Understanding state Medicaid spending on prescription drugs

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Abstract

Objective:

In this research paper, we aim to provide a summary of estimated net state Medicaid spending on prescription drugs in fiscal year (FY) 2023 based on publicly available sources (e.g., state budgets, Centers for Medicare and Medicaid Services (CMS) reports).

Methodology:

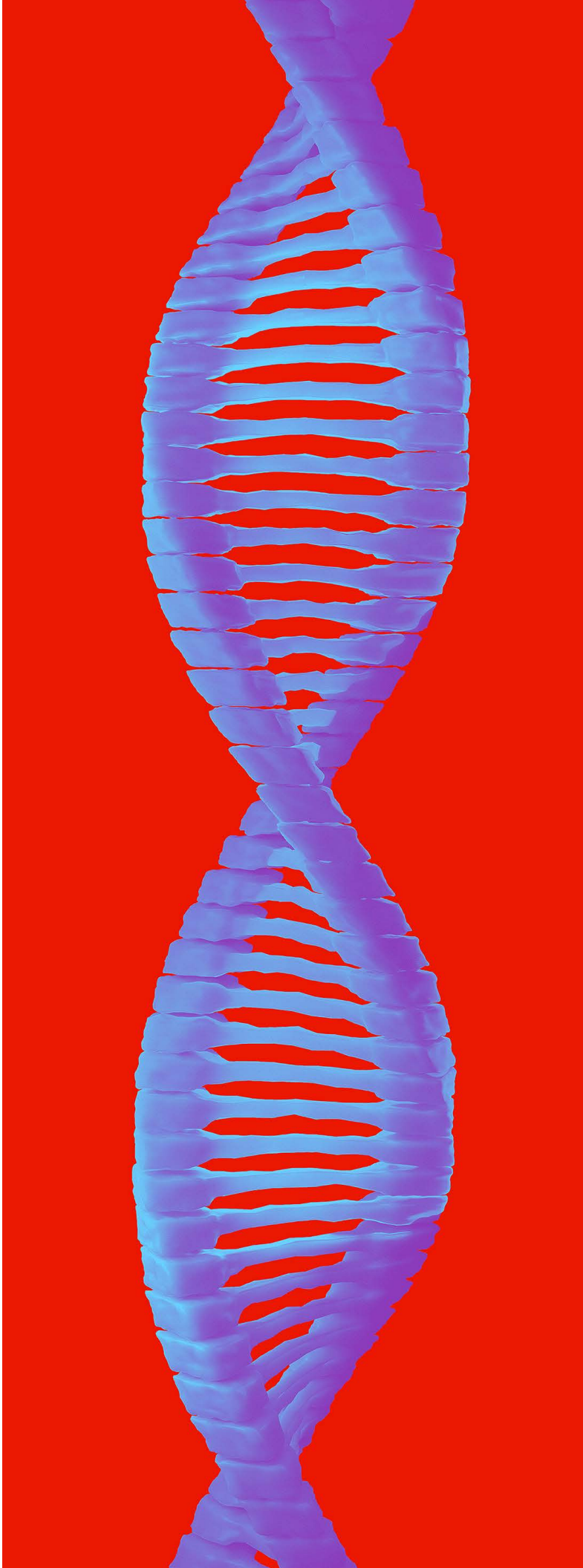
Publicly available sources, including state budget documents and state-reported data submitted to CMS for the 2023 calendar year (e.g., CMS-64) were reviewed and analyzed.

Results:

Across the 10 states studied, the estimated percentage of state Medicaid spending that was net prescription drug spending ranged from 4.7% to 14.3%. Manufacturer drug rebates back to states ranged from $83M (OR) to $1.9B (NY). These findings are near or below the national rate of drug spending as a share of overall healthcare spending of 14%, which is also below the drug spending share across comparable countries.

Conclusion:

This analysis demonstrates that state Medicaid programs are estimated to be spending near or below the national average on prescription drugs. While high drug pricing makes headlines and is often the focus of legislation and policymaker attention, drug pricing is not the main driver of state Medicaid spending. A better understanding of state spending on medicine in Medicaid from states and CMS would help drive effective policy solutions to balance access and spending.



