

## Take Steps to Make Prescription Drugs More Affordable

Drug prices continue to rise and Medicare covers very little of the cost for most older people. Drug prices are also rising for the state as a whole. We need a system to promote appropriate and effective lower cost drugs for individuals and the state.

**P**rescription drugs—we all need them at some point, they cost too much, and their producers are the most profitable companies in the nation. Those with good insurance or those who can afford to pay the high cost get the drugs they need. But many without drug coverage, including elders and people with disabilities on Medicare, cannot afford the cost of a few pills that could save their lives.

Drug costs under private insurance are the most rapidly rising category of benefits and employers and insurers are looking for ways to decrease those costs. Typically, private insurance brings down expenses by making consumers pay more out-of-pocket for prescriptions. State public insurance programs, like Medicaid and CHIP and the AIDS medication program are seeking ways to cut costs—but there are no easy and simple answers when the people covered have very low incomes.

Clearly, the public demand for action will not fade until drugs become more reasonably priced. Although this

### In Short

State leaders have been the first to initiate programs lowering the price of prescription drugs because budget deficits and patients demand action. Some states are creating a “preferred drug list” for Medicaid to steer doctors away from expensive, unnecessary new drugs.

is ultimately a national problem, state leaders have been the first to move toward bringing the price of prescription drugs down out of necessity because of budget deficits and out of the need of the people in their communities.



### STRETCH THE MEDICAID DRUG BUDGET TO SERVE MORE PEOPLE

Medicaid is a \$14 billion program, and prescription drugs make up a significant portion of that budget. The ever rising cost of medicines puts pressure on the state to get the lowest price possible for prescription drugs. The Medicaid Vendor Drug Program already maximizes the use of generics, as allowed by law.

To assist states, the federal government negotiates “rebates” with drug manufacturers as a condition of participation in Medicaid and requires them to give Medicaid the “best price” for drugs. In reality, the “best price” is a moving target and Medicaid struggles to monitor the market in order to get the most for our dollars.

To give certain providers even deeper discounts, Congress created what is commonly referred to as the “340B drug pricing program” referencing the section of the federal law.

Federally Qualified Health Centers that serve low-income and uninsured Texans and prisons are providers who can purchase drugs at these prices, which are significantly lower than wholesale and retail prices. An analysis of 100 popular outpatient

drugs found that on average, 340B prices are at least 34 percent lower than wholesale prices.

If the state used the 340B price as the discounted price for Medicaid and other state programs that purchase drugs, significant savings could be achieved.

These savings could prevent cuts to vital public programs while saving or improving the lives of many Texans.

### PREFERRED DRUG LISTS, PRIOR AUTHORIZATION, AND STATE REBATES

Consumers are not the only ones who do not have access to reliable, objective and understandable information about prescription drugs. The doctors who prescribe them often don't have good information either. Busy schedules make them overly dependent on drug company marketing, or “detailing,” for information, and their prescribing patterns show it.

One strategy for reducing the cost of drugs in state Medicaid programs throughout the country is to establish a “preferred drug list” (PDL) to create extra steps for physicians who want to prescribe expensive new brand drugs. Many private insurers use similar tactics.

There are numerous ways PDLs can be set up. One method requires physicians to get prior authorization from the program before a prescription for a drug not on the PDL can be filled. Another strategy is to require physicians to write “dispense as written” on the prescription to indicate that a particular non-PDL drug is medically necessary. Programs can include a retrospective review of physician drug prescribing patterns and follow up with education about using effective and less expensive

therapeutic alternatives to brand drugs.

There are also various ways to build PDLs. States can allow drug companies to basically bribe their way onto a “preferred” list. By paying a rebate to the state, their very expensive, very profitable drugs go on the list, even when more effective and cheaper alternative drugs are available. The immediate cost comes down, but as the federal government discovered, this method can easily be manipulated when the drug companies simply change their pricing to make up for their losses from the rebates. A better way to build PDLs is by selecting specific classes of drugs that represent a high cost to the program and developing evidence-based drug management protocols for physicians to follow when prescribing these drugs. When this method is paired with a discounted price, such as the 340B pricing structure, there is much more potential for savings than a one-time rebate. This method—used by several states, countries, and health plans—changes prescribing behavior for the long term. Focusing on certain classes of drugs avoids the problem of risking harm to people with complex conditions who need highly specialized drugs.

The development of these protocols should be done in public and the protocols should be available to the public. That is what Oregon did. Physicians and patients have reliable, unbiased information about the effectiveness of drugs. In Texas, the Medicaid program asked the Texas Medical Association and PhARMA to develop protocols for certain classes of drugs in an effort to educate doctors about appropriate therapeutic alternatives. These protocols are a start, but they were developed in private and should be publicly vetted to ensure they are not biased toward any particular drugs.

### **MEDICARE ‘GAPS’ HARM THOSE MOST IN NEED**

Medicare covers over two million Texans over the age of 65 and people with disabilities. But that coverage does not include prescription drugs.

States must step in to help this vulnerable population where Congress has failed to do so.

A recent survey of seniors, including Texans, reveals a bleak picture about elder Texans’ access to life sustaining and live saving prescription drugs: 31 percent had no coverage for drugs; 38 percent of low-income Texas seniors (with annual incomes less than \$18,000) fared much worse since they have few resources to pay out of pocket. Only about one third elder Texans are covered by employer plans compared to some other states surveyed where employers were a major source of senior coverage (40-50%). Texas Medicaid covers



drugs for less than half (44 percent) of the seniors living below poverty (less than \$8860/year); 14 percent with incomes below poverty spend \$100 or more for drugs each month, four times the rate in the other states surveyed. Over one in 5 (22 percent) skip taking medications or do not fill prescriptions because of cost.

In 2001, the Legislature created a program (HB1094) to help very low income seniors by offering them coverage for prescription drugs through Medicaid. This was a cost-effective initiative because state funds spent are matched by federal dollars. Unfortunately, it was not funded. Even with a looming deficit, Texas should not turn its back on its poorest, frail elders or people with disabilities and should fund this program.

### **MANY TEXANS CANNOT AFFORD TO PURCHASE PRESCRIBED DRUGS**

While the state should provide coverage for the lowest income people, there are other ways we can help all seniors and people with disabilities on Medicare and people with low to moderate incomes who have no drug coverage. A drug assistance program could be created that allows them to purchase prescription drugs at the pharmacy at a lower cost. There would be no cost to the state, as the consumer would pay for the drugs—the state would only make lower cost drugs available to them. An annual fee could be charged for those wishing to join the program, as is done in Maine.

The best choice for the discounted price would be to offer drugs to participating consumers at the Medicaid price, which ideally would be tied to the 340B price as described above.

### **RECOMMENDATIONS**

- The Legislature should fund the state program created by HB1094, 77<sup>th</sup> Legislature, to provide Medicaid prescription drug coverage for the poorest elders and people with disabilities on Medicare.
- Design preferred drug lists and prior authorization for certain classes of drugs in a public process using evidence-based medicine and with protections for Medicaid recipients with special needs and complex conditions.
- Create drug management protocols to educate physicians and consumers about effective therapeutic alternatives to costly brand drugs and the safe and effective use of generics.
- Establish a drug purchasing program that makes drugs available to all people on Medicare and others without drug coverage with annual incomes up to 300 percent of poverty (less than \$26,600).
- If supplemental rebates from drug manufacturers are sought, they should not be tied to placing drugs on a preferred drug list.