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State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update

Executive Summary

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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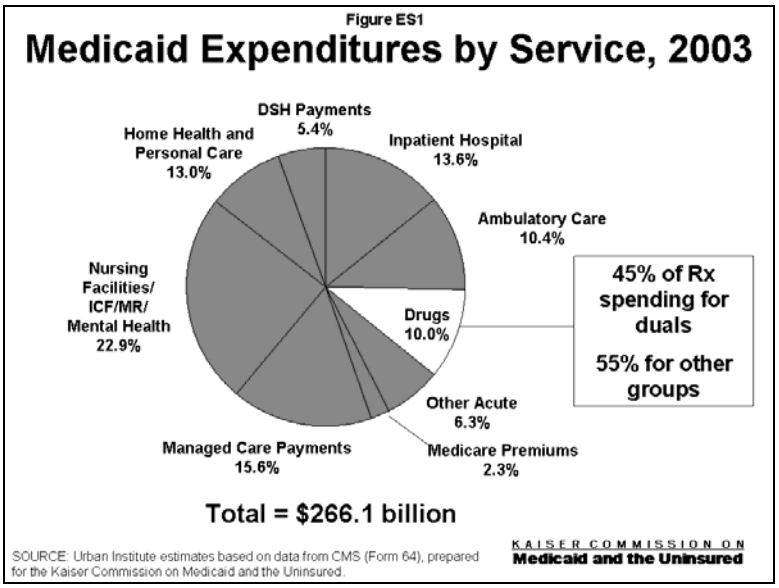
EXECUTIVE SUMMARY

The populations served by Medicaid and the diversity and intensity of their health care needs make Medicaid a major purchaser of prescription drugs. In 2003, Medicaid spent $33.7 billion on prescription drugs, accounting for 19% of national spending for this service.[i] Comprehensive prescription drug coverage is an essential benefit for Medicaid's 58.5 million low-income beneficiaries, including 9.2 million non-elderly people with disabilities and 5.4 million seniors, cohorts that are especially reliant on pharmaceuticals for the management of chronic illness.[ii]

In 2005, a broad spectrum of policy makers is focused on ways to reduce Medicaid spending growth. At the federal level, the Congressional budget resolution for fiscal year 2006 (which began on October 1, 2005) calls for the Senate Finance Committee to achieve savings of $10 billion over the next five years by identifying savings in the programs under its jurisdiction (and a corresponding level of savings is required from the House Energy and Commerce Committee). Even amid the changing priorities prompted by Hurricane Katrina, it is believed that a significant portion of these savings will come from Medicaid—and several policy makers have identified prescription drug policy changes as one of the primary ways that the Congress could meet the budget resolution's budget reduction target.

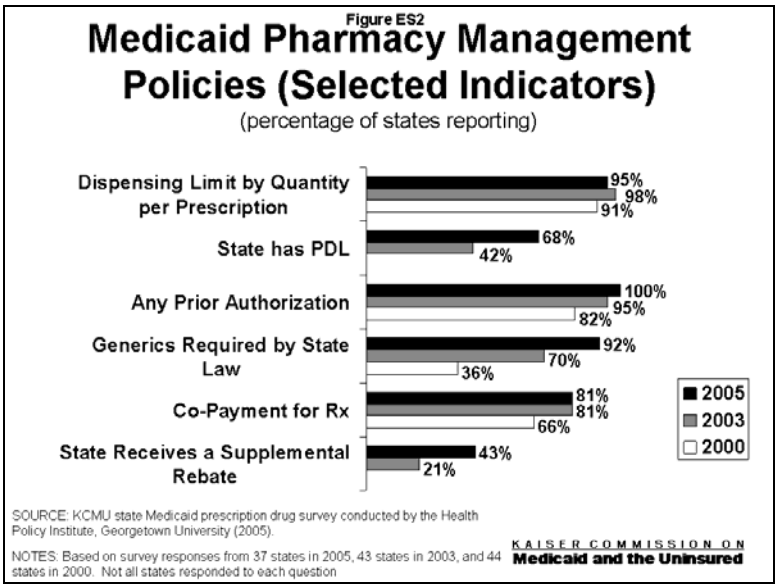
Medicaid will undergo additional changes as a result of the implementation of the Medicare Modernization Act (MMA)[iii]. On January 1, 2006, an estimated 13.6% of current Medicaid beneficiaries, who account for 48% of Medicaid prescription drug spending, will be transitioned to Medicare prescription drug coverage.[iv] Medicaid programs will have continued responsibility for meeting the long-term services and supports needs of dual eligibles and will continue to fill in for other gaps in Medicare coverage, even though they are barred by the MMA from receiving federal Medicaid financing for filling in any gaps in Medicare drug coverage **(Figure ES1)**. They will also be responsible for continuing Medicaid drug coverage for those beneficiaries who are not dual eligibles, but the amount spent and the mix of drugs purchased through the program will change considerably.



