare Prescription Drug Benefit Affect North Carolina's Spending?

Many low income elderly people and other Medicaid recipients are considered dual eligibles – that is, they are eligible for both Medicaid (because of income) and Medicare (typically because of age). This population usually includes people who are high users of prescription drugs. One industry group (PhRMA) estimates that while people 65 and older account for only 9% of the total Medicaid population, they comprise almost 30% of the population group with the highest drug spending.³

Medicare will begin covering many prescription drugs for the dual eligibles beginning in 2006. The U.S. Department of Health and Human Services projects that when these populations are shifted over to Medicare, Medicaid spending as a percentage of all prescription drug spending will decrease from 18.1% in 2005 to 9.4% in 2006. This decrease, however, does not account for what many refer to as the clawback provision of the new Medicare law.⁴ Under that provision, states are required to assist the federal government with paying for the prescription drug benefit for these dual eligibles. Every state must make monthly payments to the federal government. The calculation of the payment is based on a percentage of what the state would have paid for prescription drugs for these dual eligibles under Medicaid. In 2006, states must pay 90% of the amount they would have paid. By 2015, the percentage will decrease to 75%.

In addition to the concerns related to the clawback provision, state agencies are also worried about the potential woodwork effect following implementation of the Medicare drug benefit. Some agencies are actually anticipating an increase in Medicaid spending because they expect the number of dual eligibles enrolled in Medicaid to increase. This could happen because seniors may first learn of their eligibility for Medicaid when they enroll in the new Medicare drug benefit.⁵ Taking both the clawback and woodwork issues into consideration, overall cost savings to state Medicaid programs may not be significant.

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How Does North Carolina Medicaid Decide How Much to Pay for a Particular Prescription Drug?

The total amount a state pays for outpatient prescription drugs is a combination of the state's reimbursement formula and any rebates that the state receives from pharmaceutical manufacturers.⁶ State Medicaid programs have some flexibility in establishing their reimbursement formulas. The federal government establishes an absolute ceiling (the Federal Upper Limit or FUL) for some generic drugs. Each state then has the flexibility to decide on a specific reimbursement formula. The state's formula is expected to represent the Estimated Acquisition Cost (EAC) for the drugs. States have developed a variety of different formulas over the years. In North Carolina, prescription drugs are reimbursed at the lower of:

- The average wholesale price (AWP) minus 10%⁷
- The state maximum allowable cost (MAC)⁸
- The FUL
- The provider's usual and customary charge⁹

In addition, a dispensing fee is added to the charge. Most other states' formulas rely on deducting a percentage of cost from the AWP and/or adding a percentage of the cost to the Wholesale Acquisition Cost (WAC).¹⁰

After the state has paid for a drug, it will receive a rebate from the manufacturer. All states are entitled to a rebate based on a federal formula. In order for an outpatient prescription drug to be covered under any states' Medicaid program, the drug manufacturer must enter into an agreement with the federal government to provide a rebate of a percentage of the cost of the drug. The rebate is calculated by the federal government and the cost savings is shared with the states. In short, the federal rebate amount for brand name drugs is the greater of either:

- 15.1% of the average manufacturer price (AMP)¹¹
- The difference between the AMP and the best price offered by the manufacturer to nonfederal purchasers¹²

For generic drugs, the rebate amount is 11% of the AMP. According to the Centers for Medicare and Medicaid Services (CMS), these rebates totaled about \$6.4 billion in FY 2003.¹³ In addition to these mandatory federal rebates, some states also receive supplemental rebates (discussed further below).

What Types of Prescription Drug Cost Containment Strategies Are States Implementing?

Most strategies being used by state Medicaid programs to contain prescription drug spending can be characterized as tools that either limit prescription drug use or control the costs of medications or the dispensing fees.¹⁴ The types of strategies receiving the most attention from state legislatures in recent years:

- Instituting aggressive generic substitution policies
- Increasing cost sharing or copayments
- Implementing comprehensive drug utilization review programs
- Decreasing dispensing fees
- Requiring prior authorization for certain medications
- Developing preferred drug lists (PDL) or formularies
- Requiring supplemental rebates from manufacturers
- Entering into multistate purchasing pools¹⁵

North Carolina has adopted measures that incorporate the first five of the above strategies. For example, the state:¹⁶

