TAHP
The Texas Association of Health Plans

Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.

The Prescription for Medicaid Rx Savings: Carve It *ALL* In!

A new study reveals that the State of Texas' failure to allow Medicaid health plans to fully manage prescription drugs is costing Texas taxpayers $1 million every 4 days and nearly $100 million a year.

Texas' Current Approach Favors More Expensive Brand-Name Drugs

Texas policymakers did the right thing in 2012 when they decided to allow managed care organizations (MCOs), health plans that manage the Texas Medicaid program, to manage the prescription drug benefit, known as a "carve-in" of the Rx benefit. However, while handing off financial responsibility of the benefit to health plans, the State failed to give them the ability to fully manage the prescription drug program because it required the plans to use a single, uniform state Medicaid formulary (also called a PDL) instead of their own formularies. Texas' current uniform Medicaid PDL approach favors more expensive brand-name drugs and a strategy of pursuing rebates from pharmaceutical companies to offset Rx costs.

Texas Taxpayers Lose $1 Million GR Every 4 Days and Have Lost $1 Billion AF since 2012

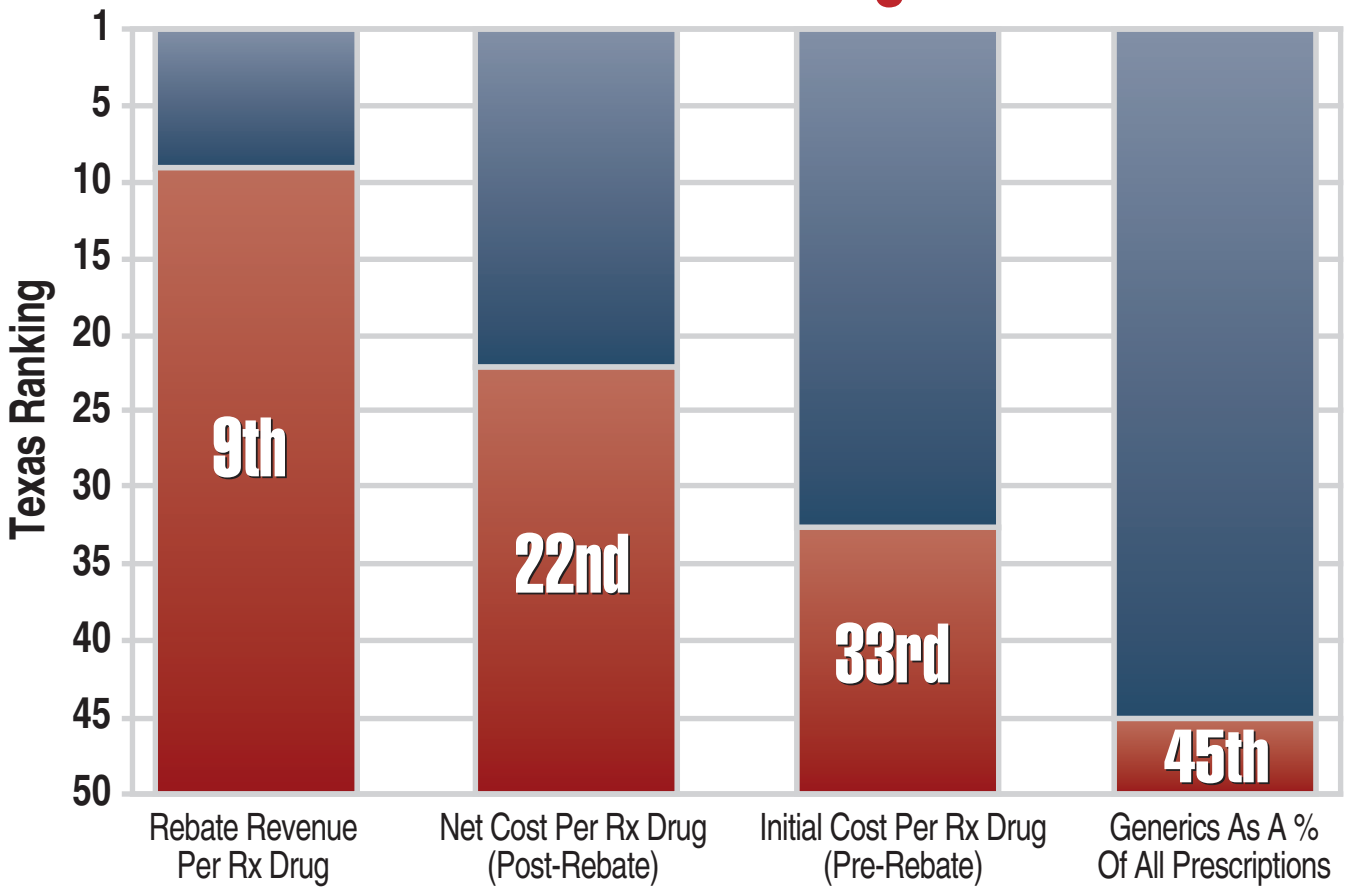
Playing The Wrong Game Well

