

Medicaid Report: New Hampshire and Vermont

Prescription Drug Cost Containment

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Prepared by:
Jaime Padgett, Oyebola Olabisi, and Maxwell Young

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Contact:

Nelson A. Rockefeller Center, 6082 Rockefeller Hall, Dartmouth College, Hanover, NH 03755
<http://policyresearch.dartmouth.edu> • Email: Policy.Research@Dartmouth.edu

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EXECUTIVE SUMMARY

New Hampshire and Vermont, along with many other states, are currently struggling to contain the continually rising cost of Medicaid. In recent years, prescription drugs have been one of the largest and the fastest growing component of these costs in both states and across the nation. This report examines the impact of prescription drug costs on New Hampshire and Vermont Medicaid budgets. It presents the use of preferred drug lists (PDLs) and generic drugs, “fail first” requirements, and the extraction of supplemental rebates from drug manufacturers as possible options for reducing the strain placed on the states’ limited budgets. It explains the existing use of these methods in each state (where present), identifies potential avenues for further savings and provides important caveats to bear in mind when using these methods.

1. PRESCRIPTION DRUGS AND ESCALATING MEDICAID COSTS

Prescription drugs are the fastest growing component of Medicaid costs nationwide. Between 1997 and 2000, their share of Medicaid costs rose at an average of 18.1 percent per year.¹ New Hampshire and Vermont have both been especially affected by these rising costs. From 2002 – 2003, the total sales of retail prescriptions rose by 11.9 percent in New Hampshire and 10.4 percent in Vermont, both higher than the national average increase of 8.3 percent.²

Prescription drugs are not only the most rapidly increasing portion of Medicaid costs, they are also one of the largest components. Medicaid officials from 48 states cited pharmacy costs as one of the three top Medicaid costs in 2001.³ In 2004, Medicaid programs accounted for 29.6 percent of the total budget of New Hampshire; prescription drug costs accounted for 21.8 percent of total Medicaid expenditures, making pharmacy costs the second largest expenditure after only outpatient services.⁴ In the same year, Vermont allocated approximately 10.4 percent of its budget to Medicaid programs; 24.6 percent of that budget was used to pay for prescription drugs⁵.

New Hampshire spends about \$130 million on prescriptions drugs for its Medicaid recipients each year.⁶ Despite the co-pay (\$1 for generic drugs, \$2 for brand name or compound drugs) by recipients, a significant portion of these costs is borne by the state. The trend of rising pharmaceutical costs is expected to continue and total spending on prescription drugs in New Hampshire (not just Medicaid prescriptions) is projected to double in absolute terms from \$931 million to \$1.85 billion between 2004 and 2011.

Vermont has been similarly impacted by rising costs of prescription drugs, especially since it has several pharmaceutical assistance programs such as *VHAP Pharmacy*, *VScript*, and *Healthy Vermonters*. In a 2004 survey, Vermont officials listed rising cost of pharmaceuticals as one of the most important challenges the state faces in maintaining a balanced Medicaid budget.⁷ The cost of pharmaceuticals tripled from \$29.7 million in 1996 to \$87.4 million in 2002, an annual average growth rate of just under 20 percent.⁸

Given these two qualities of prescription drugs—their rapidly rising costs and large share of Medicaid budgets—a continuation of the current trend in their costs could have severe consequences for New Hampshire and Vermont Medicaid and state budgets. Although the provision of pharmaceutical drug coverage under Medicaid is optional, most states, including New Hampshire and Vermont, have decided to provide it.⁹ To fulfill this commitment without reducing the number of citizens eligible for Medicaid, both New Hampshire and Vermont are taking measures to contain the skyrocketing costs of these programs. They are pursuing their goals using three related programs: preferred drug lists, generic drug substitution, and supplemental rebates from manufacturers.

2. PREFERRED DRUG LISTS

Preferred drug lists (PDLs) are a listing of drugs in different therapeutic categories that have been identified by healthcare practitioners as efficacious, safe and cost effective choices. Medical practitioners are encouraged to prescribe drugs on this list, but if a Medicaid patient requires a drug that is not on the list, the practitioner may request Prior Approval (PA) from the state board by explaining why the preferred drug would not be medically appropriate. In most states, this request is made by sending a one-page form that indicates the basis for choosing a non-preferred drug to the designated office. The rationale for PA may include allergic reactions, drug-to-drug interaction, previous therapeutic failure, unacceptable side results, or unacceptable clinical risk from change.¹⁰ The approval process normally takes several days. Pending the receipt of the approval, the patient may obtain a three-day supply of the desired non-preferred drug.