Introduction

As science and technology continue to evolve, prescription drugs have become an increasingly important part of the United States healthcare system. They offer a wide range of benefits, including curing diseases, alleviating symptoms, reducing pain, and improving overall quality of life. Additionally, prescription drugs can offset other major healthcare costs by reducing the need for services provided by physicians and hospitals.[1]

In recent years, the cost of healthcare, and specifically prescription drugs, has become a topic of interest for policymakers. States are considering and advancing legislation on payment limits and other drug pricing policies, including establishing Prescription Drug Affordability Boards (PDABs).[2]

Despite widespread stakeholder interest, there is no central source of data to identify the amount that states are spending on prescription drugs as a part of total Medicaid spending. As such, discussion of prescription drug costs lacks context on actual drug spending as a portion of state spending on healthcare.

To advance the discussion around prescription drug spending in Medicaid, the objective of this analysis was to estimate 2023 Medicaid prescription drug spending using state budgets and other publicly available sources. As such, this analysis seeks to quantify net state Medicaid spending on prescription drugs in 10 states with significant Medicaid spend and/or policy discussions around spend (CA, CO, FL, MA, MI, NY, OH, OR, PA, and WA) in FY 2023 to enable evidence-based discussions around net drug spend and proposed drug pricing policies.

Background

Drug spending in the U.S.

Scientific and medical advances have led to unprecedented innovation in the discovery of medicine and medical technology. In 2023 alone, the Food and Drug Administration (FDA) approved 55 new drugs focused on prevention, diagnosis, and treatment of diseases and conditions including infectious diseases, neurological conditions, opioid use disorder, heart disease, and different types of cancers (e.g., colorectal, prostate, and brain).[3] In 2023, around half of the FDA's novel drug approvals received Orphan Drug designations since they targeted rare diseases.[3] As a result, consumers' use of prescription drugs has increased over time.

Greater use of both innovative therapies (e.g., cell and gene therapies) and generic therapies are key factors contributing to this increase in use of prescription drugs. An IQVIA report found that at $10,841 per capita in 2018, the United States spent more on healthcare than comparable countries, driven mostly by higher payments to hospitals and physicians, and administrative costs for insurance and healthcare services.[4] In the United States, drug spending made up around 14% of total healthcare spending, which was below the average drug spending share across comparable countries (15%) as of 2018.[4] In addition, drug pricing growth was below medical inflation, or declined between 2010 and 2020.[4]