- Requires pharmacists participating in the Medicaid program to substitute less expensive generic drugs for brand name drugs (with limited exceptions)
- Imposes the highest cost sharing allowed under federal law (\$1/generic and selected over-the-counter products and \$3/brand name), although several categories of beneficiaries are exempt from copayments under federal law (e.g., child, pregnant woman, nursing home resident)¹⁷
- Established a prior authorization program for high cost specialty drugs. When a pharmacy is asked to fill a prescription for one of these drugs, it must contact the state agency (or its contractor) for approval and the state must respond within 24 hours¹⁸
- Operates both prospective and retrospective drug utilization review programs. The prospective program helps pharmacists identify potential problems (e.g., drug interactions, therapeutic duplication, drug-disease contraindications) and cost savings at the point of sale. The retrospective program is a pilot designed to evaluate pharmacy regimens for certain nursing home and adult care home residents

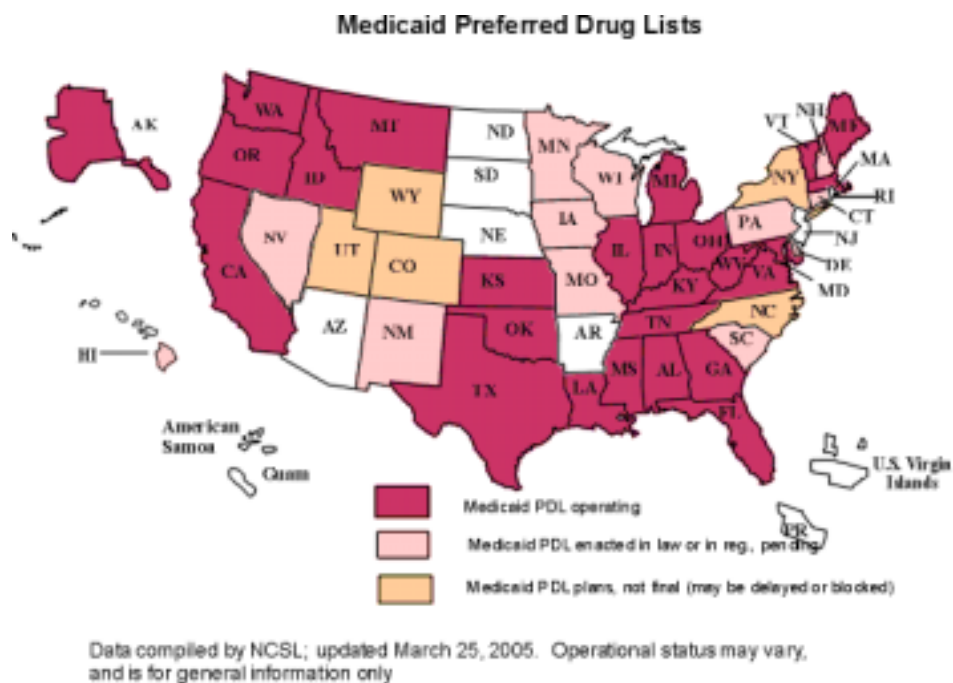
Many of North Carolina's strategies focus on building a pharmacy system that encourages pharmacists and physicians to prescribe the best, cost effective medicines. The state Division of Medical Assistance develops these strategies collaboratively with the provider community, receiving regular policy guidance from the Physician Advisory Group.¹⁹ In addition to these administrative and management tools, North Carolina has implemented several regulatory strategies intended to limit utilization, such as exclusion of certain prescription drugs from coverage (e.g., weight loss and infertility drugs) and placement of restrictions on the numbers of reimbursable prescriptions and pills.

It is important for policymakers to consider how each of these cost containment strategies will affect families – particularly those families that are heavy users of prescription drugs. Families with elderly adults or special needs children, for example, will likely feel the effect of any change to the program, however minor.

In order to familiarize North Carolina policymakers with some of the emerging cost containment strategies that the state has not yet adopted, the remainder of this brief discusses the last three NCSL strategies identified above (preferred drug lists, supplemental rebates, and multistate pools). In addition, because Florida has adopted or considered each of these strategies, its experience will also be highlighted.

What Is a Preferred Drug List and How Can It Save States Money?

A preferred drug list (PDL) is a list of prescription drugs that is selected by the state to receive somewhat special treatment. In general, states agree to provide coverage for drugs on the PDL without requiring prior authorization or approval. Thus, health care providers may be encouraged to prescribe a drug listed on the PDL instead of a drug that is not listed because there are fewer administrative burdens. Drug manufacturers, therefore, usually would like their drugs to be included on a state's PDL. According to NCSL, at least 38 states now have PDL programs in operation or in progress.