Although PDLs were initially controversial when first adopted by California, they are now widely used across the country. Only five states are not either already operating a PDL or deliberating its use.¹¹ Vermont started operating a PDL in March 2001 and New Hampshire joined three years later in late 2004. Vermont has been able to gather substantial savings from its use of a PDL. Significant changes in the cost-sharing requirements of different Medicaid programs occurred simultaneously with the implementation of the PDL so the savings obtained cannot be exclusively attributed to the PDL. Pharmacy spending for the Aged, Blind and Disabled (a group that represents more than half of Medicaid pharmaceutical spending, and in which no cost-sharing changes were made) is a good program to isolate the effects of the PDL and other drug cost management programs. The growth rate of pharmaceutical spending of this group was substantially reduced by half from 5.7 percent in 2002 to 2.6 percent in 2003.¹²

Given the recent implementation of the PDL in New Hampshire, the savings it provides are still unclear. At its initiation in 2004, it was expected to produce \$6 million through rebates negotiated with manufacturers.¹³

3. GENERIC DRUG SUBSTITUTION

The national Centers for Medicare and Medicaid Services (CMS) encourages the aggressive substitution of brand name products with generic drugs as a major way states can save money using PDLs.¹⁴ FDA-approved generic drugs are subject to the same rigorous standards for effectiveness and safety as brand-name drugs. They are also similar to the brand-name product in terms of active ingredients, strength, dosage, labeling for approved uses, and route of administration. Hence, generic products perform the same functions as brand-name ones and have the same safety standards for a much lower cost. Both New Hampshire and Vermont have taken advantage of generic products and included several in their PDLs.

Some other states, most notably Minnesota and Idaho, have gone as far as to require that generic products be dispensed to Medicaid patients whenever one that is cheaper than the brand-name drug is available (even when a brand-name prescription was made). Both Minnesota and Idaho expect this policy to save \$10 million and \$11.7 million respectively.¹⁵ New Hampshire and Vermont may be able to obtain further savings through this program.

4. “FAIL FIRST” REQUIREMENTS

New Hampshire currently uses a preferred drug list and has experienced success with this strategy. However, this idea can be expanded to have increased cost savings. Using a fail first requirement (also known as step therapy), lists of drugs are developed in terms of cost efficiency. Before a patient is allowed to move on to a more expensive drug, the patient must have tried and found its cheaper version to be unsuccessful. For example, a patient would be prescribed ibuprofen before being prescribed Celebrex, which is more expensive. These types of programs are common for proton-pump inhibiting drugs, gastrointestinal conditions, and anti-arthritis drugs. In 2003, 27 states and the District of Columbia had a fail first requirement,¹⁶ resulting in a 74 percent reduction in the growth rate of costs as compared to prior years without the fail first requirement.¹⁷ However, the additional costs from the increased number of required doctor and pharmacy visits must be weighed against the potential savings from cheaper pharmaceuticals.

5. SUPPLEMENTAL REBATES

The savings from PDLs do not only come from having lower-priced drugs on the lists. The bulk of savings are normally obtained by demanding supplemental rebates from drug manufacturers. Pharmaceutical companies are required by law (The Federal Omnibus Budget Reconciliation Act of 1990, OBRA 90) to grant rebates to the government in order to have their product covered by Medicaid. These rebates are intended to guarantee that the government, through Medicaid, is not paying more than big chain stores or HMOs would pay for the same drugs.¹⁸ In addition to this standard rebate however,

several states are pursuing supplemental rebates from pharmaceutical companies as a criterion for being on their Preferred Drug Lists.

A key leverage point in negotiating these debates is the number of the Medicaid beneficiaries. As such, there are Multi-State Pooling Agreements in negotiations with pharmaceutical companies. Both New Hampshire and Vermont are participants in a multi-state pool that also includes Michigan, Alaska, Nevada, Minnesota and Hawaii. This arrangement was pioneered in 2003 by Vermont and Michigan who announced an 11 percent reduction in the growth rate of their respective pharmacy programs at the end of that year.¹⁹ This arrangement is particularly beneficial for small states like New Hampshire and Vermont, as it increases their negotiating capacity with pharmaceutical companies.

