NATIONAL CENTER FOR POLICY ANALYSIS

Reforming Oklahoma's Medicaid Drug Program

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Oklahoma has moved most of its Medicaid enrollees into privately-administered managed care plans, under a program known as SoonerCare. The state should also move Medicaid enrollees to managed drug plans. Virtually all state Medicaid programs distribute some drugs on a fee-for-service (FFS) basis separately from any health plan.

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However, less than half of the states distribute almost all their Medicaid drugs this way; Oklahoma is one of them [see Figure I].[2]

Reforming Medicaid Drug Programs. State Medicaid programs that carve out drug benefits often ignore drug therapy coordination and management. By contrast, integrating prescription drugs benefits with Medicaid managed care health plans improves quality and increases efficiency. A Lewin Group analysis for Medicaid Health Plans of America, a trade association of managed care providers, found that integrating health and drug plans in 14 states that currently carve out drug benefits would collectively save nearly $12 billion over a decade.[3]

Private health plans that provide medical care to Medicaid enrollees are the logical entities to manage drug benefits. The health plans are paid a set fee per enrollee to provide Medicare care; thus, the plans are liable for the cost of nondrug therapies, whereas a drug regime is often a less costly substitute for surgery or other treatment.

Drug therapies often reduce the need for hospitalization, and avoid expensive emergency room visits and medical complications — especially for such chronic conditions as asthma, diabetes and schizophrenia. An IMS Health analysis of Medicaid managed pharmacy benefits in several states found utilization rates for many of these therapies is higher under managed care than fee for service.[4]

The Role of Medicaid Drug Plan Administrators. Private health plans use a variety of techniques to control drug costs, including preferred-drug lists (PDL), formularies, required use of mail-order drug suppliers, negotiated prices with drug companies and drug distributors, and contracting with exclusive pharmacy network providers.[5] Private Medicaid managed care plans frequently contract with pharmacy benefit managers (PBMs), private firms that act as third-party prescription drug plan administrators. PBMs process and reimburse claims, and negotiate drug prices and rebates with drug manufacturers. They also negotiate dispensing fees — the amount paid to pharmacies for the service of filling a prescription. Regardless of how a drug program operates, Medicaid

enrollees generally obtain prescriptions at local pharmacies, which are reimbursed for each prescription filled.[6]

A recent analysis by the Menges Group identified ways in which privately managed Medicaid drug plans are more efficient than state-administered Medicaid drug benefit programs.[7] Rather than negotiating with pharmacy networks, state fee-for-service Medicaid programs often arbitrarily pay much higher dispensing fees than they would in a competitive market. Utilization of generic drugs is often lower in fee-for-service Medicaid.

Medicaid programs face political opposition to negotiating exclusive pharmacy network contracts that deliver lower drug prices to taxpayers. As a result:

- Just over three-fourths (77 percent) of drug prescriptions in Oklahoma's Medicaid plan are filled with generic drugs, whereas the national average for managed Medicaid drug benefits is about 80 percent.
- Oklahoma Medicaid pays pharmacies $4.02 to dispense a prescription, whereas the average for private Medicare Part D plans is about one-half as much — about $2.00.
- The number of prescriptions per Medicaid enrollee is generally higher among enrollees in Medicaid compared to managed care.

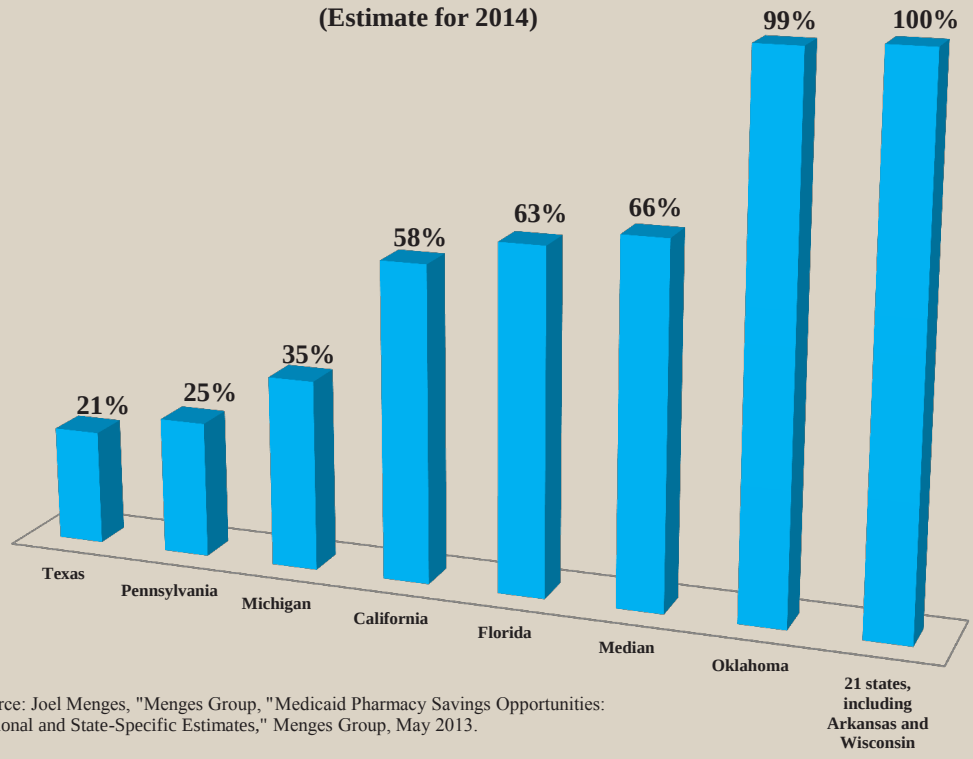
According to Menges, integrating drug and health benefits in a statewide managed care program could save Oklahoma Medicaid $1.5 billion over 10 years in federal and state spending.[8] Specifically [see Figure II]:

