NATIONAL CONFERENCE *of* STATE LEGISLATURES
FORUM *for* STATE HEALTH POLICY LEADERSHIP

FREQUENTLY ASKED QUESTIONS

Prescription Drugs

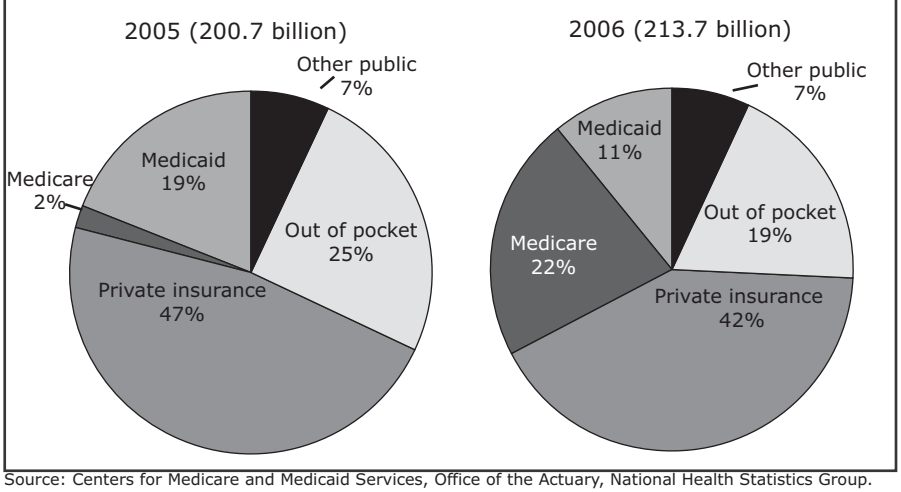
In This FAQ...

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 that once were considered untreatable, while others offer safer and quicker treatment for conditions that once might have required hospitalization or other costly services. In surveys conducted by the Kaiser Family Foundation, 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 that 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.

What are current trends in prescription drug spending?

The continued increases in prescription drug spending are placing a growing burden on consumers, employers and public programs. This drug spending nationwide increased at an average annual rate of 14.5 percent from 1997 to 2003. The annual rate moderated visibly by 2005-2006, to below 5.8 percent, but total spending nationwide reached $213 billion in 2006.[1] Although prescription drug spending remains a relatively small proportion of total personal health care spending at 10.1 percent, it has been the single fastest growing component. Costs are likely to continue to exceed the rate of inflation by a substantial factor: price inflation alone was 3.2 percent in 2006, but increased utilization added another 5 percent annually.[2, 3]

Figure 1. Prescripition Drug Spending, By Payer, 2005 and 2006



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

At the state level, spending increases for prescription drugs place financial pressure on Medicaid and other state-managed health financing programs, including employee and retiree health systems and state prescription drug subsidy programs. In 2005, Medicaid paid for prescription drug benefits to more than 50 million Americans,[4] and the program was the primary source of prescription drugs for the low-income elderly and disabled. In fact, Medicaid provided 69 percent of public coverage for prescription drugs through 2005, although Medicare supplanted that in 2006 and now provides about 55 percent of public coverage.[5] Prescription drug spending increases account for a growing proportion of Medicaid expenditures: between 2003 and 2004, expenditures for prescription drugs (fee-for-service only) increased by an average of 18.1 percent annually, faster than any other major type of Medicaid service.[6]

What factors are driving increases in prescription drug expenditures?

As Figure 2 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. Increased use of prescription drugs is fueled by rising demand among populations who benefit from access to pharmaceuticals—especially elderly Americans—and has accelerated during the last decade. From 1994 to 2005, the number of prescriptions purchased increased 71 percent (from 2.1 billion to 3.6 billion), while the U.S. population grew by only 9 percent. The average number of retail prescriptions per capita increased from 7.9 in 1994 to 12.3 in 2005.[7]