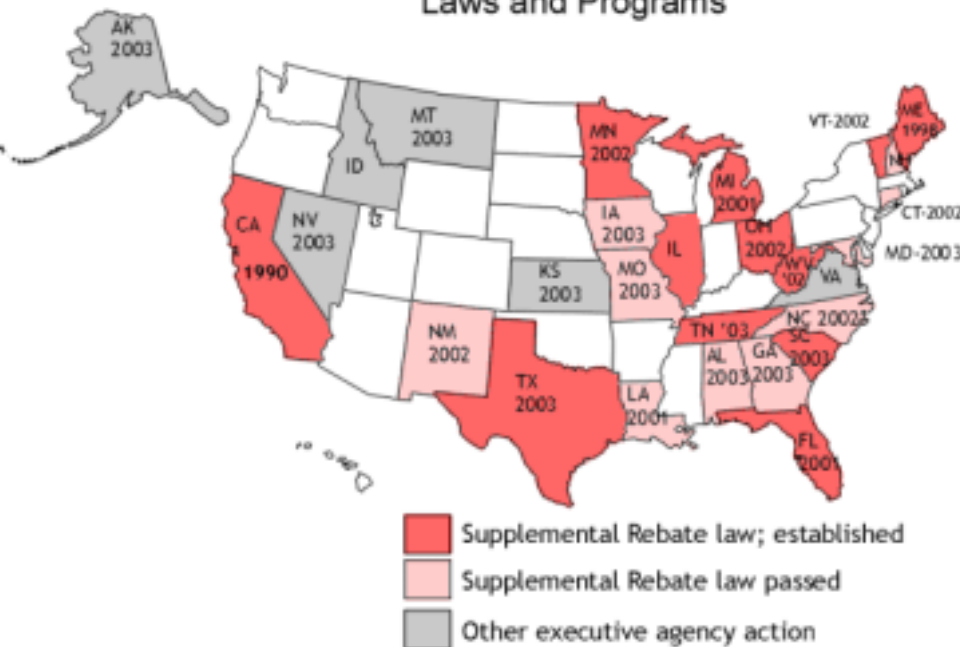
In 2001, Florida was one of the first states to establish a PDL. The state established a committee that determines which classes of drugs may be included on the list based on clinical factors, therapeutic evaluations, and cost considerations. The committee includes heavy representation from clinicians, but also includes a consumer representative and a pharmaceutical industry representative.²⁰ Many states follow the same process. In Florida and some other states, the PDL is tied directly to a supplemental rebate program. Specifically, once the classes of drugs are identified, the state's contractor (Provider Synergies) negotiates supplemental rebates with the manufacturers of drugs in those classes (see discussion of supplement rebates below).

North Carolina has an established list of preferred drugs that is called the Prescription Advantage List (PAL). The PAL is different from a traditional PDL, however, because the PAL is intended only to provide guidance to providers. In other words, if a provider wishes to prescribe or provide a drug for a Medicaid beneficiary that is not on the PAL, the provider is not required to obtain permission (i.e., prior authorization) from the state agency. Compliance with the PAL is entirely voluntary. The PAL is developed in consultation with an advisory group comprised of health care providers. Within each of the 16 top therapeutic drug classes, the PAL ranks each drug from the least expensive to the most expensive.²¹

What Is a Supplemental Rebate Program and How Can It Save States Money?

As mentioned earlier, all drug manufacturers wishing to sell their products to the Medicaid program must agree to provide rebates of a certain percentage of the drug's cost. States, however, have the option of entering into agreements directly with a drug manufacturer to receive rebates that go above and beyond the federal rebate. These are called supplemental rebate programs. Over 20 states have set up supplemental rebate programs in order to receive additional money or services directly from the drug manufacturers.²² States must obtain approval for such

**Medicaid State Supplemental Rebates
Laws and Programs**



Some 2002-04 programs are not operational or are in varying stages of implementation. Additional agency initiatives may not be listed. Data as of March 1, 2004. © NCSL.

Florida established its supplemental rebate program in 2001. The program is tied directly to the state's PDL. In order for a brand name drug to have the opportunity to be included on the PDL, the drug manufacturer must offer a minimum rebate of 29.1% of AMP.²⁵ There is no upper limit on the rebate that the state may negotiate. The program is authorized by state law to receive supplemental rebates for generic drugs, but does not yet do so.

When Florida's program was first implemented, the state allowed drug manufacturers to substitute program benefits that have guaranteed savings to the Medicaid program.²⁶ A couple of manufacturers elected to offer such benefits in lieu of the additional rebate. For example, Pfizer, Inc. funded and operated a disease management program for chronically ill Medicaid beneficiaries in exchange for its drugs being placed on Florida's PDL. Pfizer was not required to pay the supplemental rebate. Florida ultimately concluded that these manufacturer programs were not cost effective and therefore is planning to discontinue this substitution option in the near future. All manufacturers who wish to have products included on the PDL in the future will be required to provide financial rebates.

