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State Reform of Medicaid Drug Programs

Policy Backgrounder No. 165 by Devon Herrick May 2012

Medicaid is a joint federal-state program that provides medical care to more than 60 million low-income individuals and families.[1] Medicaid rolls in many states have risen over the past several years as a result of the recession and continuing high unemployment. Indeed, in 2011 the average growth rate in Medicaid spending was about 6.1 percent.[2]

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The program is the largest single expenditure by state governments today, accounting for one-in-every-five dollars of state spending. Medicaid is currently on course to consume the entire budgets of some state governments in just a few decades.[3, 4]

Restraining the growth of Medicaid spending is a fiscal imperative for state budgets. States should start by looking for ways to control spending in their drug benefit programs. Billions of dollars in potential savings could be realized without reducing access to needed care for any Medicaid enrollees.

Broader use of prescription drugs for chronic illness can reduce Medicaid costs by avoiding expensive emergency room visits, costly complications and surgeries. Examples include drugs to treat asthma, diabetes and heart disease. State Medicaid programs that fail to realize the full benefits of drug therapy could end up paying more for more costly hospital treatments. This problem is particularly acute due to the expected increase in Medicaid enrollment as a result of the Patient Protection and Affordable Care Act (ACA).

The ACA will significantly expand Medicaid eligibility to individuals with incomes from 100 percent to 133 percent of the federal poverty level. Over the next few years, Medicaid and Children's Health Insurance Program (CHIP) enrollment is expected to swell to nearly 84 million people.[5] The Congressional Budget Office estimates the new law will add 16 million Medicaid enrollees.[6] Other estimates place the number of additional enrollees closer to 20 million.[7]

Initially, the federal government will pay 100 percent of the cost for the newly eligible who enroll, and 95 percent of costs through 2019. However, new enrollees who were previously eligible for Medicaid must be paid for under each state's current federal matching formula.[8] When the individual mandate requiring all legal U.S. residents to obtain health coverage takes effect in 2014, 10 million or more previously eligible uninsured are likely to be enrolled in Medicaid through outreach efforts.[9] As a result, state Medicaid spending will soar.[10]

Medicaid Spending on Drug Therapy

Americans see their doctors more than 890 million times each year, and two-thirds of office visits to physicians result in prescription drug therapy.[11] Indeed, drug expenditures are one of the fastest growing components of the Medicaid program.

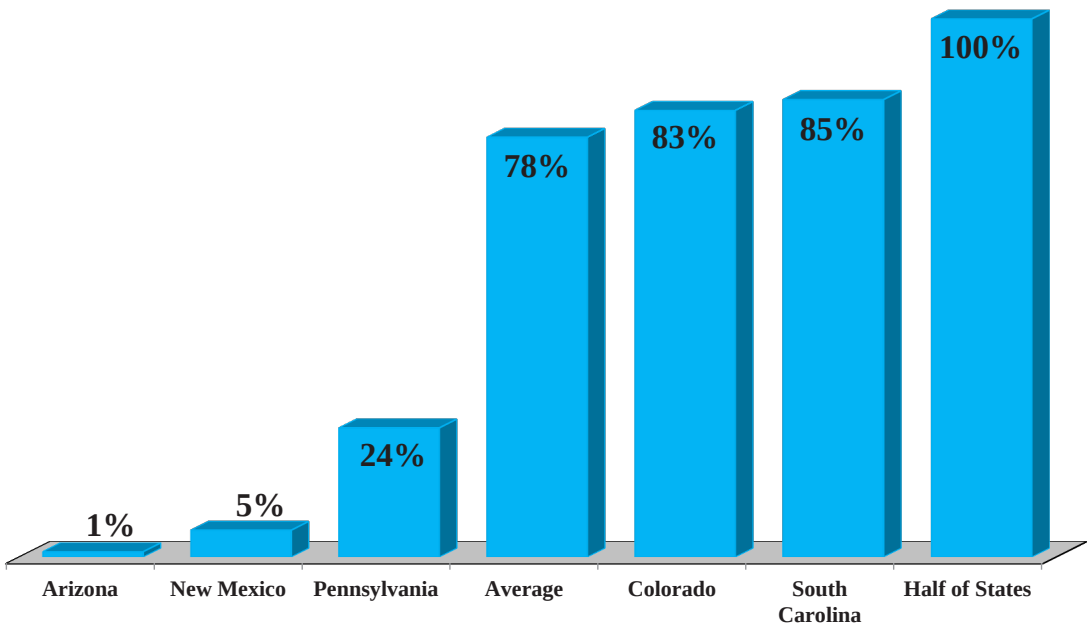
Numerous studies by Columbia University professor Frank Lichtenberg have found that increased spending on newer, patented drug therapies is often offset by reduced spending on inpatient care.[12] Drug treatment for schizophrenia, for example, can help avoid costly hospitalizations. A variety of drugs exist to treat this condition, but some are more effective and better tolerated by some patients than by others. Thus, individual state laws that make it difficult for schizophrenia patients to obtain the appropriate medication result in more expensive inpatient treatment.

