Analysis of Dual Eligible Pharmacy Costs Under Medicaid and Medicare Part D

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I. EXECUTIVE SUMMARY

Approximately 8 million Americans are simultaneously covered by Medicare and Medicaid. These "dual eligibles" account for approximately 40 percent of the nation's Medicaid spending as well as approximately 25 percent of Medicare expenditures.

Prior to 2006, the pharmacy benefit for these dual eligibles was covered through the states' Medicaid programs. Through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the pharmacy benefit for these dual eligibles was transferred from Medicaid to the Medicare Part D program once it was implemented in 2006. Because of the different legislations governing drug pricing under Medicaid and Medicare, this transfer of the prescription drug benefit to Medicare Part D has decreased the drug rebates given by manufacturers, and ultimately increased the cost of drugs given to this dual eligible population.

Under Medicaid, drug purchases made by the state through its fee-for-service (FFS) program receive federally-mandated rebates from drug manufacturers predicated on the "best price" available to other payers, with some exceptions to federal government purchasers such as the Department of Veterans Affairs (VA). In addition, several states have negotiated supplemental Medicaid rebates on top of the federally-mandated rebates. In total, these Medicaid rebates to state FFS programs can exceed 30 percent of initial drug claims cost.

Under Medicare Part D, the drug benefit is not administered through the federal government but through commercial stand-alone prescription drug plans (PDPs) and Medicare Advantage plans (MA-PDs), which are typically sponsored by large health insurance companies. As these Part D sponsors cover millions of lives, they have been able to negotiate rebates with drug manufacturers as well. However, these rebates for Part D plans typically average approximately 5-8 percent of initial claims cost, well below the federally-mandated rebates available to the Medicaid FFS program. Part D plans have demonstrated the ability to better manage the pharmacy benefit compared to the FFS setting through a reduction in overall drug utilization and an increase in use of generic drugs. Part D plans also pay slightly lower initial costs for prescriptions than do Medicaid FFS programs. However, the large rebate differential outweighs the other factors, creating considerably higher net pharmacy costs under Part D for duals eligibles than would otherwise have occurred under Medicaid.

Based on our estimates of price, rebate, and utilization differentials achieved through Medicaid and Medicare Part D, the transfer of the pharmacy benefit for dual eligibles into Part D increased pharmacy costs approximately $2.5 billion in 2006, or 15.2 percent, over the amount that would have been paid had the dual eligible pharmacy benefit remained covered under Medicaid. Trending at an annual rate of 8.6 percent, the pharmacy costs for the dual eligible population for the 5-year period of 2006-2010 are projected to be about $15.1 billion more under Part D than Medicaid, and over a 10-year period of 2006-2015, the costs are projected to be $37.9 billion more under Part D.

II. INTRODUCTION AND BACKGROUND

The Association for Community Affiliated Plans (ACAP) has engaged The Lewin Group to quantify the change in pharmacy expenditures for the dual eligible population under the Medicaid environment and the Part D environment. This report estimates the change in net pharmacy expenditures for the dual eligible population under Medicaid and Part D, from 2006 to 2015, making assumptions about the differences in initial pricing, benefits management, and rebates between Medicaid and Part D.

Approximately 8 million Americans are simultaneously covered by Medicare and Medicaid. This population, commonly referred to as "dual eligibles," accounts for approximately 40 percent of the nation's Medicaid spending as well as approximately 25 percent of Medicare expenditures.

Lewin tabulations using CMS MSIS data indicate that during 2005, total Medicaid spending on dual eligibles totaled $122 billion, or 44.6 percent of total Medicaid spending of $273 billion. With the 2006 implementation of Medicare Part D, Medicare became the primary payer for dual eligibles' prescription drugs. This shifts approximately $23 billion of claims expense from Medicaid to Medicare and lowers dual eligibles' share of Medicaid expenditures to 39.5 percent. However, states continue to contribute to the dual eligibles pharmacy costs through a financing mechanism referred to as the "clawback." When these clawback funds are included, dual eligibles represent approximately 42 percent of total Medicaid expenditures.

In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) established a prescription drug benefit, Medicare Part D, for the Medicare population beginning in 2006. Under Part D, the drug benefit is not administered by the federal government, but instead administered by private insurers who contract with Medicare. Included in the MMA was a provision that required the dual eligible beneficiaries to obtain their drug coverage through Medicare Part D starting January 1, 2006. Prior to the implementation of Part D, these dual eligible beneficiaries received their prescription drug coverage through their state's Medicaid program. This shift of pharmacy benefit for the dual eligible population from Medicaid to Medicare Part D has changed the dynamics of reimbursement, and ultimately the amount paid, for the prescription drugs for these eligibles.