In 2002, North Carolina began the process of developing a supplemental rebate program tied to a PDL. The General Assembly, however, included a provision in the 2002 budget bill prohibiting DHHS from requesting or requiring supplemental rebates from manufacturers.²⁷ The General Assembly removed the provision the following year, but the state has not yet exercised its authority to adopt either a PDL or supplemental rebate program.

How Do States Use Multistate Pooling to Save Money?

Several state Medicaid programs have joined forces to form prescription drug purchasing pools. In 2004, CMS approved a plan for seven states (Michigan, Vermont, Alaska, Nevada, New Hampshire, Minnesota, and Hawaii) to participate in a joint purchasing pool that also included a supplemental rebate component. According to CMS, the pool will purchase drugs for 1.1 million Medicaid beneficiaries and generate savings of \$19.5 million for FY 2004.²⁸

Other states are also considering joining or developing purchasing pools. Smaller states are particularly concerned about their potential loss of purchasing power once they stop covering prescription drugs for the dual eligible population. As discussed earlier, when the Medicare prescription drug benefit goes into effect next year, states will no longer directly pay for the costs of outpatient drugs for low income seniors. At this point in time, Florida has decided not to join in a pooling arrangement. Given the size of its Medicaid population, the state expects to maintain sufficient purchasing power on its own to negotiate reason-

able prices with manufacturers. North Carolina does not currently participate in any Medicaid purchasing pools, although a bill was introduced this session to create a Study Commission on Managing State Prescription Drug Costs. One of the commission's charges would be to evaluate the experiences of other states with "multistate compacts, bulk purchasing, or negotiated discounts."²⁹

Endnotes

¹ Fact Sheet: Prescription Drug Trends, Kaiser Family Foundation (Oct. 2004). Available at <http://www.kff.org/rxdrugs/3057-03.cfm>.

² Heffler, Stephen et al., Trends: U.S. Health Spending Projections for 2004-2014, Health Affairs, W5-74 (Feb. 23, 2005) Web exclusive; projections prepared by the Office of the Actuary, Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

³ See Press Release: New Study Profiles "High Users" of Medicaid Prescription Drug Coverage: Elderly, Female with Multiple Chronic Conditions, Pharmaceutical Research and Manufacturers of America (Dec. 9, 2003). Available at <http://www.phrma.org/mediaroom/press/releases/09.12.2003.879.cfm>.

⁴ See Schneider, Andy, The "Clawback": State Financing of Medicare Drug Coverage, Kaiser Commission on Medicaid and the Uninsured (June 2004). Available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=39919>.

⁵ Questions and Answers about the Medicare Prescription Drug Legislation, National Association of State Medicaid Directors and the American Public Health Services Association (Dec. 2003). Available at http://www.nasmd.org/Medicare%20Bill_QA_Revised.pdf.

⁶ Committee on Health Care, Review of Medicaid Prescription Drug Pricing, Florida Senate, Interim Project Report 2005-141 (Nov. 2004). Available at http://www.flsenate.gov/data/Publications/2005/Senate/reports/interim_reports/pdf/2005-141he.pdf.

⁷ The AWP is intended to represent a national average of list prices charged by wholesalers to pharmacies. It is often referred to as the sticker price and generally represents a price much higher than what a large purchaser might actually pay. In North Carolina, the AWP is usually calculated by adding 20-25% to the Wholesale Acquisition Cost (WAC). The WAC is intended to reflect the price paid by a wholesaler for drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug. See Glossary, Office of Pharmacy Affairs, Health Resources and Services Administration, U.S. Department of Health and Human Services (available at <http://www.bphc.hrsa.gov/opa/glossary.htm>). See also presentation of Nancy Henley of the North Carolina Division of Medical Assistance to the Blue Ribbon Commission on Medicaid Reform (Oct. 6, 2004). See Appendix E. Available at http://www.ncleg.net/committees/blueribboncommi_/2005report/2005report.pdf.

⁸ Many states set their own MAC lists. These lists are similar to the FUL list in that they establish a ceiling that the state will pay. State MAC lists, however, tend to include more drugs and assign lower prices than the FUL list. See Abramson, Richard G. et al, *Generic drug cost containment in Medicaid: Lessons from five State MAC programs*, Health Care Financing Review (Spring 2004). Available at <http://www.cms.hhs.gov/review/04Spring/04Springpg25.pdf>.

⁹ The usual and customary charge is generally the price that the general public would pay for the drug at the retail pharmacy.

