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Increasing the Cost-Effectiveness of Medicaid Drug Programs

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Medicaid is a joint federal-state program that provides medical care to more than 60 million low-income individuals and families. Over the next few years, Medicaid enrollment is expected to swell and spending is set to explode.

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Introduction

Medicaid is a joint federal-state program that provides medical care to more than 60 million low-income individuals and families.[1] Over the next few years, Medicaid enrollment is expected to swell and spending is set to explode. [See sidebar, "The Growth of Medicaid Enrollment."]

The Importance of Drug Therapies. Drug therapies often substitute for more expensive and less effective surgical treatment and can reduce the need for hospitalization. Americans see their doctors more than 890 million times each year, and two-thirds of office visits to physicians result in prescription drug therapy.[12] Even though they appear to provide better value for money than other forms of therapy, drug expenditures are one of the fastest growing components of the Medicaid program.

Prescription drugs can reduce Medicaid program costs by avoiding expensive emergency room visits and surgeries. Examples include drugs to treat asthma and diabetes. State Medicaid programs could end up paying more for hospital treatments if they do not realize the full benefits of drug therapy.

But reform of drug benefit programs should not be designed to merely lower drug costs. Whereas cost effective drug strategies can reduce costs without harming patient welfare, poorly designed and implemented drug policies can harm patients without even reducing costs because of adverse health effects.[13]

Numerous studies by Columbia University professor Frank Lichtenberg have found that increased spending on newer, patented drug therapies is often offset by spending on inpatient care.[14] Drug treatment for schizophrenia, for example, can help avoid costly hospitalizations. There are a variety of drugs to treat this condition, but some are more effective and better tolerated by some patients than by others. Thus, making it difficult for schizophrenia patients to obtain the appropriate medication could lead to more costly inpatient treatment. Furthermore, recent research by Lichtenberg has found the use of innovator drugs reduces mortality.[15] Patients need access to the drug therapies that treat their conditions and prevent costly complications.

The Growth of Medicaid Enrollment

The *Patient Protection and Affordable Care Act* (ACA) will significantly expand Medicaid eligibility to individuals with incomes from 100 percent to 133 percent of the federal poverty level. The Congressional Budget Office (CBO) estimates the new law will add 16 million Medicaid enrollees.[2] Some estimates put the number of additional enrollees closer to 20 million.[3] The ACA also requires states to streamline their enrollment process — making it easier for eligible populations to apply for and retain Medicaid coverage.[4]

Initially, the federal government will pay 100 percent of the cost for the newly eligible who enroll, and 95 percent of costs through 2019. However, when the individual mandate takes effect in 2014 and requires all legal U.S. residents to obtain health coverage, 10 million or more previously eligible uninsured are likely to be enrolled in Medicaid through outreach efforts.[5] New enrollees who were previously eligible for Medicaid must be paid for under each state's current federal matching formula.[6] Thus, Medicaid spending by the states will soar.[7]

Medicaid rolls in many states have risen over the past several years as a result of the 2008-2009 recession and continuing high unemployment. In 2010 the average growth rate in Medicaid spending was about 8.8 percent.[8] States as a whole now spend more on Medicaid than they spend on primary and secondary education.[9] Indeed, Medicaid is the largest single expenditure by state governments today.[10] Medicaid, which accounts for one-in-every-five dollars of state spending, is on course to consume the entire budgets of state governments in just a few decades.[11]

The Role of Pharmacy Benefit Managers. Private health plans use a variety of techniques to control drug costs, including preferred-drug lists (PDL), formularies, required use of mail-order drug suppliers, negotiated prices with drug companies and drug distributors.[16] Most states use preferred drug lists and formularies to promote the use of cost-effective drugs within specific classes to reduce costs.

Health plans frequently contract with pharmacy benefit managers (PBM), private firms that act as third-party administrators of prescription drug plans. PBMs process and reimburse claims, and negotiate drug prices and rebates with drug manufacturers. They also negotiate dispensing fees — the amount paid to pharmacies for the service of filling a prescription.

