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State Medicaid Prescription Drug Expenditures for Medicare–Medicaid Dual Eligibles

Estimates of Medicaid Savings and Federal Expenditures Resulting from Expanded Medicare Prescription Coverage

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There is widespread interest in providing expanded Medicare coverage for prescription drugs. In June and July 2002, the U.S. House approved a bill that would provide such coverage, and the Senate considered but did not approve several different Medicare drug coverage proposals. Medicare coverage of prescription drugs could produce major savings for Medicaid programs, which are jointly funded by state and federal governments and administered by states. Overall, Medicaid spent an estimated $16 billion in 2002 to provide prescription drug coverage to the six million low-income Medicare beneficiaries who also are eligible for Medicaid—the "dual eligibles." States were responsible for nearly $7 billion of this spending. These dual eligibles account for nearly half of Medicaid's total spending on prescription drugs for 47 million beneficiaries ($16 billion out of $33 billion in 2002).[1] The average cost of drug coverage for a dual-eligible beneficiary is more than $2,800 a year, compared with $1,240 a year for all Medicaid beneficiaries.

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With states facing their worst budget crises in at least two decades, a Medicare takeover of some or all of the responsibility for prescription drug coverage for dual eligibles could provide significant fiscal relief to states and avert the need for Medicaid benefit or eligibility reductions that might otherwise be necessary.

In addition, low-income Medicare beneficiaries could find drug coverage under Medicare preferable to Medicaid coverage, because there can be significant obstacles to enrollment in Medicaid and states place a variety of limits on the program's drug coverage. Completely covering prescription drugs under Medicare would improve access to drug coverage for dual eligibles and facilitate coordination of their acute care (e.g., hospitals, physicians, prescription drugs, and laboratory and X-ray services), since only one payer would be responsible for these various services.

State Budget Problems and Medicaid Prescription Drug Costs

Medicaid expenditures have been growing by almost 10 percent a year since 1998 (Centers for Medicare and Medicaid Services, 2002). In the last two years, this unrelenting growth in Medicaid spending has collided with sharp declines in state revenue growth, contributing to the most serious budget problems for states in at least two decades. In state fiscal year 2002, 37 states had to cut a total of $12.8 billion out of their budgets after they had passed; thus far in fiscal year 2003, 23 states are planning to reduce their enacted budgets by more than $8.3 billion. Total year-end balances have dropped from $48.8 billion in fiscal year 2000 (10.4 percent of expenditures) to a projected $14.5 billion at the end of fiscal year 2003 (2.9 percent of expenditures). Meanwhile, Medicaid spending grew 13.2 percent in fiscal year 2002—the fastest rate of growth since 1992—while overall state spending grew only 1.3 percent (National Governors Association and National Association of State Budget Officers, 2002).

Prescription drug costs are a major contributor to these Medicaid growth trends. Between 1997 and 2000, overall Medicaid expenditures for prescription drugs grew by 18.1 percent a year, compared with an annual rate of 7.7 percent for all Medicaid services combined (Bruen, 2002). The prescription drug share of total Medicaid spending grew from 8.4 percent in 1998 to 10.8 percent in 2001.

Actuaries at the Centers for Medicare and Medicaid Services (CMS) predict a continuation of these trends. They project that Medicaid spending will grow an average of 9 percent a year between 2001 and 2011, while prescription drug spending will grow by more than 13 percent a year. The share of total Medicaid spending accounted for by prescription drugs is projected to grow from 10.8 percent in 2001 to 15.5 percent by 2011 (CMS, 2002).

Congressional Proposals for Medicare Prescription Drug Coverage

In June 2002, the U.S. House of Representatives approved a bill that would extend Medicare coverage to prescription drugs, and the U.S. Senate considered but did not approve several different Medicare prescription drug proposals (Health Policy Alternatives, 2002). These bills would shift responsibility for prescription drug coverage for dual eligibles from Medicaid to Medicare, but in most cases would make states responsible for some or all of the premiums and other cost-sharing (deductibles, coinsurance, and copayments) for low-income beneficiaries, including dual eligibles. These proposals could increase federal spending by $300 billion to $600 billion from 2003 to 2012 (Congressional Budget Office, 2002a and 2002c).

The House-passed Medicare prescription drug coverage bill (H.R. 4954) would provide Medicare coverage for dual-eligible drug costs starting in 2005. Financial responsibility for beneficiary cost-sharing initially would remain with Medicaid, through a reduction in the Medicaid federal matching payments states would otherwise

receive. This reduction in federal payments would gradually decline over time, with Medicaid's financial responsibility for most beneficiary cost-sharing ending in 2014.