Under the Medicaid Drug Rebate Program created under the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), brand name prescription drugs for the Medicaid population purchased by the state are subject to rebates from drug manufacturers based on the "average manufacturer price" (AMP) and "best price." AMP represents the average price paid by wholesalers or retail pharmacies to manufacturers. "Best price" is the lowest price available from the manufacturer to any payer excluding certain federal government purchasers (e.g., DOD, VA). For brand-name drugs, the OBRA rebate has two components. The basic rebate component for brand-name drugs is the maximum of either: (1) 15.1 percent of AMP or (2) the difference between AMP and best price. For multi-source generic drugs, the rebate is equal to 11 percent of AMP; there is no best price provision. In addition to the basic rebate, there is an additional rebate paid by manufacturers on brand-name drugs should the AMP of the drug increase faster than the overall inflation rate as measured by the Consumer Price Index (CPI-U). In addition to the federally mandated OBRA rebates, many states have negotiated supplemental rebates with

drug manufacturers on top of the OBRA rebates to ensure placement of particular drugs on the states' preferred drug lists.

The OBRA rebates are only given on purchases made directly by the state for the Medicaid population; Medicaid health plans do not receive these mandated rebates. Medicaid health plans have been able to negotiate some rebates with manufacturers on their own or through pharmacy benefits managers (PBMs) based on their large number of covered lives and ability to shift market share through formulary placement, though these rebates obtained by commercial plans are not nearly as substantial as the OBRA rebates obtained by state Medicaid programs. These health plans have used better management techniques to decrease overall drug volume and increase generic utilization rates in comparison to Medicaid fee-for-service (FFS); however, it has become increasing difficult for health plans to make up the costs difference between their management and rebates and the OBRA rebates. Much like the Medicaid managed care plans, the commercial Medicare Part D plans also do not have access to these OBRA rebates and will likely face similar rebate differentials. Due to the loss of the OBRA rebates, the coverage of the pharmacy benefit through Medicare Part D will increase net pharmacy expenditures for the dual eligible population as compared to coverage under Medicaid.

III. DERIVATION OF ESTIMATES

In order to model the impact of moving the pharmacy benefit for the dual-eligible population from Medicaid to Medicare Part D, we began with the estimated pharmacy costs for the dual-eligible population using the 2005 MSIS data for Medicaid. 2005 was the last year that the dual-eligible pharmacy costs were covered by Medicaid. Using assumptions about drug costs and utilization based on the differences in ingredient costs, dispensing fees, rebates, volume, and drug mix between Medicaid fee-for-service and Medicare Part D plans, we estimated the projected costs for these dual-eligibles under Medicaid and Medicare Part D for 2006 to 2015.

1. Estimate Initial Drugs Costs under Medicaid and Medicare Part D, before rebate

To estimate the initial dual-eligible pharmacy costs, pre-rebate, for 2006 to 2015 under Medicaid, we trended the 2005 MSIS data at 7 percent for price inflation and 1.5 percent for dual eligible population increases. These baseline costs are displayed in Table 4 as the "Initial Rx Claims Expense, Duals" estimates in the absence of Part D section. To estimate the initial Rx claims expense for duals under Part D, we made adjustments to the Medicaid FFS pre-rebate costs to account for the following factors:

a. Differences in initial reimbursement

Medicare Part D plans often reimburse pharmacies slightly less than Medicaid FFS for ingredient costs and dispensing fees for both brand and generic drugs. Based on published Medicaid reimbursement policies reported by CMS and confidential Medicaid HMO reimbursement policies shared with Lewin, we estimate that commercial plans, on average, reimburse pharmacies 4.2 percent less than Medicaid FFS for brand name drugs and 8.6 percent less for generic drugs.

We used the Medicaid drug utilization data available through CMS – these data are for purchases subject to the Drug Rebate Program and include the number of prescriptions, total reimbursement amount (before rebate, dispensing fee included), and brand/generic status for drugs at the NDC code level.[1] Using the national level data, we were able to calculate average cost per script for brand and generic drugs for the entire Medicaid FFS population for the first three quarters of 2007. Based on the national average cost per script for brand and generic drugs and drug mix for the Medicaid FFS population, the average weighted cost per script initially would be 4.7 percent lower for Medicare Part D plans than for Medicaid FFS due to the plans' lower reimbursement to pharmacies on ingredient costs and dispensing fees.