In addition to pooling with other states, New Hampshire and Vermont can pursue additional rebates by combining their pools of Medicaid recipients with their state employees to increase their negotiating power. This method was pioneered by Delaware which now has a buying entity that accounts for one-third of the entire pharmaceutical market for the state.²⁰

The experience of California, however, raises a warning for New Hampshire and Vermont. Obtaining more significant rebate contracts is not an end in itself; careful monitoring is essential for the actual collection of rebates. In California, it is estimated that about \$1 billion savings are lost in uncollected rebates each year due to loose record-keeping.²¹ Since maintaining detailed records is not a costless process, states must be sure to consider these extra costs when calculating the actual savings obtained from rebates.

6. CAVEATS REGARDING COST-CONTAINMENT STRATEGIES

Two major groups have raised substantial concerns to the aggressive pursuit of PDLs and supplemental rebates: advocates of patients with chronic illnesses who are concerned about the effects on patient care for this vulnerable group and pharmaceutical companies whose are financially adversely affected. A failed attempt at prescription caps in New Hampshire also provides valuable lessons on the need for cautious planning.

1. Health Advocates

Advocates of patients with chronic illnesses such as HIV/AIDS, mental disabilities, diabetes and chronic pain have given emphatic warnings across the country to exclude drugs in these therapeutic areas from PDLs.²² Currently, mental health advocates in New Hampshire are battling to keep in place certain protections that were granted to mental health patients when the use of PDLs was voted in. The protections include exempting drugs that are used to treat severe mental illnesses (such as schizophrenia, severe depression, and bipolar disorder) from the PDL and allowing patients already enrolled in Medicaid and stable on one or more drugs to continue using those drugs even if they do not make the preferred drug list.²³ These advocates highlight the importance of not

sacrificing patient care for savings, especially when dealing with the most vulnerable patients.

However, the largest cost items in the New Hampshire and Vermont prescription budgets—mental health (antipsychotics, anticonvulsants, and antidepressants), organ transplant, diabetes and anti-viral drugs—are the products used by these highly vulnerable patients.²⁴ Exempting these therapeutic areas from PDLs appears counter-intuitive since the resultant savings would not be as significant. However, the chronic, life-threatening nature of these diseases demands that policy makers proceed with extreme caution when making decisions. A delicate trade-off must be made between ensuring that adequate flexibility is provided so that patients can get the medicine they actually need regardless of whether or not they are “preferred,” and substituting for generic or otherwise cheaper drugs when possible. Currently, both New Hampshire and Vermont include mental health and diabetic therapeutic categories on their PDLs. However, the consensus reached by both the NPAF Principles for Implementation and the Kaiser Model Prescription Drug Prior Authorization Process for State Medicaid Programs is to recommend that these drugs be exempt from prior authorization.^{25,26}

2. Pharmaceutical Manufacturers

The pharmaceutical industry has been very aggressive in resisting these drug cost cutting strategies in order to prevent reductions in profits. The Pharmaceutical Research and Manufacturers Association of America has protested the collusion of states as buyers since prescription drugs for Medicaid are already discounted by at least 15 percent under the Omnibus Reconciliation Act.²⁷ The multi-state pooling initiative was thus strongly contested, but eventually upheld by a Federal Appeals Court in Washington.

3. Prescription Drug Cap

For an 11-month period, New Hampshire experimented with a prescription drug cap as a cost containment strategy. This strategy restricted the number of prescriptions each month, allowing only three prescriptions to be filled. The Agency for Healthcare Research and Quality determined that this strategy was ineffective. While expenditures on prescription drugs did decrease, an overall increase in expenditures was seen. Without necessary prescriptions, the overall health of Medicaid beneficiaries declined, resulting in overall program cost increases that were 17 times greater than the savings, with hospitalizations increasing by 35 percent.²⁸ The cap on prescriptions was removed.

7. CONCLUSION

New Hampshire and Vermont are involved in similar strategies to control the costs of pharmaceuticals, namely the use of Preferred Drug Lists and membership in a Multi-State Pooling Agreement to secure supplemental rebates. To further cut costs, these states may follow the examples of other states by

- expanding their PDLs to include a mandatory substitution of cheaper generic products instead of brand-name products, as is the case in Minnesota and Idaho;
- implementing a fail first requirement to encourage the use of cheaper drugs; or

- pooling the Medicaid and state employees to create greater buying leverage for supplemental rebates from pharmaceutical companies as Delaware does.

As New Hampshire and Vermont pursue cost cutting strategies, policy makers may also want to consider the long-term effect of policies on the chronically ill with sensitive medication requirements and the overall health maintenance of the Medicaid population.