There is one significant exception to this proposed Medicare takeover of dual-eligible drug costs. Under the House bill, all Medicare beneficiaries would be fully responsible for their prescription drug expenditures between a $2,000 benefit limit and a $3,700 stop-loss threshold.[2] Medicaid programs would thus have to pay for this "hole" in coverage for dual eligibles, even after the 10-year phase-out of Medicaid funding responsibility for other beneficiary cost-sharing. The amount of dual-eligible drug expenditures that would occur in this coverage gap is not known, but the Congressional Budget Office (CBO) estimates that more than one-fifth of total drug spending by all Medicare beneficiaries in 2005 will occur in the range between $2,000 and $4,000 of per-beneficiary spending (CBO, 2002c).

CBO estimates that, under the House bill, net Medicaid savings for states would be $46 billion between 2003 and 2012 ($58 billion in reduced Medicaid prescription drug costs, offset by $12 billion to cover premiums and cost-sharing for low-income beneficiaries). Significant net state savings would not begin until 2006, but would reach approximately $10 billion a year by 2012, the final year in the CBO 10-year cost estimate (CBO, 2002b).

A bill proposed at the same time by House Democrats (H.R. 5019) would have required substantially lower premiums and cost-sharing for low-income beneficiaries, with states responsible for those amounts at current-law Medicaid match rates for beneficiaries at or below 100 percent of poverty. States would receive 100 percent federal matching funds for Medicaid-paid premiums and cost-sharing for beneficiaries between 100 percent and 175 percent of poverty (Health Policy Alternatives, 2002). CBO did not publish a cost estimate for this bill, so it is not possible to determine the net fiscal impact of these provisions on states.

Two of the bills voted on but not approved in the Senate (S.2625 and S.2729) adopted a similar approach. Under the bills, Medicare would take over the drug costs for dual eligibles but state Medicaid programs would remain responsible for at least a portion of the premiums and cost-sharing for low-income beneficiaries (Health Policy Alternatives, 2002). Unlike the House-passed bill, in the Senate proposals Medicaid would retain responsibility for beneficiary cost-sharing for prescription drugs for dual eligibles, rather than phasing out responsibility for these costs over time. In addition, at least one of the Senate bills (S. 2625) would require states to cover beneficiary premiums and cost-sharing at higher income levels than current law requires, further offsetting state savings from Medicare coverage of dual eligibles' drug costs. The CBO has not published estimates of the impact on state Medicaid costs of the bills considered in the Senate.

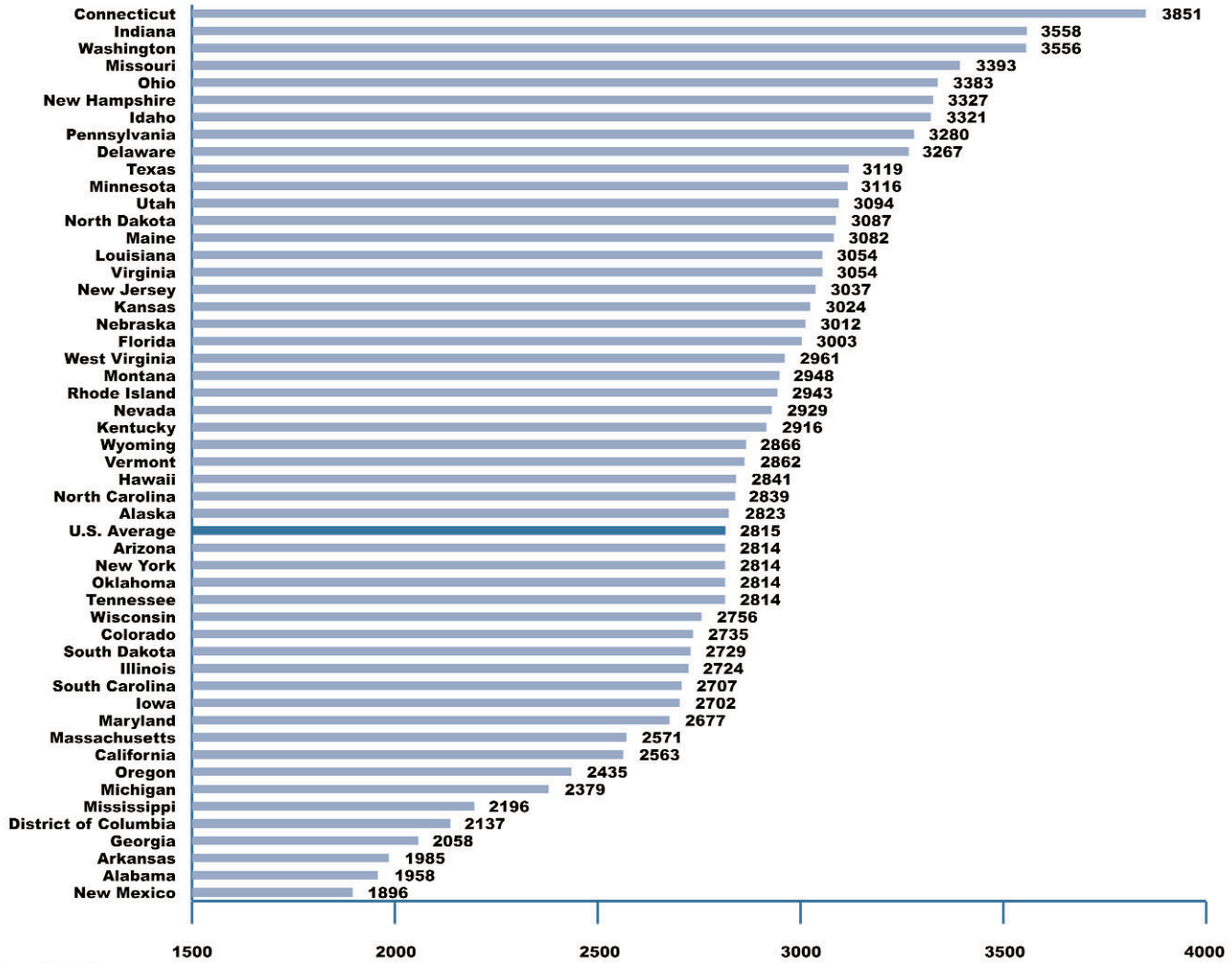
State-by-State Medicaid Expenditures for Prescription Drugs for Dual Eligibles, 2002

