



## Frequently Asked Questions...

# Prescription Drugs

### *In this FAQ...*

- *What are current trends in prescription drug spending?*
- *What factors are driving increases in drug expenditures?*
- *Will patterns of prescription drug spending change in the future?*
- *What tools can states use to assess and evaluate their pharmaceutical expenditures and trends in utilization?*
- *What are states doing to increase access to drugs and to control pharmaceutical expenditures?*
- *How will the Medicare Prescription Drug, Improvement and Modernization Act (MMA) affect the states?*

### *What are current trends in prescription drug spending?*

Spending on prescription drugs in the United States increased at an average annual rate of 14.5 percent from 1997 to 2002, topping \$162 billion in 2002.<sup>1</sup> Although prescription drug spending is a relatively small proportion of total personal health care spending at 10.2 percent, it is the single fastest growing component. The rate of spending growth is predicted to slow somewhat in the future. However, it is likely to continue to exceed the rate of inflation by a large factor: price inflation was 2.2 percent in 2003 and is predicted to be 3 percent in 2004.<sup>2,3</sup> The rapid increases in prescription drug spending are placing a growing burden on consumers, employers and public programs.

At the state level, spending increases for prescription drugs are placing financial pressure on Medicaid and on other health financing programs managed by states, including retiree health systems and state prescription drug subsidy programs. Medicaid provided prescription drug benefits to 42.4 million Americans<sup>4</sup> (approximately 14.6 percent<sup>5</sup>) of Americans in 2003 and is the primary source of prescription drugs for the low-income elderly and disabled. In fact, this program is currently the largest source of public coverage for prescription drugs. Prescription drug spending increases account for a growing proportion of Medicaid expenditures: "... between 2000 and 2002 expenditures for prescription drugs (fee-for-service only) increased by an average of 18.8



percent per year, faster than any other major type of Medicaid service.”<sup>6</sup>

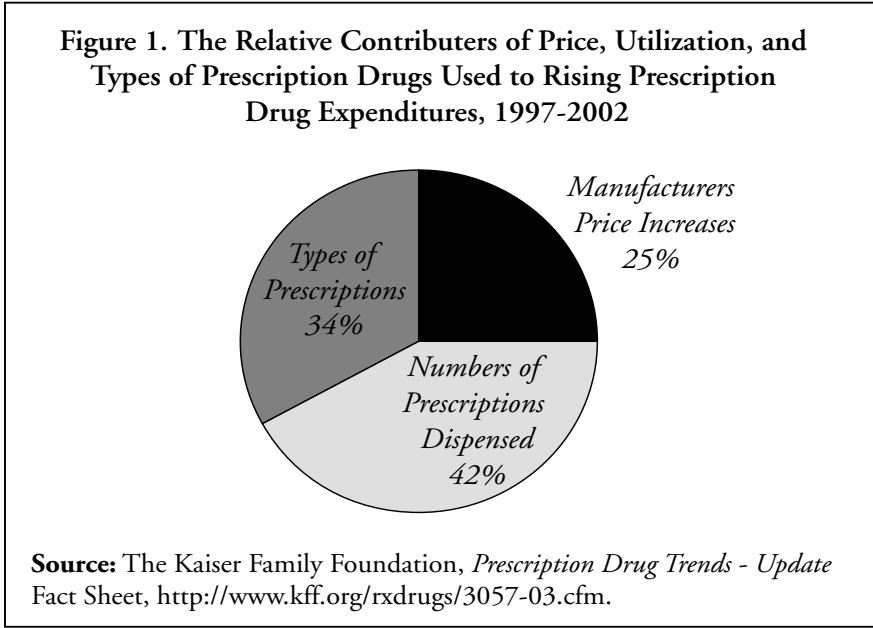
### *What factors are driving increases in prescription drug expenditures?*

As figure 1 shows, the major reasons for growth in prescription drug expenditures are the increasing volume or use of prescriptions, changes in the types of drugs being used, and increases in manufacturers’ prices for existing drugs. Each of these effects is associated with specific and often interacting economic conditions: increased use of prescription drugs is fueled by rising demand among populations who benefit from access to pharmaceuticals, especially elderly Americans. Changes in the rate of new drug introductions are associated with shifting patterns of use and overall growth in pharmaceutical prices.

