

Appendix B

DRUG TREND
2002 Report

Medicaid Prescription Drugs

History

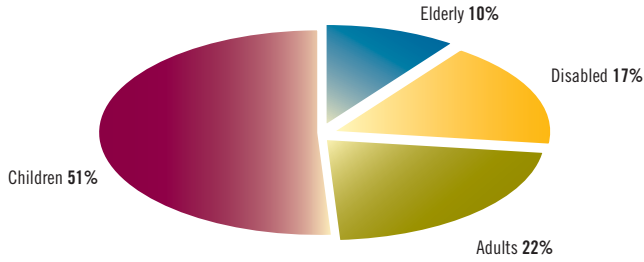
In 1965, amendments to the Social Security Act (SSA) established Medicare and Medicaid. Both programs were designed to provide publicly-funded healthcare for low-income Americans across the nation. Initially, Medicaid covered limited healthcare services for certain children and the relatives taking care of them, as well as for elderly, blind and disabled people unable to afford health insurance. Program expansions have extended benefits for eligible recipients to include prenatal and infant care; preventive, diagnostic and treatment services for children; medical care for the working poor and a wide range of other services.

Enrollment

About one American in seven uses Medicaid at some time in a given year.¹ During FY 2002, Medicaid served nearly 48 million recipients (approximately 24 million children, 13 million elderly or disabled people and 11 million non-elderly, non-disabled adults)² (See Figure B1). While children make up the largest group of Medicaid recipients, they account for less than 20 percent of Medicaid spending.³ Approximately two-thirds of Medicaid money covers care for about one-third of participants who are elderly or disabled.^{4,5} By 1998, for instance, Medicaid was responsible for medical costs incurred by as many as 90 percent of American children living with AIDS and more than half of all U.S. AIDS victims.⁶ Because of the large percentage of high healthcare utilizers among Medicaid recipients, people on Medicaid use services more intensely than the general population.⁷

- 1 Kaiser Commission on Medicaid and the Uninsured. State budgets under stress: how are states planning to reduce the growth in Medicaid costs? July 30, 2002. Available at: <http://www.kff.org/content/2002/20020730/20020730.pdf>. Accessed October 3, 2002.
- 2 Smith V, Ellis E, Gifford K, Ramesh R, Wachino V. Medicaid spending growth: results from a 2002 survey. Kaiser Commission on Medicaid and the Uninsured. September 2002. Available at: <http://www.kff.org/content/2002/4064/4064.pdf>. Accessed October 3, 2002.
- 3 DeParle N-A. A profile of Medicaid. Chartbook 2000. Health Care Financing Administration. U.S. Department of Health and Human Services. September 2000. Available at: <http://cms.hhs.gov/statistics/2Tchartbk.pdf>. Accessed November 12, 2002.
- 4 Smith V, Ellis E, Gifford K, Ramesh R, Wachino V. Medicaid spending growth: results from a 2002 survey. Kaiser Commission on Medicaid and the Uninsured. September 2002. Available at: <http://www.kff.org/content/2002/4064/4064.pdf>. Accessed October 3, 2002.
- 5 Fenz C. State Coverage Initiatives Issue Brief. State health care spending: a systems perspective. 2002;3(1). Available at <http://www.statecoverage.net/pdf/issuebrief502.pdf>. Accessed October 16, 2002.
- 6 Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. Fact Sheet. Medicaid and acquired immune deficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection. Last updated April 18, 2002. Available at: <http://cms.hhs.gov/hiv/hivfs.asp>. Accessed November 12, 2002.
- 7 Smith V, Ellis E, Gifford K, Ramesh R, Wachino V. Medicaid spending growth: results from a 2002 survey. Kaiser Commission on Medicaid and the Uninsured. September 2002. Available at: <http://www.kff.org/content/2002/4064/4064.pdf>. Accessed October 3, 2002.

Figure B1
Medicaid Enrollment Sectors 2001



Adapted from: Kaiser Commission on Medicaid and the Uninsured. State budgets under stress: how are states planning to reduce the growth in Medicaid costs? July 30, 2002. Available at: <http://www.kff.org/content/2002/20020730/20020730.pdf>. Accessed October 3, 2002.

Enrollment Volatility

The Medicaid population is highly volatile, with some enrollees changing status frequently — usually when income changes. According to the *2000 HCFA Chartbook*, the average length of time that any person is eligible annually is 9 months.⁸ Income eligibility for most optional and mandatory eligibility groups is tied to the federal poverty limit (FPL), which was set for FY 2002 at \$8,860 for an individual and \$18,100 for a family of four in the contiguous 48 states or the District of Columbia.⁹ Alaska, Hawaii and the territories use slightly different thresholds to administer their programs.

In one notable exception to the income eligibility rules, states may choose to extend Medicaid coverage to low-income, uninsured women under the age of 65 who need treatment for breast or cervical cancer, as discovered through the Centers for Disease Control and Prevention’s National Breast and Cervical Cancer Early Detection program. Most states participating in the program waive income and asset limits for women who qualify under the Federal Breast and Cervical Cancer Prevention and Treatment Act of 2000.

8 DeParle N-A. A profile of Medicaid. Chartbook 2000. Health Care Financing Administration. U.S. Department of Health and Human Services. September 2000. Available at: <http://cms.hhs.gov/statistics/2Tchartbk.pdf>. Accessed November 12, 2002.
 9 67 Fed. Reg. 6931 (February 14, 2002) Annual Update of the HHS Poverty Guidelines. From the Federal Register Online via GAO Access. Available at: <http://frwebgate1.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=38012827632+0+0+0&WAISSaction=retrieve>. Accessed November 15, 2002.

Eligibility Requirements

To comply with federal requirements, states/territories must extend Medicaid to:

- Families who receive Temporary Assistance for Needy Families (TANF) cash assistance
- Children under 6 with family income under 133 percent of the FPL
- Pregnant women and children under age 1 with family income under 133 percent of the FPL
- People receiving SSI (unless the state is a 209(b) state)
- Some Medicare recipients
- Children under age 18 in families with incomes below 100 percent of the FPL¹⁰

It should be noted that for the mandatory category TANF, the state establishes a percent of the federal poverty level. For example, in one state the eligibility income level may be set at 40 percent and in another at 77 percent of the federal level.

The administering jurisdiction may also choose to cover other populations that may include:

- Low-income parents (beyond the mandatory TANF group)
- Medically needy individuals (those with high medical bills who would be eligible if their incomes/assets were low enough)¹¹
- Some working disabled people who would qualify for Supplemental Security Income (SSI) if they did not have work income
- Individuals residing in nursing facilities with incomes between 100 percent and 300 percent of SSI
- Individuals living in community settings but who would be eligible if they were institutionalized

Medicaid enrollment is on the rise. The recent recession means more unemployment and, therefore, more people eligible for Medicaid, as well as less state revenues to fund the growing Medicaid population. One estimate is that Medicaid will gain approximately 1.6 million new enrollees for each percentage point that unemployment rises.¹² In addition, an aging population means more low-income elderly participants will enter the system. For FY 2003, general enrollment is expected to increase about 9 percent across the states.¹³

The Administration's 2004 federal budget proposed significant changes to the Medicaid structure. Under the proposed new rules, states would be allowed to revise their Medicaid programs for optional recipients without needing to obtain federal waivers. Approximately one-third of Medicaid

10 Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. Medicaid: a brief summary. Last Updated July 30, 2002. Available at: <http://cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp>. Accessed September 25, 2002.