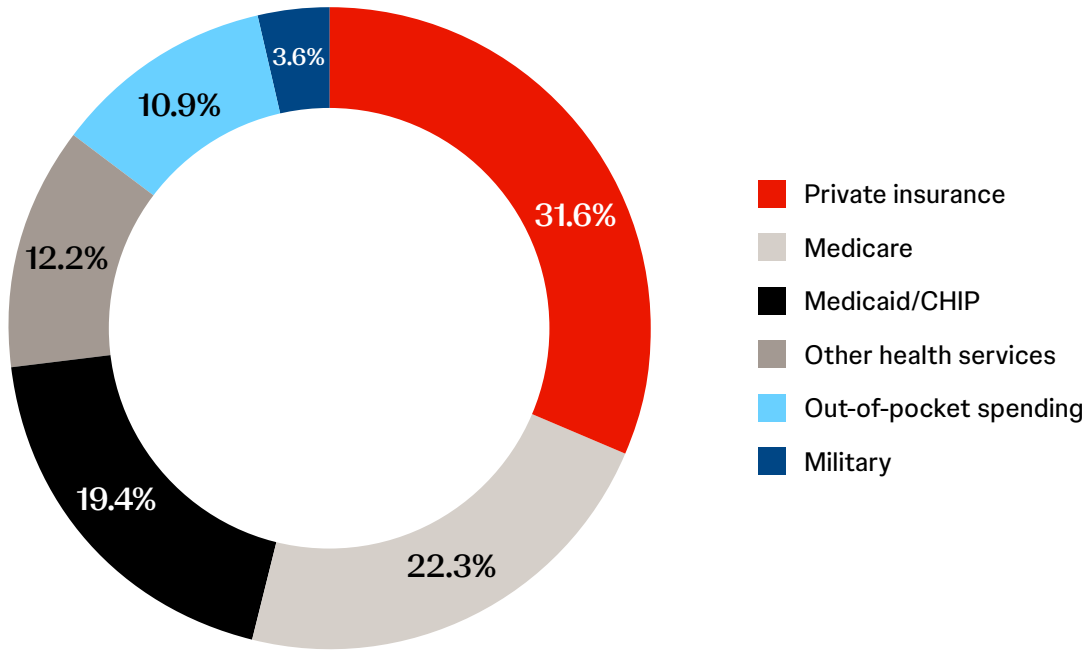
Medicaid coverage

In 2023, 92 million Americans received drug coverage from Medicaid, a joint federal-state insurance program that provides medical and drug coverage to lower-income Americans.[5] Also in 2023, Medicaid represented about 19%, or around $1 out of every $6, of healthcare spending in the US. The Medicaid program was and continues to be the source for states to provide health coverage and long-term care services for low-income individuals.[6]

Medicare and private health insurance made up approximately 22% and 32% of health spending, respectively (Figure 1).[6] Out-of-pocket expenses made up about 10% of health spending.[6]

Medicaid programs are jointly funded by states and the federal government, but are administered by states. The Federal Medical Assistance Percentage (FMAP) determines the federal share for most Medicaid expenditures.[7] States may pay for beneficiaries' care under a fee-for-service (FFS) arrangement, or may implement a managed care program, whereby managed care organizations (MCOs) are paid a per-member-per-month capitation rate to cover all services provided to Medicaid beneficiaries. Overall, most Medicaid beneficiaries are in MCO arrangements, but the share of population covered under FFS versus MCO varies significantly by state.[8]

Figure 1: Total U.S. Health Expenditures by Source, 2023 (total = $4T)[6]



Medicaid's prescription drug benefit

Medicaid provides both medical and pharmacy coverage. The medical benefit includes hospital and physician office care, including physician-administered drugs, while the pharmacy benefit covers prescribed medications for use in a patient's home. All 50 states, D.C., and Puerto Rico cover prescription drugs in Medicaid through the Medicaid Drug Rebate Program (MDRP), which requires manufacturers to enter into an agreement with CMS to provide rebates to state Medicaid programs.[9] In return, states must cover a participating manufacturer's products but may use a preferred drug list (PDL) or otherwise limit use through prior authorization or step therapy.[10]

The MDRP drug rebates offset a significant portion of Medicaid drug costs. A 2022 Medicaid and CHIP Payment and Access Commission (MACPAC) Report found that MDRP drug rebates reduce gross drug spending by over half.[11] In FY 2021, for example, total gross Medicaid drug spending was $80.6 billion, while net spending was $38.1 billion.[11]

In addition, states or MCOs may negotiate with manufacturers to receive supplemental rebates above what is statutorily required. The rebate for brand drugs is a minimum of 23.1% of the drug's average manufacturer price, or more if the manufacturer sells the drug at a steeper discount to certain purchasers, such as a commercial insurance plan.[10] Additional rebates may be applied if the manufacturer has raised the price of the drug greater than the rate of inflation. In total, a manufacturer may be required to pay MDRP rebates to states that are greater than the price of the drug.[12] Furthermore, the state's share of the rebate is not mandated to go back into Medicaid or patient care but go into the state's general fund.[10]

The net amount that a Medicaid program spends on a particular outpatient prescription drug reflects a payment from Medicaid to the pharmacy or medical provider, and a rebate from the drug manufacturer paid to Medicaid.[13]

340B drug pricing program

The MDRP and the 340B Drug Pricing Program both require manufacturers to provide significant discounts on their products.[14] In the 340B program, which is overseen by the Health Resources and Services Administration (HRSA), manufacturers are required to offer outpatient prescription drugs to eligible providers, known as covered entities, at a significantly reduced price.[14] A 340B covered entity receives the 340B-discounted price on drugs used for qualifying patients, regardless of the patient's insurance or income.[15] Covered entities are able to bill commercial insurance, Medicare, or Medicaid for drugs purchased through the 340B program.[14] 340B covered entities are not required to share the 340B discount with Medicare or commercially insured patients, meaning they can keep the profits that come from purchasing at the low 340B price and selling to patients at the higher, standard list price.[15]

The interaction between Medicaid and 340B has notable implications for Medicaid spending. Manufacturers are only required to provide a price reduction for a particular drug under one program; therefore, any drugs purchased through 340B are ineligible for MDRP rebates; this is known as the "duplicate discount" prohibition.[16]