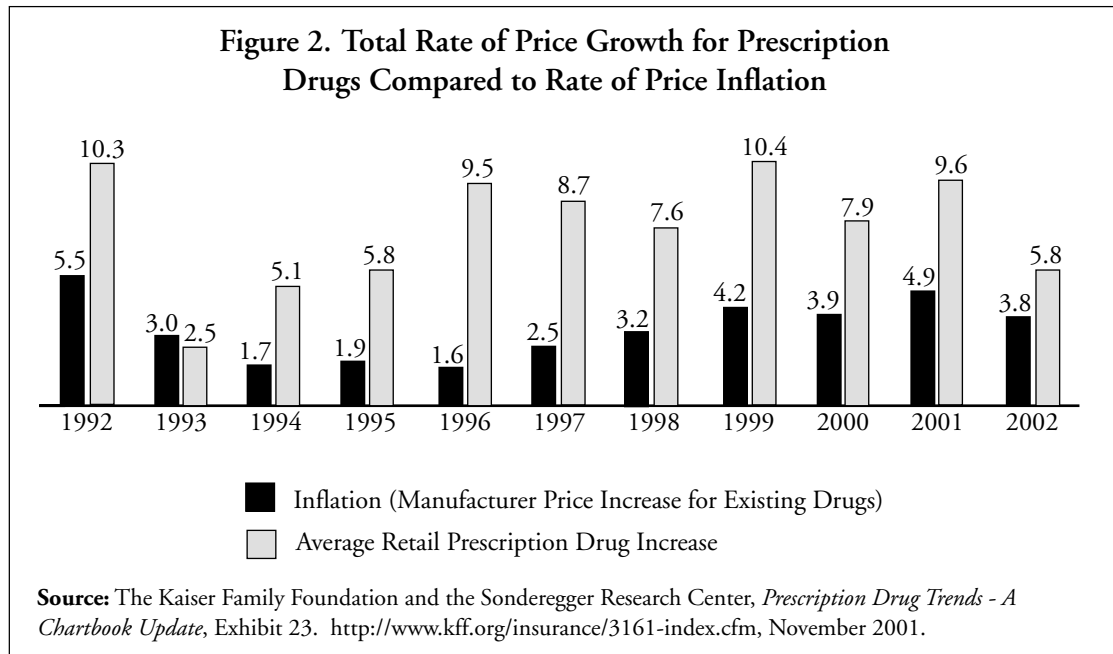
*Increased Use.* Prescription drugs, which have become an integral part of the practice of medicine, are helping to keep people healthy and save lives. Some prescription drugs provide relief for conditions once considered untreatable, while others offer safer and

quicker treatment for conditions that once might have required hospitalization or other costly services. In recent surveys conducted by the Kaiser Family Foundation (September 2000), 91 percent of Americans report they take prescription drugs. More than half (54 percent) say they take prescription drugs regularly, and almost 10 percent estimate they spent \$1,000 or more out of their own pockets on prescription drugs in the previous year. These percentages increase dramatically for elderly Americans over age 65.

Use of prescription drugs has accelerated during the last few years. On average, Americans use about 11.8 prescriptions per year. From 1993 to 2003, the number of prescriptions purchased increased by 70 percent (from 2.0 billion to 3.4 billion), compared to a U.S. population growth of 13 percent.<sup>7</sup> Many Americans now control chronic diseases with pharmaceutical therapies that previously were not available. Improvements in diagnostic and screening practices and technology also mean that a greater number of patients are being treated and are taking prescription drugs for months or years. Use of prescriptions also is affected by increased advertising directed toward consumers. As consumers are educated about new drugs and therapies, they seek the most innovative treatments available. Demographic changes such as an aging U.S. population also contribute to an increase in the use of prescription drugs.



*Growth in Use of New Drugs.* The growth in expenditures for drugs is also being driven by the entrance and substitution of new, higher priced products. Several studies have suggested that, although prices for pharmaceuticals are increasing across the board, prices are most likely to increase for newly branded drugs. Most of the top 20 selling drugs are newer, more expensive brand-name drugs. Research and development (R&D) spending by pharmaceutical manufacturers also has increased 12.7 percent in 1993 to an estimated \$33.2 billion in 2003<sup>8</sup> and has contributed to the availability of new drugs. New drugs that are developed receive considerable attention and are heavily marketed to both consumers and providers.



