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## REDUCING MEDICAID AND MEDICARE DRUG COSTS COULD HELP PAY FOR HEALTH REFORM

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By lowering the costs that Medicaid and Medicare pay for prescription drugs, Congress could generate substantial savings to help pay for comprehensive health reform that achieves universal coverage.

Prescription drugs are critical to providing effective health care; for many people, they are important to maintaining health and preventing complications that could lead to hospitalizations. At the same time, the rate of growth in prescription drug spending has concerned both public and private payers, and use of needed prescription drugs would increase significantly under a reformed health care system that achieves universal coverage.

For these reasons, health reform should include policies that slow the growth in spending on prescription drugs and free up savings to finance expanded coverage. Reducing Medicaid and Medicare prescription drug costs would help achieve these goals.

### **Medicaid: Improving the Drug Rebate and Management of Drug Utilization**

Congress could substantially reduce the costs of prescription drugs in Medicaid by increasing and extending the rebates that drug manufacturers pay state Medicaid programs and by requiring or encouraging states to adopt promising “best practices” in their management of prescription drug usage.

### **Increasing the Minimum Rebate for Brand-Name and Generic Drugs**

Under federal law, as a condition of Medicaid coverage of their products, drug manufacturers must pay rebates to the federal and state governments for outpatient prescription drugs that Medicaid dispenses to beneficiaries. These rebates effectively lower the price that Medicaid pays for prescription drugs and ensure that state Medicaid programs pay no more than private purchasers for the same drugs.

Congress should consider increasing the minimum rebates for brand-name and generic drugs, which have remained unchanged since 1996 and 1994, respectively. Currently, the minimum rebate for brand-name drugs equals the higher of 15.1 percent of the Average Manufacturer Price (AMP) — the price that manufacturers charge to wholesalers — or the difference between the AMP and the lowest price offered to any private purchaser. For generic drugs, the minimum rebate is 11 percent of the AMP.

Increasing the minimum rebates would substantially reduce federal and state Medicaid costs without harming beneficiaries. For example, the Congressional Budget Office (CBO) estimates that increasing the minimum rebate for brand-name drugs to 23.1 percent of the AMP would generate \$7.2 billion in savings over ten years.<sup>1</sup>

The Senate passed legislation increasing the minimum rebate for both brand-name and generic drugs in 2005, and the House passed an increase in the minimum rebate for brand-name drugs in 2007. In addition, President Obama's budget proposed increasing the minimum rebate for brand-name drugs to help finance health reform. The National Governors Association has endorsed raising the minimum rebates as well.

### **Applying the Additional Rebate to Generics and New Formulations of Existing Drugs**

In addition to the minimum rebate, manufacturers of brand-name drugs must pay an additional rebate if the price of their product increases faster than inflation; this helps slow the rising cost of brand-name drugs in Medicaid. The Office of Inspector General (OIG) at the Department of Health and Human Services has recommended applying a similar rebate to generic drugs, which are currently exempt from the additional rebate.

The OIG has estimated that with this adjustment, Medicaid would have received an additional \$151 million in rebates in 2004 for the top 200 generic drugs dispensed to enrollees.<sup>2</sup> Based on this estimate, savings from applying the Medicaid additional rebate to generic drugs could reach \$2 billion over ten years.

Congress could also apply the additional rebate to new formulations of existing drugs. Currently, if a manufacturer introduces a new dosage or formulation (such as an extended-release version) of an existing drug, it is considered a new drug and is therefore exempt from the additional rebate that manufacturers would normally be charged if prices rise faster than inflation. This encourages drug manufacturers to make slight alterations to existing products to avoid paying the additional rebate. CBO estimates that removing this loophole would save Medicaid \$3 billion over ten years.<sup>3</sup> The President included this proposal in his budget.

### **Extending the Rebate to Drugs Dispensed Through Managed Care Plans**

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<sup>1</sup> Congressional Budget Office, "Budget Options Volume I: Health Care," December 2008.

<sup>2</sup> Daniel Levinson, "Review of Generic Drug Price Increases," Department of Health and Human Services Office of the Inspector General, October 24, 2007.

<sup>3</sup> See Congressional Budget Office, *op cit*.

Drug manufacturers are not required to pay rebates on drugs dispensed to beneficiaries enrolled in Medicaid managed care plans. Congress based this exception on the assumption that managed care plans could negotiate discounted drug prices as favorable as those required under the Medicaid drug rebate. However, evidence shows that this likely is not the case, and that plans may be paying 11 percent more for drugs than fee-for-service Medicaid.<sup>4</sup>

Requiring manufacturers to pay rebates for drugs provided through managed care plans would ensure that Medicaid is obtaining the best prices for all of the drugs it covers. Given the large proportion of Medicaid beneficiaries who are in managed care, it would also generate meaningful savings — about \$11 billion over ten years, according to CBO.<sup>5</sup> The Senate passed such a proposal in 2005, and President Obama has included it in his budget.<sup>6</sup>

### **Promoting Best Practices for Managing High Prescribers and High Drug Users**

In addition, the federal government could require or encourage states to adopt best practices in managing drug utilization in their Medicaid programs.