The Role of Private Drug Plans in Reducing Medicaid Drug Costs. The way state Medicaid drug programs work depends on whether drug benefits are managed by a private health plan, run by state officials or administered by a pharmacy benefit manager (PBM) — a private firm that contracts with a state. Regardless of the program's structure, Medicaid enrollees still usually purchase their drugs at local pharmacies that are reimbursed for the cost of each prescription filled, plus a dispensing fee.

States that manage their own drug benefits may negotiate drug discounts and also receive federally-required drug rebates. The prices states pay for drugs often differ from one state to the next; sometimes from one pharmacy to the next. In private plans, pharmacy benefit managers typically negotiate drug dispensing fees with pharmacies. Rather than using these negotiated fees, however, states often arbitrarily pay pharmacies much more. For instance, most conventional Medicaid programs pay higher dispensing fees than privately run Medicare Part D drug plans. Virtually all state Medicaid programs manage some of their drug distribution, and half the states distribute all of their Medicaid drugs this way. Overall, nearly three-fourths (73 percent) of Medicaid drug spending is reimbursed and administered separately from a health plan.

Figure I

Percent of Medicaid Drugs on a Fee-for-Service Basis



Source: Joel Menges, Shirley Kang and Chris Park, "Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs Were Optimally Managed," Lewin Group, February 2011.

Many states "carve out" pharmacy benefits and administer them separately from health plans on a fee-for-service basis. This is the way conventional state Medicaid drug benefits are administered for enrollees not in managed care. [See Figure I.]

Private health

plans use a variety of techniques to control drug costs, including preferred drug lists, formularies, required use of mail-order drug suppliers, and negotiated prices with drug companies and distributors.[13] Health plans frequently contract with pharmacy benefit managers to promote the use of cost-effective drugs within specific classes to reduce costs.

Because they operate in a competitive environment, private drug plans tend to administer drug benefits more efficiently than state Medicaid programs. They can negotiate agreements for drug reimbursements and dispensing fees that are less lucrative to providers than state-run Medicaid programs, which are susceptible to the political influence of lobbyists and special interests.

Special interests lobby legislatures to restrict the ability of pharmacy benefit managers to negotiate better deals. Their efforts have been intense. Indeed, when the Lewin Group, a consulting firm, released reports highlighting methods to improve Medicaid drug program efficiency, trade associations at risk of losing income responded swiftly.[14] Representatives for community pharmacists argued that patients could be harmed, alleging Lewin's results were "bought and paid for" by drug plans.[15]

How Federal Policy Discourages Integrating Drug Benefits with Health Benefits. The federal government requires drug manufacturers to rebate to state Medicaid programs at least 23.1 percent of the average manufacturer's (wholesale) price for brand drugs and 13 percent for generic drugs. States often negotiate additional rebates, and total Medicaid rebates average nearly 40 percent.[16] Prior to the ACA, the rebates were available for state-administered drug programs, but not to privately operated drug plans. Thus, in order to receive the rebates, many states chose to carve out drug benefits and administer them separately from private contractors' integrated health plans.[17] Lately, states have begun to "carve in" (that is, integrate) Medicaid drug benefits with enrollees' health benefits and place more Medicaid enrollees in managed care plans.

> *"States that administer their own Medicaid drug benefits could save money by using private contractors."*

How State Policies Preclude Efficient Drug Programs. A variety of state laws hamper negotiations between Medicaid drug plans, drug makers and pharmacies. Two of these are "any willing provider" and "freedom of choice" laws. Nearly half the states have any willing provider laws that require insurers, health maintenance organizations and drug plans to allow into their provider network any pharmacy that accepts the terms of their provider contract.[18] Similarly, freedom of choice laws allow enrollees to fill a prescription at almost any pharmacy willing to abide by the terms of the networks' contracts. In general, enrollees cannot be required to fill prescriptions only at selected pharmacies and often cannot be required to use the drug plans' mail-order pharmacy. This is the case in Texas and other states. Recent changes to the Texas Medicaid drug program prevent drug plans from requiring enrollees to use more efficient mail-order pharmacies. Regulations also deter selective contracting with some pharmacies while excluding others. In addition, drug plans must adhere to the Vendor Drug Program (which processes out-patient pharmacy prescriptions for Medicaid, CHIP and other public health programs in Texas) and the state drug list.[19]