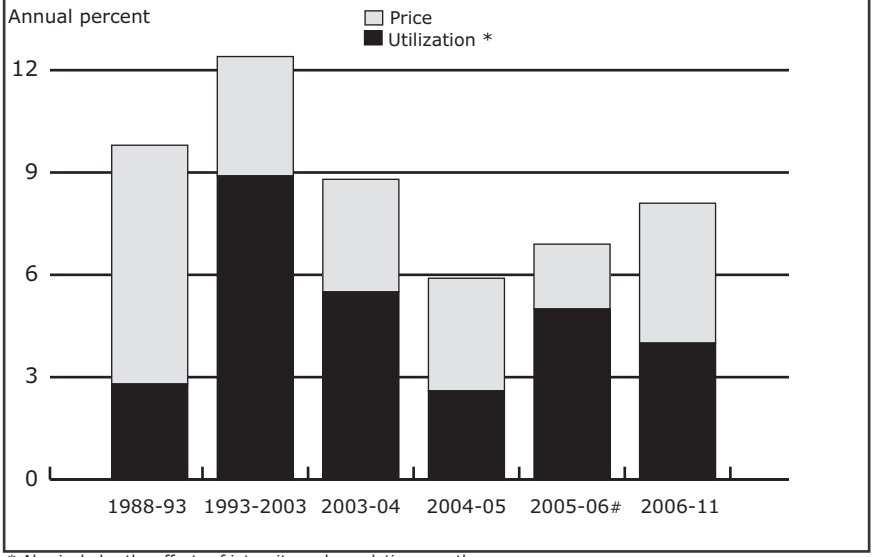
Many Americans now control chronic diseases with pharmaceutical treatments that previously were not available. Improvements in diagnostic and screening practices and technology also mean that a greater number of patients are being treated and are taking prescription drugs for months or years. Use of 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 also is 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. New drugs receive

considerable attention and are heavily marketed to both consumers and providers. Research and development (R&D) spending by pharmaceutical manufacturers also has increased to an industry-estimated $55 billion worldwide in 2006[8] and is intended to result in the availability of new and better drugs.

The Complex Picture of Drug Prices. Some information suggests that, although R&D costs for new drugs have risen, the contribution of new drug introductions to prescription drug cost growth may be declining. A federal agency analysis (shown in Figure 2) concludes that, from 1993 to 2003, the total rate of price growth for all prescription drugs was approximately twice the rate of price inflation for existing drugs. This relationship changed around 2002, with growth in retail prescription drug prices dropping to 1.5 times growth in existing retail drug prices per year.[9] Slower growth in drug costs may be due in part to increased scrutiny of new drug applications by the Food and Drug Administration (FDA) and to declining marginal capacity of pharmaceutical industry technology to create new drugs to address medical conditions.[10] Sales prices also are affected by wholesale and retail markups, state-negotiated reimbursement rates for public programs, and dispensing fees set by state-administered programs such as Medicaid and other assistance programs. In 2007, for example, retail pharmacists are seeking higher fees from states to offset changes in federal payments.

Figure 2. Factors Contributing to Total Prescripition Drug Spending Growth, 1988-2016



* Also includes the effects of intensity and population growth.
\# Without the effect of Part D, overall growth would be 6.9 percent (4.3 percent price, 2.6 percent utilization).
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Statistics Group.

Will patterns of prescription drug spending change in the future?

Overall spending on prescription drugs is projected to continue to increase during the next five years. Private insurers and state governments are credited with slowing spending through widespread use of generic products and use of higher beneficiary copayments to emphasize consumer-directed buying decisions. However, the number of new drugs likely will continue to grow in the future, due to increased R&D spending by pharmaceutical manufacturers and advances in scientific fields, such as genetics and biologically based pharmaceutical products.[11] Patients with life-threatening conditions and their physicians will continue to seek the latest treatments regardless of costs.

What tools are available to help states 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 often is the best source of information. A paper by Brian Bruen and Arunabh Ghosh contains an excellent description of how to use Medicaid administrative data to assess spending and drug use; it also draws conclusions about patterns of Medicaid drug spending.[12]

Medicaid service data have recently become more accessible through a new tool, the Statistical Compendium. This data set is a compilation of information about state and national pharmaceutical benefit use and reimbursement. Detailed tables are included for all Medicaid beneficiaries combined, and separate tables are included 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 2001, see http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp.

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 nationwide.
- 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 are 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 in 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.