¹⁰ For a table comparing North Carolina's formula with those in other southern states, see the presentation of Nancy Henley of the N.C. Division of Medical Assistance to the Blue Ribbon Commission on Medicaid Reform (Oct. 6, 2004). See Appendix E, pages 10-11. Available at http://www.ncleg.net/committees/blueribboncommi_/2005report/2005report.pdf.

¹¹ The Average Manufacturer Price (AMP) is intended to reflect the price paid by wholesalers to drug manufacturers.

¹² The manufacturer is required to report its best price to CMS. Provost Peters, Christie, *Fundamentals of the Prescription Drug Market*, National Health Policy Forum Background Paper (Aug. 24, 2004). Available at http://www.nhpf.org/pdfs_bp/BP_RxIndustry_08-24-04.pdf.

¹³ Testimony of Dennis Smith, Director of the Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services, before the House Energy and Commerce Subcommittee on Oversight and Investigations (Dec. 7, 2004). Available at <http://www.hhs.gov/asl/testify/t041207.html>.

¹⁴ For detailed information about prescription drug cost containment strategies in Medicaid, see e.g., Crowley, Jeffrey S. et al., *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003* (December 2003). Available at <http://www.kff.org/medicaid/4164.cfm>.

¹⁵ See National Conference of State Legislatures, *Recent Medicaid Prescription Drug Laws and Strategies 2001-2004* (updated Jan. 2005). Available at <http://www.ncsl.org/programs/health/medicaidrx.htm>. See also Crowley, Jeffrey S. et al., *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003* (December 2003). Available at <http://www.kff.org/medicaid/4164.cfm>.

¹⁶ Please note that this is not intended to be an exhaustive list of North Carolina's cost containment measures. For a full description of the state's program, see Division of Medical Assistance, *Outpatient Pharmacy Manual*. Available at <http://www.dhhs.state.nc.us/dma/pharmacy.htm>.

¹⁷ Federal law prohibits a pharmacist from withholding a medication if the Medicaid beneficiary is unable to pay the cost sharing. As a result, it is often the pharmacy that assumes responsibility for any cost sharing.

¹⁸ For more information, see <http://www.ncmedicaidpbm.com>.

¹⁹ Hooker Odom, Carmen and Wade, Torlen, *The Department of Health and Human Services: Medicaid Pharmacy Management Strategy- 2003-2005*. NC Medical Journal (Nov/Dec 2003), Available at <http://www.ncmedicaljournal.com/nov-dec-03/ar110305.pdf>.

²⁰ See Fla. Stat. § 409.91195 regarding the membership and scope of the state's Pharmaceutical and Therapeutics Committee.

²¹ North Carolina's PAL list is available on the website for the Division of Medical Assistance. See <http://www.dhhs.state.nc.us/dma/pal/pal.xls>.

²² Folkemer, Donna, *Prescription Drugs: Issues for States in 2005*, NCSL Presentation (Feb. 2, 2005). Available at <http://64.82.65.67/health/Governing—Rx-Folkemer.pdf>. CMS reports that as of September 2004, 33 states are receiving supplemental rebates. Center for Medicare and Medicaid Services, *Safe and Effective Approaches to Lowering State Prescription Drug Costs: Best Practices Among State Medicaid Drug Programs* (Sept. 9, 2004). Available at <http://www.cms.hhs.gov/medicaid/drugs/strategies.pdf>.

²³ Letter from Dennis Smith, Director of the Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, to State Medicaid Directors, SMDL #02-014 (Sept. 18, 2002). Available at <http://www.cms.hhs.gov/states/letters/smd91802.pdf>.

²⁴ Materials related to a lawsuit in Michigan are available on the website of the National Conference of State Legislatures, <http://www.ncsl.org/programs/health/medicaidrx.htm>.

²⁵ If a pharmaceutical manufacturer offers the minimum rebate for a particular drug, the drug is not automatically included on the PDL. It must be reviewed by the advisory committee to evaluate whether it should be included for clinical reasons.

²⁶ Fla. Stat. § 409.912 (39). See descriptions of Florida's program in the Addenda to *Issue Brief: State Pharmaceutical Assistance Programs*, National Governors' Association Center for Best Practices (May 10, 2001). Available at http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_2420,00.html.

²⁷ See North Carolina S.L. 2002-126 (budget bill); North Carolina S.L. 2002-159 (technical corrections bill).

²⁸ Center for Medicare and Medicaid Services, *Safe and Effective Approaches to Lowering State Prescription Drug Costs: Best Practices Among State Medicaid Drug Programs* (Sept. 9, 2004). Available at <http://www.cms.hhs.gov/medicaid/drugs/strategies.pdf>.

²⁹ S 424 (sponsored by Senators Boseman and Atwater).