Compliance with the prohibition against duplicate discounts presents a long-standing concern.[17] Both states and 340B covered entities have statutory obligations to prevent duplicate discounts, but a patchwork of approaches and inconsistent enforcement has hampered compliance. Specific actions on duplicate discounts recommended by the Government Accountability Office (GAO) in 2020 to restore program oversight and integrity remain unimplemented by federal agencies.[14] Meanwhile recent HRSA audits continue to expose widespread instances of duplicate discounts and program diversion across the country.[18] These findings are particularly problematic given that HRSA audits exclude any potential duplicate discounting in Medicaid managed care claims, even though, in 2022, 75% of Medicaid beneficiaries were enrolled in MCOs, and 34 states along with the District of Columbia exclusively operate under managed care models.[8] This leads to concerns that the true extent of violations is likely far greater than commonly reported. As a result, increased transparency in 340B reporting has been identified as a critical measure for states to better analyze expenditures and guide policy decisions surrounding the program's implementation.[19]

State approaches to prescription drug coverage in Medicaid

Medicaid beneficiaries may be covered under a state's FFS Medicaid program, in which the state manages the drug benefit and bears the financial responsibility for drug costs, or in an MCO arrangement, in which the state contracts with an MCO to administer Medicaid benefits. Within managed care, the MCO covers and pays for medical care. States can either "carve in" or "carve out" the drug benefit management for MCO members.[20] If a state "carves in" the drug benefit management, then it includes prescription drug coverage and risk in MCOs' contracts. If a state "carves out" the drug benefit management, then it manages the drug benefit and bears the financial responsibility for drug costs.

Additionally, states may also implement a uniform PDL, in which a state includes prescription drug provisions in MCOs' contracts but MCOs must follow the state's established PDL for coverage.[20]

State Medicaid programs use various utilization management techniques to contain pharmacy costs for their state. Most commonly, state Medicaid programs maintain a PDL for outpatient prescription drugs.[20]

PDLs allow states to drive the use of lower net drug costs by covering those drugs without restrictions and requiring prior authorization for a drug not on a PDL.[20] Other strategies include implementing prescription limits or using state Maximum Allowable Cost programs to limit costs for generic drugs.[20] Often, drugs on PDLs are less expensive (net of rebates) or include drugs for which a manufacturer has provided supplemental rebates.[20]

According to a KFF survey of state Medicaid directors, most states (46 of 50 reporting states) reported having a PDL in place for FFS prescriptions as of July 1, 2019.[21] In recent years, a growing number of MCO states have adopted "uniform PDLs," which require all MCOs to cover the same drugs as the state FFS program. Notably, uniform PDLs assist states in maximizing supplemental rebates by covering drugs administered under both the FFS and MCO delivery system.[19] In FY 2023, 19 MCO states reported having a uniform PDL for some or all classes and eight states planned to establish or expand a uniform PDL.[22]

Methods

In this analysis, researchers analyzed state Medicaid drug expenditures and drug rebate income to generate an overview of total state spending on prescription drugs and an estimate of Medicaid drug spending as a percentage of total Medicaid expenditures for the following states: CA, CO, FL, MA, MI, NY, OH, OR, PA, and WA in FY 2023.

Sources included:

- Medicaid State Drug Utilization Data to obtain total (non-340B) outpatient drug spending, separated by MCO and FFS spending[23]
- Medicaid Budget and Expenditure System/State Children's Health Insurance Program (CHIP) Budget and Expenditure System (MBES/CBES) Form CMS-64; data includes state-reported drug rebate amounts[24]
- Kaiser Family Foundation FMAP 2023 data[25]
- State budget documents[26]
- MACStats: Medicaid and CHIP Data Book[27]

The sources above were used to inform estimates of Medicaid spending. A summary of the calculations used to estimate gross and net drug spend is listed in Table 1.

Table 1: Calculations to estimate gross and net drug spend[26]

Gross (total) Medicaid spending	=	State Medicaid contribution	+	Federal Medicaid contribution
Net state Medicaid spending on drugs	=	State share of Medicaid spending on outpatient, non-340B drugs	–	State share of Medicaid rebates (statutory and supplemental)
Percentage of state Medicaid spending that is drug spending	=	Net state Medicaid spending on drugs	÷	State share of Medicaid spending

Note: Gross spending reflects expenditures before the subtraction of manufacturer rebate.