11 Coughlin TA, Zuckerman S. States' use of Medicaid maximization strategies to tap federal revenues: program implications and consequences. Urban Institute. June 2002. Available at: http://www.urban.org/UploadedPDF/310525_DP0209.pdf. Accessed October 29, 2002.

12 Smith V, Ellis E, Gifford K, Ramesh R, Wachino V. Medicaid spending growth: results from a 2002 survey. Kaiser Commission on Medicaid and the Uninsured. September 2002. Available at: <http://www.kff.org/content/2002/4064/4064.pdf>. Accessed October 3, 2002.

13 Smith V, Ellis E, Gifford K, Ramesh R, Wachino V. Medicaid spending growth: a 50-state update for fiscal year 2003. Kaiser Commission on Medicaid and the Uninsured. January 2003. Available at: <http://www.kff.org/content/2003/20030113/4082.pdf>. Accessed January 14, 2003.

recipients receive benefits under programs states choose to offer. Benefits could be extended — or denied — to specific groups or individuals without affecting the entire population.¹⁴

Greater emphasis would be placed on home and community care settings to prevent or delay institutionalizing Medicaid recipients. In addition, fixed amounts of money rather than matching funds would be given to the states for financing both Medicaid and the State Children's Health Insurance Program (SCHIP). Established in 1997, SCHIP is funded by federally matched block grants that allow states to provide healthcare coverage for children whose family incomes are below 200 percent of the FPL and who do not have private health insurance or Medicaid eligibility. States can use federal funds to initiate child-health programs, expand Medicaid or both. In FY 2002, SCHIP covered about 5.3 million children under the age of 18.¹⁵ States that participate voluntarily in the new system would receive one federal dispersal for acute care and a separate allowance for long-term and community care. Similar to the current SCHIP plan, states could then transfer money between the funds as needed. States that do not opt for the new plan would still operate their Medicaid and SCHIP programs under current rules.¹⁶

Services

Broad general guidelines for Medicaid programs are determined by the Centers for Medicare & Medicaid Services (CMS, formerly the Health Care Financing Administration, or HCFA) of the U.S. Department of Health and Human Services. Each state or territory, however, establishes its own recipient eligibility criteria, service offerings and provider payment scales.¹⁷ The result essentially amounts to 56 different plans with wide variations in the range of services offered.

To qualify for federal funding, each jurisdiction must provide specific basic health services, such as:

- Inpatient and outpatient hospital care
- Laboratory and radiology testing
- Physician services
- Prenatal care
- Family planning
- Vaccinations and periodic health examinations for recipients under 21 years of age (referred to as EPSDT)¹⁸

14 Leuck S. Advocates for poor criticize Bush's Medicaid proposal. *The Wall Street Journal*. February 3, 2003.

15 Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. Fiscal year 2002 number of children ever enrolled in SCHIP — preliminary data summary. January 30, 2003. Available at: <http://cms.gov/schip/schip02.pdf>. Accessed February 17, 2003.

16 Bush administration will propose innovative improvements in states' health coverage for low-income Americans [press release]. U.S. Department of Health and Human Services. January 31, 2003. Available at: <http://hhs.gov/news/press/2003pres/20030131d.html>. Accessed February 11, 2003.

17 Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. Medicaid: a brief summary. Last updated July 30, 2002. Available at: <http://cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp>. Accessed September 25, 2002.

18 Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. Medicaid: a brief summary. Last updated July 30, 2002. Available at: <http://cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp>. Accessed September 25, 2002.

States and territories may also choose to cover more than 30 additional services including:

- Dental care
- Eyeglasses and eye examinations
- Hospice
- Physical therapy
- Prescription drugs
- Prostheses

Any of the Medicaid-offered services — required or optional — can be limited in type, length or extent; but states must assure that services are long enough and broad enough to produce reasonable results. Services must be the same for all Medicaid recipients in the state, unless a waiver designating specific locations as demonstration sites is in effect.¹⁹ In addition, services may not be restricted in ways that could discriminate unfairly against persons with certain conditions or diagnoses.²⁰

Waivers

CMS reviews and approves state proposals for Medicaid service delivery. Major changes may require a waiver, which is a suspension of federal requirements that allows a Medicaid agency to try new ways of providing services. Waivers typically last for a defined period of time, but they can be renewed. Programs authorized under waivers must not be more expensive to the federal government than the services they replace, and they must represent substantial innovations to existing services. Waivers are authorized under two sections of the SSA:

1. A section 1115 “Research and Demonstration” waiver allows states to test pilot programs that may “promote the objectives of the Medicaid program”²¹ and possibly benefit other Medicaid sponsors.
2. A section 1915 “Program” waiver gives Medicaid administrators more flexibility in expanding services for Medicaid recipients — including requiring Medicaid recipients to enroll in managed care programs or developing alternative community-based care systems.

19 Schlosberg C, Jerath S. Fact sheet: prescription drug coverage under Medicaid. National Health Law Program. July 1999. Available at: <http://www.healthlaw.org/pubs/19990808MedicaidDrugs.html>. Accessed November 15, 2002.

20 Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. Medicaid: a brief summary. Last Updated July 30, 2002. Available at: <http://cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp>. Accessed September 25, 2002.

21 Health Care Financing Administration. U.S. Department of Health and Human Services. Medicaid and SCHIP waivers: promoting state flexibility and innovation. May 9, 2001. Available at: <http://www.hhs.gov/news/press/2001pres/01fsmcicaid.html>. Accessed November 27, 2002.

Medicaid Managed Care

Arizona was the last state to implement a Medicaid program in October 1982. Unlike other states, which offered mainly fee-for-service (FFS) Medicaid plans, Arizona obtained federal permission to establish the first statewide all-managed care system, the Arizona Health Cost Containment System, (AHCCS).²² Twenty years later, nearly 60 percent of Medicaid enrollees across the country were in managed care plans²³ (see Figure B2).

After a period of managed care growth, however, health plans began leaving the Medicaid market in the late 1990s as their profits declined. Especially hard hit were large plans with relatively high percentages of non-Medicaid enrollees. Health plans operating on small margins per individual need a big and diverse pool of participants, but welfare reform reduced Medicaid enrollments. At the same time, some states drastically cut the rates paid to the plans.

Currently operating in the District of Columbia, in some of the territories and in every state except Alaska and Wyoming, Medicaid managed care programs range from nearly “universal” care to very limited programs for specific populations. Most states and territories use mixed models that combine two basic types of features:

1. In the HMO or prepaid health plan model, providers receive a capitated fixed monthly fee for each recipient. The provider assumes financial risk for services that exceed the payment. In 2001, approximately 70 percent of Medicaid managed-care enrollees were in a prepaid plan.^{24,25}
2. The primary care case management (PCCM) model uses a primary physician, physician assistant or nurse practitioner “gatekeeper” to coordinate care for individual Medicaid recipients. Providers assume no financial risk, receiving instead a set monthly case management fee for each recipient.^{26,27}

A recent report from the Center for Health Care Strategies used representative prescription cost and utilization data to compare FFS and managed care Medicaid plans. While the study found that prescription prices paid to pharmacies before rebates were about the same for both types of plan, managed Medicaid was able to achieve a 10 percent to 15 percent lower overall cost for

22 Arizona Health Care Cost Containment System. 2001 AHCCCS Overview: Chapter 1. Beginnings and future of AHCCCS. 2001. Available at: http://www.ahcccs.state.az.us/Publications/Overview/2001/Chapter1/Chap1_2001.asp. Accessed November 26, 2002.