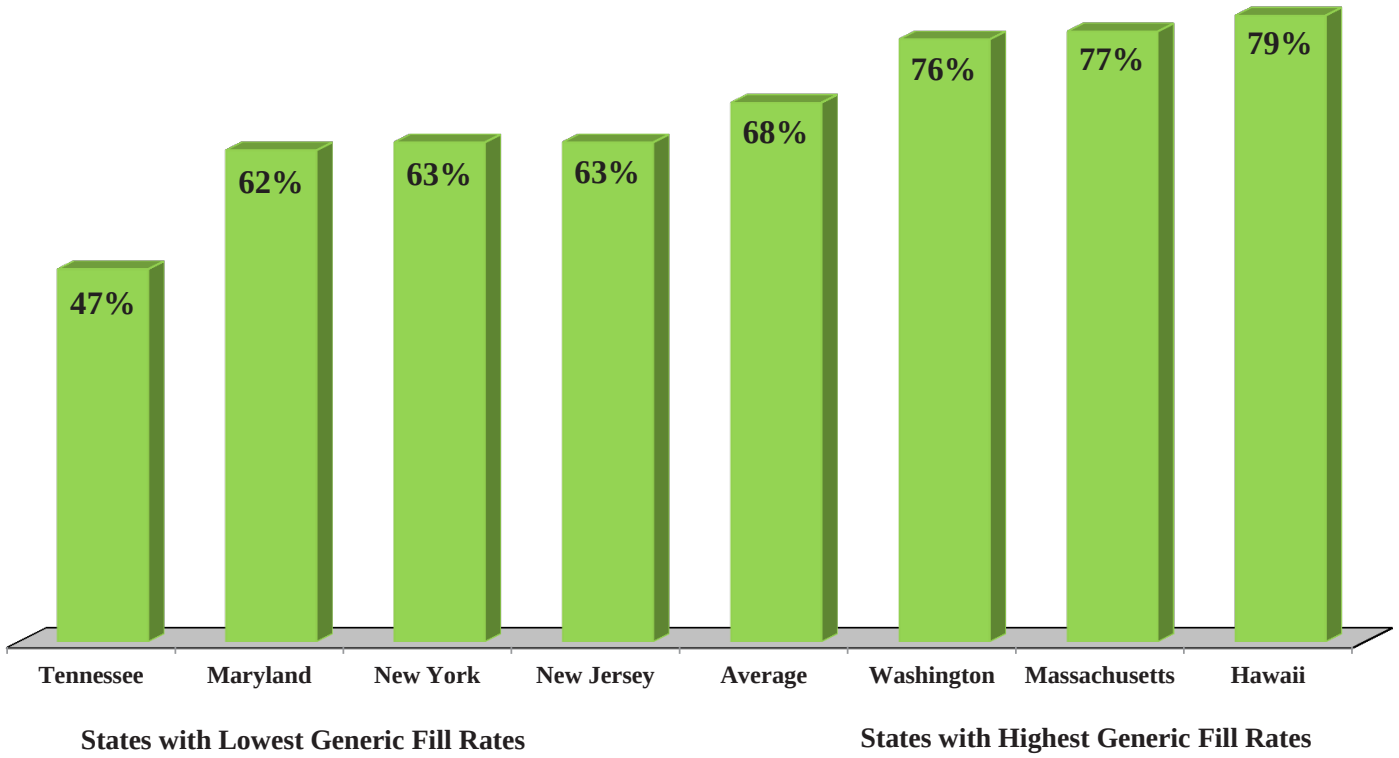
Consumer protection laws are costly to taxpayers; when drug plans create pharmacy networks they negotiate with pharmacies for the best prices. This ultimately holds down state Medicaid drug plan expenditures. The negotiated prices are the result of bargaining power — the ability of the drug plan to deny business to a firm. However, any willing provider and freedom of choice laws interfere with that negotiating process by reducing the drug plans' bargaining power.[20]

Proponents of unrestricted drug plans argue they offer enrollees a larger network of providers, with more choice and competition. Opponents counter that these laws prevent selective contracting, whereby a pharmacy chain agrees to deeper discounts in return for steering a greater volume of business to them by making them the exclusive in-network drug vendor. The evidence is that any willing provider laws increase drug expenditures by preventing the sort

Figure II

Use of Generic Drugs in Fee-for-Service Medicaid

(percent of prescriptions)



Source: Joel Menges, Shirley Kang and Chris Park, "Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs Were Optimally Managed," Lewin Group, February 2011.

of negotiation that accompanies the ability to selectively contract.[21] These laws also boost the administrative burden by about 43 percent, by increasing the number of pharmacy claims that must be adjudicated and paid.[22]

Laws limiting the ability of drug plans to sign exclusive agreements in return for lower prices protect less-efficient pharmacies from competition. The Federal Trade Commission notes that these laws reduce bargaining power, which leads to higher drug prices and higher premiums.[23] Thus, any willing provider and freedom of choice typically benefit pharmacies rather than consumers.[24]

Some states also specifically limit copayments and prohibit different copayment amounts among pharmacies, keeping managed care organizations and pharmacy benefit management companies from steering Medicaid enrollees to preferred pharmacies. This policy reduces competition by artificially standardizing copayments.