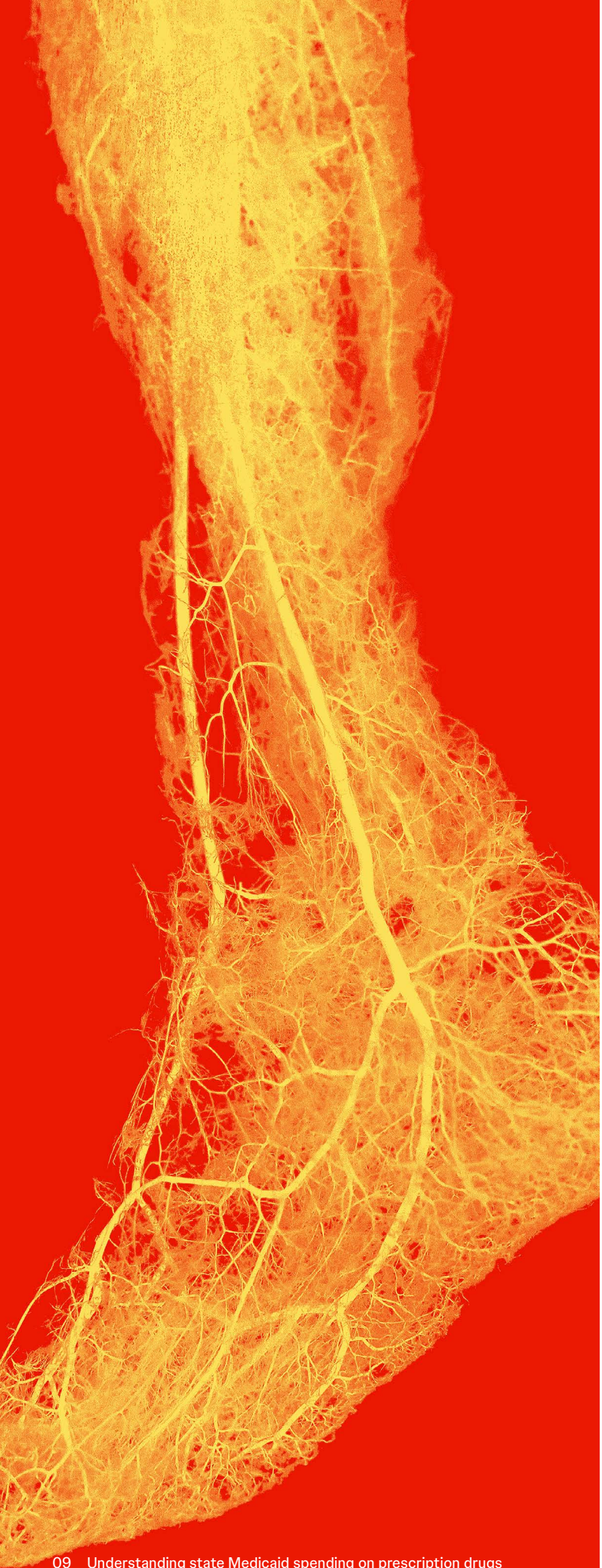
Findings

Among the 10 states studied, the estimated state drug spending in FY 2023 was near or below the national average of 14% (drug spend as a percentage of total healthcare spending).[4] The net prescription drug spending as a percentage of total state Medicaid spending ranged from around 4.7% to 14.3% for the 10 states (Table 2).[26] Rebates back to states ranged from $83M (OR) to $1.9B (NY), which include statutory and supplemental.[26]

Table 2: Summary of state Medicaid spending, FY 2023[26]

	Total Medicaid budget	Medicaid budget, state share	Gross (pre-rebate) spending on outpatient, non-340B drugs, state share	Drug rebate income, state share	Net Medicaid spending on drugs, state share	Percentage of state Medicaid spending on prescription drugs, net of rebates
CA	$144.2B	$54.9B	$5.7B	$1.3B	$4.3B	**7.9%**
CO	$13.5B	$4.8B	$673M	$240M	$433M	**9.0%**
FL	$36.4B	$12.3B	$1.3B	$716M	$582M	**4.7%**
MA	$18.6B	$7.2B	$971M	$407M	$563M	**7.9%**
MI	$24.3B	$6.1B	$1.1B	$414M	$662M	**10.8%**
NY	$92.0B	$28.7B	$3.7B	$1.9B	$1.9B	**6.5%**
OH	$36.1B	$9.6B	$1.2B	$561M	$648M	**6.7%**
OR	$13.2B	$3.8B	$281M	$83M	$198M	**5.2%**
PA	$28.3B	$9.7B	$1.8B	$687M	$1.1B	**11.5%**
WA	$9.7B	$3.0B	$696M	$256M	$440M	**14.3%**

Original J&J data on file.