- Some 17 percent of the savings would come from paying market-based, competitive dispensing fees.
- More than one-third (38 percent) would come from use of generic drugs where appropriate.
- More than one-third (36 percent) would come from negotiating steep discounts with exclusive (limited) networks.

Despite the potential savings, some oppose moving from fee-for-service to privately managed drug programs. Trade associations for small pharmacies advocate laws to prohibit exclusive Medicaid pharmacy networks. Small pharmacies that serve Medicaid beneficiaries often fight to maintain the status quo and lobby to keep dispensing fees artificially high.

The pharmacy industry has launched an initiative in recent years to limit the ability of drug plans to audit pharmacies that bill for drug plan member prescriptions. If taxpayers are to be protected from fraudulent operators, drug plans must be allowed to audit for compliance.

Figure I
Percentage of Medicaid Drugs Dispensed Fee-For-Service
(Estimate for 2014)



Source: Joel Menges, "Menges Group, "Medicaid Pharmacy Savings Opportunities: National and State-Specific Estimates," Menges Group, May 2013.

A few of these barriers to efficient Medicaid drug plans are discussed in greater detail below.

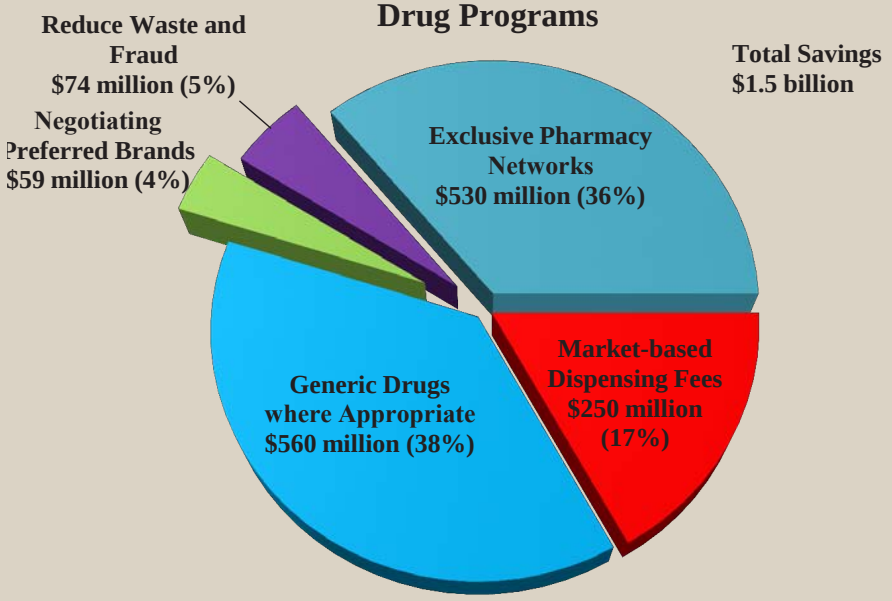
Barriers to Efficient Networks. Many pharmacists are small business owners. Thus, state legislators often view them sympathetically when they lobby for protection from competition. For instance, PBMs and health plans are increasingly experimenting with limited or "narrow" pharmacy networks in order to negotiate lower drug prices and dispensing fees. Pharmacies compete to become one of the exclusive network drug providers.[9] Enrollees, insurers and employers share in the savings that result.[10]

However, many states allow *any willing pharmacy* to participate in Medicaid drug programs, preventing the development of exclusive networks. Supporters argue that open pharmacy networks offer enrollees more choices and more convenience, and promote competition. PBMs and drug plans counter that pharmacies in exclusive networks agree to deeper discounts.[11]