23 Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. National summary of Medicaid managed care programs and enrollment. June 30, 2002. No Date Given. Available at: <http://cms.hhs.gov/medicaid/managedcare/trends01.pdf>. Accessed December 10, 2002.

24 Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. Medicaid drug rebate program. Last updated May 22, 2002. Available at: <http://cms.hhs.gov/medicaid/drugs/drughmpg.asp>. Accessed November 26, 2002.

25 Kaiser Commission on Medicaid and the Uninsured. Medicaid and Managed Care. December 2001. Available at: <http://www.kff.org/content/2001/206803.pdf>. Accessed September 23, 2002.

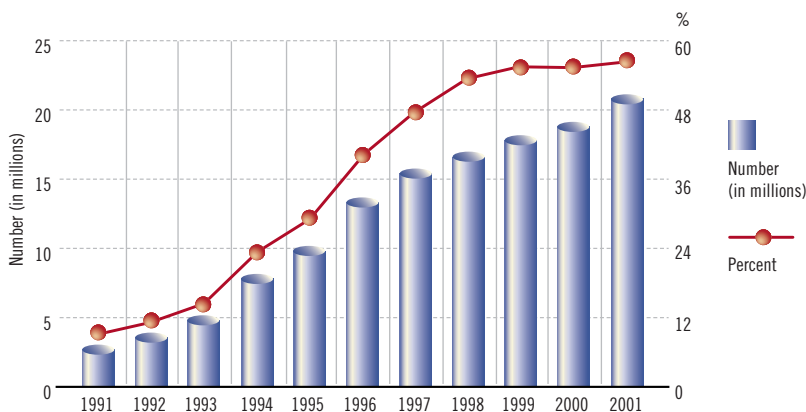
26 Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. Medicaid drug rebate program. Last Updated May 22, 2002. Available at: <http://cms.hhs.gov/medicaid/drugs/drughmpg.asp>. Accessed November 26, 2002.

27 Kaiser Commission on Medicaid and the Uninsured. Medicaid and Managed Care. December 2001. Available at: <http://www.kff.org/content/2001/206803.pdf>. Accessed September 23, 2002.

pharmacy services. In general, FFS plans received larger average rebates. Managed care plans, however, more than made up the difference by paying much lower dispensing fees, using stricter formularies and increasing generic utilization. Although selection bias and different requirements for retrospective coverage may have influenced the finding, managed pharmacy plans also appeared to result in significantly fewer prescriptions dispensed PMPM, as well.²⁸

Figure B2

Growth of Enrollment in Medicaid Managed Care Programs by Percent of Recipients 1991-2001



Adapted from: Centers for Medicare and Medicaid Services. National Summary of Medicaid Managed Care Programs and Enrollment. Managed Care Trends. June 30, 1996. Available at: <http://www.cms.hhs.gov/medicaid/namagedcare/trends1.pdf> and National Summary of Medicaid Managed Care Programs and Enrollment. June 30, 2001. Available at: <http://www.cms.hhs.gov/medicaid/namagedcare/trends01.asp>. Both accessed February 18, 2003.

Prescription Drug Coverage and Pricing

Even though a drug benefit is optional under Medicaid, all states and territories provide at least some outpatient prescription drug coverage.²⁹ Averaging about 10 percent of the total Medicaid spending in each state,³⁰ prescription drugs cost Medicaid programs nearly \$12 billion in FY 1998. In comparison, Medicaid expenditures in FY 1998 included \$44 billion for long-term institutional care, almost \$29 billion for hospitalizations, close to \$28 billion for health insurance, about \$12 billion for community-based long-term care, nearly \$7 billion for physician services and approximately \$6 billion for ancillary medical services such as laboratory tests and X-rays.³¹

28 Beronja N, Menges J, Cheng A. Comparison of Medicaid pharmacy costs and usage between the fee-for-service and capitated setting. Center for Health Management Strategies. January 2003. Available at: <http://www.chcs.org/resource/pdf/CHCSpharmacy.pdf>. Accessed February 21, 2003.

29 Yacker HG. Outpatient prescription drugs: acquisition and reimbursement policies under selected federal programs. August 9, 1999. Available at: <http://rxpolicy.com/studies/crs-oupatientpaying-0899.pdf>. Accessed November 25, 2002.

30 Smith V, Ellis E, Gifford K, Ramesh R, Wachino V. Medicaid spending growth: results from a 2002 survey. Kaiser Commission on Medicaid and the Uninsured. September 2002. Available at: <http://www.kff.org/content/2002/4064/4064.pdf>. Accessed October 3, 2002.

31 DeParle N-A. A profile of Medicaid. Chartbook 2000. Health Care Financing Administration. U.S. Department of Health and Human Services. September 2000. Available at: <http://cms.hhs.gov/statistics/2Tchartbk.pdf>. Accessed November 12, 2002.

Federal Government Price Discounts

The federal government negotiates discounted prices from pharmaceutical manufacturers for the large volume of drugs used by the Public Health Service, the Veterans' Administration and military personnel and their dependents. With a few exceptions, the price paid by the federal government under contracts is the lowest price available to any customer — including not-for-profit organizations, private providers and wholesalers.³²

Drug Rebates

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) established drug rebates so that states could take advantage of volume drug buying power, as well. Unlike the federal government, however, states do not buy drugs directly from manufacturers, but participate in a rebate system. Manufacturers are required to have national rebating agreements with CMS before their branded drugs can be reimbursed through Medicaid or state-funded prescription programs for the low-income elderly. Rebates for brand-name drugs are set at 15.1 percent of the Average Manufacturer Price (AMP), or 100 percent of the difference between the AMP and the best price. The AMP is the average price of a drug product distributed through retail pharmacies. For generics and OTCs, the rebate is 11 percent.^{33,34} The best price is the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity or governmental entity within the United States, excluding federal government contract prices and any state pharmacy assistance programs. Some states allow Medicaid managed care plans to negotiate their own manufacturer rebate contracts. In these cases, the expected rebate amounts are built into the state capitation payment to the plan.

In a move to contain Medicaid cost for FY 2004, CMS officials have proposed replacing the best price system with a standard discount they feel will mean bigger rebates for all public and private purchasers. Citing confusion over the ways best price is determined, as well as its potential restriction on the rebates that private suppliers can realize, CMS has suggested a flat rate discount — in the 25 percent range — applied to the average wholesale price (AWP) instead of to the AMP.³⁵ Nominally, AWP is a national average of the prices that pharmacies and physicians actually pay to drug wholesalers.

Under the current system, Medicaid programs must cover all drugs from manufacturers that enter into rebate agreements with the CMS. Exceptions are made for specific classes, such as cosmetic and experimental drugs, which are excluded from coverage, and for some drugs that require prior authorization before dispensing. Manufacturers make quarterly rebates to each state based on the

32 Mangano M. U.S. Department of Health and Human Services. Office of the Inspector General. Medicaid drug rebates — sales to repackagers excluded from best price determinations. March 2001. Available at: <http://oig.hhs.gov/oas/reports/region6/60000056.pdf>. Accessed November 25, 2002.