State Drug Lists as a Barrier to Reform. Many states carve out portions of their pharmacy program to retain state control of pharmacy benefits for special beneficiary groups and classes of drugs. For instance, some states use state-specific prescription drug lists, rather than preferred drug lists negotiated and developed by pharmacy benefit managers. One survey comparing drug lists from state-run Medicaid programs to the World Health Organization's "Essential Medicines" list found the drugs automatically covered were arbitrary and varied from state to state.[25] State-sponsored drug lists give special interests and lobbying organizations the opportunity to influence state Medicaid

formularies, increasing costs to taxpayers and reducing competition among drug makers vying to be on the preferred drug list. One example is New York state, where "prescriber prevails" regulations limit the ability of drug plans to steer enrollees to more cost-effective drugs, such as generic versions of name-brand drugs.[26]

State drug lists can also adversely impact patient care when they are poorly designed. Indeed, Medicaid programs run the risk of creating lists that boost utilization of other, more costly medical services — such as inpatient services.[27] Pharmaceutical trade associations caution that expensive physician (and inpatient) care often substitutes for less expensive drug therapies.[28] There is evidence that some states do not consistently establish preferred drug lists that satisfy patients' needs.[29] Poorly designed drug lists discourage the use of beneficial medications or encourage the use of medications that are less safe and effective.[30]

Potential Savings from Integrating Drug Benefits and Coordinating Care. State Medicaid programs that carve out drug benefits often do not pay sufficient attention to coordination and management of drug therapies. This responsibility is essentially taken away from health plans and taken over by the state. This can lead to drug policies that harm patients.[31] For instance, the state of New Hampshire implemented an arbitrary prescription limit on psychiatric drugs in 1990 that led to an increase in the use of emergency mental health services and hospitalizations for people with schizophrenia. The additional medical costs associated with poor medication management was 17 times the savings from limiting prescriptions.[32] The Lewin Group has found that drug benefit programs that are integrated with privately-run health plans are more cost-effective than when they are administered separately.[33] Indeed, a Lewin analysis found that integrating Medicaid health plan and drug benefits in 14 states that currently exclude drug coverage from Medicaid private health plans would collectively save nearly $12 billion over a decade.[34]

"Combining drug and medical plans could save Medicaid billions of dollars."

Cost-Saving Strategies

The Lewin Group estimates that state and federal governments could save $32.7 billion over 10 years by improving the efficiency of their Medicaid drug programs without detriment to enrollees' health.[35]

There are several effective strategies that states can use to better manage and lower Medicaid drug costs. Two of the most important are encouraging generic drug use when appropriate and paying competitive market rates for drug dispensing.

Encouraging Generic Drug Use Where Appropriate. There are numerous drug therapies to treat most conditions, some of which cost more than others. Patients can lower drug expenditures by taking available generic versions of medications. For instance:

- The U.S. health care system saved $824 billion over the past decade from the use of generic drugs, according to one estimate.[36]
- For retail customers, generic drug prices are generally 20 percent to 80 percent lower than the original branded drug.[37]

Only those medications whose patent has expired are available in generic form, however. Some well-known drugs that have recently lost patent protection include Prozac and Zoloft (for depression), Claritin, Allegra and Zyrtec (for allergy relief), Zocor (to lower blood cholesterol), and Prevacid and Prilosec (for ulcers and gastric reflux disease). The number of generic equivalents available will increase over the next few years as many so-called blockbuster drugs lose patent protection and face generic competition. Indeed, many of the current top-selling name brand drugs will lose patent protection by the end of 2014.[38]

Today about 78 percent of the prescriptions Americans fill are generic drugs.[39] This compares to about 19 percent in 1985.[40] Two-thirds of the drugs dispensed by the Veterans Affairs (VA) health system are generic, but they represent only 8 percent of the VA's prescription costs.[41] Though generic drugs are widely prescribed, there are potential

savings from even wider use:[42]

- Generic drugs make up 64 percent of all Medicaid prescriptions, but less than one-fifth (18 percent) of Medicaid drug spending.
- The average cost of a generic drug prescription in the Medicaid program is $20, compared to the $201 average for name-brand medications (including drugs for which there are no generic equivalents).