Though Texas does well on rebates and ranks 9th among states on rebate revenue, this only tells half of the story. By focusing primarily on rebate revenue, ***"Texas is playing the wrong game well,"*** **according to a new study commissioned by the Texas Association of Health Plans and carried out by national consulting firm The Menges Group.** Maximizing rebates, at the expense of choosing lower-cost prescription drug alternatives, **is not an effective strategy** for achieving an overall low net cost per prescription across all Medicaid prescriptions (both brand and generic).

The study found that:

- Even after rebate revenue is accounted for, the cost of brand-name drugs is still **5X higher** than the lower-cost generic alternatives in the Texas Medicaid program
- **21 other states outperform Texas** on lower Medicaid net costs per prescription drug (after rebates), and Texas ranks 45th in the country on the use of generics
- The top third of high-performing states, which focus more on lowering drug costs rather than maximizing rebates, have Medicaid net per-prescription-drug costs that are 21% lower than the national average and **19% lower than Texas**

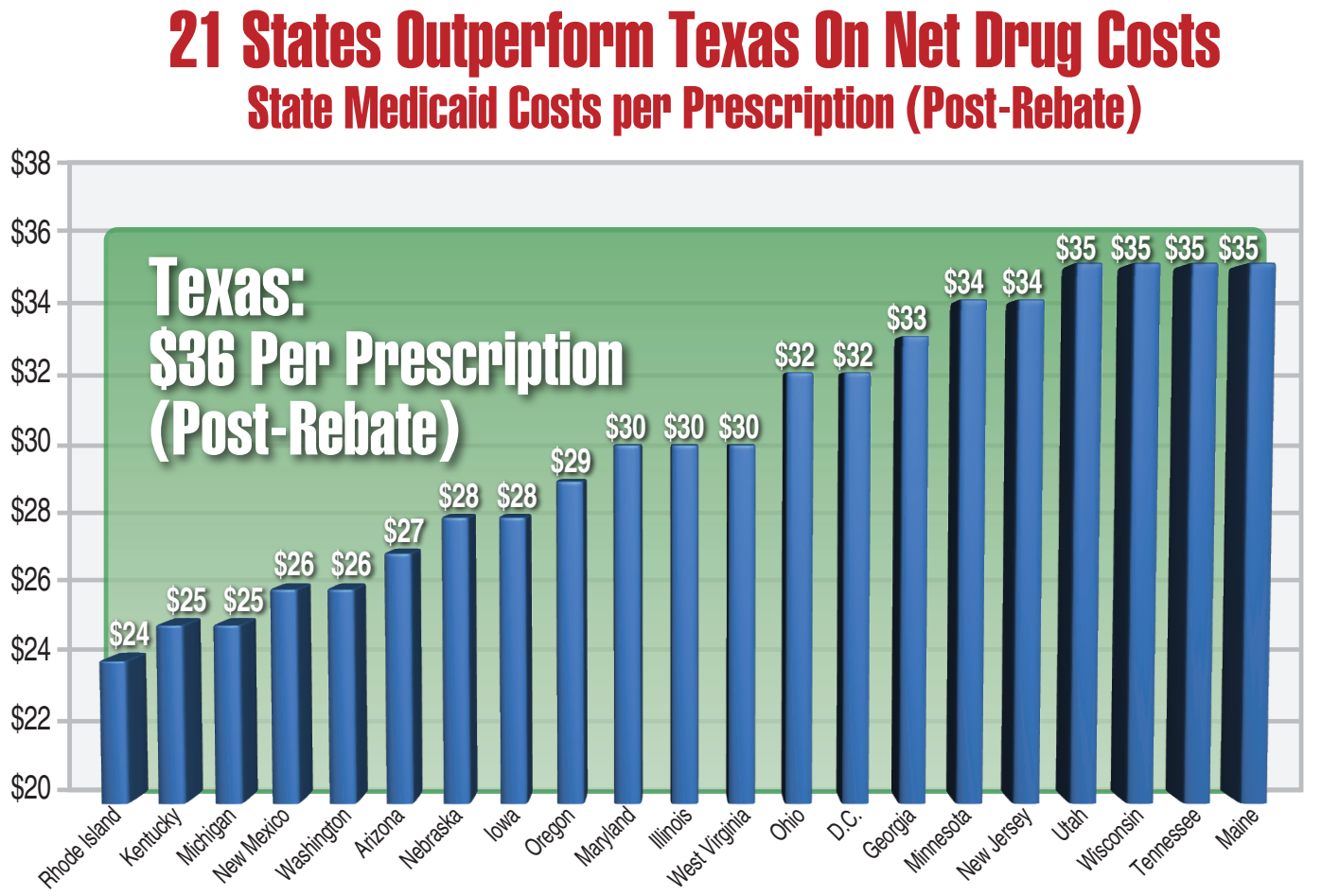
Texas Medicaid Prescription Drug Performance: State Rankings