33 U.S. General Accounting Office. Prescription Drugs. Expanding access to federal prices could cause other price changes. August 2000. Available at: <http://www.gao.gov/new.items/he00118.pdf>. Accessed November 25, 2002.

34 Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. Medicaid drug rebate program. Last Updated May 22, 2002. Available at: <http://cms.hhs.gov/medicaid/drugs/drugmpg.asp>. Accessed November 26, 2002.

35 CMS wants bigger Medicaid rebates, elimination of "best price." *The Pink Sheet*. 2003;65(6):13.

amount of drugs dispensed.³⁶ The Medicaid agencies, in turn, reimburse participating pharmacies.³⁷ Partly in response to legal challenges on behalf of pharmaceutical manufacturers, the CMS formally restated in September 2002 that individual Medicaid programs can negotiate their own supplemental rebates directly with manufacturers and can establish a preferred drug list as a mechanism for obtaining additional rebates from manufacturers. Drugs not on that list require prior authorization.³⁸ Rebate amounts reflect a percent of the state's net drug spend, and depend on both the volume of specific drugs that are used and the state's arrangements with individual drug manufacturers. In 1999, a sample of state pharmaceutical programs reported receiving a wide range of rebate dollars, with the most common amounts being in the 10 percent to 20 percent range.³⁹

Other Volume-Based Price Discounts

To acquire even better volume pricing, some individual states combine their drug purchasing for several departments, such as employees' health plans, health departments, prison systems and Medicaid. Additionally, states are beginning to join purchasing groups so they can attain more efficiency in the acquisition of pharmaceuticals.

Expenditures

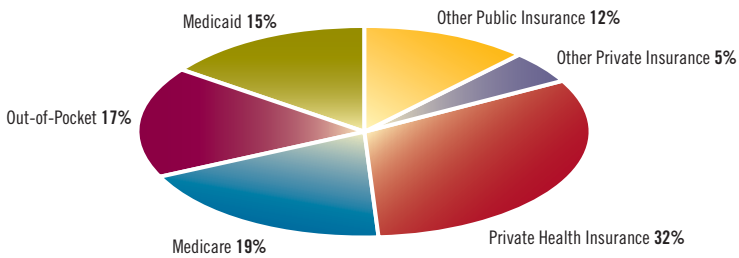
In 1966, the first full year of its operation, Medicaid spending amounted to under \$1 billion on behalf of about 4 million recipients.⁴⁰ For FY 2002 (July 1, 2001 through June 30, 2002), the estimated total Medicaid expenditure was \$248 billion, with about \$142 billion from federal funding and the rest from the state and local governments.⁴¹ Original enrollment has multiplied nearly 12-fold, and the average annual outlay per participant has increased from about \$200 to over \$6,000.⁴² In 2002, Medicaid spending increased 13.4 percent overall, after an 11 percent rise in 2001.⁴³ For FY 2003 total Medicaid spending is expected to increase by about 9 percent on average.⁴⁴

-
- 36 Yacker HG. Outpatient prescription drugs: acquisition and reimbursement policies under selected federal programs. August 9, 1999. Available at: <http://rxpolicy.com/studies/crs-oupatientpaying-0899.pdf>. Accessed November 25, 2002.
- 37 Hansen J. United States prescription drug pricing and reimbursement policies. The European Agency for the Evaluation of Medicinal Products. No Date Given. Available at: <http://pharmacos.eudra.org/F3/g10/docs/tse/USA.pdf>. Accessed November, 25 2002.
- 38 Smith DG. Letter to State Medicaid Directors. September 18, 2002. Available at: <http://www.cms.hhs.gov/states/letters/smd91802.pdf>. Accessed November 25, 2002.
- 39 U.S. General Accounting Office. State pharmacy programs. Assistance designed to target coverage and stretch budgets. Available at: <http://www.gao.gov/new.items/he00162.pdf>. Accessed November 25, 2002.
- 40 Klemm JD. Medicaid spending: a brief history. Health Care Financing Review. 2000;22(1):105-112.
- 41 Holahan J. Variations among states in health insurance coverage and medical expenditures: how much is too much? The Urban Institute. June 2002. Available at: http://www.urban.org/UploadedPDF/310520_DP0207.pdf. Accessed October 29, 2002.
- 42 Klemm JD. Medicaid spending: a brief history. Health Care Financing Review. 2000;22(1):105-112.
- 43 National Governors Association and National Association of State Budget Officers. The fiscal survey of states. May 2002. Available at: <http://www.nasbo.org/Publications/fiscsurv/may2002fiscalsurvey.pdf>. Accessed September 23, 2002.
- 44 Smith V, Ellis E, Gifford K, Ramesh R, Wachino V. Medicaid spending growth: a 50-state update for fiscal year 2003. Kaiser Commission on Medicaid and the Uninsured. January 2003. Available at: <http://www.kff.org/content/2003/20030113/4082.pdf>. Accessed January 14, 2003.

The late 1990s saw large increases in Medicaid expenditures spurred by federal and state initiatives, as well as by factors that could not be predicted, such as the AIDS epidemic. Now the largest funding source for healthcare among the poor in America, Medicaid is also among the largest part of each state’s budget. After education, it is the second largest expenditure for each state, totaling, in the aggregate, an average of 19.5 percent of budgets in FY 2002.⁴⁵ According to a survey of state Budget Officers, the biggest contributors to recent increases in Medicaid spend are from:

- Prescription drugs
- Nursing home care
- Long-term community-based care
- Health plan payments⁴⁶ (see Figure B3)

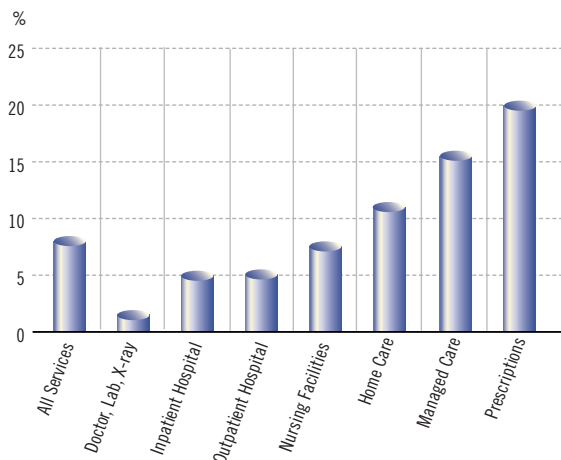
Figure B3
Medicaid Spending as a Percent of All Health Spending 1998



Adapted from: DeParle N-A. A profile of Medicaid. Chartbook 2000. Health Care Financing Administration. U.S. Department of Health and Human Services. September 2000. Available at: <http://cms.hhs.gov/statistics/2Tchartbk.pdf>. Accessed November 12, 2002.

45 National Governors Association and National Association of State Budget Officers. The fiscal survey of states. May 2002. Available at: <http://www.nasbo.org/Publications/fiscsurv/may2002fiscalsurvey.pdf>. Accessed September 23, 2002.
 46 National Association of State Budget Officers and National Governors Association. Medicaid and other state healthcare issues: the current situation. May 2002. Available at: <http://www.nasbo.org/Publications/PDFs/fsmedicaidmay2002.pdf>. Accessed September 23, 2002.