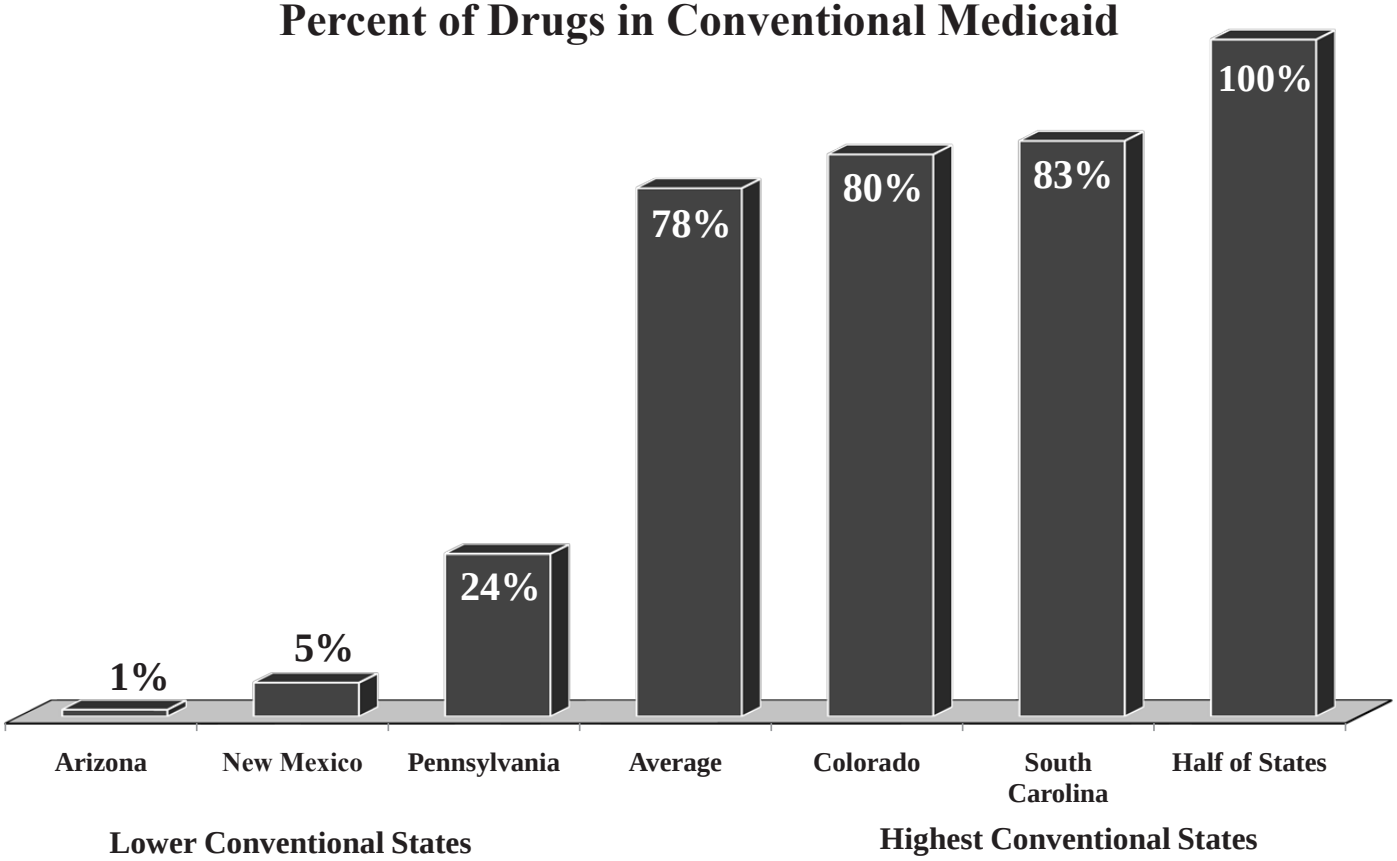
For instance, PBMs manage the pharmacy benefits of the private Medicare Part D drug plans, employer-provided drug plans and some state Medicaid plans.[17] Generally, an employer or government health program pays a managed care health plan a negotiated annual fee per enrollee to provide health services directly, or through contracts negotiated with providers (hospitals and physician groups). Drug benefits are generally included in private health plans through a so-called "carve-in."

Some state Medicaid programs use private health plans extensively to provide coverage for Medicaid enrollees and administer their drug benefits through the plan. However, many states also "carve-out" pharmacy benefits and administer the drug benefits separately from the health plan. This is the way conventional state Medicaid drug benefits are administered for enrollees not in managed care.[18] The way a state Medicaid drug program works varies depending on whether drug benefits are managed by a health plan, administered by a PBM contracting with a state or run by state officials themselves. Regardless of how the program is structured, Medicaid enrollees still usually purchase their drugs at a local pharmacy, which is reimbursed for each prescription filled.

States that manage their own drug benefits may negotiate drug discounts and also receive federally-required drug rebates. The price states pay for drugs is often different from one state to the next; sometimes from one pharmacy to the next. Rather

Figure I

Percent of Drugs in Conventional Medicaid



Source: Joel Menges, Shirley Kang and Chris Park, "Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs were Optimally Managed," Lewin Group, February 2011.

than relying on the negotiated dispensing fees PBMs pay to pharmacies for filling the prescriptions in private plans, states often arbitrarily pay much higher dispensing fees. For instance, most conventional Medicaid programs pay dispensing fees to pharmacies that are higher than in privately run Medicare Part D drug plans. When states manage their own drug plans it often means that state bureaucrats determine the range of drugs physicians can prescribe.

Virtually all state Medicaid programs distribute some of their drugs in this way, and half of the states distribute all of their Medicaid drugs this way. Overall, nearly three-fourths (73 percent) of Medicaid drug spending is reimbursed and administered separately from a health plan.

How Federal Policy Discourages Integrating Drug Programs with Other Benefits. The federal government requires drug manufacturers to rebate to state Medicaid programs at least 23.1 percent of the average manufacturer's (wholesale) price for brand drugs and 13 percent for generic drugs. States often negotiate additional rebates so total Medicaid rebates average nearly 40 percent.[19] Prior to the Patient Protection and Affordable Care Act (ACA), the rebates were only available for drugs in the separate programs administered by state Medicaid agencies. The drug rebates were not available to drug plans operated by private health plans under contracts with state Medicaid programs. Thus, in order to receive the rebates, many states chose to separate (or "carve-out") drug benefits and administer them separately from the integrated health plans operated by private contractors.[20]

State Medicaid programs that carve-out drug benefits often do not pay sufficient attention to coordination

Potential Savings in Texas

The Texas Health and Human Services (HHS) Commission predicts Texas' Medicaid rolls will climb from an estimated population of 1.81 million enrollees in 2014 to 2.35 million enrollees in 2023, nearly a decade after the ACA's implementation in 2014. Of the 2.4 million additional enrollees, only 1.5 million enrollees will be newly eligible due to the ACA. About 824,000 of those individuals were eligible before the ACA but not enrolled. Due to these new enrollees, Medicaid expansion in Texas will cost more than $27 billion over the first 10 years, according to the Texas HHS Commission.[25]

Texas ranks in the top five states with the greatest opportunity to save money through better Medicaid drug program administration (another large state with significant opportunity is California). With that enormous tab looming, Texas needs to look for ways to cut waste in its Medicaid program — drug program optimization would be a good place to start.