In the first half of 2005, the Kaiser Commission on Medicaid and the Uninsured conducted a survey of state Medicaid prescription drug policies that was carried out by the Health Policy Institute at Georgetown University. Thirty-six states plus the District of Columbia responded to the survey.[v] This survey updates and supplements work conducted for the Commission in 2003 and 2000 and covers key elements of utilization management, drug purchasing and potential impacts of the implementation of Medicare Part D.[vi]

Summary and Highlights from the 2005 Survey

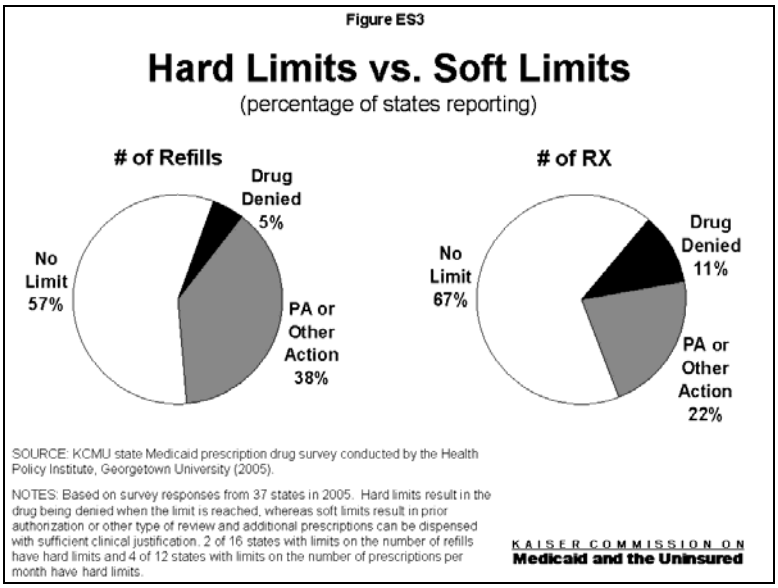
States have several tools available to them to manage the pharmacy benefit and to control costs. Increased health care costs and recent fiscal constraints have led most state Medicaid programs to use many of these tools. Medicaid programs anticipated 14.3% growth in drug spending in fiscal 2005, continuing a trend of double-digit growth. Consequently, in 2005, among responding states, nearly all programs used dispensing limits; roughly two-thirds operated preferred drug lists (PDLs); all required some prior authorization; nearly all required the use of generics, and four in five states charged co-payments for prescription drugs **(Figure ES2)**.



Dispensing Limits: In 2005, nearly all programs (35 of 37) reported that they impose limits on the amount of a drug that can be dispensed per prescription; lesser numbers imposed limits on refills per prescription (16 of 37) or number of prescriptions (12 of 37).

- **New Finding in 2005: Most states with dispensing limits apply soft limits**

Policy makers and beneficiary groups have focused on the imposition of hard dispensing limits in a small number of states, where beneficiaries may be denied medically necessary drugs above the established limit. While the ability of states to establish limits on dispensing is not new, the use of hard limits versus soft limits may reflect a new policy direction. In states with hard limits, Medicaid will not pay for drugs dispensed to an individual above a certain number of prescriptions or refills. Under soft limits, when individuals reach the established limit, their subsequent prescriptions typically become subject to prior authorization. Providers are given the opportunity to provide clinical justification for prescribing drugs above the limit, but drugs may be denied at this stage. States were asked in 2005 what action they take when beneficiaries hit the limits on the number of refills and the number of prescriptions. In most cases, individuals are subject to some form of prior authorization. In only 13% of responding states (2 of 16 states in 2005) are individuals automatically denied drugs (i.e., a hard limit is imposed) with respect to the number of refills and in only 33% of responding states (4 of 12 states in 2005) are individuals automatically denied drugs with respect to the number of prescriptions **(Figure ES3)**.