8. REFERENCES

- ¹ The Kaiser Family Foundation. State Health Facts. Available: <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Health>. Accessed October 14, 2005.
- ² The Kaiser Family Foundation. State Health Facts. Available: <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Health>. Accessed October 14, 2005.
- ³ Vernon Smith and Eileen Ellis, Medicaid Budgets Under Stress: Survey Findings for State Fiscal Year 2000, 2001, and 2002, Health Management Associates, October 2001.
- ⁴ The Henry J. Kaiser Family Foundation, *Distribution of State General Fund Expenditures (dollar amount in millions), SFY2004* <<http://statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Demographics+and+the+Economy&subcategory=State+Budgets&topic=Distribution+of+General+Fund+Spending&gsaview=1>>.
- ⁵ Ibid.
- ⁶ NH Follows 37 Other States in Phasing in Preferred Drug list, Nov 12, 2004 – drug benefit news.
- ⁷ The Kaiser Commission on Medicaid and the Uninsured “Medicaid Financing” Available: <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=14261>. Last accessed October 16, 2005.
- ⁸ Rockefeller Report: Medicaid in New Hampshire and Vermont.
- ⁹ Managing Medicaid in Tough Times, State Legislatures Magazine, June 2002, Trinity D. Tomsic; Jo Donlin, NCSL.
- ¹⁰ New Hampshire Medicaid Prior Approval Form.
- ¹¹ The Kaiser Commission on Medicaid and the Uninsured “Medicaid Financing” Available: <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=14261>. Last accessed October 16, 2005.
- ¹² “Evaluation of Savings Attributable to Medicaid Pharmaceutical Cost Containment” February 2003. <<http://www.leg.state.vt.us/JFO/Healthcare/Pharmaceutical%20Savings.pdf>> Last accessed October 15, 2005.
- ¹³ NH Follows 37 Other States in Phasing in Preferred Drug list, Nov 12, 2004.
- ¹⁴ Safe and Effective Approaches to Lowering State Prescription Drug Costs: Best Practices Among State Medicaid Drug Programs. Centers for Medicaid and Medicare Services. <www.cms.hhs.gov/MedicaidDrugRebateProgram/downloads/StateStrategiestoLowerMedicaidPharmacyCosts.pdf> October 15, 2005.
- ¹⁵ Safe and Effective Approaches to Lowering State Prescription Drug Costs: Best Practices Among State Medicaid Drug Programs. Centers for Medicaid and Medicare Services. <www.cms.hhs.gov/MedicaidDrugRebateProgram/downloads/StateStrategiestoLowerMedicaidPharmacyCosts.pdf> October 15, 2005.
- ¹⁶ The Henry J. Kasier Family Foundation, “Cost Containment Strategies for Prescription Drugs: Assessing the Evidence in the Literature: Step Therapy or Fail First Requirements, 2005, p. 21.
- ¹⁷ Tucker, Gregory, et al., “A Cost Analysis of Four Benefit Strategies for Managing a Cox II Inhibitor, *Journal of Managed Care Pharmacy* 7(3): 224-227, May/June 2001.
- ¹⁸ Safe and Effective Approaches to lowering state prescription costs: Best Practices among state Medicaid Drug Programs (9/9/04) by Center for Medicare and Medicaid Services.
- ¹⁹ Press Release from Jim Douglas, Governor of Vermont February 17, 2004.
- ²⁰ “States That Stand Out.” Congressional Quarterly, Inc., DBA Governing Magazine February 2004.
- ²¹ “States That Stand Out.” Congressional Quarterly, Inc., DBA Governing Magazine February 2004.
- ²² “Health Advocates Question Medicaid Rules.” Managed Care Weekly Digest. March 1 2004.
- ²³ National Alliance for Mental Illness (NAMI). Mental Health Advocates-Ask your state senator to kill SB 383.
- ²⁴ Centers for Medicaid and Medicare Services (CMS), 2000 National Medicaid Statistical Information System Data.
- ²⁵ National Patients Advocates Foundation, “Principles for Implementation of a Preferred Drug List” <<http://www.npaf.org/statements.php?p=221>> Last Accessed October 15, 2005.

²⁶ A Model Prescription Drug Authorization Process for State Medicaid Programs, Kaiser Commission on Medicaid and the Uninsured, April 2003, prepared by the National Health Program.

²⁷ Associated Press State and Local Wire. Michigan and VT save money by managing drug purchases. Kathy Barks, October 30, 2003.

²⁸ *AHRQ Research to Reduce Cost and Improve the Quality of Health Care*, 2002, <http://www.ahrq.gov/research/costqual.htm>.