As shown in Table 1, Medicaid expenditures for prescription drugs for dual eligibles vary widely among states, reflecting differences in state size, Medicaid eligibility requirements, and prescription drug benefit features. The state share of Medicaid expenditures also varies, ranging in 2002 from 24 percent in Mississippi to 50 percent in 11 high-income states, and averaging around 43 percent.

The federal government funds the remaining 57 percent of Medicaid expenditures and would share proportionally in the savings from a Medicare takeover of Medicaid prescription drug costs. If Medicare assumed all prescription drug costs for dual eligibles in 2002, federal Medicare costs would go up by $16 billion, which would be partially offset in the federal budget by about $9 billion in federal Medicaid savings.

Table 2 demonstrates total estimated Medicaid prescription drug expenditures per dual eligible in 2002 for all states. The amount ranges

Figure 1. Projected Annual Medicaid Prescription Drug Expenditures per Dual Eligible with Full Medicaid Benefits, 2002 (in Dollars)



Source: Table 2.

from $1,896 per year in New Mexico to $3,851 in Connecticut, with a weighted national average of $2,815. Figure 1 ranks states by their prescription drug costs per dual eligible. The per-person drug costs for dual eligibles substantially exceed the per-person costs for other Medicaid beneficiaries. For all Medicaid beneficiaries combined, including dual eligibles, per beneficiary prescription drug costs were about $1,240 in 2002, less than half the estimated cost for dual eligibles alone. Even among elderly and disabled Medicaid beneficiaries—by far the heaviest users of prescription drugs in Medicaid—we estimate that dual eligibles' drug costs are more than 50 percent above the average for elderly and disabled beneficiaries who are not dual eligibles.

The estimated figure of $16 billion in Medicaid expenditures for prescription drugs for dual eligibles in 2002 provides a starting point for estimates of some or all of these costs. If Medicaid remained responsible for beneficiary cost-sharing or gaps in the benefit, as was the case in the bills considered by Congress in 2002, the estimated Medicaid savings would be reduced. Estimates for a takeover that took effect after 2002 would have to reflect estimates of Medicaid dual-eligible drug expenditures in those later years. These refinements are not incorporated in this analysis, in part because Medicare prescription drug coverage proposals remain in considerable flux with respect to program design and financing issues.

Benefits for Dual Eligibles from Medicare Prescription Drug Coverage

Medicare coverage of prescription drugs for dual eligibles could make coverage more uniform, increase beneficiary access to coverage, and improve coordination of care.