Nearly two-thirds (64.6 percent) of Texas Medicaid enrollees are in managed care plans.[26] But 100 percent of its Medicaid drug program is run by conventional Medicaid. In 2011, Texas legislators began debating whether or not to integrate more prescription drug benefits with the Medicaid managed care health plans in which many Texans are enrolled.

The Lewin Group, a health and human services consulting firm, estimates that Texas could reduce its Medicaid drug costs by nearly one-fifth (19 percent) if it optimally managed Medicaid prescription drug benefits using four of the five strategies outlined below.[27]

One example of a cost saving is allowing PBMs to negotiate the dispensing fees paid to pharmacies for filling a prescription. Currently, these fees are set by the state. At $7.50, the Medicaid dispensing fee in Texas ranks near the highest — more than 50 percent higher than the national average of $4.81.[28] It is also nearly four times as much as the average Medicare Part D drug plan dispensing fee (about $2). Only a few states are higher than Texas: Alaska (up to $11.46), Alabama ($10.64) and California ($7.25).

Using all four strategies Lewin recommends, Texas could save to nearly $273 million in 2012. Over the course of a decade (2012-2021), Texas would save nearly $1.2 billion. The federal government would save about double that amount ($2.6 billion).[29]

and management of drug therapies. This responsibility is essentially taken away from health plans and taken over by the state. This can lead to drug policies that can harm patients.[21] For instance, the state of New Hampshire implemented an arbitrary prescription limit on psychiatric drugs in 1990 that led to an increase in the use of emergency mental health services and hospitalizations for people with schizophrenia. The additional medical costs associated with poor medication management was 17 times the savings from limiting prescriptions.[22]

Potential Savings from Integrating Drug Benefits and Coordinating Care. The Lewin Group has found that drug benefit programs that are integrated with privately-run health plans are more cost-effective than when they are administered separately.[23] Indeed, a Lewin analysis commissioned by Medicaid Health Plans of America, a trade association of Medicaid managed care providers, found that integrating Medicaid health plan and drug benefits in 14 states that currently exclude drug coverage from Medicaid private health plans would collectively save nearly $12 billion over a decade.[24] [For example, see the sidebar "Potential Savings in Texas."]

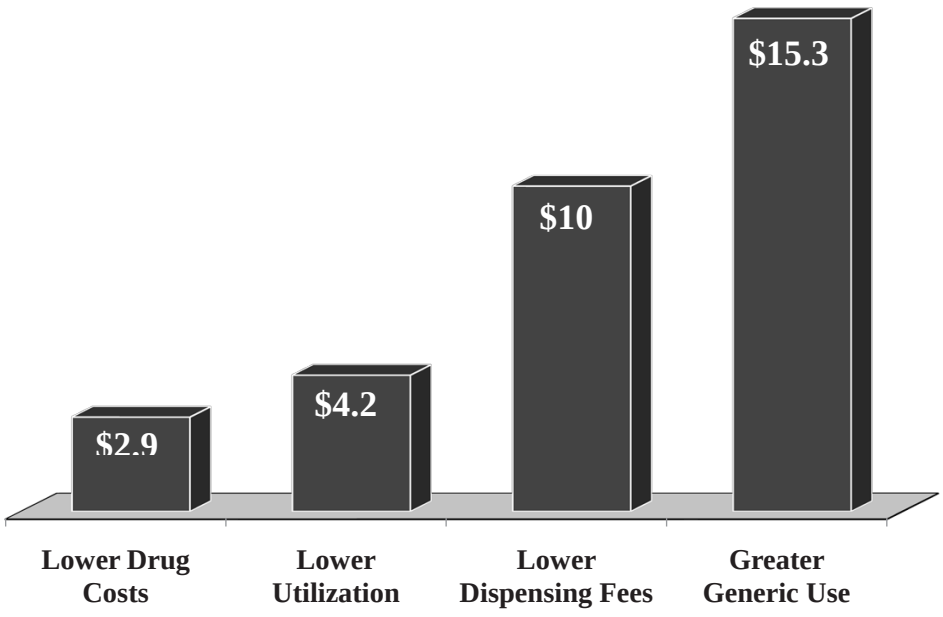
Five Cost-Saving Strategies

There are several effective strategies that states can use to better manage and lower Medicaid drug costs, according to the Lewin Group and other researchers.

Five important ones are: (1) encouraging generic drug use when appropriate, (2) paying competitive market rates for drug dispensing, (3) coordinating and tracking drug therapies, (4) establishing reimbursement rates for drug makers similar to what commercial drug plans pay, and (5) empowering patients with control of some of the dollars spent on their drug therapies so that they become better consumers. The Lewin Group estimates that the state and federal governments could save $32.7 billion over 10 years by improving the efficiency of their Medicaid drug programs without detriment to enrollees' health.[30] [See Figure II.] Ideally, coordinated care would improve the quality of health care received by Medicaid enrollees. Following is a brief discussion of each strategy.

Figure II

Potential Savings on Medicaid Drugs (2012–2021 in billions)



Note: Figures represent both federal and state share.

Source: Joel Menges, Shirley Kang and Chris Park, "Potential Federal and State-by-State Savings if Medicdaid Pharmacy Programs were Optimally Managed," Lewin Group, February 2011.