Texas could achieve **at least $100 million GR (General Revenue) savings** per year if it allows Medicaid health plans to fully manage prescription drugs. This more effective approach would allow MCOs to manage the Rx benefit using their own PDLs and time-tested care management tools to provide quality, affordable prescription drugs to beneficiaries and save taxpayer money. This approach has worked successfully in many other state Medicaid programs, as well as private, individual, and employer-sponsored insurance, Medicare Advantage, and other state health insurance programs (TRS and ERS).

21 Other States Outperform Texas

Texas is being outperformed by states that have chosen to effectively manage drug costs in their Medicaid programs by maximizing generics through their Medicaid health plan formularies. **Twenty-one other states do better than Texas** in net spending per prescription drug, even after rebates are taken into account.



One reason Texas is being outperformed is that Texas ranks 45th in the use of generics as a percentage of all Medicaid prescriptions. The use of generics in Texas is 4.6% below the national average. Because brand-name drugs are 5X more expensive than generics in Texas (even after accounting for rebates), these percentage points translate to large dollar spending differences. Texas' approach favors more expensive brand-name drugs and a strategy of pursuing rebates from pharmaceutical companies to offset Rx costs. As a result, Texas ranks 9th in rebate revenue, but only **ranks 22nd in the most important metric: overall net cost per Rx after rebates.**