Figure B4

Growth Rates in Each Type of Expenditure 1998-2000

Adapted from: Kaiser Commission on Medicaid and the Uninsured. State budgets under stress: how are states planning to reduce the growth in Medicaid costs? July 30, 2002. Available at: <http://www.kff.org/content/2002/20020730/20020730.pdf>. Accessed October 3, 2002.

By far the biggest growing segment of almost every state's Medicaid budget is the prescription drug component. Between 1996 and 2001, Medicaid prescription drug expenditures grew by 144 percent, from \$10.2 billion in 1996 to \$24.8 billion in 2001 (See Table B1). The annual rate of growth in prescription drug spend was 9.8 percent between 1996 and 1997; then it grew annually by 20.1 percent, 18.9 percent and 20.9 percent between 1998 and 2000; and jumped by 28.6 percent in 2001. This dramatic growth in aggregate prescription drug costs is due only partially to changes in Medicaid enrollment (See Figure B4). Medicaid enrollment grew by 14.4 percent between 1996 and 2001. Because of a strong economy and new welfare work requirements, Medicaid enrollment actually declined by 4.2 percent between 1996 and 1997 and by 2.1 percent 1997 and 1998, respectively, before growing modestly through 2000. However, as economic conditions worsened and more children were served through expanded Medicaid programs, enrollment rose by 9.8 percent to 36.6 million recipients in 2001. On a PMPM basis, costs between 1996 and 2001 grew by a robust 106.4 percent, with the ebbs and flows of PMPM prescription drug costs mirroring those seen in the aggregate costs figures, indicating that the number of Medicaid recipients played a relatively minor role in this cost explosion.

Table B1

Total Medicaid Prescription Cost 1996-2001 (\$ in millions)

STATE	1996	1997	1998	1999	2000	2001
AK	\$22,652,912	\$27,585,094	\$34,278,008	\$44,595,460	\$56,863,656	\$73,913,702
AL	\$214,725,840	\$222,342,480	\$238,218,688	\$141,873,120	\$258,707,344	\$400,599,777
AR	\$115,935,560	\$131,949,168	\$117,689,360	\$141,572,544	\$213,908,240	\$251,966,280
AZ	N/A	N/A	N/A	N/A	N/A	N/A
CA	\$1,229,832,960	\$1,349,681,280	\$1,648,249,088	\$2,066,267,904	\$2,533,645,312	\$3,057,283,564
CO	\$62,186,532	\$50,554,620	\$111,213,928	\$129,808,040	\$112,321,016	\$129,021,184
CT	\$151,588,432	\$172,702,496	\$147,877,824	\$237,115,952	\$265,818,176	\$308,908,096
DC	\$27,676,754	\$35,702,144	\$40,721,680	\$47,227,824	\$46,394,872	\$59,115,141
DE	\$26,262,956	\$34,843,584	\$32,378,286	\$28,042,914	\$49,628,964	\$61,512,965
FL	\$644,640,128	\$757,986,944	\$894,057,216	\$1,116,200,192	\$1,341,303,040	\$1,508,140,974
GA	\$314,138,976	\$337,595,776	\$288,832,736	\$489,015,648	\$589,638,336	\$741,182,423
HI	\$30,285,508	\$31,486,198	\$38,517,096	\$33,592,148	\$56,756,284	\$32,960,635
IA	\$81,085,488	\$17,822,988	\$100,478,784	\$44,072,412	\$103,820,688	\$187,868,918
ID	\$33,802,708	\$40,312,228	\$26,621,974	\$59,183,064	\$76,250,104	\$98,019,666
IL	\$463,891,648	\$261,310,384	\$611,898,688	\$690,822,336	\$833,848,512	\$965,821,317
IN	\$89,154,808	\$77,445,600	\$75,495,184	\$393,639,232	\$256,746,656	\$595,203,400
KS	\$41,927,724	\$105,635,456	\$119,321,360	\$103,836,072	\$127,139,408	\$191,869,522
KY	\$300,226,112	\$327,725,696	\$321,762,016	\$379,888,480	\$506,781,408	\$632,639,898
LA	\$305,680,544	\$316,861,024	\$354,937,440	\$424,644,000	\$491,903,136	\$582,324,716
MA	\$320,861,440	\$415,087,520	\$508,334,336	\$612,308,544	\$690,727,360	\$825,119,539
MD	\$159,317,856	\$160,868,352	\$99,742,264	\$133,958,952	\$102,436,688	\$252,401,234
ME	\$176,108,544	\$103,255,992	\$120,980,768	\$149,917,344	\$179,881,904	\$205,385,605
MI	\$357,715,712	\$355,218,976	\$354,543,872	\$312,865,888	\$341,014,912	\$623,294,259
MN	\$144,381,488	\$146,414,320	\$163,401,248	\$192,487,760	\$171,119,152	\$273,026,888
MO	\$219,189,792	\$326,682,816	\$386,301,504	\$504,317,824	\$618,370,496	\$525,661,471
MS	\$173,522,096	\$190,193,312	\$216,194,000	\$67,926,008	\$270,486,560	\$469,912,904
MT	\$31,806,020	\$35,776,720	\$40,988,696	\$50,250,684	\$61,321,740	\$74,395,812
NC	\$264,482,832	\$308,883,104	\$480,707,136	\$484,610,464	\$817,920,448	\$1,018,073,252
ND	\$23,150,188	\$23,930,996	\$20,796,460	\$32,606,064	\$38,470,680	\$44,960,036
NE	\$54,684,064	\$82,186,048	\$99,787,824	\$120,912,464	\$143,045,328	\$174,798,602
NH	\$20,132,966	\$41,221,872	\$54,835,152	\$69,076,272	\$45,766,716	\$50,061,353
NJ	\$363,044,032	\$369,383,168	\$416,317,632	\$498,670,240	\$585,815,680	\$644,422,410