Five factors that impact state spending on prescription drugs and the extent of transparency in state reporting on drug spending were identified:

- **Prescription drug benefit carved in or out:** Because they have a more direct line of sight to medication spend, states that carve the pharmacy benefit out of MCOs (CA, NY, OH) may have more transparency and control over pharmacy benefit spending than provider-administered drug spending, which can be wrapped into other line items.
- **State share of FFS vs Managed Care enrollees:** FFS offers more transparency in drug pricing compared to MCO. The states researched range from majority FFS (CO, with over 89% FFS) to majority MCO enrollment (PA with over 92% and OR with over 84% MCO).[27]
- **340B drug spend:** 340B utilization should be excluded from state drug utilization data, likely leading to underestimates of total Medicaid drug spending. While 340B covered entities should be passing 340B discounts through to Medicaid via acquisition cost billing, it is unclear from the data whether this is happening due to lack of transparency, particularly with respect to Managed Medicaid. Drugs purchased through 340B are not eligible for MDRP rebates; therefore, it is hard to quantify how much spending by state Medicaid agencies is on 340B drugs and whether these drugs cost more or less than the net cost of non-340B drugs after rebates.
- **FMAP variation:** The FMAP statutory minimum is set at 50% and the statutory maximum at 83%. FMAP varies considerably across states and is dependent upon key factors related to the state's economy, (e.g., per-capita personal income in relation to the US average), state Medicaid expansion status, and enhanced FMAP for certain populations, providers, and services (e.g., family planning).[28]
- **Innovative contracting:** The presence of value-based contracts between state Medicaid agencies and manufacturers (such as for additional rebates based on outcomes of high-cost drugs like gene therapies) may not be realized until several years after the drug expenditure.

State case study: Colorado

Health First Colorado provides health insurance to low-income adults and children.[29] In CO, the FMAP was a minimum of 56.2% in 2023.[30]

Colorado Medicaid overview

In June 2023, CO had 1.7 million individuals enrolled in Medicaid and CHIP.[5] In CO, drugs are carved into MCO contracts, which means that MCOs manage prescription drug spending. 11% of CO Medicaid beneficiaries were enrolled in Medicaid managed care.[27] In FY 2023, Colorado's total Medicaid budget was $13.5B, of which $4.8B was state spending.[26]

Figure 2: Medicaid in Colorado Snapshot

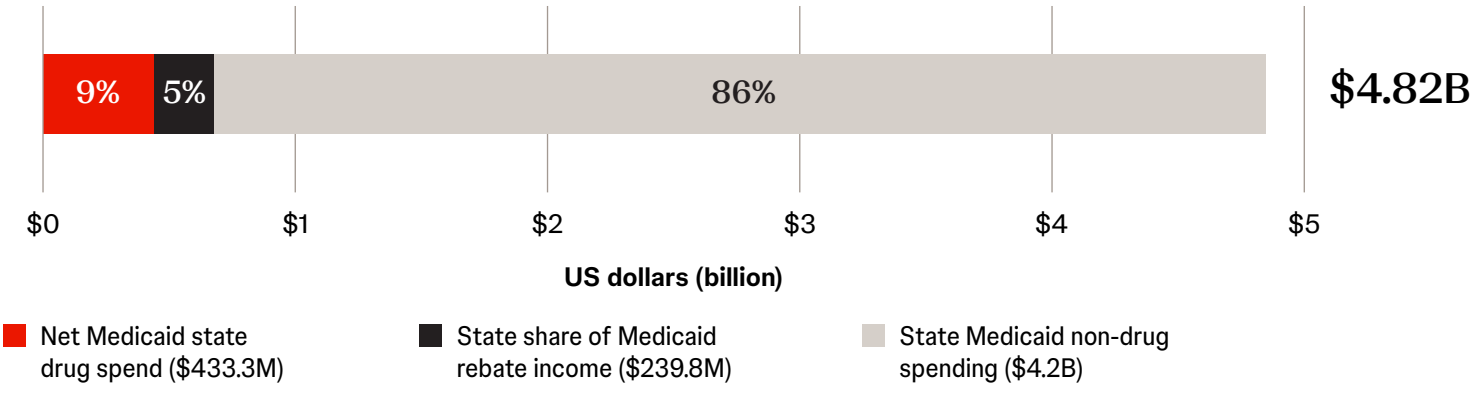
29%
Share of CO population covered by Medicaid[31, 32]