Greater Uniformity. State Medicaid programs vary widely in their basic eligibility rules, the kinds of restrictions they impose on prescription drug use (prior authorization requirements, limits on the number of prescriptions and refills, formulary limits, generic substitution requirements), the amount of beneficiary cost-sharing required, and methods of reimbursing pharmacists, all of which can affect dual eligibles' prescription drug coverage. (See text box for details on variations in Medicaid prescription drug coverage.)

Improved Access. Depending on how Medicare coverage of prescription drugs would be structured and implemented, poor beneficiaries could have improved access to prescription drugs in states where full Medicaid coverage is now limited to Medicare beneficiaries with incomes below 74 percent of poverty or where there are cost-sharing requirements or other limits on coverage.

In addition, low-income Medicare beneficiaries may be more likely to obtain prescription drug coverage if they can do so through Medicare, rather than having to enroll in Medicaid. Many Medicare beneficiaries who are eligible for full Medicaid coverage do not enroll in the program, either because they are not aware of this option, find Medicaid enrollment burdensome, or believe that the program carries a social stigma (Perry et al.,

MEDICAID PRESCRIPTION DRUG COVERAGE

State Medicaid prescription drug coverage for dual eligibles varies significantly from state to state, depending in large measure on state eligibility rules and the specific features of the Medicaid drug benefit. For example, in mid-2000 (Schwalberg et al., 2001):

- Only 16 states provided full Medicaid coverage (including prescription drug coverage) to Medicare beneficiaries up to 100 percent of the federal poverty level. (Federal law requires coverage up to 74 percent of poverty.)
- At least 36 states required prior authorization for some drugs.
- At least 40 states excluded some drugs from their formulary of covered drugs.
- Forty-one states limited the amount of medication per prescription, the number of refills, and/or the number of prescriptions per month.
- At least 16 states required use of generic rather than brand-name drugs when generic substitutes were available.
- At least 28 states required copayments for prescription drugs, which under federal regulations can range from 50 cents to $3, depending on the price of the drug, or can be set at 5 percent of the cost of the drug.
- Reimbursement to pharmacists in 2000 for drug ingredient costs ranged from 4 percent below average wholesale price to 15 percent below, and dispensing fees ranged from $2.50 per prescription to $5.77.

As Medicaid increased pressure on state budgets in 2001 and 2002, many states further restricted or reduced pharmacy reimbursement in their Medicaid prescription drug programs or considered doing so (National Association of State Medicaid Directors, 2002b; National Governors Association and National Association of State Budget Officers, 2002; and Smith et al., 2002).

2002; Nemore, 1999; Rosenbach and Lamphere, 1999; Barents Group, 1999).

Improved Care Coordination. Including prescription drugs in the Medicare benefit package for dual-eligible beneficiaries could improve coordination of prescription drug use with other aspects of their care, including physician, inpatient, home health and skilled nursing facility care, and laboratory and X-ray services. The current system presents major obstacles (1) to beneficiaries, who may have trouble understanding their coverage or obtaining access to appropriate care; (2) to health care providers, who will be better able to oversee drug and acute care services with one coverage source; and (3) to federal and state governments, which must deal with the complexity, cost-shifting, and problematic incentives that characterize this shared coverage (Clark and Hulbert, 1998; and General Accounting Office [GAO], 2000). Expanding Medicare coverage of prescription drugs for dual eligibles would by no means solve all of these coordination problems, but it could make such obstacles easier to overcome.[3]

Opportunities for improved care coordination may be greatest in managed care arrangements, because a single managed care organization (MCO) could be responsible for all Medicare-covered services. Physicians could be provided with information on all Medicare-covered prescription drugs used by their patients, and MCOs would have an incentive to develop more effective ways of using drugs to avert costly hospital, home health, and nursing facility care. However, states have had difficulty enrolling dual eligibles in Medicaid managed care, and some of them have looked for ways of better coordinating care for dual eligibles in fee-for-service settings (GAO, 2000; Bratesman and Saucier, 2002). Medicare coverage of prescription drugs for dual eligibles could encourage coordination of care in Medicare MCOs.

Potential Uses of Medicaid Savings

Given states' current budget problems, Medicaid savings from a Medicare takeover of prescription drug costs for dual eligibles would likely be used in most states to avert benefit or eligibility cutbacks that may otherwise be required.

As discussed above, we estimate that a complete Medicare takeover of all prescription drug costs for dual eligibles would save states about $6.8 billion in state Medicaid dollars at 2002 spending levels.[4] Medicaid savings for specific states are shown in Table 1. These estimates represent the maximum savings that states could receive. To the extent that states are financially responsible for deductibles, copayments, coinsurance, and other cost-sharing for dual eligibles, savings would be reduced.