However, some information suggests that, although research and development costs for new drugs have risen, the contribution of new drug introductions to prescription drug cost growth may be declining. As shown in figure 2, from 1992 to 2000, the total rate of price growth for all prescription drugs was approximately twice the rate of price inflation for existing drugs. This relationship changed in 2001 and even more visibly in 2002, with growth in retail prescription drug prices dropping to 1.96 and 1.53 times growth in existing retail drug prices per year, respectively.<sup>9</sup> Slower growth in drug costs may be partly due to increased scrutiny of new drug applications by the Food and Drug Administration (FDA) and declining marginal capacity of pharmaceutical industry technology to create new drugs to address medical conditions.<sup>10</sup> If this pattern continues, price inflation of existing drugs may begin to represent a larger portion of total drug price growth.

*Will patterns of prescription drug spending change in the future?*

Spending on prescription drugs will almost surely continue to increase rapidly during the next decade. As more new pharmaceuticals come onto the market and the scope of new therapies becomes broader, demand will increase for new and better drugs. However, some signs indicate that the relative speed of growth in costs is beginning to decelerate from its peak of 19.7 percent

annually from 1989 to 1999. The Kaiser Family Foundation said that “ ... U.S. spending for prescription drugs is projected to increase by 10.7 percent annually between 2004 and 2013.”<sup>11</sup>

Two factors that contribute to deceleration in total cost growth are a decline in the rate of growth of new drug introductions and a decline in the amount of direct-to-consumer advertising.<sup>12</sup> Although the introduction rate of new drugs is slowing, however, the number of new drugs will continue to grow in the future, due to increased research and development spending by pharmaceutical manufacturers and advances in scientific fields, such as genetics. The use of new drugs also is affected by the number of drugs approved by the FDA. During the last decade, the median approval time has decreased from 22 months to 12 months.<sup>13</sup>

---

### *What tools are available to help states assess and evaluate their pharmaceutical expenditures?*

An important first step for states that are interested in controlling costs and ensuring effective and safe use of pharmaceuticals is to use data to assess their needs and develop interventions. National studies provide general trends in spending and use, but states need data specific to their individual prescription drug programs to make informed decisions. For Medicaid and other state-managed programs, administrative data used to make payments is often the best source of information. An excellent description of how to use Medicaid administrative data to assess spending and drug use is in a recent paper by Brian Bruen and Arunabh Ghosh.<sup>14</sup> Bruen and Ghosh use Medicaid payment data, Medicaid service data, and data used to administer the drug rebate program to draw conclusions about patterns of Medicaid drug spending.

Medicaid service data have recently become more accessible through a new tool, the Statistical Compendium. This data set is a compilation of information on state and national level pharmaceutical benefit use and reimbursement. The first sets of data are for 1999, the first year in which states were required to submit person-level data on service use to the federal government. Detailed tables are included for all Medicaid beneficiaries combined and there are separate tables for dual-eligibles and for full-year residents of nursing facilities. The tables show drug use and reimbursement by brand status, therapeutic category and drug group. For more information about the Statistical Compendium compiled by Medicaid for pharmacy benefit use and reimbursement in 1999 please see [http://www.cms.hhs.gov/researchers/projects/Medicaid\\_rx/](http://www.cms.hhs.gov/researchers/projects/Medicaid_rx/).

---

### *What are states doing to increase access to drugs and to control pharmaceutical expenditures?*

States play a major role in ensuring prescription drug access and in developing strategies for more efficient purchasing of drugs. The major roles for states in the prescription drug arena are:

- In all states, managing a prescription drug program for Medicaid beneficiaries.
- In all states, managing prescription drug programs for approximately 3.5 million state employees and retirees.
- In some states, setting up and managing state-designed pharmacy subsidy and pharmacy discount programs.
- In all states, regulating pharmacies, pharmacists, and some wholesale pharmaceutical facilities.

With enactment of the Medicare Modernization Act in 2003, states now will be required to make significant adjustments in their Medicaid programs and may choose to change their state prescription drug programs and their retiree programs in response to provisions of the law.

A variety of materials are available online that describe current state activities related to prescription drugs. Given the rapid pace of change in this policy area, it is important for policymakers to know about essential background information and about regularly updated sources of information on state activity.

*Medicaid.* For an understanding of the types of strategies states are using to contain costs and make their drug purchasing more efficient under Medicaid, an excellent background piece is *State Strategies to Contain Medicaid Drug Costs* by the Office of the Inspector General of the Department of Health and Human Services (Publication Number OEI-05-02-00680, October 2003, located at <http://oig.hhs.gov>). The document describes each of the strategies in use in the states and discusses the rules that govern their use. Among the items discussed are generic substitution, cost-sharing, drug utilization review, prior authorization, preferred drug lists and supplemental rebates.