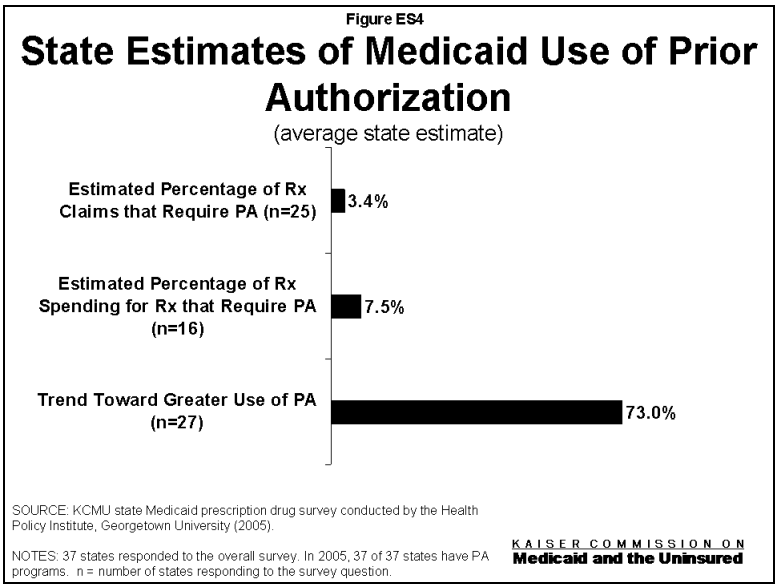
Preferred Drug Lists (PDLS)*:* In 2005, more than two-thirds of responding states operated PDLs. Of those with PDLs, most states provide for public input into drugs that should be on the PDL, and 40% use the same PDL for other state programs such as the State Children's Insurance Program (SCHIP) or the State Pharmacy Assistance Program (SPAP).

Prior Authorization (PA): In 2005, all responding states required PA for certain drugs paid for by Medicaid, and roughly three-fourths reported that the recent trend has been toward a greater reliance on PA. Three-fourths also indicated that they exempt certain classes of drugs from PA.

- **New finding in 2005: While all surveyed states use prior authorization (PA), states apply it selectively**

While PA has become a central pharmacy cost containment strategy in virtually all states, PA is used selectively. On average, states estimate that only 3.4% of prescription drug claims are for drugs that require PA (based on estimates from 25 states in 2005) **(Figure ES4)**. Additionally, the average estimate is that only 7.5% of Medicaid prescription drug spending is for drugs that require PA (based on estimates from 16 states). Some policy makers may interpret these low percentages to indicate that states could require PA for far more drugs. The success of PA programs, however, may rely on targeting efforts appropriately. Nonetheless, roughly three-fourths of respondents (27 of 37 states in 2005) reported that the recent trend has been toward a greater reliance on PA.

Figure ES4



***Generic Substitution**:* In 2005, nearly all states (34 of 37 responding) reported that they require generics to be dispensed when available, but the majority of these states (30 of 34) permit the requirement to be overridden if the prescriber requests. States estimated that 52% of prescriptions are filled with generics and that 19% of Medicaid drug spending is for generics.

***Cost Sharing**:* In 2005, four in five states (30 of 37 responding) charged co-payments for Medicaid prescription drugs. Seven of those 30 report that they permit prescription drugs to be withheld for non-payment of cost sharing.

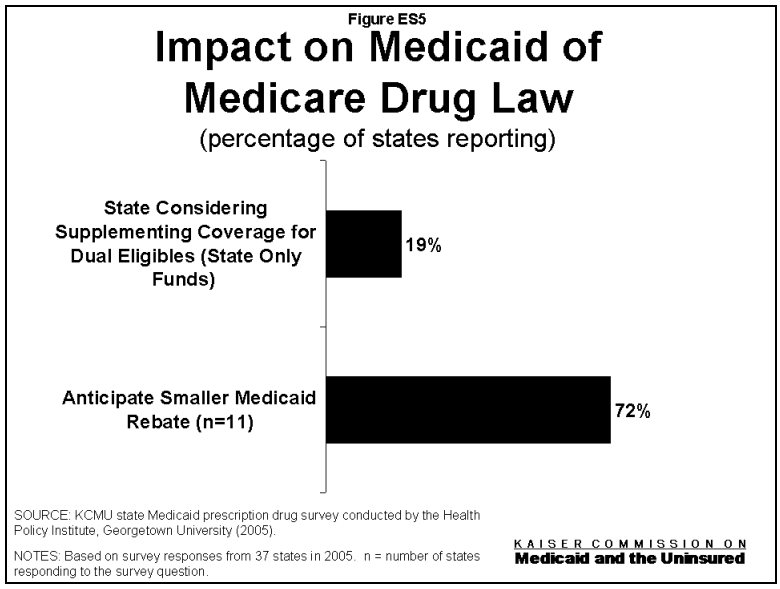
High Cost Management: In 2005, 23 of 37 responding states reported that they operate special programs targeting high cost patients who are identified sometimes using claims data or by chronic condition (e.g., diabetes or asthma). States typically use strategies such as disease management and provider education to address these groups.