1.72M
Total Medicaid & CHIP population[31, 32]

89% FFS, 11% MCO
Percent Medicaid population in FFS vs MCO[27]

$13.5B
CO total Medicaid budget (Federal and State)[26]

Figure 3: Prescription drug spending as a proportion of state Medicaid spending in Colorado, FY 2023[26]

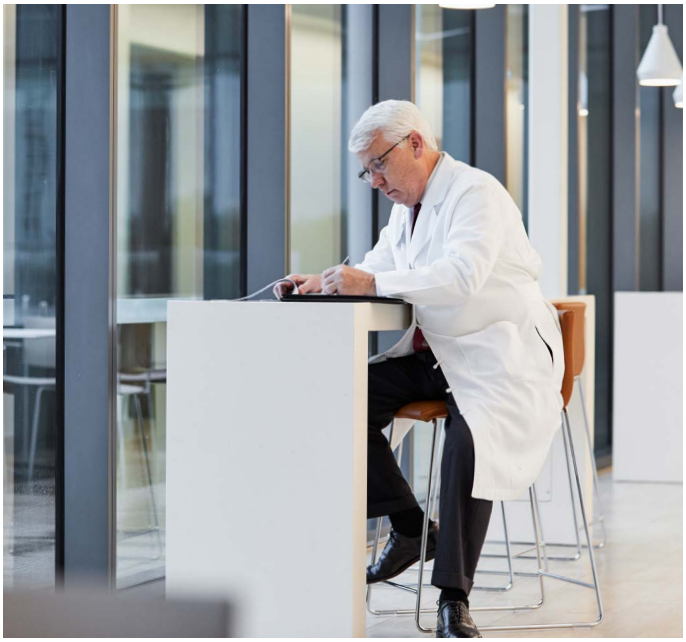


After drug rebates were taken into account (CO retained $239.8 million in rebates), the net state Medicaid spending on prescription drugs in Colorado was $433.3 million. Colorado's non-drug spending was approximately $4.2 billion. Of Colorado's Medicaid budget, approximately 9% was spent on prescription drugs in FY 2023. Colorado's Medicaid drug spending in FY 2023 was approximately $433 million, or an average of $252 per Medicaid beneficiary.[26]

Limitations

Important limitations to this analysis should be considered. First, there is uncertainty regarding inpatient hospital spending on drugs due to bundled payments (i.e., drug costs not separately identified from hospital costs), and MCO spending on prescription drugs due to limited public reporting.

Furthermore, the drug rebates collected by states in each quarter are generally attributable to drugs administered or dispensed in prior quarters. As a result, gross spending in a given time period does not necessarily align with the rebate dollars received in that period. In addition, there is a lack of transparency across states as to what types of information states publish relating to Medicaid spending. Some states had detailed Medicaid budget documents, while others limited publicly available information about specific spending areas. Finally, this analysis does not consider 340B drug spending due to lack of transparency regarding the amount of 340B drugs used for Medicaid beneficiaries. 340B entities should be passing 340B discounts through to Medicaid by acquisition cost billing, but it's unclear that it's happening particularly in the Medicaid managed care case due to lack of transparency. The net Medicaid spend may be higher to the extent covered entities are billing Medicaid and Managed Medicaid at regular rates.



Discussion

This analysis demonstrates that states are estimated to be spending near or below the national average for drug spending as a proportion of total healthcare spending, getting sizable rebates, and covering large populations through drug coverage.

While high drug pricing makes headlines and is often the focus of legislation and policymaker attention, drug pricing is not the main driver of state Medicaid spending. Discussions around healthcare spending and drug pricing should be rooted in a factual understanding of what states are spending on medications and the value that spending may bring, as well as a better understanding of what is driving healthcare costs in individual states. A better understanding of state spending on medicine in Medicaid would help this conversation and drive better policy solutions.

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