Any-willing-provider and freedom-of-choice laws reduce the drug plans' bargaining power.[12] They prevent health plan sponsors from selectively negotiating and contracting with pharmacies.[13] The Federal Trade Commission notes that these laws lead to higher drug prices and higher premiums by protecting less efficient pharmacies from competition.[14] Thus, they could be costly to taxpayers, employers and patients.[15] The Lewin Group calculated that if there were a nationwide any-willing-provider mandate, prescription mail-order pharmacy costs would increase 3 percent.[16] Thus, any-willing-provider and freedom-of-choice laws typically benefit local pharmacies rather than consumers.[17]

Barriers to Mail-Order Pharmacies. Drug plans offer incentives that encourage patients to use mail-order pharmacies for medications to treat chronic conditions, such as diabetes, hypertension and high cholesterol. Many plan sponsors charge higher deductibles for retail purchases, offer lower copayments for mail-order dispensing, or only reimburse patients for mail-order maintenance medications.[18] Some plans limit the number of times a prescription may be refilled at a retail pharmacy before patients are required to use mail order.

Figure II
Potential 10-Year Savings from Efficient Management of Oklahoma Medicaid Drug Programs



Source: Joel Menges, "Medicaid Pharmacy Savings Opportunities: National and State-Specific Estimates," Menges Group, May 2013.

Unfortunately, lawmakers sometimes pursue unwise policies designed to benefit local constituents. One way is to enact laws that limit drug plans' ability to reward enrollees who use mail order. In 2011, New York State passed Assembly Bill 5502, which allows consumers to fill prescriptions at any pharmacy without incurring additional cost sharing or fees. The law benefits local community pharmacies — not consumers or taxpayers.

As one consultant described it: "Imagine that your local bookstore owner lobbied your state Senate to pass a law preventing you from buying a book less expensively via Amazon.com. You would immediately recognize that the bookstore was trying to protect its business at your expense. This is precisely what has happened for prescription drugs in New York."[19] The Federal Trade Commission agreed, stating "By reducing competition between pharmacies, this legislation likely will raise prices for, and reduce access to, prescription drugs…."[20]

Retail-choice laws may increase convenience for some enrollees, but they drive up costs for all health plan members and their plan sponsors. Maryland passed legislation similar to New York's. If retail choice was required nationwide, mail-order prescription costs would rise more than 5 percent, according to the Lewin Group.[21]

Any-willing-pharmacy laws that allow outsiders to participate in a drug plan's network reduce the power of managers to negotiate lower prices and unnecessarily facilitate waste, fraud and abuse. For example, an unlimited supply of pharmacies allows unscrupulous patients to shop for multiple doctors willing to prescribe narcotics — avoiding detection by filling each prescription at a different pharmacy. Requiring Medicaid drug plans to reimburse large networks (with numerous small pharmacies) also makes it more difficult to detect billing fraud by pharmacy operators (or fake pharmacies). Oklahoma should also avoid calls by local pharmacies to interfere with mail-order programs that drug plans sometime implement to provide more efficient delivery of drugs to enrollees through the mail at lower costs.

Pharmacy Board Regulation. As in most states, the state insurance commissioner regulates insurance sold in Oklahoma, including health and drug plans. However, some pharmacy interests are lobbying to transfer some regulatory authority over drug plans to the State Board of Pharmacy.[22] For instance, House Bill 2100, introduced in the first session of the 54th Oklahoma Legislature, would require PBMs to obtain a license from the pharmacy board. Pharmacists and their allies typically dominate the membership of such boards.[23] The bill would also grant the Board of Pharmacy the power to demand sensitive information on PBMs' business practices, which could be disclosed to pharmacy trade groups, boosting their power in negotiations with the PBMs.

Indeed, when the Mississippi House of Representatives debated this issue in 2013, the Federal Trade Commission (FTC) questioned claims that increased regulation would benefit consumers — concluding that more restrictive controls would harm competition and raise costs for consumers.[24]

Conclusion. Medicaid will best serve Oklahoma taxpayers by providing drugs to enrollees at the lowest possible cost. After Oklahoma moves its Medicaid enrollees into managed care, it should also integrate drug benefits into enrollees' health plans. In addition, legislators should avoid the temptation to enact protectionist regulations designed to limit competition among pharmacies participating in the Medicaid program. The state will likely find that drug plan managers will lower costs — if they allow drug plans to use the tools to do so. However, Oklahoma legislators will undoubtedly come under political pressure to protect local providers from the competition that could save taxpayers money.

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References and sources can be found in the online version at www.ncpa.org/pub/ib138.

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