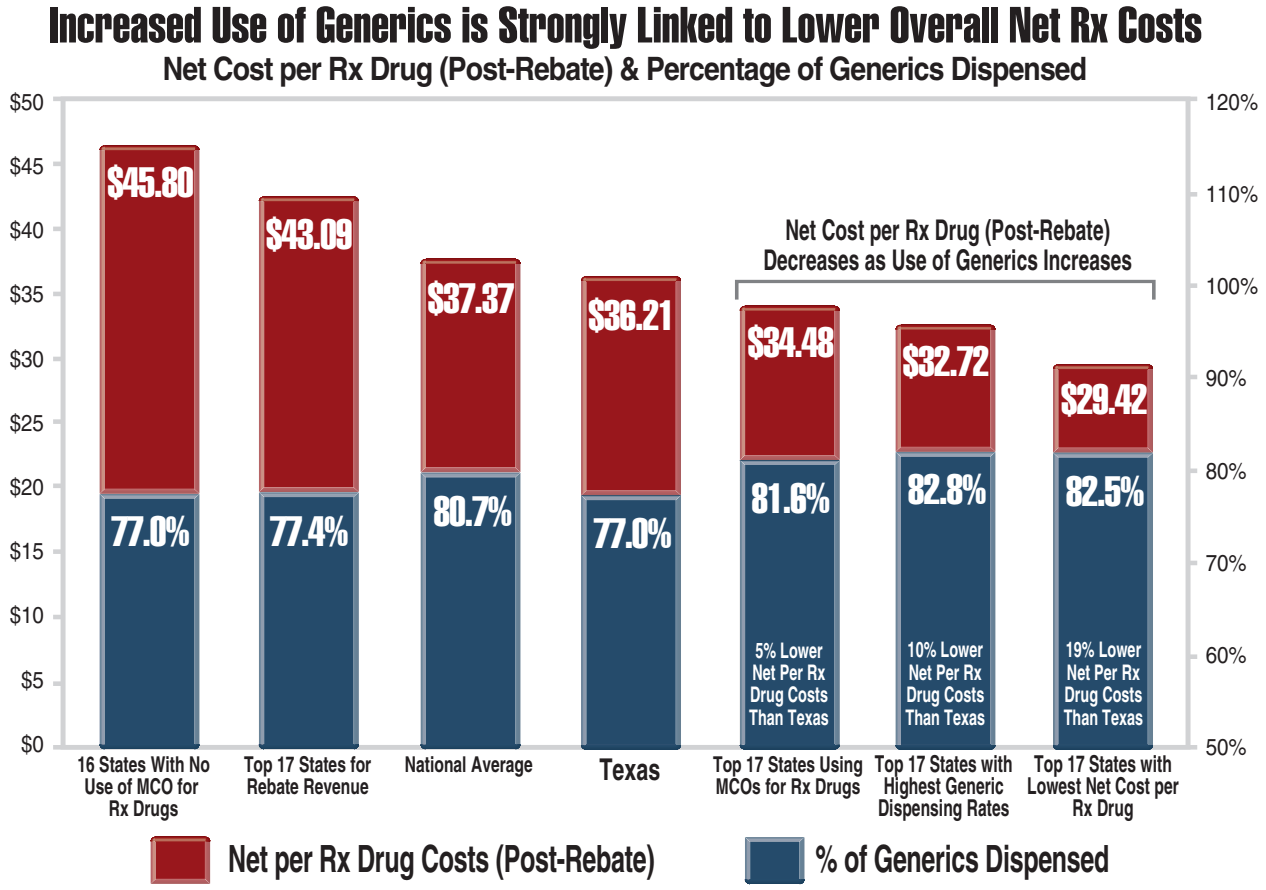
Maximizing Rebates vs. Managing Drug Costs (Maximizing Generics)

How are other states outperforming Texas? There are two main strategies for lowering total net prescription drug spending: 1) off-setting the cost of drugs by maximizing rebate revenue; or 2) reducing drug spending by managing the drug mix including maximizing the use of lower-cost generics.

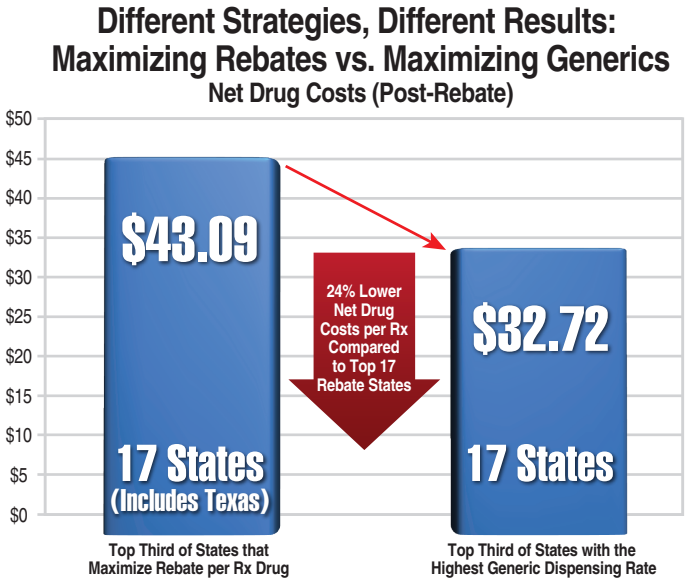
Texas' formulary is **driven primarily by maximizing rebates** from pharmaceutical companies, which makes the state's formulary **brand-name heavy.** As a result, Texas has achieved a relatively low net cost per prescription for **brand-name drugs.** However, maximizing rebates **is not an effective primary strategy** for achieving an overall low net cost per prescription across all Medicaid prescriptions (both brand and generic). Brand-name drugs (even after accounting for rebates) are still **5 times higher in cost** than generic drugs in Texas (6.5 times higher nationally). As a result, the greater use of brand-name drugs over generics is not offset by the increased rebate revenue.