States can save money by encouraging generic drug utilization when appropriate. Indeed, most patients should consider a generic drug with the understanding they can switch to a newer (brand) drug under patent protection if they have an adverse reaction or do not respond well to the generic.

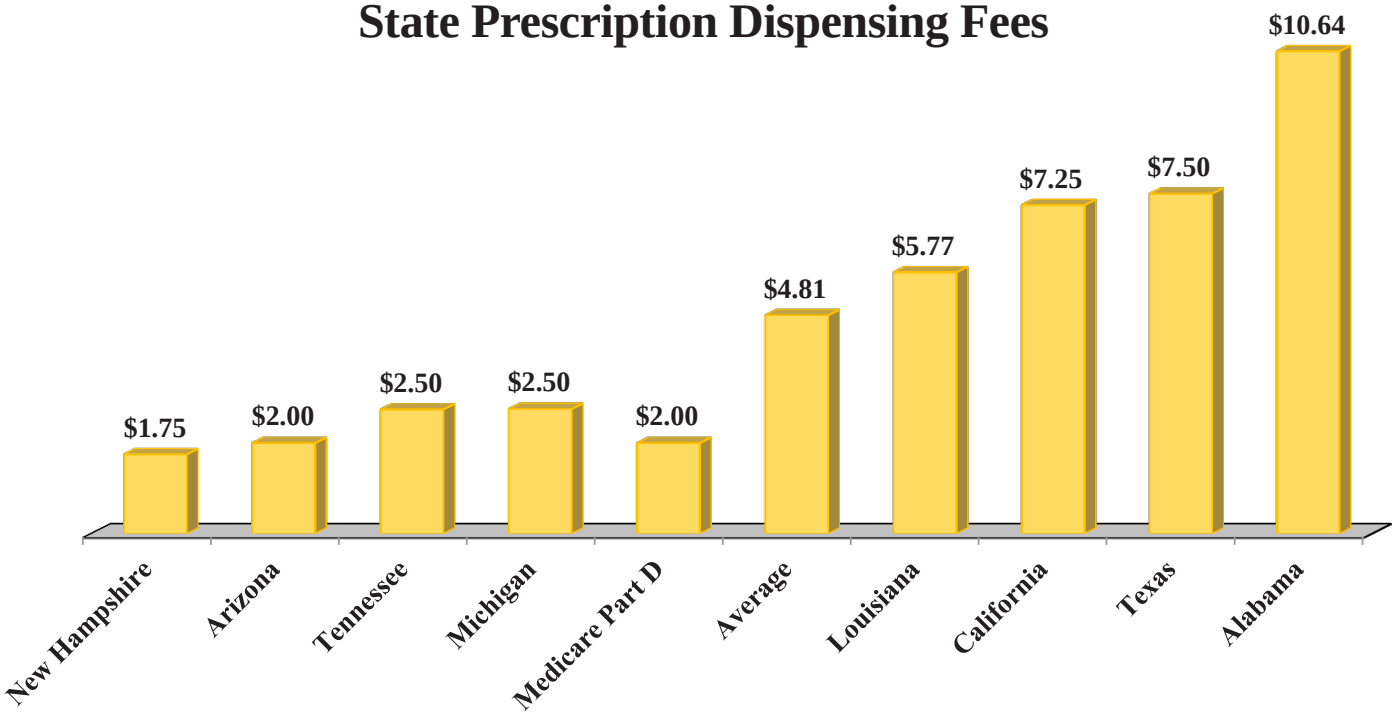
A 100 percent generic fill-rate is not the ideal way to save money or ensure quality. The appropriate use of generic drugs — including those circumstances when a newer, patented drug is more suitable — will vary from patient to patient and from drug to drug. Lichtenberg has repeatedly argued that reduced mortality is associated with the introduction of innovative (patented) drugs.[43] In creating preferred drug lists, the health of the patient should be the primary concern. There should also be protocols for those situations when a physician believes a patented drug is more appropriate.

Across all 50 states, the average proportion of prescriptions filled with a generic drug in conventional state-managed Medicaid drug programs is just over two-thirds (68 percent), compared to 80 percent for drug programs that are run by Medicaid health plans.[44]

- The lowest users of generic drugs are Tennessee (47 percent), Maryland (62 percent), New York

Figure III

State Prescription Dispensing Fees



Note: Arizona has a small fee-for-service program; Medicare Part D for comparison purposes only.

Source: "Medicaid Prescription Reimbursement Information by State – Quarter Ending December 2011," Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, February 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Downloads/4QStatePrescriptionDrugRes.pdf.

(63 percent) and New Jersey (63 percent).

- The highest users of generic drugs are Hawaii (79 percent), Massachusetts (77 percent) and Washington (76 percent). [See Figure II.]

