

**BRIEF ANALYSIS**

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## Medicaid Waivers: Wrong Cure for High Drug Prices

By Robert Goldberg

The Health Care Financing Administration (the agency that runs Medicare and Medicaid) can waive some federal requirements for Medicaid eligibility to allow states to experiment with new ways of delivering health care to the poor. Near the end of the Clinton administration, HCFA granted waivers to Maine and Vermont for programs allowing many people ineligible for Medicaid to get Medicaid prescription drug coverage.

For regular Medicaid beneficiaries, the state Medicaid program pays prescription costs for drugs that the program covers. Under federal law, the drug companies then rebate at least 18 percent of the price to Medicaid. However, individuals added under the waivers would pay for the prescriptions themselves, but would get a discount at the pharmacy of about 18 percent on Medicaid-approved drugs. The drug companies would have to pay the rebate to Medicaid, which would reimburse the pharmacy for the discount. The idea is to lower prescription drug prices for low-income consumers, especially seniors without drug coverage through a managed care plan or medigap policy.

State health officials see the discount as a cost-free way of offering a drug benefit, since the benefit would be subsidized by the drug companies rather than by taxpayers. As a result, several other states, including Wisconsin and California, are planning to submit similar waiver requests.

**Misdirecting Resources.** The Medicaid waivers granted in Vermont and Maine will do little to help those

with the greatest need. For instance, the Vermont program covers individuals with incomes at or below 300 percent of the federal poverty level (about \$26,800 for an individual). As a group, seniors at that income level without drug coverage spend only 3 percent or less of their income on prescription drugs, and non-seniors spend only half that much. Chronically ill seniors at that income level spend nearly 30 percent of their income on drugs, but even for them a waiver-enforced discount would offer only marginal help. As the figure shows, a senior at the federal poverty level of \$8,959 and spending 30 percent of his or her income or \$2,688 would

receive only about \$483 in discounts under a waiver plan.

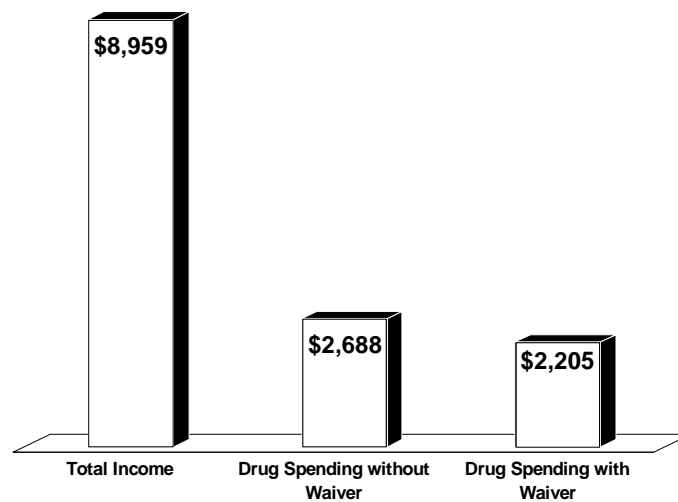
In addition, past federal efforts to lower Medicaid drug prices have partially backfired. For example, in 1990 Congress required drug manufacturers to give state Medicaid programs rebates for outpatient drugs based on the lowest prices they charged managed care plans and hospitals. Because the Medicaid market was so large, many drug manufacturers sought to minimize the impact of the rebates by raising their lowest prices to private customers. Thus an attempt to help

one group of consumers harmed another group.

**Crowding Out Private Prescription Drug Coverage.** Subsidizing prescription drug coverage for those currently without it attracts many people who would otherwise purchase private coverage. This is what has happened with health insurance. For example:

- Between 50 percent and 75 percent of the increase in Medicaid coverage between 1987 and 1992 was associated with a reduction in private insurance coverage, according to a study by the National Bureau of Economic Research.
- In the first year after the State Children's Health Insurance Program was implemented in 1997, the

### Effect of a Waiver on Poor Chronically Ill Senior's Prescription Drug Spending



percentage of children from low-income families with public coverage rose from 29 percent to 33 percent, the rate of private coverage fell from 47 percent to 42 percent and the percentage of uninsured stayed about the same.

If drug coverage waivers were extended, companies would have an incentive to scale back drug coverage for workers, particularly older workers and retirees. And HMOs that have already reduced drug coverage in the Medicare HMO program for seniors would have an incentive to reduce coverage even more.

**Leading to Restrictions on Access to New Medicines.** If more Americans received their prescription drug coverage from Medicaid, more would face restrictions and delays in access to important medicines: For example:

- In one HMO, children with private insurance were 70 percent more likely than Medicaid-insured children to receive asthma-controlling medication, and Medicaid-insured children were 1.4 times more likely to need emergency care and 1.3 times more likely to be hospitalized for their asthma.
- A 1992 study found that a typical new drug took 20 months after approval by the Food and Drug Administration to get on Medicaid's list of approved drugs, and new drugs were available to Medicaid patients less than 40 percent of the time during their first four years of market life.

In Canada and Europe, where the governments negotiate for large public health programs, the protracted price negotiations lead to long delays in getting new drugs.

- Of 22 breakthrough drugs approved for sale in Europe since 1986, patients had to wait an average of more than two years after approval (three years or longer in France, Germany, Belgium, Greece and Portugal) to get the drugs, due to price negotiations.
- In 1998, in Canada's four most populous provinces — Ontario, Quebec, British Columbia and Alberta — delays related to formulary coverage decisions for all new drugs ranged from 445 days to 984 days.

**Backdoor Price Controls.** Currently Medicaid constitutes 15 percent of the U.S. pharmaceutical market. If Medicaid drug benefits were extended to all individuals with incomes below 300 percent of the poverty level through waivers, that would put 47 percent of all con-

sumers under a price control scheme, creating de facto national price controls on pharmaceuticals. A waiver for California alone would expand Medicaid price controls to 11 million people in addition to about 3.1 million already on the state Medicaid program.

In the past, companies have been able to offset Medicaid price rebates with price increases and discount reductions. But if the federal government controls a much larger market and is able to delay access to that market through protracted price negotiations, it's likely that private companies will lose more revenue in the future. Further, government control of a larger share of the pharmaceutical market will provide even greater leverage for deeper discounts.

**Less Research and Development.** In Europe, Japan and Canada, price controls, rebates and limits on profits have been associated with a steady decline in the rate of introducing important new medicines compared to American companies. As a result, foreign companies have moved their research operations to the United States and have invested heavily in U.S. biotech concerns. The United States leads the world in new drugs, capital formation and patents involving biotechnology, genomics and the emerging field of sequencing proteins from genetic information. Profits from drugs consumed today are invested in these technologies, which in turn are used to pursue drug discovery and development that may not bear fruit for several years. If the profits are not there, there will simply be less research or the research and the medicines that flow from it will be more expensive.

**Conclusion.** Medicaid waivers to allow consumers to purchase prescription drugs at a controlled Medicaid price have been heralded by some as an interim solution to the problem of high drug costs for people without prescription drug coverage. In fact, Medicaid discounts will do little to help individuals in greatest need and will have adverse effects including the crowding out of private coverage, limits on access to new drugs and longer waits for important new medicines. Further, waivers can result in de facto price controls that sap revenues from research at a time when America's investment in medical progress is poised to yield even greater blessings for human health.

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