A Strategy for Lowering Overall Drug Spending

The Menges study found that employing a strategy that focuses **first** on managing the drug mix and maximizing the use of generics, with focusing on maximizing rebate revenue as a **secondary** strategy, is a more effective approach for lowering overall drug spending for states. Allowing health plans to fully manage drug costs and increase the use of generics is strongly linked to lowering overall Medicaid net per Rx costs. The net per drug costs for the top-third performing states, which focus more on managing drug costs instead of maximizing rebates, are 21% lower than the national average and **19% lower than Texas.**



So, why not employ both strategies? The problem is that maximizing rebates and managing drug costs are two separate strategies that are in conflict with each other, and only one strategy—**managing drug costs—produces lower overall prescription drug spending** for state Medicaid programs. You can employ both strategies, but you cannot do them both well at the same time. Take for example: There is currently no overlap between the 17 states with the highest generic dispensing rate and the 17 states with the largest rebates per prescription. States with the highest generic dispensing rate have net drug costs per Rx ($32.72) that are 24% lower than the top 17 states that maximize rebate revenue ($43.09). Texas is in the group of 17 states that has focused more on maximizing rebate revenue and as a result have higher net per-prescription-drug costs, **missing an opportunity to have a more efficient Medicaid prescription drug program.**



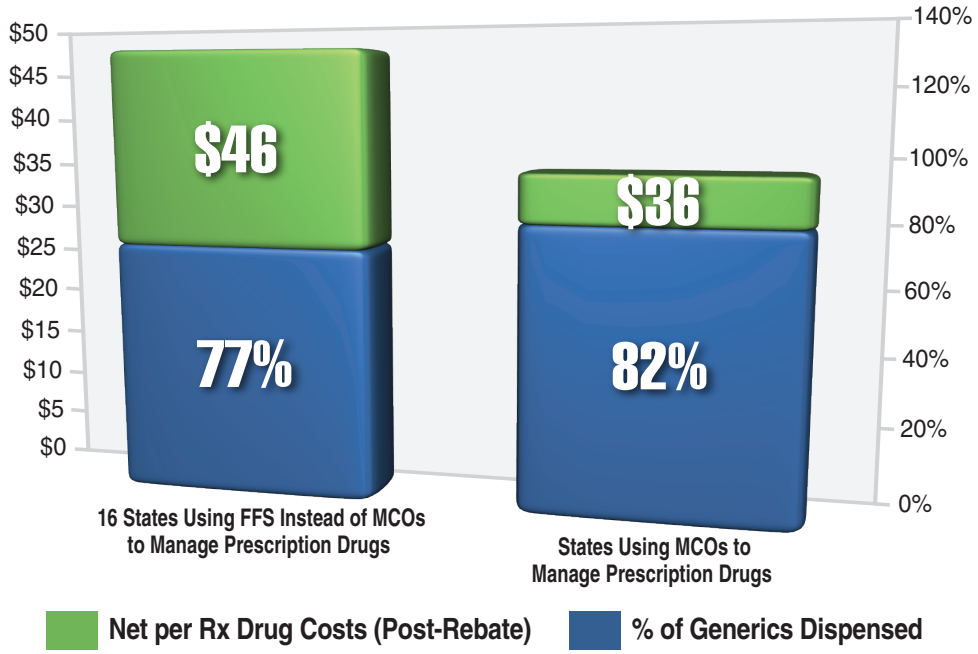
Note: The 17 states with the highest generic dispensing rate and the 17 states with the largest rebates per prescription are entirely separate groups of states. No state is in both categories.