Drug Purchasing: While the proportion of states receiving supplemental rebates has increased over time, fewer than half (16 of 37 responding in 2005) reported receiving them. A little more than half of responding states (20 of 37) reported returning rebate payment to Medicaid, with the remainder applying rebate payments to the state general fund. Six of 37 states reported pooling drug purchasing across several states, and three of 37 reported pooling drug purchasing across several state programs.

Impact on Medicaid of Medicare Drug Coverage: Early in Medicare drug coverage implementation, a minority of states reported considering using Medicaid to fill gaps in coverage for dual eligibles, yet the majority of surveyed states anticipated that the MMA will lead to smaller Medicaid rebates.

The implementation of the Medicare Modernization Act (MMA) has the potential to improve access to prescription drugs for millions of Medicare beneficiaries. The impact on dual eligibles, however, is unclear. CMS in its rulemaking and subsequent guidance has taken steps to ensure that Medicare Part D plan formularies are comprehensive, including the requirement that plans cover substantially all drugs in six key classes: anticonvulsants; antidepressants; antineoplastics; antipsychotics; antiretrovirals, and immunosuppressants.

Nonetheless, states and many other stakeholders are concerned that coverage gaps will arise for dual eligibles, both because plans will not cover necessary medications or because drugs will be denied due to the inability to pay cost-sharing. Some states (7 of 37 states in 2005) reported that they are actively considering using state-only funds to fill in gaps in Medicare coverage **(Figure ES5)**. While many state respondents said that they could not anticipate the impact of the implementation of the MMA on Medicaid, of those responding, nearly three-fourths indicated a belief that their Medicaid program would receive smaller rebates due to the loss of market share (8 of 11 states responding to this question in 2005).



Conclusion

Until now, Medicaid has played a unique role in providing access to prescription drugs to the neediest and costliest cohorts of Americans (low-income people with severe disabilities and low-income elderly individuals). Beginning in 2006, this responsibility will be shared with the Medicare Part D prescription drug program. Medicaid programs will grapple with the impact of the MMA on prescription drug costs and access for the remainder of the Medicaid population. Meanwhile, the Congress is considering changes to some of the basic approaches to purchasing prescription drugs in Medicaid and sharing responsibility for costs with beneficiaries. What will not change is the

central role that prescription drugs have come to play in modern health care and their vital role in the health and functioning of many of the poorest and sickest Americans.

The results presented are based on self-reported data by state Medicaid pharmacy officials. Participating states responded to a written survey or provided information through telephone interviews in the first half of 2005. Participating states were given the opportunity to review their responses for accuracy in July-August 2005, and states were asked to ensure that policies were up-to-date in cases where policies may have changed since originally completing the survey. Multiple efforts were made to secure the participation of all states.

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[i] *National Health Expenditures Tables, 2003,* Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, January 2005.

[ii] Congressional Budget Office, March 2005 Baseline.

[iii] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), also called Medicare Part D (Public Law 108-173), creates a right for Medicare beneficiaries to purchase Medicare prescription drug coverage beginning on January 1, 2006. While technically voluntary, low-income Medicare beneficiaries who also receive Medicaid (dual eligibles) will lose their Medicaid drug coverage and will be automatically enrolled in a Medicare prescription drug plan.

[iv] John Holahan and Arunabh Ghosh, *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003*, Kaiser Commission on Medicaid and the Uninsured, July 2005.

[v] For ease of reference, throughout this report, references to "states" should be inferred to include the District of Columbia.

[vi] For 2003 survey, go to http://www.kff.org/medicaid/4164.cfm. For 2000 survey, go to http://www.kff.org/medicaid/2225-index.cfm.

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