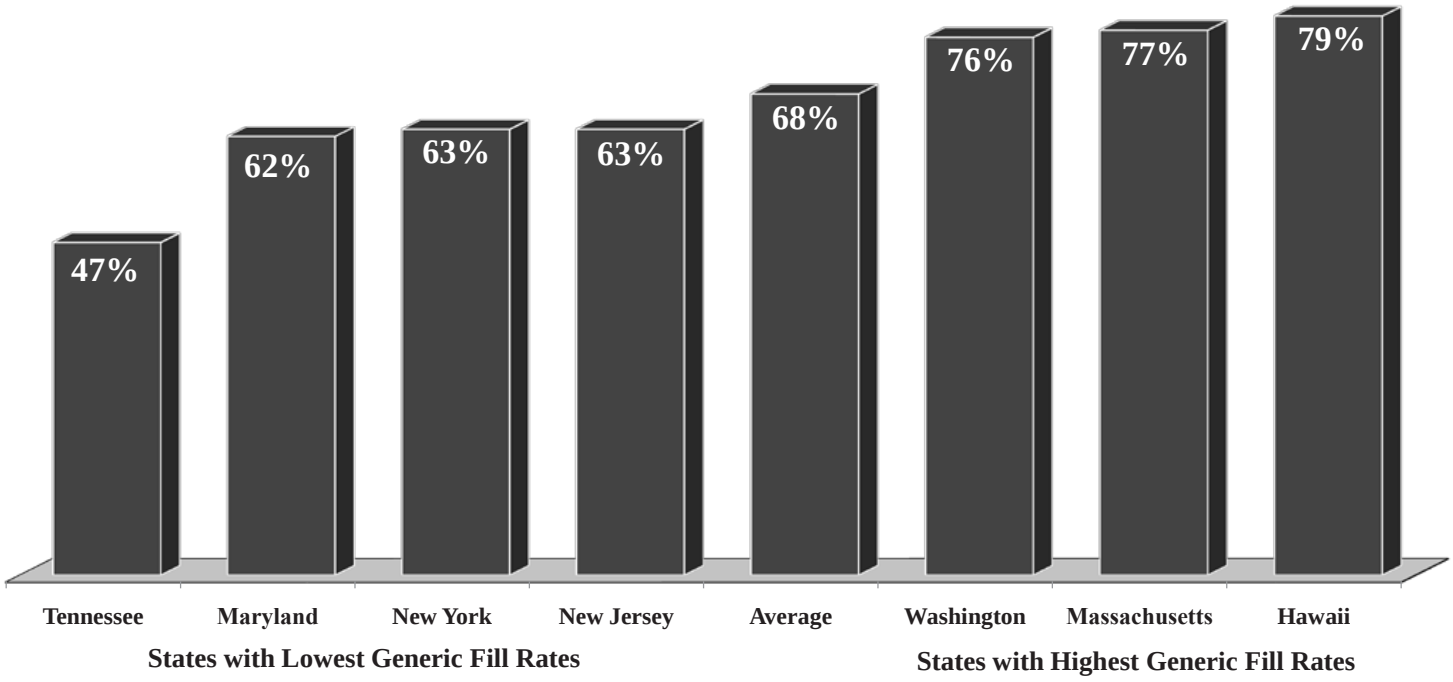
Cost-Saving Strategy No. 1: Encouraging Generic Drug Use Where Appropriate. There are numerous drug therapies to treat most conditions, some of which cost more than others. Patients can lower drug expenditures by taking the generic version of medications when a generic is available. Generic drugs are a great value: The U.S. health care system saved $824 billion over the past decade from the use of generic drugs, according to one estimate.[31] For retail customers, generic drugs are generally priced 20 percent to 80 percent lower than the original branded drug.[32] Only those medications whose patent has expired are available in generic form, however. Some well-known drugs that have recently lost patent protection include Prozac and Zoloft (for depression), Claritin, Allegra and Zyrtec (for allergy relief), Zocor (to lower blood cholesterol), and Prevacid and Prilosec (for ulcers and gastric reflux disease). The number of generic equivalents available will increase over the next few years as many so-called blockbuster drugs lose patent protection and face generic competition. Indeed, many of the current top-selling name brand drugs will have lost patent protection by the end of 2014.[33]

Today about 78 percent of the prescriptions Americans fill are generic drugs.[34] This compares to about 19 percent in 1985.[35] Two-thirds of the drugs dispensed by the Veterans Affairs (VA) health system are generic, but they represent only 8 percent of the VA's prescription costs.[36] Though generic drugs are widely prescribed, there are potential savings from even wider use:

- Generic drugs make up two-thirds of all Medicaid prescriptions, but less than one-quarter (22 percent) of Medicaid drug spending.[37]
- The average cost of a generic drug prescription in the Medicaid program is $20.61, compared to the $195.54 average for name brand medications (including drugs for which there is no generic equivalent).

Figure III

Use of Generic Drugs in Conventional Medicaid (percent of prescriptions)



Source: Joel Menges, Shirley Kang and Chris Park, "Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs were Optimally Managed," The Lewin Group, February 2011.

States have an opportunity to save money by encouraging generic drug utilization when appropriate. Indeed, most patients should probably consider a generic drug with the understanding they can switch to a newer (brand) drug under patent protection if they have an adverse reaction or do not respond well to a generic. Too often states fail to weigh the costs and benefits of drugs on the formulary or preferred drug list. There is a down side to rigid adherence to preferred drug lists without taking into account the risks to some patients that need a nonpreferred alternative. A preferable alternative is to allow patients themselves to participate in these decisions through cost-sharing, tiered formulary copayments or incentives that allow enrollees more control and appropriate incentives (more on this later).

