THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

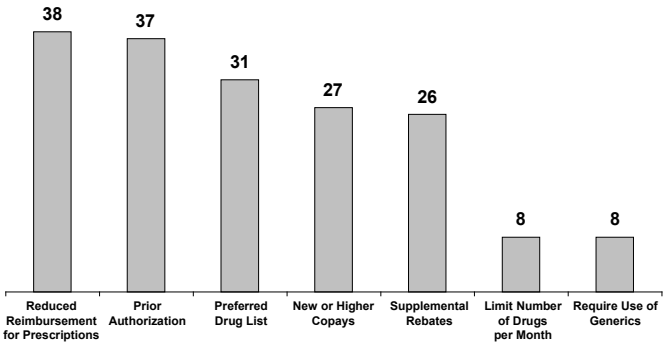
The Medicaid Drug Benefit: Highlights From the KCMU 2003 Survey of States

Medicaid plays a fundamental role in the provision of outpatient pharmacy services to the low-income population. Pharmaceutical coverage is an optional Medicaid benefit but all states provide drugs to categorically needy beneficiaries and most provide drugs to at least some of their medically needy populations. Medicaid's drug benefit is particularly vital to those enrollees who depend most upon drugs to maintain or improve their health and functioning, including individuals with chronic physical or mental illnesses and many low-income elderly. Medicaid provides prescription drug coverage for almost 6 million low-income Medicare beneficiaries or 15% of the Medicare population. While the elderly and people with disabilities constitute roughly a quarter of Medicaid enrollees, they account for approximately 80% of Medicaid prescription drug spending.

Prescription drug coverage is the fastest growing component of Medicaid spending and one of the most widely utilized benefits in Medicaid programs. Medicaid payments for outpatient prescription drugs rose over 18% annually between 1997 and 2000, compared to 7.7% annual growth for total Medicaid expenditures over the same period. Increased drug spending and state budget restrictions have prompted significant benefit changes over the last several years and have exacerbated the great variation between states' drug policies. All states use some combination of pharmaceutical cost or utilization control strategies, including formularies/preferred drug lists, prior authorization, generic substitution, fail first, dispensing limits, generic substitution and the imposition of copayments.

Figure 1

Action Taken by 50 States to Reduce Growth in Medicaid Prescription Drug Spending, 2003-2004



NOTE: Data reflect the number of states adopting or expanding their use of these strategies in their FY 2003 or 2004 budgets.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and forthcoming September 2003.

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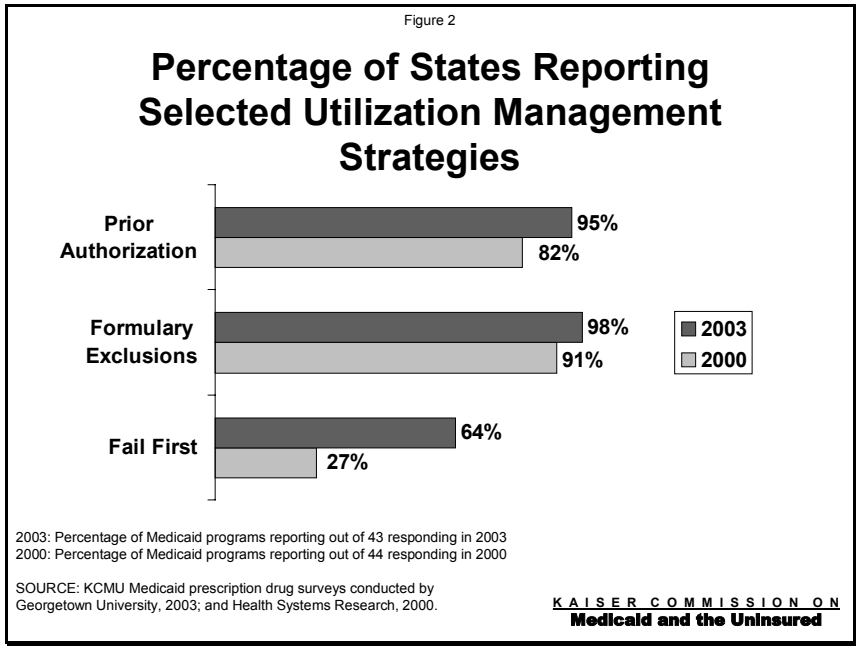
In the spring of 2003, the Kaiser Commission on Medicaid and the Uninsured (KCMU), and the Georgetown University Institute for Health Care Research and Policy

updated a survey of state Medicaid prescription drug benefit policies first conducted in 2000[1]. The 2003 survey was completed by 42 states and the District of Columbia[2] and this brief highlights some of the surveys' major findings and trends.

Formularies/Preferred Drug Lists

States can establish Medicaid formularies with some caveats: they must have a P&T (Pharmacy and Therapeutics) committee in place; the formulary must include drugs manufactured by firms participating in the federal rebate program; only specific formulary exclusions are permitted; and non-formulary drugs must be available through prior authorization. An increasingly popular variant of the formulary is the preferred drug list or PDL, and in 2003, 18 programs reported using PDLs. In most cases, the Medicaid agency and/or the P&T committee sets PDL policy but, in addition, 11 programs report public input in the PDL. Six states report that the PDL is also used for programs other than Medicaid.