Medicaid Health Plans Successfully Lower Net Prescription Drug Spending for States

Health plans already manage their own formularies successfully in all other health care markets including the private market, Medicare, Tricare, and ERS/TRS. Medicaid health plans also have experience reducing net drug costs and maximizing generics in states that, unlike Texas, allow their Medicaid health plans to manage their own formularies.

In states that use fee for service (FFS) to pay for Medicaid prescription drugs, net costs per prescription were **22.5% above the national average and 27% above states** that have at least some portion of prescriptions paid by Medicaid health plans through managed care.

Managed Care vs. Fee For Service Prescription Drug Costs



Nationally, Medicaid MCOs that fully manage the prescription drug benefit have demonstrated stronger ability to maximize the use of generic therapies. Generics comprised 77% of Medicaid prescriptions across the states using FFS, versus nearly 82% in states using MCOs. However, in Texas, the use of generics within MCO-paid medications is 4.6% lower than the nationwide figure. These percentage point differences translate to large dollar spending differences, given that brand-name drugs' average costs are more than five times higher than generics on a post-rebate basis in Texas (and 6.5 times higher nationally). Given that Texas' Medicaid prescriptions are predominately purchased through MCOs (82.5%) and Texas ranks 9th on its use of MCOs, one would expect Texas to be a national leader in the use of generics rather than performing 45th on this measure. However, it is clear that Texas health plans' ability to manage the mix of drugs has been significantly constrained. Instead of using health plans to fully manage drugs the same way they are used to manage all other benefits, the MCOs' hands have been tied by the uniform PDL and restrictions on the use of care management tools such as clinical/safety edits, prior authorizations, and step therapy.

In many instances, the state's uniform PDL unnecessarily favors brand-name drugs over generic drugs—even when it is clear that the rebate may not be high enough to offset the cost-savings of using the generic drug instead. For example, Nexium (brand drug) remains on the state's PDL even though an average 30-day supply of Nexium costs $249.36 and there are generic alternatives available for $18.30 and $15.17.

Medicaid Costs are Lower When MCOs use Their Own PDLs

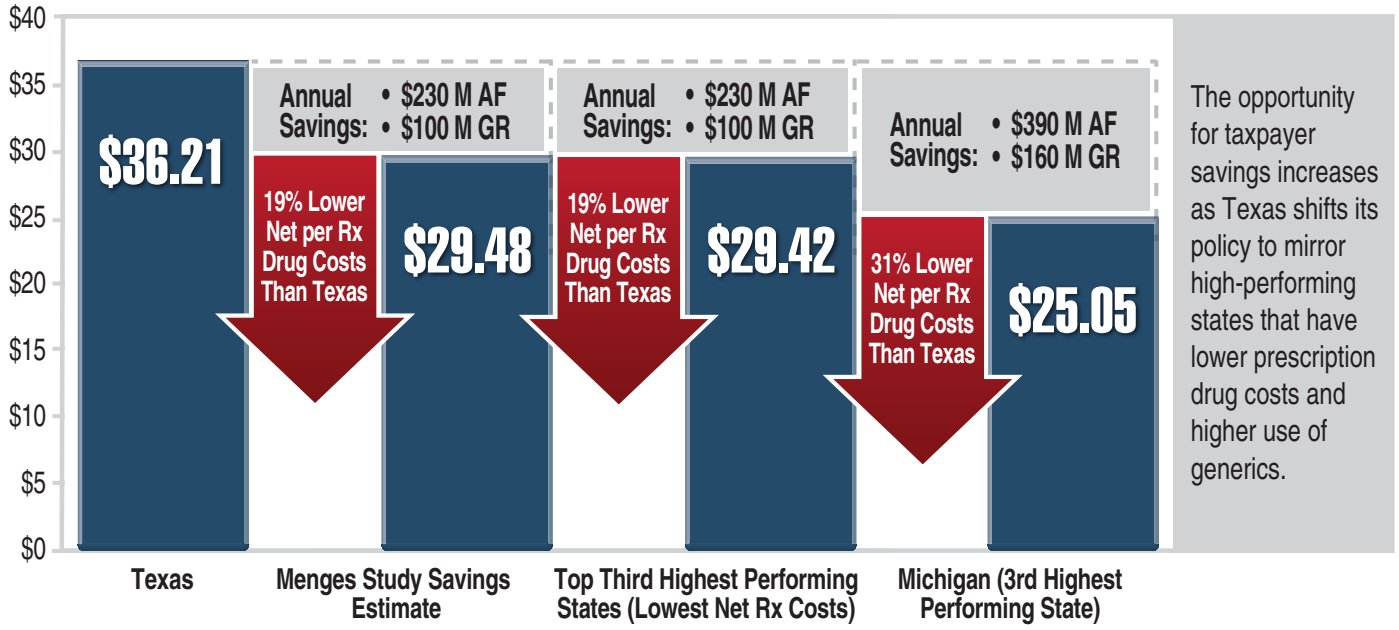
The 30 states that use MCOs to pay for prescriptions **and** allow the MCOs to use their own PDLs and care management tools performed better than the four states (Florida, Kansas, Texas, and West Virginia) that use MCOs to pay for prescriptions but require MCOs to use a uniform PDL. The net per-Rx costs in these 30 states were **10% lower** than the net per-prescription costs in the four states with a uniform PDL.