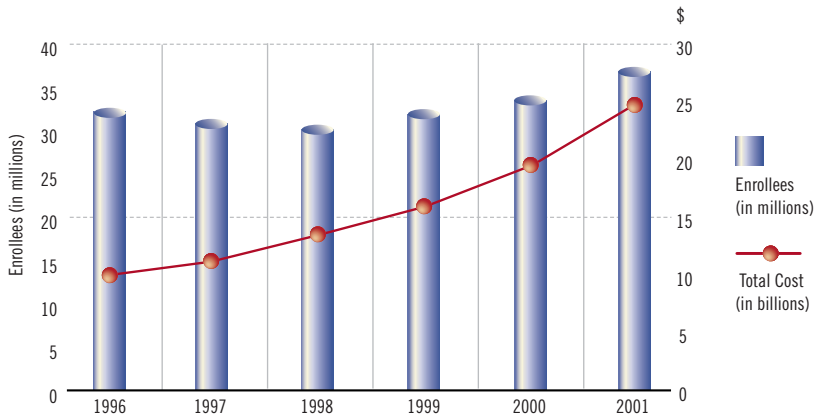
STATE	1996	1997	1998	1999	2000	2001
NM	\$63,177,252	\$60,520,568	\$39,257,704	\$43,470,856	\$51,427,124	\$62,619,361
NV	\$18,986,590	\$12,752,982	\$35,126,896	\$41,358,852	\$53,899,244	\$67,219,840
NY	\$977,705,216	\$1,179,280,000	\$1,578,070,400	\$2,002,225,408	\$2,431,010,304	\$2,928,037,396
OH	\$397,066,720	\$450,933,152	\$662,439,360	\$793,736,576	\$918,909,632	\$1,172,485,407
OK	\$102,954,752	\$116,453,336	\$141,473,776	\$168,218,288	\$186,678,688	\$226,818,621
OR	\$69,046,136	\$76,583,744	\$96,748,080	\$130,533,896	\$174,673,248	\$238,591,713
PA	\$421,090,432	\$533,202,496	\$550,914,816	\$175,416,112	\$313,010,720	\$704,679,608
RI	\$35,521,852	\$52,651,104	\$64,809,252	\$77,146,880	\$91,885,648	\$51,898,926
SC	\$125,836,600	\$148,398,960	\$176,488,736	\$306,686,752	\$400,135,264	\$442,694,984
SD	\$21,433,930	\$28,560,276	\$28,341,832	\$34,746,092	\$40,848,668	\$53,426,657
TN	N/A	N/A	N/A	\$168,709,952	\$378,674,208	\$728,891,310
TX	\$674,936,704	\$761,227,584	\$830,905,664	\$980,665,920	\$837,284,160	\$1,375,879,987
UT	\$47,544,024	\$50,378,992	\$70,671,056	\$84,383,304	\$74,907,552	\$114,555,945
VA	\$220,780,640	\$251,110,624	\$289,628,096	\$343,695,264	\$385,415,584	\$431,668,511
VT	\$30,756,826	\$40,902,512	\$31,931,558	\$54,796,320	\$14,604,945	\$18,322,941
WA	\$187,534,912	\$204,092,688	\$246,445,152	\$307,927,424	\$390,384,032	\$478,661,919
WI	\$189,557,904	\$203,087,680	\$235,371,472	\$291,480,896	\$351,614,592	\$399,206,236
WV	\$121,711,408	\$130,796,888	\$161,836,640	\$137,902,896	\$190,561,184	\$250,532,987
WY	\$5,430,774	\$15,179,210	\$18,086,050	\$22,568,148	\$27,456,108	\$23,795,610
Total	\$10,175,165,292	\$11,174,759,152	\$13,424,026,788	\$15,966,975,686	\$19,301,233,721	\$24,829,853,501

Adapted from: Medicaid Statistical Information Systems (MSIS) and HCFA-2082 State Tables. Available at: <http://cms.hhs.gov/medicaid/msis/mstats.asp>. Accessed September 24 and 27, 2002, and October 2 and 16, 2002.

What is unknown due to lack of data is the degree to which the eligibility mix of Medicaid recipients has influenced changes in overall Medicaid prescription drug costs. It is known that SSI recipients are far sicker, and therefore higher utilizers and more costly than other Medicaid eligibility categories. It is also true that SSI recipients are much more likely to maintain their eligibility status than some other eligibility groups. Thus, as is true in the commercial sector, Medicaid prescription drug costs are fueled by higher utilization and increased cost per prescription. But assessing the relative magnitude of utilization versus cost per prescription is more difficult because of the dearth of information pertaining to drug costs by Medicaid eligibility category. Having said that, except for 2001, utilization played a lesser role in driving cost increases than did increases in the cost per prescription (see Figure B5). PMPM utilization increased by only 17 percent between 1996 and

2001. In fact, PMPM utilization actually declined in 1999, grew by less than 2.5 percent in 1997 and 2000, and rose by 8.1 percent and 9.0 percent in 1998 and 2001, respectively (see Table B2). In contrast, cost per prescription increased by over three-quarters between 1996 and 2001, annually rising between 12.4 percent and 14.0 percent from 1996 through 2000, before dropping to a 7.7 percent rate of increase in 2001.

Figure B5

Total Medicaid Prescription Drug Cost vs. Number of Enrollees 1996-2001

Adapted from: Medicaid Statistical Information Systems (MSIS) and HCFA-2082 State Tables. Available at: <http://cms.hhs.gov/medicaid/msis/mstats.asp>. Accessed September 24 and 27, 2002, and October 2 and 16, 2002.

Table B2

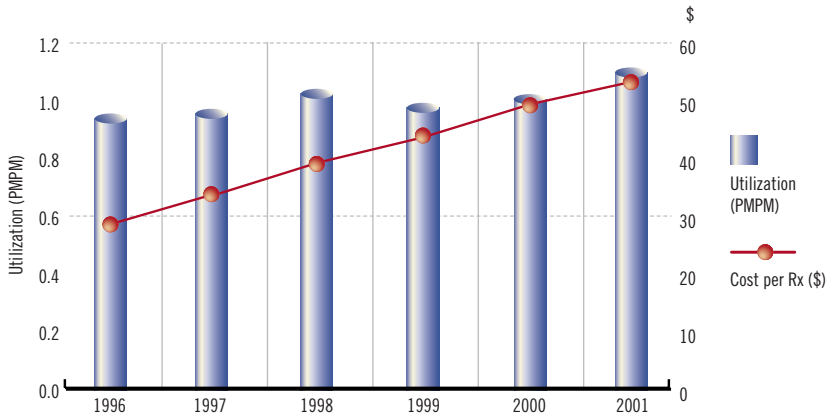
PMPY Medicaid Prescription Drug Use 1996-2001

STATE	1996	1997	1998	1999	2000	2001
AK	0.50	0.56	0.91	0.89	1.05	1.18
AL	1.32	1.29	1.28	0.68	0.91	1.19
AR	0.87	1.25	0.75	0.85	0.93	1.04
AZ	N/A	N/A	N/A	N/A	N/A	N/A
CA	0.70	0.72	0.69	0.73	0.75	0.72
CO	0.64	0.52	1.14	1.22	0.82	0.82
CT	1.15	0.97	0.89	1.23	1.23	1.21
DC	0.53	0.61	0.67	0.64	0.55	0.64
DE	0.92	1.04	0.86	0.56	0.83	0.86
FL	0.96	1.09	1.08	1.07	1.05	1.08
GA	1.19	1.16	0.81	1.17	1.35	1.32
HI	0.58	0.55	0.58	0.45	0.66	0.31
IA	1.56	1.20	1.80	0.47	0.93	1.39
ID	1.13	1.21	0.68	1.22	1.05	1.02