For example, some states seek to limit fraud and abuse, improve patient safety, and produce better health outcomes by conducting periodic reviews of prescription drug usage — particularly among high users — to ensure that the drugs prescribed are medically necessary. Some states also monitor physicians' prescribing patterns and initiate general provider education efforts known as “counter-detailing” or “academic detailing,” which have been shown to reduce costs that stem from inappropriate prescribing. Moreover, some states intervene with specific providers who prescribe an unusually high number of prescriptions.<sup>7</sup> State Medicaid programs nationwide could adopt these sound practices.

### **Medicare: Allowing Part D to Obtain the Same Rebates as Medicaid for Dual Eligibles**

Prior to the establishment of the Medicare Part D drug benefit, Medicaid provided prescription drug coverage to more than 6 million “dual eligibles” (low-income Medicare beneficiaries who also are enrolled in Medicaid). In 2006, drug coverage for these dual eligibles shifted to Medicare.

When Congress created the drug benefit, it assumed that the private insurers participating in Part D would be able to negotiate greater rebates from drug manufacturers than Medicaid had required. But an increasing body of research demonstrates that the rebates negotiated by Part D plans are well

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<sup>4</sup> Center for Health Care Strategies, Inc., “Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Settings,” January 2003 and The Lewin Group, “Extending the Federal Drug Rebate Program to Medicaid MCOs: Analysis of Impacts,” May 2003.

<sup>5</sup> See Congressional Budget Office, *op cit*.

<sup>6</sup> Due to interactions between the rebate provisions, CBO has estimated that together the Administration's proposals to increase the minimum rebate for brand-name drugs to 22.1 percent (as opposed to 23.1 percent in the CBO Budget Option), apply the additional rebate to new formulations of existing drugs, and extend the rebate to drugs dispensed through Medicaid managed care plans would save \$16.1 billion over ten years. Congressional Budget Office, “CBO Estimate of Spending Provisions in the President's Budget Proposal for a Health Reform Reserve Fund,” March 2009.

<sup>7</sup> See Jeffrey Crowley and Edwin Park, “Advancing Efficient Management and Purchasing of Prescription Drugs in Medicaid,” Center for Children and Families at the Georgetown University Health Policy Institute, March 2008.

below the Medicaid rebates, which means the federal government is incurring higher drug costs for dual eligibles than it previously incurred under Medicaid. For example:

- Harvard health economists Richard Frank and Joseph Newhouse examined SEC filings among manufacturers of drugs used heavily by dual eligibles, such as anti-psychotic medications. They found that the prices obtained by Medicare Part D plans were higher than those obtained by Medicaid. As a result, “manufacturers have realized significant gains simply from the change in responsibility for purchasing from Medicaid to Medicare.”<sup>8</sup>
- Stephen Schondelmeyer, a University of Minnesota expert on prescription drug pricing, has estimated that most of the publicly released Medicare Part D prescription drug prices are 20 to 30 percent higher than the estimated prices in Medicaid (net of the manufacturers’ rebates).
- The majority staff of the House Committee on Oversight and Government Reform has reported that the federal government paid \$3.7 billion more in 2006 and 2007 for the 100 drugs most often used by dual eligibles than it would have paid under the prices that Medicaid paid for those medications.<sup>9</sup> The Committee derived this figure from its review of confidential pricing documents that insurers and drug manufacturers provided at the Committee’s request.

Congress could require drug manufacturers to provide, at a minimum, the same rebates for drugs provided to dual eligibles under Medicare Part D as Medicaid would require. While CBO has not estimated the savings of this policy option, the House Oversight and Government Reform Committee staff estimated it would save as much as \$86 billion over ten years.

## Conclusion

Paying for comprehensive health reform will require both revenue increases and program savings. The measures outlined above — improving the Medicaid drug rebate program, adopting best practices in managing Medicaid drug utilization, and restoring Medicaid-level rebates for prescription drugs provided to dual eligibles under the Medicare drug benefit — are not only sound policy, but would also produce substantial savings to help cover millions of uninsured Americans.

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<sup>8</sup> Richard Frank and Joseph Newhouse, “Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Purchasing,” The Hamilton Project at the Brookings Institution, April 2007.

<sup>9</sup> House Committee on Oversight and Government Reform, “Medicare Part D: Drug Pricing and Manufacturer Windfalls,” July 2008, <http://oversight.house.gov/documents/20080724101850.pdf>.