[1] http://www.cms.hhs.gov/MedicaidDrugRebateProgram/SDUD/list.asp

Table 1
Difference in Initial Cost per Script
Between Medicaid and Part D Plans

Cost per Script, Medicaid FFS mix	Brand	Generic	Avg. Weighted
Initial Medicaid FFS cost per script	$160.55	$19.41	$84.34
Percent Decrease under Part D plans	(4.2%)	(8.6%)	(4.7%)
Initial Part D cost per script	$153.85	$17.75	$80.36

b. Differences in brand/generic mix

Several studies have documented greater use of generics in the managed care setting compared to the FFS setting. Previous Lewin studies[2] have found upwards of a 10 percent increase in the generic utilization rate when carving-in the pharmacy benefit from FFS to Medicaid managed care plans. A 2007 Committee on Oversight and Government Reform analysis[3] showed the Medicaid FFS generic utilization rate at 54 percent and the Medicare Part D generic utilization rate at 59 percent, a 5 percent improvement for the commercial plans. Based on the Committee's analysis, we attributed a 5 percent increase in the generic utilization rate for the Part D plans over Medicaid FFS. With a 5 percent increase in the generic utilization rate and the initial Part D plan cost per script from Table 1, the initial cost for Part D plans will decrease an additional 8.5 percent.

Table 2
Shift in Generic Utilization Rate
From Medicaid FFS Mix to Part D Plan Mix

Part D Plan Cost per Script	Brand	% of Scripts	Generic	% of Scripts	Avg. Weighted
Cost per script, Medicaid FFS mix	$153.85	46%	$17.75	54%	$80.36
Cost per script, Part D mix	$153.85	41%	$17.75	59%	$73.56
Percent Difference	$153.85		$17.75		(8.5%)

c. Differences in overall utilization

Additionally, Lewin has also documented that the usage rate of prescriptions is lower in the Medicaid managed care setting than in the Medicaid FFS setting. While these Lewin studies have found substantial volume reductions for the Medicaid population under managed care, these studies did not directly break out differences among the dual eligible population. Based on the small shift in generic utilization we estimated above, we believe that Part D plans have

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[2] Lewin Group studies include, "Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs" (October 2007), "Financial Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs" (October 2007), "Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System" (November 2003), and "Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting" (January 2003).

[3] US House of Representatives Committee on Oversight and Government Reform, Majority Staff; Private Medicare Drug Plans: High Expenses and Low Rebates Increase the Costs of Medicare Drug Coverage; October 2007.

had some success in managing the dual-eligible Medicare population, but not to the extent that Medicaid MCOs have had managing the TANF and non-dual eligible SSI population. We estimated a conservative decrease of 3 percent on the prescription volume under Part D.

Table 3
Adjustments to Initial Medicaid FFS costs, Pre-rebate

	Adjustment	Initial Dual Eligible Rx Spend, 2006 (in Billions $)
Medicaid FFS, pre-rebate		$24.8
Part D plan, difference in initial reimbursement	(4.7%)	$23.7
Part D plan, difference in generic/brand mix	(8.5%)	$21.6
Part D plan, difference in overall prescription volume	(3.0%)	$21.0

Collectively, these adjustment create a 15.4 percent decrease in the initial drug spend for the dual eligible population under the Part D plans (note the impact of each of the three adjustments are multiplicative rather than additive).

2. Estimate Rebates under Medicaid and Medicare Part D

Under the Medicaid Drug Rebate Program, prescription drugs for the Medicaid population purchased by the state are subject to rebates from drug manufacturers based on AMP and best price. In addition, there is an additional rebate paid by manufacturers should the AMP of the brand-name drugs increase faster than the normal inflation as measured by the CPI-U. In addition to the federally mandated OBRA rebates, many states have negotiated supplemental rebates with drug manufacturers to ensure placement of their drugs on the states' preferred drug lists. Based on Medicaid pharmacy rebate information we have for a few states, we estimate that an average rebate total of approximately 32. 5 percent of initial claims cost (30 percent in OBRA rebates and 2.5 percent in supplemental rebates). These OBRA and supplemental rebates would no longer apply for the dual-eligible population under the Part D plans.

Commercial plans do not have access to the substantial OBRA rebates. However, many plans have been able to negotiate rebates with drug manufacturers based on their substantial volume of covered lives and the ability to shift market share through formulary placement. These rebates negotiated by commercial plans are not nearly as substantial as the OBRA rebates. Based on conversations with actuaries that have prepared Part D plan bids and data collected from the US House of Representatives Committee on Oversight and Government Reform,[4] we have placed these rebates at 8.1 percent.