STATE	1996	1997	1998	1999	2000	2001
IL	1.03	0.54	1.16	1.10	1.12	1.17
IN	0.55	0.45	0.39	1.52	0.79	1.51
KS	0.56	1.41	1.52	1.08	1.17	1.56
KY	1.70	1.73	1.57	1.51	1.62	1.80
LA	1.12	1.34	1.48	1.33	1.32	1.27
MA	1.32	1.33	1.22	1.26	1.36	1.31
MD	0.83	0.76	0.41	0.48	0.34	0.57
ME	1.38	1.49	1.51	1.59	1.65	1.60
MI	0.96	0.87	0.81	0.64	0.59	0.92
MN	0.86	0.97	0.92	0.82	0.62	0.78
MO	0.93	1.29	1.29	1.33	1.24	0.99
MS	0.91	0.82	1.13	0.28	0.76	1.05
MT	1.21	1.35	1.49	1.52	1.53	1.60
NC	0.83	0.86	1.20	1.04	1.44	1.56
ND	1.46	1.41	1.15	1.66	1.77	1.81
NE	1.21	1.63	1.53	1.55	1.58	1.61
NH	0.86	1.58	1.78	1.81	0.94	0.86
NJ	1.10	1.01	1.18	1.32	1.31	1.10
NM	0.59	0.70	0.36	0.34	0.33	0.35
NV	0.72	0.31	0.79	0.71	0.72	0.69
NY	0.88	1.09	1.33	1.25	1.33	1.29
OH	1.66	1.11	1.62	1.82	1.54	1.73
OK	0.77	0.60	0.84	0.78	0.75	0.76
OR	0.46	0.48	0.53	0.68	0.77	0.91
PA	0.70	0.82	0.90	0.24	0.42	0.83
RI	1.25	1.05	1.09	0.98	0.98	0.47
SC	0.71	0.70	0.63	0.92	1.18	0.91
SD	0.92	1.13	0.96	0.99	0.96	1.04
TN	N/A	N/A	N/A	0.25	0.60	0.96
TX	0.98	0.96	1.08	1.13	0.83	1.23
UT	1.24	1.14	1.37	1.41	1.07	1.38
VA	0.93	1.27	1.37	1.43	1.51	1.47
VT	1.00	1.04	0.60	0.95	0.21	0.22
WA	0.73	0.68	0.78	0.84	0.90	0.94
WI	1.16	1.23	1.34	1.32	1.31	1.23
WV	1.31	1.29	1.66	1.22	1.49	1.72
WY	0.92	0.73	1.08	1.20	1.18	0.82
Total	0.93	0.95	1.02	0.97	1.00	1.09

Adapted from: Medicaid Statistical Information Systems (MSIS) and HCFA-2082 State Tables. Available at: <http://cms.hhs.gov/medicaid/msis/mstats.asp>. Accessed September 24 and 27, 2002, and October 2 and 16, 2002.

Figure B6

Medicaid PMPM Utilization vs. Cost per Rx 1996-2001

Adapted from: Medicaid Statistical Information Systems (MSIS) and HCFA-2082 State Tables. Available at: <http://cms.hhs.gov/medicaid/msis/mstats.asp>. Accessed September 24 and 27, 2002, and October 2 and 16, 2002.

As one would expect, the distribution of costs is very different in the Medicaid population as opposed to the commercial sector. Medicaid basically covers high-utilizing SSI Aged, Blind and Disabled recipients on one hand, and low-utilizing women and children on the other. By comparison, the commercially insured population comprises more of a cross-section of the overall U.S. population. The distribution of Medicaid drug costs across therapy classes reflects the unique population served. After ranking second in 1996 and 1997, antipsychotics represent the most expensive therapy class for the Medicaid program (see Table B3). The proportion of cost for this class has climbed steadily from 6.9 percent of total prescription drug costs in 1996 to 12 percent in 2002. Again, not surprisingly, costs for antidepressants, anticonvulsants and antivirals are among the top therapy classes in terms of costs over most of the period. Together, these classes accounted for 17.8 percent of the 2001 Medicaid drug spend. Finally, the proportion of total prescription drug costs attributable to antidiabetic and antiasthmatic classes has grown to a combined 8.8 percent in 2001.

Table B3

Percent of Total Cost by Therapy Class, Medicaid vs. Commercial Population

THERAPY CLASS NAME	MEDICAID						COMMERCIAL
	1996	1997	1998	1999	2000	2001	2001
Antipsychotics	6.9%	8.3%	10.1%	11.0%	11.4%	12.0%	1.1%
Antidepressants	6.3%	7.1%	7.6%	7.9%	8.0%	7.9%	8.6%
Gastrointestinals	9.4%	9.2%	8.4%	7.7%	7.9%	7.1%	8.2%
Anticonvulsants	4.6%	4.9%	5.1%	5.3%	5.5%	5.5%	2.2%
Antivirals	3.0%	4.6%	5.0%	5.0%	4.8%	4.4%	2.1%
Antidiabetics	3.1%	3.4%	3.8%	3.7%	4.0%	4.4%	4.5%
Antiasthmatics	4.6%	4.1%	3.6%	3.7%	3.7%	4.4%	3.8%
Anti-Rheum (NSAIDs)	3.1%	2.7%	2.4%	3.3%	4.2%	4.1%	4.9%
Narcotic Analgesics	2.7%	2.8%	2.9%	3.2%	3.5%	3.8%	2.7%
Antihyperlipidemics	2.3%	2.7%	2.9%	3.0%	3.3%	3.6%	8.3%
Antihypertensives	4.2%	3.8%	3.9%	3.8%	3.7%	3.5%	5.4%
Calcium Blockers	5.2%	4.6%	4.0%	3.4%	3.0%	2.6%	2.8%
Misc. Hematologicals	1.9%	1.9%	1.8%	1.8%	1.9%	2.1%	0.7%
Dermatologicals	3.2%	2.8%	2.6%	2.4%	2.2%	2.0%	3.1%
Antihistamines	1.4%	1.3%	1.4%	1.6%	1.8%	2.0%	3.7%
Misc. Endocrines	1.1%	1.4%	1.7%	2.0%	2.1%	2.0%	2.3%
Anticancer	1.5%	1.6%	1.6%	1.5%	1.5%	1.6%	2.2%
Antianxiety Agents	1.7%	1.6%	2.0%	2.1%	1.9%	1.6%	1.1%
Hematopoietic Agents	1.7%	1.6%	1.5%	1.6%	1.6%	1.4%	0.7%
Ophthalmic Products	1.4%	1.4%	1.3%	1.3%	1.2%	1.2%	1.1%
Penicillins	1.9%	1.7%	1.4%	1.3%	1.2%	1.2%	1.6%
Quinolones	1.2%	1.1%	1.2%	1.2%	1.2%	1.1%	1.5%
Stimulants/Weight Loss	0.9%	0.8%	0.8%	0.8%	0.8%	1.0%	1.0%
Cephalosporins	2.7%	2.2%	1.7%	1.4%	1.1%	1.0%	1.0%
Macrolides	1.5%	1.5%	1.3%	1.2%	1.0%	0.9%	1.6%
Other	22.4%	20.7%	19.7%	18.8%	17.6%	17.6%	23.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Indicates the top 10 therapy classes in terms of expenditures.

Adapted from: Medicaid Statistical Information Systems (MSIS) and HCFA-2082 State Tables. Available at: <http://cms.hhs.gov/medicaid/msis/mstata.asp>. Accessed September 24 and 27, 2002, and October 2 and 16, 2002; and from Express Scripts, Inc.

In contrast, of the top 10 classes in terms of Medicaid drug spend, only six (gastrointestinals, antidepressants, antihyperlipidemics, narcotic analgesics, antiasthmatics and NSAIDs) are among the top 10 commercial therapy classes in terms of expenditures. The most pronounced differences between the commercial and Medicaid cost patterns are in antipsychotics, anticonvulsants and antivirals. Medicaid expenditures for antipsychotics are almost 12-fold higher than among commercial plans (12.1 percent versus 1.1 percent), and over twice as high for anticonvulsants and antivirals (5.5 percent and 4.4 percent versus 2.2 percent and 2.1 percent, respectively). Commercial spending for antihyperlipidemics, antihypertensives, dermatologicals and antihistamines is higher than in the Medicaid population.

Maximizing the Federal Share of Medicaid Spending and Controlling Costs

The federal government does not place limits on the amount a state can spend on Medicaid, but states are required to spend their own funds to qualify for federal matching. It is in a state's best interest, then, to direct as much state money as feasible into Medicaid services, and thereby maximize federal matching dollars.