Figure 2



Prior Authorization and Fail First

States can require that they provide approval or authorization before a drug is dispensed. Prior authorization has been available as a utilization management option for many years, but, in the past, states generally reserved it for particularly high-cost or high-risk drugs. States have expanded their use of prior authorization over the years and it is now often used as an incentive to prescribers to adhere to a PDL. Federal

[1] Schwalberg R, Bellamy H, Giffin M, Miller C, Williams SS, Elam L. Medicaid Outpatient Prescription Drug Benefits: Findings From a National Survey and Selected Case Study Highlights. Kaiser Commission on Medicaid and the Uninsured, Washington D.C. October 2001.

[2] The eight states that did not respond to the 2003 survey were AL, IN, NV, OH, OR, RI, TN, and WY. In 2000, 43 states and DC responded; the seven states that did not respond were AZ, CO, OH, OK, TN, TX, and WI.

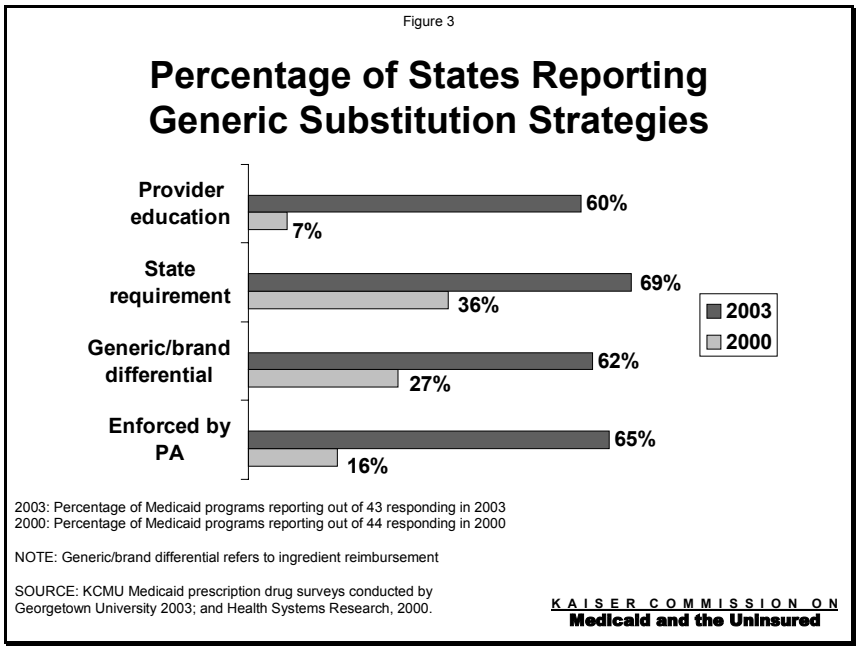
statute mandates that authorization requests must be decided upon within 24 hours, a 72-hour supply of medicine must be available in emergencies, and that the state must have in place a mechanism for the appeal of denial. In the 2003 survey, states report a wide range of requests (from 27 to over 2 million) and denials (from 0 to 39%).

Another strategy states can use is fail first or step therapy. The number of states requiring patients to receive and fail on an older or less expensive drug before they are authorized to receive a more expensive option was 12 in 2000 and 28 in 2003.

Generic Substitution

Almost all states encourage or require the use of generics when available. Most states require generic substitution when possible, and many also encourage the use of generics through differential beneficiary copayments, ingredient reimbursement and dispensing fees to pharmacists and provider education. In 2003, 28 states also enforced the use of generics through prior authorization when a generic alternative was available.