A 100 percent generic fill-rate is not the ideal way to save money or ensure quality. The appropriate use of generic drugs, including those circumstances when a newer, patented drug is more appropriate will vary from patient to patient — and from drug to drug. Professor Lichtenberg has repeatedly argued that reduced mortality is associated with the introduction of new innovative (patented) drugs.[38] In creating preferred drug lists, the health of the patient should be the primary concern. There should also be protocols for those situations when a physician believes a patented drug is more appropriate.

Across all 50 states, the average proportion of prescriptions filled with a generic drug in conventional state-managed Medicaid drug programs is just over two-thirds (68 percent), compared to 80 percent for drug programs that are run by Medicaid health plans.[39] IMS Health, a drug market research firm, reports that 78 percent of prescriptions nationally are filled with generic drugs.[40] This suggests there may be

opportunities to substitute lower-cost drugs for name brand drugs for which a generic substitute is available and appropriate:

- The lowest users of generic drugs are Tennessee (47 percent), Maryland (62 percent), New York (63 percent) and New Jersey (63 percent).
- The highest users of generic drugs are Hawaii (79 percent), Massachusetts (77 percent) and Washington (76 percent). [See Figure III.]

All states should encourage the use of less-expensive drug alternatives when the therapeutic effectiveness is the same.[41] This could result in substantial savings. [For an example, see the sidebar "The Use of Antipsychotics."]

One report identified 20 commonly-used brand drugs for which there were therapeutically equivalent generic drugs available. Had state Medicaid programs substituted generics for these 20 drugs, the savings would have amounted to $329 million in 2009, or about 22 percent more than if generic drugs had been fully utilized. Of the 20 drugs studied, Medicaid paid an average of $95 more for every brand medication sold when there was a generic available.[42]

The Use of Antipsychotics

Antipsychotic drugs are one of the fastest-growing classes of drugs paid for by Medicaid.[44] These are often used in long-term care facilities and to treat mentally ill enrollees. Most states have implemented basic policies to contain drug costs, such as encouraging the use of generics, limitations on the number of prescriptions, prior authorization, preferred drug lists and fail-first requirements. Recent research has raised concerns that newer drugs cost many times more than older drugs that appear to work as well in most people. However, this is the subject of considerable debate.[45] Many states waive restrictive drug requirements for antipsychotic drugs.[46] Yet there have also been instances of poorly-conceived programs to limit antipsychotic prescriptions that have increased other medical costs. Figure IV illustrates the wide variation in the daily cost of various antipsychotics.

Figure IV

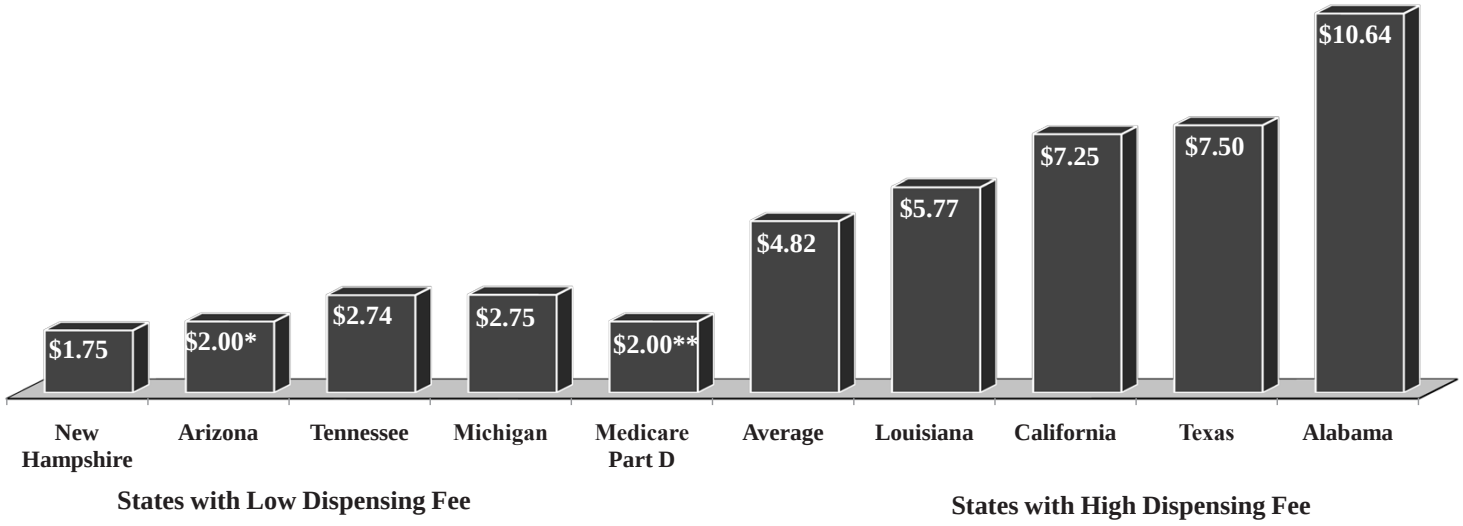
Daily Cost of Antipsychotic Medications

* generic drug

Source: Author's survey of Costco.com Web site. Competitive retail prices correspond to just below average wholesale cost.

Figure V

State Prescription Dispensing Fees



* Arizona has a small fee-for-service program;

** Medicare Part D for comparison purposes only.

Source: "Medicaid Prescription Reimbursement Information by State – Quarter Ending December 2010," Center for Medicare & Medicaid Services, U.S. Department for Health and Human Services. Available at http://www.cms.gov/Reimbursement/downloads/4Q2010ReimbursementChart.pdf.