All states should encourage the use of less-expensive drug alternatives when the therapeutic effectiveness is the same.[45] This change could result in substantial savings.

One report identified 20 commonly-used brand drugs for which there were therapeutically equivalent generic drugs available. Had state Medicaid programs substituted generics for these 20 drugs, the savings would have amounted to $329 million in 2009, or about 22 percent more than if generic drugs had been fully utilized. Of the 20 drugs studied, Medicaid paid an average of $95 more for every brand medication sold when there was a generic available.[46]

Negotiating Dispensing Fees. Consumers who are not in a drug plan do not pay a separate dispensing fee when purchasing drugs. The cost of dispensing a drug — counting tablets, filling bottles and administrative tasks — are included in the retail cost. The $4 price for selected 30-day generic prescriptions at Wal-Mart, Target, Kroger and other pharmacies, for example, includes an implicit dispensing fee. Private drug plans typically negotiate dispensing fees with a pharmacy network or chain. By contrast, dispensing fees in state-managed, conventional Medicaid plans are set by state officials with guidance from the state legislatures. Many states also have a statutory dispensing fee rather than allowing pharmacy benefit management companies to negotiate fees, as is common among Medicare Part D plans. As a result, pharmacy benefit management companies cannot negotiate dispensing fees with pharmacies based on the competitive environment.

State reimbursement rates to pharmacies filling Medicaid prescriptions vary more than is warranted by market conditions and business costs. State officials and state legislatures often yield to political pressure and set dispensing fees for conventional Medicaid programs that are not what the market would. If fees are too low, the revenue from filling Medicaid prescriptions is less than the cost of providing the service. As a result, enrollees may lack access to pharmacies willing to dispense drugs for Medicaid patients. On the other hand, if the fees are set too high, taxpayers end up paying pharmacies more than a competitive market. Politicians often protect local constituents — including local pharmacies — from competition for Medicaid's business.[47]

Lobbyists for pharmacies are keen to take advantage of this tendency. For instance, when the Texas Legislature began to debate reforming its Medicaid drug program, the Pharmacy Choice and Access Now Coalition opposed moving Medicaid drug reimbursements from the Vendor Drug Program to managed care. This move would not only reduce state Medicaid administrative costs, but could lower reimbursements to pharmacies as well. Under the old reimbursement model, pharmacies that filled a Medicaid prescription were paid approximately $7.50 plus a separate cost for the drug. By contrast, a pharmacy benefit management company contracting with a managed care plan may have negotiated a dispensing fee that is only one-third that price. Indeed, the Texas Pharmacy Business Council, which represents pharmacies, complained that in some cases privately-run pharmacy benefit management companies could drive down Medicaid dispensing fees as much as 80 percent if they were allowed to negotiate them down to market rates. The Choice and Access Now Coalition also opposed similar moves in Illinois and California.[48] What many of the special interest groups fail to disclose, however, is that the reimbursements and dispensing fees are not being cut due to legislation, but due to negotiated contracts in a free market.

"The drug dispensing fee is $1.75 in New Hampshire and $10.64 in Alabama."

- Across the country, the average Medicaid dispensing fee is $4.81 per prescription.[49]
- However, fees range from $1.75 in New Hampshire to $10.64 in Alabama.[50] [See Figure III and the table.]
- Under certain conditions, the dispensing fees climb even higher

State Prescription Dispensing Fees

	Fee or Lower Tier	Upper Tier	
Alabama	$10.64		
Alaska	$3.45	$11.46	**
Arizona	$2.00		
Arkansas	$5.51		
California	$7.25	$8.00	+
Colorado	$4.00	$1.89	+
Connecticut	$3.15		
Delaware	$3.65		
District of Columbia	$4.50		
Florida	$3.73	$7.50	
Georgia	$4.33	$4.63	
Hawaii	$4.67		
Idaho	$4.94		
Illinois	$3.40	$4.60	*
Indiana	$4.90		
Iowa	$4.34		
Kansas	$3.40		
Kentucky	$4.50	$5.00	*
Louisiana	$5.77		
Maine	$3.35		
Maryland	$2.67	$3.69	*
Massachusetts	$3.00		
Michigan	$2.50	$2.75	+
Minnesota	$3.65		
Mississippi	$3.91	$5.50	*
Missouri	$4.09		
Montana	$5.04		
Nebraska	$3.27	$5.00	
Nevada	$4.76		
New Hampshire	$1.75		
New Jersey	$3.73	$3.99	
New Mexico	$2.50	$3.65	
New York	$3.50	$4.50	*
North Carolina	$4.00	$5.60	*
North Dakota	$4.60	$5.60	*
Ohio	$3.70		
Oklahoma	$4.02		
Oregon	$9.68	$14.01	**
Pennsylvania	$4.00		
Rhode Island	$3.40		
South Carolina	$4.05		
South Dakota	$4.75		
Tennessee	$2.50	$3.00	*
Texas	$7.50	Plus 2%	
Utah	$3.90	$4.40	++
Vermont	$4.75		
Virginia	$3.75		
Washington	$4.24	$5.25	
West Virginia	$2.50	$5.30	*
Wisconsin	$3.44	$3.94	*
Wyoming	$5.00		
Average	$4.23	$5.42	