Despite their efforts to maximize federal funding, the states' total estimated Medicaid spending for FY 2002 was still about \$2.8 billion over budget.⁴⁷ At least 40 states experienced significant revenue deficits,⁴⁸ including unexpected Medicaid shortfalls. Most states and territories exempted Medicaid from mid-year 2002 budget cuts,⁴⁹ opting instead for short-term solutions, such as using tobacco settlement money.⁵⁰ Many states have now depleted their one-time reserve funding, and most state revenues are still falling.

Like other sectors of state government, therefore, Medicaid agencies are being forced to reduce expenses. When a state cuts Medicaid costs, though, it must balance the risks with the gains. It loses some federal matching money, but at the same time it also loses the ability to influence the use of health services by individuals who leave the Medicaid system.⁵¹ Reductions in administrative staff could mean delays in beginning service for newly-eligible persons, in authorizing services for enrollees and in paying providers. Reduced payment schedules may force some providers to discontinue treating Medicaid patients. The numbers of people with no healthcare coverage and no access to preventive healthcare are likely to go up, potentially putting extra strain on emergency departments, county and local health facilities, and private charities.

-
- 47 National Association of State Budget Officers and National Governors Association. Medicaid and other state healthcare issues: the current situation. May 2002. Available at: <http://www.nasbo.org/Publications/PDFs/fsmedicaidmay2002.pdf>. Accessed September 23, 2002.
- 48 National Governors Association and National Association of State Budget Officers. The fiscal survey of states. May 2002. Available at: <http://www.nasbo.org/Publications/fiscsurv/may2002fiscalsurvey.pdf>. Accessed September 23, 2002.
- 49 National Governors Association and National Association of State Budget Officers. The fiscal survey of states. May 2002. Available at: <http://www.nasbo.org/Publications/fiscsurv/may2002fiscalsurvey.pdf>. Accessed September 23, 2002.
- 50 Smith V, Ellis E. Medicaid budgets under stress: survey findings for state fiscal year 2000, 2001 and 2002. Kaiser Commission on Medicaid and the Uninsured. October 2001. Available at: <http://www.kff.org/content/2001/4020/4020.pdf>. Accessed October 3, 2002.
- 51 Kaiser Commission on Medicaid and the Uninsured. State budgets under stress: how are states planning to reduce the growth in Medicaid costs? July 30, 2002. Available at: <http://www.kff.org/content/2002/20020730/20020730.pdf>. Accessed October 3, 2002.

Strategies to Reduce Spending on Prescription Drugs

Just as private plans adopt strategies to minimize prescription drug spending, Medicaid programs can also implement a number of cost management approaches. Among the most familiar are:

- Retail Pharmacy Discounts
- Drug Utilization Review (DUR)
- Formularies/Preferred Drug Lists with Supplemental Rebates
- Mandatory Generics
- Prior Authorization
- Quantity Limits
- Step Therapy
- Disease Management⁵²

Some states are beginning to experiment with other methods, such as mail service pharmacy and tiered copayments.⁵³

According to survey information released in January 2003 by the Kaiser Commission on Medicaid and the Uninsured, about half of the states are pursuing ways to curb their costs for prescription drugs under Medicaid. Twelve state Medicaid agencies say that they will require prior authorization for more drugs; nine are beginning or extending lists of preferred products; eight are seeking higher discounts for their prescription drug purchases; seven are establishing or raising participant copayments; five are asking pharmaceutical manufacturers for supplemental rebates; and two are requiring generics. Nine states will be using additional strategies such as limited days' supplies, step therapy and stricter maximum allowable cost (MAC) lists. Despite poor results from previous similar restrictions, five states are also re-imposing limits on the number of prescriptions that can be filled per given time period.⁵⁴

Paradoxically, a number of states have made recent changes to their Medicaid programs in an effort to increase coverage for prescription drugs. Under section 1115 waivers, some states are testing "Pharmacy Plus" strategies that extend a prescription drug benefit to low-income seniors and disabled adults who are not otherwise eligible for Medicaid. More than 30 states have similar, self-funded plans — many probably will apply for a waiver in order to get the federal match.⁵⁵

52 Smith V, Ellis E, Gifford K, Ramesh R, Wachino V. Medicaid spending growth: a 50-state update for fiscal year 2003. Kaiser Commission on Medicaid and the Uninsured. September 2002. Available at: <http://www.kff.org/content/2003/20030113/4082.pdf>. Accessed January 14, 2003.

53 National Conference of State Legislatures. Recent Medicaid Prescription Drug Laws and Strategies, 2001-2003. Updated February 5, 2003. Available at: <http://www.ncsl.org/programs/health/medicaidrx.htm>. Accessed February 25, 2003.

54 Smith V, Ellis E, Gifford K, Ramesh R, Wachino V. Medicaid spending growth: a 50-state update for fiscal year 2003. Kaiser Commission on Medicaid and the Uninsured. January 2003. Available at: <http://www.kff.org/content/2003/20030113/4082.pdf>. Accessed January 14, 2003.

55 Smith V, Ellis E, Gifford K, Ramesh R, Wachino V. Medicaid spending growth: results from a 2002 survey. Kaiser Commission on Medicaid and the Uninsured. September 2002. Available at: <http://www.kff.org/content/2002/4064/4064.pdf>. Accessed October 3, 2002.

Waivers take two distinctive forms:

Subsidies:

Typified by the Illinois SeniorCare Rx program, subsidy-type plans use state and federal funding to cover medications for low- and moderate-income elderly state residents whose income is up to 200 percent of the FPL. Based on their incomes, recipients pay a minimal annual fee and/or a small copayment for each prescription.⁵⁶

Discount Only:

The Healthy Maine Prescription Program, for example, would allow any Maine resident with an income below 300 percent of the current federal poverty limit to buy prescription drugs at the same discounted prices in effect for Medicaid recipients. Although the state would incur some small expense with the plan, the majority of the cost would rest on the users of the benefit.⁵⁷ As the result of legal actions, however, the Healthy Maine Prescription Program and similar plans in other jurisdictions have been suspended. A decision from the U.S. Supreme Court will decide whether states can extend drug benefits to non-Medicaid recipients.

Summary

Since its beginning in 1965, the Medicaid program has grown dramatically in terms of enrollment, scope of covered services and costs. Prescription drugs are among the program services for which costs have grown most substantially. As states try to deal with severely decreasing revenues and rapidly increasing Medicaid costs, they will have to become much more aggressive in controlling higher prescription drug costs. To help meet their budget needs and still provide adequate services, state Medicaid agencies are beginning to adopt many of the approaches used by the private sector to contain prescription costs.

56 National Conference of State Legislatures. States and “pharmacy plus” Medicaid waiver options. Updated November 11, 2002. Available at: <http://www.ncsl.org/programs/health/pharmplus.html>. Accessed November 14, 2002.

57 Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. Fact Sheet. Maine 1115 pharmacy demonstration. No Date Given. Available at: <http://cms.hhs.gov/medicaid/1115/mefs.pdf>. Accessed November 26, 2002.

NOTES

Table of Contents

Preface

Introduction

Trends in Expenditures

Cost Forecast

Specialty Injectables

Actions

Appendix A

APPENDIX B