Many of the health plans in Texas also manage the prescription benefit in other state Medicaid programs where they are allowed to use their own PDLs, rather than a uniform state PDL. When these plans' performance in Texas is compared to their performance in other states where they are able use their own PDLs, the plans' per member per month costs were far lower and their generic drug use higher than in Texas.

Opportunity for Texas Medicaid Savings: Texas Can Do Better

The Menges study considers a number of savings scenarios based on Texas allowing its Medicaid health plans to use their own PDLs. The findings show that by eliminating the barriers and restrictions that prevent Medicaid health plans from better managing the mix of drugs and maximizing the use of generics prescribed in Texas' Medicaid program, annual Medicaid savings of $119 million AF (All Funds) to $392 AF million would occur. If Texas performs as well as the average of the top third-performing states, it would reduce the Medicaid prescription drug program by $100 million GR and $230 million AF annually. If Texas health plans perform as well as one of the top performing states, Michigan, a large state with high Medicaid managed care enrollment and whose Medicaid health plans fully manage the prescription drug program, it would reduce costs for the Medicaid prescription drug program by $390 million AF annually, including $160 million GR. **Based on the experience from these other states, The Menges Group estimates that Texas has the opportunity to save $100 million GR and $230 million AF by allowing the Medicaid health plans to fully manage the prescription drug benefit.**

Opportunities for Medicaid Prescription Drug Savings in Texas
Net Costs per Prescription (Post-Rebate)



A Single State-Operated Medicaid Formulary Puts Quality Of Care And Patient Outcomes At Risk

In addition to providing greater cost-savings in the Medicaid program, fully integrating the pharmacy benefit would allow MCOs to apply pharmacy management tools that improve quality of care and health outcomes for patients. Unlike HHSC, MCOs have direct relationships with prescribing providers and can communicate with them in a more timely manner to assist with formulary changes and best practices in prescribing. Additionally, MCOs have the ability to update PDLs in real time and put in place important clinical standards that ensure patients are receiving the right medications they need when they need them.

Concerns with the state's uniform PDL include the following:

Confusion for Prescribers

The use of a single statewide formulary adds complexity for prescribing providers, who are accustomed to clinically relevant formularies that do not change which drugs are allowed on the formulary as rebates change. Providers have expressed frustration with not being able to prescribe the most clinically appropriate drug because it is not on the state's formulary.

Confusion for Pharmacies and Drug Shortages

The single statewide formulary is inconsistent with the way pharmacies stock drugs. Because every other health care market focuses on using-lower cost generic alternatives when available, pharmacies tend to stock more generic drugs and may not keep the more expensive brand drugs stocked. However, the state's single Medicaid formulary is brand-name heavy, which can lead to covered drugs not being available when a Medicaid enrollee shows up to the pharmacy, causing delays in treatment.