* generic drugs; ** higher fee for low-volume pharmacies; + institutional pharmacy; ++ higher fees for rural pharmacies

Source: "Medicaid Prescription Reimbursement Information by State – Quarter Ending December 2011" Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, February 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Downloads/4QStatePrescriptionDrugRes.pdf.

— in some cases as high as $12.50, about double the market rate pharmacy benefit managers pay pharmacies for prescriptions covered by private drugs plans.[51]

- By contrast, the privately-managed Medicare Part D plans pay pharmacies a fee of about $2 for every prescription they fill, or about $1.90 for a short-term supply of pills and $2.20 for an extended supply of drugs.[52]

The appropriate dispensing fee varies from region to region. As a result, state officials need to allow pharmacy benefit managers for Medicaid to negotiate dispensing fees with pharmacy networks the way they do for private drug plans. This does not mean fees would be the same in every state or every pharmacy. However, it does mean dispensing fees would reflect local market conditions, such as the cost of doing business and competition.

Other Cost-Saving Strategies. Other cost-savings strategies include coordinating and tracking drug therapies, establishing reimbursement rates for drug makers similar to what commercial drug plans pay, and empowering patients with control of some of the dollars spent on their drug therapies so that they become better consumers.

Coordinating and Tracking Drug Therapy Utilization. Many states do not optimally manage their Medicaid drug programs.[53] For instance, conventional Medicaid programs do little to track the number of providers a Medicaid enrollee sees or the number of prescription drugs an enrollee has filled. Not tracking drug utilization makes conventional Medicaid programs susceptible to waste and fraud.

While some states manage their own Medicaid drug programs or contract directly with pharmacy benefit managers, others rely on insurers to manage benefits. Some states that previously carved out drug benefits are considering moving to carve-in arrangements, where the private insurers are responsible for managing integrated drug benefits.[54]

Proponents tout the advantages of carve-in drug programs, including improving the detection of substance abuse and "drug seekers," raising the quality of care through better care coordination,

and identifying drug interactions and inappropriate or duplicate prescriptions. It makes sense for the health plan responsible for managing physician visits and hospital needs to also coordinate drug therapies, because skimping on drug therapies often leads to higher medical costs.

Negotiating Drug Prices. The cost of drugs purchased for state Medicaid programs varies from one state to another. A 2004 report by the Office of Inspector General of the U.S. Department of Health and Human Services compared the amounts states paid for 28 common drugs across 42 state Medicaid programs.[55] Michigan and Texas performed the best; New York and New Jersey fared the worst. The price of Lipitor (a popular drug used to treat high cholesterol) varied from $2.58 to $2.89 — only about a 12 percent difference. For Depakote (a drug used to treat bipolar disorder), costs varied by more than 70 percent. State payment for generic drugs with multiple suppliers varied the most. For example, the cost of Atenolol (a popular beta blocker used to treat high blood pressure) varied by 4,073 percent between low- and high-cost states.

A 2009 Inspector General's report compared the cost of drugs obtained for the privately-run Medicare Part D program with the cost of drugs for Medicaid. Costs of brand-name drugs under patent protection varied by less than 5 percent. For generic drugs, state Medicaid programs paid at least 10 percent more than Medicare Part D plans for three-fourths of the drugs surveyed.[56] This is in contrast to the private firms that manage Medicare Part D and private drug plans, which often pay less for drugs than Medicaid fee-for-service programs because pharmacy benefit managers negotiate prices with manufacturers more aggressively.[57]

Empowering Consumers.[58] In the private sector, patients are increasingly required to share in the cost of health care by paying deductibles and copayments. The evidence shows that when individuals have the proper financial incentives, they will be better consumers of health care.[59] This usually involves health plans in which a person pays some medical expenses out-of-pocket or from a personal account established for that purpose. For instance, a number of states have received federal waivers to set up cash accounts that allow disabled Medicaid recipients to manage their own health care dollars and personally control the hiring of home care services.[60] These programs, called "Cash and Counseling," use a defined contribution approach.[61] Remarkably, patient satisfaction is almost 100 percent.[62]

"What states pay for one popular drug varies by 4,073 percent!"