For example, a 2003 study from Brigham and Women's Hospital and Harvard Medical School examined the effect of substituting comparable generic drugs for brand-name drugs in an unnamed state's Medicaid program. The cost of the brand-name drugs purchased through Medicaid totaled about $95.3 million.[43] Among commonly prescribed drugs, the study found:

- Generic nonsteroidal, anti-inflammatory drugs would have saved Medicaid $294,000.
- Using generic calcium channel blockers would have saved $420,000.
- The use of generic anti-anxiety medicine would have saved $461,000.

There were other drug savings as well. Using just the generic form of the top-three prescribed drugs would have saved the state's Medicaid program well over $1 million. Total savings on all drugs examined would have totaled $3.4 million.

Cost-Saving Strategy No. 2: Negotiating Dispensing Fees. Consumers who are not in a drug plan do not pay a separate dispensing fee when purchasing drugs. The cost of dispensing a drug — counting tablets, filling bottles and administrative tasks— are included in the retail cost. The $4 price for selected 30-day generic prescriptions at Walmart, Target, Kroger and other pharmacies, for example, includes an implicit dispensing fee. Private drug plans typically negotiate dispensing fees with a pharmacy network or chain. By contrast, dispensing fees in state-managed, conventional Medicaid are set by state officials with guidance from the state legislatures.

State reimbursement rates to pharmacies for filling Medicaid prescriptions vary more than is warranted by market conditions, competition and business costs. State officials and state legislatures often yield to political pressure and set dispensing fees for conventional Medicaid programs that are often above (or below) what the market would normally compensate pharmacies. If fees are too low, the revenue from filling Medicaid prescriptions is less than the cost of providing the service. As a result, enrollees may lack access to pharmacies willing to dispense

drugs for Medicaid patients. On the other hand, if the fees are set too high, taxpayers end up paying pharmacies more than a competitive market would require. Politicians often protect local constituents — including protecting local pharmacies from competition for Medicaid's business.[47]

- Across the country, the average conventional Medicaid dispensing fee is $4.81 per prescription.[48]
- However, dispensing fees range from $1.75 in New Hampshire to $10.64 in Alabama.[49] [See the table.]
- Under certain conditions, the dispensing fees climb even higher — in some cases as high as $12.50, about double the market rate PBMs pay pharmacies for prescriptions covered by private drugs plans.[50]
- By contrast, the privately-managed Medicare Part D plans pay pharmacies a dispensing fee of about $2 for every prescription they fill, or about $1.90 for a short-term supply of pills and $2.20 for an extended supply of drugs.[51] [See Figure V.]

Many pharmacies can survive on $2 dispensing fees from the PBMs that manage private drugs plans. Some chain drug store and big box retail pharmacies succeed on $4 generic prescriptions they fill for consumers without a drug plan. This suggests Medicaid fee-for-service dispensing fees are arbitrarily set too high in many jurisdictions.

The appropriate dispensing fee varies from region to region. As a

Table I

State Prescription Dispensing Fees

	Fee or Lower Tier	Upper Tier	
Alabama	$10.64		
Alaska	$3.45	$11.46	**
Arizona	$2.00		
Arkansas	$5.51		
California	$7.25	$8.00	+
Colorado	$4.00	$1.89	+
Connecticut	$3.15		
Delaware	$3.65		
District of Columbia	$4.50		
Florida	$3.73	$7.50	
Georgia	$4.33	$4.63	
Hawaii	$4.67		
Idaho	$4.94		
Illinois	$3.40	$4.60	*
Indiana	$4.90		
Iowa	$4.34		
Kansas	$3.40		
Kentucky	$4.50	$5.00	*
Louisiana	$5.77		
Maine	$3.35		
Maryland	$2.67	$3.69	*
Massachusetts	$3.00		
Michigan	$2.50	$2.75	+
Minnesota	$3.65		
Mississippi	$3.91	$5.50	*
Missouri	$4.09		
Montana	$5.04		
Nebraska	$3.27	$5.00	
Nevada	$4.76		
New Hampshire	$1.75		
New Jersey	$3.73	$3.99	
New Mexico	$2.50	$3.65	
New York	$3.50	$4.50	*
North Carolina	$4.00	$5.60	*
North Dakota	$4.60	$5.60	*
Ohio	$3.70		
Oklahoma	$4.02		
Oregon	$9.68	$14.01	**
Pennsylvania	$4.00		
Rhode Island	$3.40		
South Carolina	$4.05		
South Dakota	$4.75		
Tennessee	$2.50	$3.00	*
Texas	$7.50	Plus 2%	
Utah	$3.90	$4.40	++
Vermont	$4.75		
Virginia	$3.75		
Washington	$4.24	$5.25	
West Virginia	$2.50	$5.30	*
Wisconsin	$3.44	$3.94	*
Wyoming	$5.00		
Average	$4.23	$5.42	

Note: * denotes generic drugs; ** denotes higher fee for low-volume pharmacies.
+denotes institutional pharmacy; ++ denotes higher fees for rural pharmacies.

result, state officials need to allow PBMs that manage Medicaid drug benefits to negotiate dispensing fees with pharmacy networks the way PBMs do for private drug plans. This does not mean fees would be the same in every state or every pharmacy. However, it does mean dispensing fees would reflect market conditions, such as the cost of doing business and competition in the local market.

> *"Medicaid pays 10 percent more than private Medicare Part D plans for most generic drugs."*

Cost-Saving Strategy No. 3: Coordinating and Tracking Drug Therapy Utilization. Many states do not optimally manage their Medicaid drug programs.[52] For instance, conventional Medicaid programs do little to track the number of providers a Medicaid enrollee sees or the number of prescription drugs an enrollee has filled. Not tracking drug utilization makes conventional Medicaid programs susceptible to waste and fraud.