Delays & Barriers to Improving Outcomes

While the state has been responsible for creating clinical safeguards and taking into account health care outcomes, it does not have the same expertise for managing care as the MCOs and is unable to respond quickly to changes in clinical standards and changes in the market. Viewing the drug benefit in isolation from other health care benefits and management tools makes it difficult to achieve the same health outcomes and safeguards for enrollees that MCOs could achieve given a full carve-in.

- Step therapy, which is commonly used in other health insurance markets and involves prescribing the lowest-cost, clinically effective drug before switching to a higher-cost drug, is underutilized in the Texas Medicaid program. Step therapy ensures that Medicaid enrollees receive the most clinically and cost-effective treatments.
- It can take more than a year for HHSC to add a new drug to the formulary. MCOs are able to make life-saving therapies available more quickly than the state's process.
- Because the state only updates the uniform PDL twice a year, when a drug becomes unavailable on the market, the state cannot react quickly to make other drugs available, causing delays and interruptions in patient treatment.
- MCOs have direct relationships with prescribing providers and can communicate with providers in a more timely manner (if allowed by HHSC) to assist with formulary changes and best practices in prescribing.
- The state's uniform PDL is not always up-to-date with the most recent clinical evidence and national guidelines. For example, Suprax is listed as a preferred antibiotic on the state's formulary; however, it is clinically suggested to be a third line of antibiotic treatment. Including Suprax as a preferred antibiotic creates greater opportunity for antibiotic resistance within the Medicaid population. The plans suggested edits for Suprax in 2013; however, the state has continued to include Suprax as a preferred drug on the Medicaid formulary.

Background And Helpful Terms

A preferred drug list (PDL) or formulary is a list of medications covered under a health plan. Prescription drug formulary design with drug clinical management is critical to effective pharmacy cost management, especially at a time when drug costs are rising at record rates.

In March of 2012, prescription drugs were carved into Medicaid managed care contracts in Texas. In the process, **managed care organizations (MCOs)** took on the full financial risk for the cost of drugs and the risk for quality and care associated with Medicaid MCO consumers, but they were not given the tools that are typically used in the private health insurance market and Medicare to manage prescription drugs, control costs and improve health outcomes. This was an incomplete carve-in (split policy):

- Medicaid Health Plans (MCOs) – Took on full risk for prescription costs and patient outcomes
- State (HHSC) – Maintained full control of a single, uniform state Medicaid formulary (PDL) that Medicaid health plans are required to use

Texas MCOs are handcuffed by a single statewide formulary (a tiered list of prescription drugs available to enrollees) that is developed and managed solely by the **Texas Health and Human Services Commission (HHSC)** with very little input or participation by MCOs. HHSC also restricts the MCO from developing any additional clinical and safety edits to protect Medicaid consumers and from managing utilization through prior authorizations and step therapy. These types of restrictions are not found in other types of health care coverage.

During the 2011 Legislative Session, when the decision was made to carve prescription drugs into managed care, legislators chose to split the full carve-in over a two-year time period (SB 7, 1st Called Special Session, 82nd Legislature). As a result, a sunset date was included that eventually eliminated the restriction for MCOs to use their own formularies and allow them to fully manage prescription drugs within two years (August 31, 2013). During the 2013 session, legislators extended this sunset date for 5 additional years to August 21, 2018 (SB 7, 83rd Legislature).

Current Sunset Language: Texas Government Code 533.005(a)(23) requires Medicaid health plans to develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

A. That exclusively employs HHSC's Medicaid formulary

B. That adheres to the preferred drug list (PDL) adopted by HHSC

C. That includes the prior authorization procedures and requirements prescribed or implemented by HHSC

(These requirements do not apply, and may not be enforced, on or after August 31, 2018.)

About TAHP

The Texas Association of Health Plans (TAHP) is the statewide trade association representing private health insurers, health maintenance organizations, and other related health care entities operating in Texas. As the voice for health plans in Texas, TAHP strives to increase public awareness about our members' services, health care delivery benefits and contributions to communities throughout the state.

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