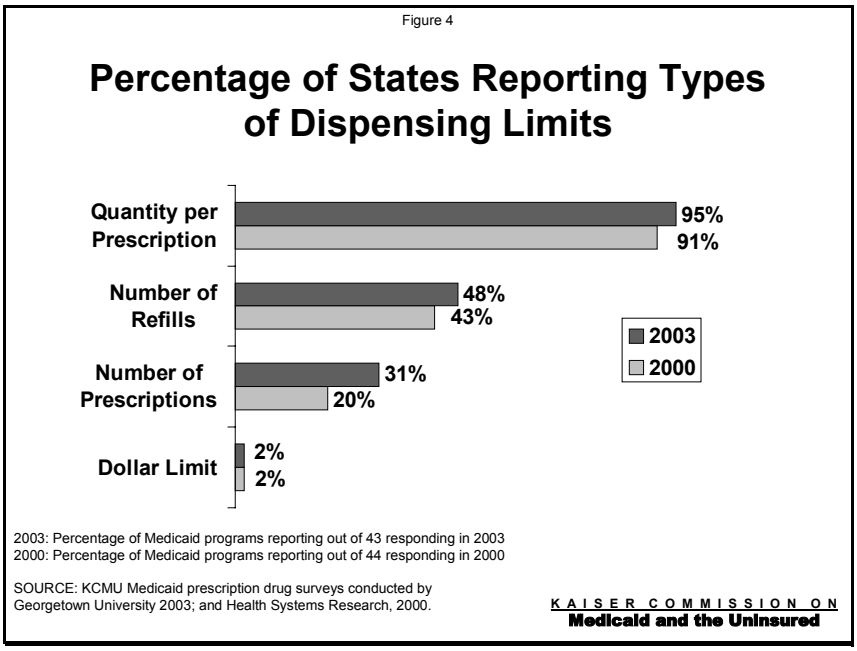
Figure 3



Dispensing Limits

Most states (41 of 43 reporting in 2003) have limits on the quantity of medication that can be dispensed per prescription, and a growing number have limits on number of refills per prescription and the number of prescriptions a beneficiary can have at one time before the state requires prior authorization. Any state reporting limits imposed a limit on the quantity dispensed per prescription.

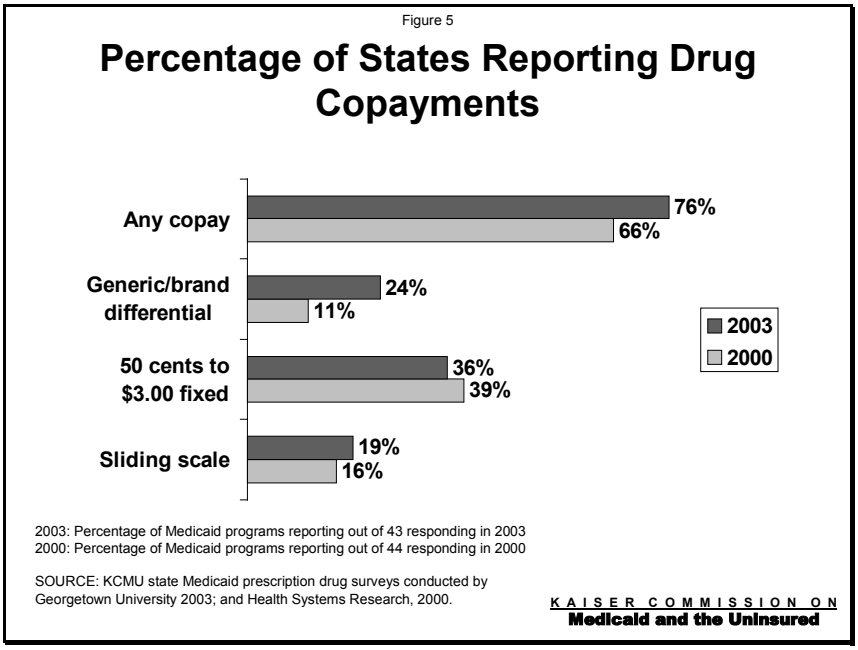
Figure 4



Copayments

States can allow nominal copayments (generally $0.50 - $3.00) when a beneficiary fills a prescription, except in the case of children and pregnant women. Thirty-three of 43 responding programs require some type of copayments. Because of the low incomes and greater prescription drug use found in the Medicaid population, therapy is not supposed to be withheld if beneficiaries do not pay copayments, however six states reported that prescriptions can be held if beneficiaries do not pay copayments.

Figure 5



State drug payment practices

In the case of brand name drugs and some multiple source drugs, Medicaid payment may not exceed the lesser of the drug's estimated acquisition cost (EAC) plus a dispensing fee or the provider's usual or customary charges to the general public. Forty-two programs use the Average Wholesale Price or AWP (which is set by manufacturers and is often described as a drug's "sticker price") to determine the EAC; their payments range from AWP–5% (AK) to AWP-50% (WA). In addition, for at least some drugs, four programs determine the EAC using the Wholesale Acquisition Cost or WAC (the average price paid by wholesalers for products, also determined by manufacturers); their payments range from WAC+6% in MA to - WAC+10% in MD and MO. Five states include dispensing fees in the EAC.

All states participate in the federal drug rebate program. In 29 of the 43 programs responding to the 2003 survey, rebates go to the Medicaid program with the remainder going to the general fund. Eight states report receiving supplemental rebates, or rebates above those collected through the federal rebate program.

Summary

The combined pressures of constrained budgets and rapidly increasing Medicaid drug spending growth have spurred state activity to control drug utilization and costs. States are taking advantage of strategies to control spending, sometimes using them in broader or more inventive ways than in the past. While this activity is to be expected, given the environment, federal and state governments and Medicaid agencies must remain attuned to impacts of policy changes on beneficiary access to care. The bulk of Medicaid drug spending is for the sickest beneficiaries, and cost containment mechanisms that may work without undue burden in the private sector, including significant copayments or drug limits, may prove harmful in the Medicaid context.

Prepared by Linda Elam of the Kaiser Commission on Medicaid and the Uninsured and Jeffrey Crowley of the Georgetown University Health Policy Institute. Survey results, including full state tables forthcoming, Fall 2003.