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) explains the types of strategies states are using to contain costs and make their drug purchasing more efficient under Medicaid. 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 40 states are implementing or have laws that authorize 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 often 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/smdl/downloads/smd091802.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/MedicaidDrugRebateProgram/downloads/StateStrategiestoLowerMedicaidPharmacyCosts.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 in 2006, discusses the elements of Medicaid pharmaceutical programs in each state.
- For comprehensive information about state-initiated access 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 report, as of mid-2007, 42 states had enacted or authorized some type of state pharmaceutical assistance law, 39 states have passed laws, and three others have executive agency initiatives. The programs vary greatly in design and targeted groups, although about half are aimed at Medicare beneficiaries who need financial assistance with premiums, co-insurance payments and gaps in federal benefits. Separately, pharmaceutical discount programs were operational or authorized in about 20 states, often serving residents under age 65. Income eligibility requirements, scope of coverage and cost-sharing requirements also differ across the states. NCSL's website 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 nine states negotiate on behalf of Medicaid beneficiaries; and the Northwest Drug Consortium, through which Oregon and Washington intend to offer reduced prices to virtually any resident who lacks insurance coverage for drugs. Georgia 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.

How does the Medicare prescription drug benefit affect the states?

Prior to January 1, 2006, the traditional Medicare program (the federal health program for the elderly and disabled) did not provide coverage for outpatient prescription drugs. As a result, 27 percent of senior citizens age 65 and older and one-third of poor (34 percent) and near-poor (33 percent) seniors had no drug coverage.[13] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established a voluntary Medicare outpatient prescription drug benefit (Part D) under which the 43 million Medicare beneficiaries could enroll in private drug plans starting January 1, 2006.

These plans vary in benefit design, covered drugs and utilization management strategies. Department of Health and Human Services (HHS) data show that, as of June 2006, 22.5 million Medicare beneficiaries had Medicare Part D drug coverage (including about 6 million low-income seniors and people with disabilities, known as dual-eligibles, who were transferred from Medicaid drug coverage to Medicare Part D drug coverage); 10.4 million had coverage from creditable employer/union plans, including FEHB and TRICARE retiree coverage; and an estimated 5.4 million had creditable drug coverage from the VA and other sources. About 5 million beneficiaries did not have coverage (were not enrolled in a Part D drug plan or a source of creditable coverage).[14]

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 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. As of mid-2007, 20 states had created some type of "wrap around" or supplemental state-funded assistance aimed at reducing the financial impact of premiums, copayments and non-covered pharmaceutical purchases. NCSL provides information about MMA and links to other important sources of information through its website.

- To gain an understanding of the issues and state options, see States and the Medicare Prescription Drug Act at **http://www.ncsl.org/programs/health/medicarerx.htm**.
- The Kaiser Family Foundation has issued several helpful articles about the effect of the law on dual-eligibles (Medicaid beneficiaries who are eligible for both Medicare and Medicaid). Those papers can be found at **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/MMAUpdate** [accessed June 2007]

Notes

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2. Congressional Budget Office, Would Prescription Drug Importation Reduce U.S. Drug Spending? (Washington, D.C.: U.S. CBO, 2004).
3. Federal Reserve Bank of Minneapolis, Consumer Price Index, 1913-Present (Minneapolis, Minn.: FRBM Web publication, 2007), http://www.minneapolisfed.org/research/data/us/calc/hist1913.cfm.
4. Kaiser Family Foundation, *Prescription Drug Trends Fact Sheet: May 2007 Update* (Washington, D.C.: Kaiser Family Foundation, 2007).
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7. Kaiser Family Foundation, *Prescription Drug Trends Fact Sheet: June 2006 Update* (Washington, D.C.: Kaiser Family Foundation, 2006).
8. Pharmaceutical Research and Manufacturers of America, R&D Spending by U.S. Biopharmaceutical Companies Reaches a Record $55.2 Billion in 2006, Feb. 12, 2007, http://www.phrma.org/.
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.
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13. Centers for Medicare and Medicaid Services, Chartbook: Medicaid Pharmacy Benefit Use and Reimbursement in 2001, http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp, accessed online April 20, 2007.
14. Centers for Medicare and Medicaid Services, Chartbook: Medicaid Pharmacy Benefit Use and Reimbursement in 2001, http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp, accessed online April 20, 2007.

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Other Sources

For updated information about state policy activities related to prescription drugs, go to NCSL's main prescription drug resource 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,** www.npcnow.org
- **AARP,** www.research.aarp.org/health
- **Pharmaceutical Research and Manufacturers of America,** www.phrma.org
- **National Association of Chain Drug Stores,** www.nacds.org
- **National Wholesale Druggists Association,** www.nwda.org
- **Generic Pharmaceutical Association,** www.gphaonline.org
- **National Community Pharmacists Association,** www.ncpanet.org
- **National Legislative Association for Prescription Drug Prices,** www.nlarx.org