Mail-Order Pharmacies. Although drugstore chains still sell the most drugs, mail-order pharmacies are gaining ground and now account for about 17 percent of the retail drug market. Mail-order and Internet pharmacies offer the best deals on prescription drugs for patients with chronic conditions.

Cost-Sharing.[63] For some years now, private health insurers have successfully used copayments and increased cost-sharing to reduce unnecessary medical services. In the past, a state was only allowed to charge nominal copayments of $1 to $3 for medical services and prescription drugs, unless it received a waiver.[64] The Deficit Reduction Act of 2005, however, allows states to charge nominal copays for all nonpreferred prescription drugs for Medicaid recipients 150 percent or more above the federal poverty level. Furthermore, states are permitted to increase copays commensurate with rises in the medical component of the consumer price index, and they may require mandatory populations to make copayments for nonpreferred prescription drugs. This principle might be applied to Medicaid by allowing enrollees to purchase a nonformulary drug if they make a higher copayment. If a physician thinks a nonformulary drug offers significant benefits, copayments could be waived.

Cost-sharing should not be imposed for those services and treatments that have been shown to reduce preventable medical costs. For example, states should provide first-dollar coverage for asthma treatments because hospitalizations for severe asthma attacks are costly, yet easily prevented.

Value-Based Benefit Design. Health plans often use formularies with one or two tiers: a low, fixed copayment for generic drugs and a higher copayment for name-brand

drugs. There are opportunities to reward more valuable services by charging different copayments for drugs to treat different conditions.[65] For instance, a beta blocker for a diabetic is so beneficial that many experts believe there should be no cost sharing. On the other hand, Cox-2 inhibitors are very costly pain relievers for which many less expensive substitutes are available. The private drugs plans that manage Medicaid drug benefits should have the authority to experiment in order to discover which benefits hold the greatest value.

Conclusion

Medicaid's drug benefit program must be reformed to keep costs under control. Billions of dollars might be found in potential Medicaid savings, if only states will look to market-based solutions rather than government-imposed cost controls. However, numerous obstacles stand in the way of reform. The most formidable roadblocks to reform are lobbyists for trade associations, professional societies, independent pharmacies and drug suppliers that serve Medicaid beneficiaries. These stakeholders often oppose market-based reforms that benefit taxpayers but prove less profitable.

Endnotes

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About the Author

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The NCPA is a nonprofit, nonpartisan organization established in 1983. Its aim is to examine public policies in areas that have a significant impact on the lives of all Americans — retirement, health care, education, taxes, the economy, the environment — and to propose innovative, market-driven solutions. The NCPA seeks to unleash the power of ideas for positive change by identifying, encouraging and aggressively marketing the best scholarly research.

Health Care Policy.

The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs), previously known as Medical Savings Accounts (MSAs). NCPA President John C. Goodman is widely acknowledged (*Wall Street Journal*, WebMD and the *National Journal*) as the "Father of HSAs." NCPA research, public education and briefings for members of Congress and the White House staff helped lead Congress to approve a pilot MSA program for small businesses and the self-employed in 1996 and to vote in 1997 to allow Medicare beneficiaries to have MSAs. In 2003, as part of Medicare reform, Congress and the President made HSAs available to all nonseniors, potentially revolutionizing the entire health care industry. HSAs now are potentially available to 250 million nonelderly Americans.

The NCPA outlined the concept of using federal tax credits to encourage private health insurance and helped formulate bipartisan proposals in both the Senate and the House. The NCPA and BlueCross BlueShield of Texas developed a plan to use money that federal, state and local governments now spend on indigent health care to help the poor purchase health insurance. The SPN Medicaid Exchange, an initiative of the NCPA for the State Policy Network, is identifying and sharing the best ideas for health care reform with researchers and policymakers in every state.

NCPA President John C. Goodman is called the "Father of HSAs" by *The Wall Street Journal*, WebMD and the *National Journal*.

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The NCPA helped shape the pro-growth approach to tax policy during the 1990s. A package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce in 1991 became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in summer 2002. The NCPA's proposal for an across-the-board tax cut became the centerpiece of President Bush's tax cut proposals.

NCPA research demonstrates the benefits of shifting the tax burden on work and productive investment to consumption. An NCPA study by Boston University economist Laurence Kotlikoff analyzed three versions of a consumption tax: a flat tax, a value-added tax and a national sales tax. Based on this work, Dr. Goodman wrote a full-page editorial for *Forbes* ("A Kinder, Gentler Flat Tax") advocating a version of the flat tax that is both progressive and fair.

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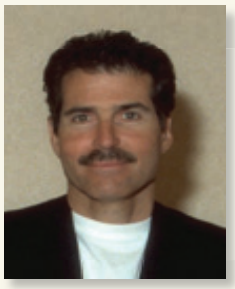

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