Preferred drug lists (PDLs) and supplemental rebates have become particularly important strategies within Medicaid in recent years. More than of 33 states are implementing or have legislation authorizing preferred drug lists in Medicaid. State select “preferred drugs” from different classes of pharmaceuticals, based on a committee’s findings of the drugs’ therapeutic action, safety, clinical outcome and cost. Drugs not on the list are not covered automatically; instead the prescribing physician must obtain prior authorization for their use. Most states that use a PDL obtain supplemental rebates from manufacturers that want their product to be included on the PDL.

- For basic data and a national perspective on Medicaid prescription drug spending, see *Medicaid Prescription Drug Spending and Use* by Brian Bruen and colleagues at <http://www.kff.org/medicaid/7111a.cfm>.
- For guidelines from the federal government for states that are considering prior authorization and Medicaid supplemental rebate agreements, see <http://www.cms.hhs.gov/states/letters/smd91802.pdf>.
- For a brief prepared for the federal government on best practices for prescription drug cost-containment within state Medicaid programs, see <http://www.cms.hhs.gov/medicaid/drugs/strategies.pdf>.
- For information about pharmacy use and cost control initiatives in specific states, see *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005: Results from a 50-State Survey* by Vernon Smith and colleagues at <http://www.kff.org/medicaid/7190.cfm>.
- For information about pharmaceutical benefits under state Medicaid assistance programs, see <http://www.npcnow.org/resources/issuearea/medicaidpharmaceutical.asp>. This resource, updated annually, discusses the elements of Medicaid pharmaceutical programs in each state.

*State-Initiated Access Programs.* For comprehensive information about state-initiated programs to provide subsidies for the purchase of prescription drugs or discounts on drug prices, see NCSL’s Web site at <http://www.ncsl.org/programs/health/pharm.htm>.

As noted in the NCSL Web document, as of October 2004, 39 states have enacted or authorized some type of state pharmaceutical assistance law; 36 states have passed laws and three others have executive agency initiatives. The programs vary greatly in design and targeted groups, although most are aimed at Medicare beneficiaries who lack drug coverage. Income eligibility requirements, scope of coverage, and cost-sharing requirements also differ across the states. NCSL's Web site provides basic design information for each state and links to additional descriptive or evaluative reports about the programs.

In addition to subsidy and discount programs, states have initiated multi-state purchasing strategies and intrastate purchasing pools to lower the costs of drugs. With the larger volume of prescriptions from aggregating purchases through a pool, states are able to increase their ability to negotiate prices with manufacturers. Multi-state purchasing can involve Medicaid beneficiaries, state employees and other groups on whose behalf states pay for pharmaceuticals. Examples of existing multi-state pools include the National Medicaid Pooling Initiative, through which several states join to negotiate on behalf of Medicaid beneficiaries; and the Rx Issuing States, through which states negotiate on behalf of state employees. Georgia provides an example of an intrastate pool where the state chose a single pharmaceutical benefit manager (PBM) to manage drug purchasing for the state's Medicaid, SCHIP, and state employee prescription coverage programs. For additional information about pooled purchasing, see *Stretching State Health Care Dollars: Pooled and Evidence-Based Pharmaceutical Purchasing*, a report by Sharon Silow-Carroll and Tanya Alteras of the Economic and Social Research Institute, at [http://www.cmwf.org/usr\\_doc/782\\_Silow-Carroll\\_stretching\\_pooledRx.pdf](http://www.cmwf.org/usr_doc/782_Silow-Carroll_stretching_pooledRx.pdf).

---

### *How will the Medicare Prescription Drug, Improvement and Modernization Act (MMA) affect the states?*

In December 2003, President Bush signed the Medicare Prescription Drug, Improvement and Modernization Act (MMA), a complex law with a range of provisions that affect states. All Medicare recipients may choose to enroll in a Medicare prescription drug benefit as of January 2006. For those eligible for both Medicare and Medicaid, the new Medicare benefit will replace the Medicaid benefit. In addition to subsidies for Medicaid beneficiaries, the law provides new subsidies for other low-income Medicare beneficiaries. Part of the cost of the new Medicare drug benefit will be paid by states through an assessment tied to per capita drug costs and the number of Medicare beneficiaries enrolled in Medicaid.