[4] US House of Representatives Committee on Oversight and Government Reform, Majority Staff; Private Medicare Drug Plans: High Expenses and Low Rebates Increase the Costs of Medicare Drug Coverage; October 2007.

IV. CONCLUSIONS

As shown in our estimates of total drug costs under Medicaid FFS and Medicare Part D for the dual eligibles in Table 4, we project that the pharmacy costs for the dual-eligible population was approximately $2.5 billion, or 15.2 percent, greater under Part D than it would have been under Medicaid FFS in 2006. Between 2006 and 2015, we have assumed a constant annual trend in pharmacy costs of 8.6 percent, which incorporates a 7 percent price inflation trend and a 1.5 percent trend for population increases. In addition, we have assumed that rebate percentages for both the Medicaid program and Part D plans remain constant over this timeframe. Over the 2006 – 2010 timeframe, the pharmacy costs for the dual eligible population are projected to be about $15.1 billion more under Part D than Medicaid, and over a 10 year period of 2006-2015, the pharmacy costs are projected to be $37.9 billion more under Part D.[5]

This difference is driven in large by the mandated OBRA rebates that Medicaid receives. Due to the additional rebate that Medicaid receives due to the AMP rising faster than typical inflation, Medicaid often pays a net amount that is below best price. Part D plans are presumed to reduce drug spend through better management of the pharmacy benefit, leading to a reduction in overall prescription volume and a better mix of brand and generic drugs.

[5] Our focus is on the cost of the medications themselves. Thus, our analyses do not factor in the costs of administering the pharmacy benefit (neither prior to nor after Part D implementation). Similarly, our assessment does not factor in the profit margins that Part D plans may be earning on the dual eligible population.

Table 4
Dual Eligible Nationwide Pharmacy Cost Estimates
With and Without Part D

Estimates In Absence of Part D	2005	2006	2007	2008	2009	2010	2006-2010	2006-2015
Initial Rx Claims Expense, Duals	$22,856,194,601	$24,822,970,146	$26,958,986,728	$29,278,807,535	$31,798,248,924	$34,534,488,244	$147,393,501,577	$370,097,203,408
Average Rebate (% of claims cost)	32.5%	32.5%	32.5%	32.5%	32.5%	32.5%	32.5%	32.5%
Rebate Dollars	$7,428,263,245	$8,067,465,298	$8,761,670,686	$9,515,612,449	$10,334,430,900	$11,223,708,679	$47,902,888,013	$120,281,591,108
Net Claims Cost	$15,427,931,356	$16,755,504,849	$18,197,316,041	$19,763,195,086	$21,463,818,024	$23,310,779,565	$99,490,613,564	$249,815,612,300

Key Assumptions:

•Initial claims expense for 2005 are actual, tabulated using CMS MSIS data.

•Annual increases assume 7% increase in costs per person and 1.5% increase in number of dual eligibles

•Rebate percentage based on data provided to Lewin from a few states

Estimates Under Part D	2005	2006	2007	2008	2009	2010	2006-2010	2006-2015
Initial Rx Claims Expense, Duals	$22,856,194,601	$21,000,136,933	$22,807,198,716	$24,769,758,166	$26,901,195,856	$29,216,043,759	$124,694,333,430	$313,100,805,596
Average Rebate (% of claims cost)	32.5%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%
Rebate Dollars	$7,428,263,245	$1,701,011,092	$1,847,383,096	$2,006,350,411	$2,178,996,864	$2,366,499,545	$10,100,241,008	$25,361,165,253
Net Claims Cost	$15,427,931,356	$19,299,125,842	$20,959,815,620	$22,763,407,754	$24,722,198,992	$26,849,544,215	$114,594,092,423	$287,739,640,343
Net Rx Spend Difference Under Part D		$2,543,620,993	$2,762,499,579	$3,000,212,668	$3,258,380,968	$3,538,764,650	$15,103,478,858	$37,924,028,043
Net % Difference Under Part D		15.2%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%

Key Assumptions:

•Initial claims expense assumed to be 15.4% below the baseline (non Part D) projections, due to lower initial reimbursement to pharmacies for ingredient costs and dispensing fees, lower overall volume, and a higher mix of generic drugs under Part D at-risk private insurance companies

•Annual increases assume 7% increase in costs per person and 1.5% increase in number of dual eligibles

•Rebate percentage based on estimates from US House of Representatives Committee on Oversight and Government Reform, Majority Staff, Private Medicare Drug Plans: High Expenses and Low Rebates Increase the Costs of Medicare Drug Coverage (Oct. 2007)