While some states manage their own or contract directly with PBMs to manage conventional Medicaid drug programs, others rely on insurers to manage benefits. Some states that previously carved-out drug benefits are considering moving to carve-in arrangements, where the private insurers are responsible for managing integrated drug benefits.[53]

Among the advantages of carve-in drug programs touted by proponents are improving the detection of substance abuse and "drug seekers," and raising the quality of care through better care coordination, and identifying drug interactions and inappropriate or duplicate prescriptions. It makes sense for the health plan entity responsible for managing physician visits and hospital needs for Medicaid enrollees to also coordinate drug therapies because skimping on drug therapies can often lead to higher medical costs.

Cost-Saving Strategy No. 4: Negotiating Drug Prices. The cost of drugs purchased for state Medicaid programs also varies from one state to another.[54] A 2004 report by the Office of Inspector General of the U.S. Department of Health and Human Services compared the amounts states paid for 28 common drugs across 42 state Medicaid programs.[55] Michigan and Texas performed the best; New York and New Jersey fared the worst. The price of Lipitor (a popular drug used to treat high cholesterol) varied from $2.58 to $2.89 — only about a 12 percent difference. For Depakote (a drug used to treat bipolar disorder), costs varied by just over 70 percent. Generic drugs with multiple suppliers varied the most in terms of how much different states paid for them. For example, Atenolol (a popular beta blocker used to treat high blood pressure), varied in cost by 4,073 percent between low-cost and high-cost states.

A 2009 Inspector General report compared the cost of drugs obtained for the privately-run Medicare Part D program with the cost of drugs for Medicaid. Single-source drugs (name-brand drugs still under patent protection) varied in cost by less than 5 percent. For generic drugs, state Medicaid programs paid at least 10 percent more than Medicare Part D plans for three-fourths of the drugs surveyed.[56] This is in contrast to the private firms that manage Medicare Part D and private drug plans, which often pay less for drugs than Medicaid fee-for-service programs because PBMs more aggressively negotiate prices with manufacturers.[57]

Cost-Saving Strategy No. 5: Empowering Consumers.[58] In the private sector, patients are increasingly required to share in the cost of health care by paying deductibles and copayments. Evidence has shown that when individuals have the proper financial incentives, they will be better consumers of health care.[59] This usually involves health plans in which a person pays some medical expenses out-of-pocket or from a personal account established for that purpose. For instance, a number of states have received waivers that allow them set up cash accounts which disabled Medicaid recipients can use to manage their own health care dollars and have direct control over the hiring of home care services.[60] These programs, called "Cash and Counseling," use a defined contribution approach.[61] Remarkably, patient satisfaction is almost 100 percent.[62]

Similarly, states could provide Medicaid recipients with Health Opportunity Accounts (HOAs),

similar to Health Savings Accounts (HSAs) used in the private sector. Through a debit card, a state could ensure that a recipient completed certain medical procedures such as child immunizations or prenatal care before accessing any of his or her balance. Currently, Medicaid enrollees have little reason to care about the cost of drugs they are prescribed. If private drug plans had the flexibility to experiment with different types of incentives, Medicaid enrollees may be able cut costs substantially by becoming aggressive consumers.[63] Some of the common techniques consumers use to control drug expenditures include:[64]

Mail-Order Pharmacies. Although drugstore chains still sell the most drugs, mail-order pharmacies are gaining ground and now account for about 17 percent of the retail drug market. Mail-order and Internet pharmacies offer the best deals on prescription drugs for patients with chronic conditions.

Pill Splitting. Patients can purchase many medications in doses double the prescribed amount and split them in half. Often, pharmacists will split the pills for them. Savings of 30 percent to 50 percent are not uncommon because many medications are sold for about the same price regardless of dosage.

Over-the-Counter Drugs. As an alternative to prescription drugs, patients may find that an over-the-counter (OTC) drug does just as well. Over-the-counter drugs comprise 60 percent of all drugs used each year. Today, consumers have access to a market with more than 100,000 different OTC drug products; more than 700 of them were previously available only by prescription.

Cost-Sharing.[65] Copayments and increased cost-sharing have been used successfully by private health insurers for years to reduce unnecessary use of medical services. In the past, a state was only allowed to charge nominal copayments of $1 to $3 for medical services and prescription drugs, unless it received a waiver.[66] The Deficit Reduction Act (DRA), however, allows states to charge nominal copays for all nonpreferred prescription drugs for Medicaid recipients 150 percent or more above the federal poverty level. Furthermore, states are permitted to increase copays commensurate with rises in the medical component of the consumer price index, and they are not prohibited from requiring mandatory populations to make copayments for nonpreferred prescription drugs. One way to apply this principle to Medicaid is to offer enrollees who wish to purchase a nonformulary drug the opportunity to receive the same drug if they make a higher copayment. If a physician thinks a nonformulary drug offers significant benefits, copayments could be waived.

> *"Control of some health care dollars would encourage Medicaid patients to shop for better prices."*

However, cost-sharing should not be imposed for those services and treatments that have been shown to reduce preventable medical costs. For example, states should provide first-dollar coverage for asthma treatments because hospitalizations for severe asthma attacks are costly, but can be easily prevented.