As managers of state pharmaceutical assistance programs, states have a number of options for coordinating their coverage with the new Medicare coverage. As administrators of state retiree health plans, states will face decisions about connections between the coverage in state plans and Medicare.

In short, states face fiscal, policy and administrative challenges in their Medicaid programs, their state pharmaceutical assistance programs, and their state employee retiree plans as implementation of MMA proceeds. NCSL provides information about MMA and links to other important sources of information through its Web site. To gain an understanding of the issues and state options, see *States and the New Medicare Prescription Drug Act* at <http://www.ncsl.org/programs/health/rxstatemma2.htm>.

Kaiser Family Foundation has issued several helpful articles about the effect of the law on dual-eligibles—those Medicaid beneficiaries who are eligible for both Medicare and Medicaid. Those papers can be found at [www.kff.org/medicaid/duals.cfm](http://www.kff.org/medicaid/duals.cfm).

The Center for Medicare and Medicaid Services of the U.S. Department of Health and Human Services has created a separate Web page with updated information on MMA at <http://www.cms.hhs.gov/medicarerreform/>.

---

### Notes

1. Congressional Budget Office, *Would Prescription Drug Importation Reduce U.S. Drug Spending?* (Washington, D.C.: U.S. CBO, 2004): 1.
2. Stephan Heffler et al., “Health Spending Projections Through 2013,” *Health Affairs Web Exclusive*, February 11, 2004.
3. Federal Reserve Bank of Minneapolis, *Consumer Price Index, 1913-Present* (Minneapolis, Minn.: FRBM Web publication, 2004).
4. Dennis Cauchon, “Medicaid rolls grow despite predicted cuts,” *USA Today* (March 1, 2004).
5. U.S. Census Bureau, *People QuikFacts, a Web publication*, <http://quickfacts.census.gov/qfd/states/00000.html>.
6. Brian Bruen and Arunabh Ghosh, “Medicaid Prescription Drug Spending and Use,” *Issue Paper* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2004): 1.
7. Kaiser Family Foundation, *Prescription Drug Trends – Update* (Washington, D.C.: Kaiser Family Foundation, 2004).
8. *Ibid.*, 1.
9. Janet Lundy, Benjamin Finder and Gary Claxton, “Trends and Indicators in the Changing Health Care Marketplace, 2004 Update,” *Chartbook update* (Washington D.C.: Kaiser Family Foundation, 2004): 23.
10. P. Humae and A. Zaugg, “IMS Review: Steady but Not Stellar,” *Medical Marketing and Media*, May 2003, [www.cpsnet.com/reprints/2003/05/IMS-May.pdf](http://www.cpsnet.com/reprints/2003/05/IMS-May.pdf) (November 19, 2004).
11. Kaiser Family Foundation, “Prescription Drug Trends.”
12. Stephen Heffler et al., “Health Spending Projections Through 2013,” *Health Affairs Web Exclusive* (2004).
13. U.S. Food and Drug Administration, Center for Drug Evaluation and Research, *FDA’s Drug Review and Approval Times*, Web publication (Washington, D.C.: U.S. FDA-CDER, 2001).
14. Brian Bruen and Arunabh Ghosh, *Medicaid Prescription Drug Spending and Use* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, June 2004).

**Staff Contacts:**

Donna Folkemer  
Program Director, Forum for State Health Policy Leadership  
National Conference of State Legislatures  
(202) 624-8171

Dick Cauchi  
Program Director, Health Program  
National Conference of State Legislatures  
(303) 364-1367

Karmen Hanson  
Policy Specialist, Health Program  
National Conference of State Legislatures  
(303) 364-1423

*Other Sources*

For updated information about state policy activities related to prescription drugs, go to NCSL's main prescription drug discount page at <http://www.ncsl.org/programs/health/pharm.htm>.

Additional groups that publish reports on state-related prescription drug are:

- **The National Pharmaceutical Council** at [www.npcnow.org](http://www.npcnow.org).
- **AARP** at [www.research.aarp.org/health](http://www.research.aarp.org/health).
- **Pharmaceutical Research and Manufacturers of America** at [www.phrma.org](http://www.phrma.org).
- **National Association of Chain Drug Stores** at [www.nacds.org](http://www.nacds.org).
- **National Wholesale Druggists Association** at [www.nwda.org](http://www.nwda.org).
- **Generic Pharmaceutical Association** at [www.gphaonline.org](http://www.gphaonline.org).
- **National Community Pharmacists Association** at [www.ncpanet.org](http://www.ncpanet.org).