Value-Based Benefit Design. Health plans often use formularies with one or two tiers: a low, fixed copayment for generics drugs and a higher copayment for name-brand drugs. There are opportunities to reward more valuable services by charging different copayments for drugs to treat different conditions.[67] For instance, a beta blocker for a diabetic is so beneficial that many experts believe there should be no cost sharing. On the other hand, Cox-2 inhibitors are very costly pain relievers that have many much less expensive substitutes. The private drugs plans that manage Medicaid drug benefits should have the authority to experiment in order to discover which benefits hold the greatest value.

Conclusion

Restraining the growth of Medicaid drug spending is a fiscal imperative for state budgets. A good place for states to start looking for ways to control spending is in their Medicaid drug benefits. There are billions of dollars in potential savings that could be realized without reducing access to needed care for any Medicaid enrollees.

Devon M. Herrick is a senior fellow with the National Center for Policy Analysis.

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The NCPA is a nonprofit, nonpartisan organization established in 1983. Its aim is to examine public policies in areas that have a significant impact on the lives of all Americans — retirement, health care, education, taxes, the economy, the environment — and to propose innovative, market-driven solutions. The NCPA seeks to unleash the power of ideas for positive change by identifying, encouraging and aggressively marketing the best scholarly research.

Health Care Policy.

The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs), previously known as Medical Savings Accounts (MSAs). NCPA President John C. Goodman is widely acknowledged (*Wall Street Journal*, WebMD and the *National Journal*) as the "Father of HSAs." NCPA research, public education and briefings for members of Congress and the White House staff helped lead Congress to approve a pilot MSA program for small businesses and the self-employed in 1996 and to vote in 1997 to allow Medicare beneficiaries to have MSAs. In 2003, as part of Medicare reform, Congress and the President made HSAs available to all nonseniors, potentially revolutionizing the entire health care industry. HSAs now are potentially available to 250 million nonelderly Americans.

The NCPA outlined the concept of using federal tax credits to encourage private health insurance and helped formulate bipartisan proposals in both the Senate and the House. The NCPA and BlueCross BlueShield of Texas developed a plan to use money that federal, state and local governments now spend on indigent health care to help the poor purchase health insurance. The SPN Medicaid Exchange, an initiative of the NCPA for the State Policy Network, is identifying and sharing the best ideas for health care reform with researchers and policymakers in every state.

NCPA President John C. Goodman is called the "Father of HSAs" by *The Wall Street Journal*, WebMD and the *National Journal*.

Taxes & Economic Growth.

The NCPA helped shape the pro-growth approach to tax policy during the 1990s. A package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce in 1991 became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in summer 2002. The NCPA's proposal for an across-the-board tax cut became the centerpiece of President Bush's tax cut proposals.

NCPA research demonstrates the benefits of shifting the tax burden on work and productive investment to consumption. An NCPA study by Boston University economist Laurence Kotlikoff analyzed three versions of a consumption tax: a flat tax, a value-added tax and a national sales tax. Based on this work, Dr. Goodman wrote a full-page editorial for *Forbes* ("A Kinder, Gentler Flat Tax") advocating a version of the flat tax that is both progressive and fair.

A major NCPA study, "Wealth, Inheritance and the Estate Tax," completely undermines the claim by proponents of the estate tax that it prevents the concentration of wealth in the hands of financial dynasties. Actually, the contribution of inheritances to the distribution of wealth in the United States is surprisingly small. Senate Majority Leader Bill Frist (R-TN) and Senator Jon Kyl (R-AZ) distributed a letter to their colleagues about the study. In his letter, Sen. Frist said, "I hope this report will offer you a fresh perspective on the merits of this issue. Now is the time for us to do something about the death tax."

Retirement Reform.

With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare.

The NCPA study, "Ten Steps to Baby Boomer Retirement," shows that as 77 million baby boomers begin to retire, the nation's institutions are totally unprepared. Promises made under Social Security, Medicare and Medicaid are inadequately funded. State and local institutions are not doing better — millions of government workers are discovering that their pensions are under-funded and local governments are retrenching on post-retirement health care promises.

Pension Reform.

Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution. Among the NCPA/Brookings 401(k) reforms are automatic enrollment of employees into companies' 401(k) plans, automatic contribution rate increases so that workers' contributions grow with their wages, and better default investment options for workers who do not make an investment choice.

The NCPA's online Social Security calculator allows visitors to discover their expected taxes and benefits and how much they would have accumulated had their taxes been invested privately.

Environment & Energy.

The NCPA's E-Team is one of the largest collections of energy and environmental policy experts and scientists who believe that sound science, economic prosperity and protecting the environment are compatible. The team seeks to correct misinformation and promote sensible solutions to energy and environment problems. A pathbreaking 2001 NCPA study showed that the costs of the Kyoto agreement to reduce carbon emissions in developed countries would far exceed any benefits.

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The NCPA's Debate Central is the most comprehensive online site for free information for 400,000 U.S. high school debaters. In 2006, the site drew more than one million hits per month. Debate Central received the prestigious Templeton Freedom Prize for Student Outreach.

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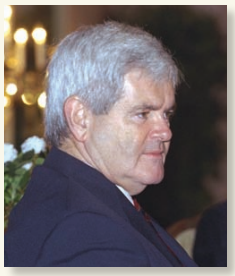

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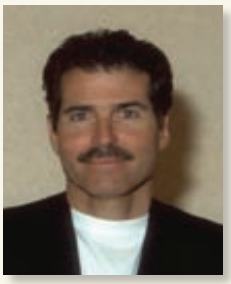
Newt Gingrich, former Speaker of the U.S. House of Representatives



"We know what works. It's what the NCPA talks about: limited government, economic freedom; things like Health Savings Accounts. These things work, allowing people choices. We've seen how this created America."

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Tommy Thompson,
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