As shown in Table 3, each $1 billion in Medicaid state-dollar savings would permit states to implement one of the following initiatives to retain or expand coverage:

- Cover 1.55 million children in their Medicaid programs. There are 18 million children enrolled in Medicaid and the state Children's Health Insurance Program (CHIP), and the Urban Institute estimates that another 4.7 million children are eligible for these programs but are uninsured (Covering Kids, 2002).
- Cover 925,000 nondisabled and nonelderly adults in their Medicaid programs. About 8 million adults in these eligibility categories are currently enrolled in Medicaid.
- Cover 170,000 to 190,000 elderly or disabled adults in their Medicaid programs. About 9 million adults in these eligibility categories are currently enrolled in Medicaid.
- Cover 2.4 million children in their CHIP programs. About 3.5 million children are now enrolled in CHIP (Smith and Rousseau, 2002).
- Cover 400,000 uninsured adults in state-funded health insurance programs.

Varying numbers of beneficiaries could be covered by the $1 billion in state-dollar savings, depending upon the per-person cost of different types of enrollees and the portion of those costs paid by state governments.

State Pharmaceutical Assistance Programs. States could also use Medicaid savings to fund state pharmaceutical assistance programs aimed at filling remaining gaps in Medicaid and Medicare prescription drug coverage. The extent of these gaps, and the state dollars needed to fill them, would depend on the details of whatever Medicare prescription drug coverage program is adopted and on details of current state programs. As of 2001, the 28 states with state pharmacy assistance programs were spending a total of $1.5 billion a year on these programs (Fox et al., 2002). A Medicare prescription drug benefit could free up a substantial portion of those state dollars for alternative uses, including state programs to offset some of the beneficiary cost-sharing that is likely to be included in a Medicare drug benefit.

Conclusion

Medicare coverage of the prescription drug costs of dual eligibles could bring much-needed fiscal relief to financially strapped states, improve access to prescription drug coverage for low-income Medicare beneficiaries, and facilitate improved coordination of care for beneficiaries who often have complex and chronic illnesses or disabilities. It could provide states with resources to preserve Medicaid coverage that might otherwise have to be cut.

Medicare prescription drug coverage would be costly for the federal government, however, and growing federal deficits limit available resources. Major differences of view remain on a number of crucial program design issues, such as whether coverage should be provided through the traditional Medicare program or through private insurance companies, whether coverage should focus on those with lower incomes or extend to people at higher income levels, and whether prescription drug coverage should be enacted on its own or only as part of a broader reform of Medicare.

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Notes

[1] These estimates do not include the savings that Medicaid receives through rebates from drug manufacturers, which reduce total Medicaid prescription drug expenditures by about 17 to 18 percent.

[2] These 2005 dollar amounts would be increased in subsequent years by the annual percentage increase in average per-capita aggregate expenditures for outpatient drugs covered by Medicaid.

[3] Coordination of Medicare drug coverage with other jointly funded services may be easier to accomplish in acute care settings, where Medicare has primary funding responsibility, than in long-term care settings, such as nursing facilities and home health, where Medicare and Medicaid coverage is intertwined in more complex and institutionally embedded ways.

[4] This amount represents the state share of the $16 billion that we estimate Medicaid spent on prescription drug costs for dual eligibles in 2002.

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Table 1

Medicaid Prescription Drug Expenditures for Dual Eligibles

	Projected 2002 Overall Medicaid Prescription Drug Expenditures for Dual Eligibles ($1,000s)[a]	State Medical Assistance Percentage[b]	State Share of Expenditures ($1,000s)[c]
United States Total	**$15,989,392**	**43%**	**$6,820,486**
Alabama	225,128	30	66,525
Alaska	26,373	47	12,393
Arizona	167,626	35	58,703
Arkansas	160,278	27	43,852
California	2,114,897	49	1,027,840
Colorado	146,307	50	73,154
Connecticut	273,624	50	136,812
Delaware	35,968	50	17,984
District of Columbia	36,796	30	11,039
Florida	1,009,956	44	440,038
Georgia	325,107	41	133,294
Hawaii	59,599	44	26,021
Idaho	32,584	29	9,443
Illinois	381,507	50	190,753
Indiana	300,811	38	114,188
Iowa	124,982	37	46,418
Kansas	121,187	40	48,232
Kentucky	342,965	30	103,095
Louisiana	305,219	30	90,650
Maine	121,556	33	40,624
Maryland	178,212	50	89,106
Massachusetts	498,862	50	249,431
Michigan	421,082	44	183,760
Minnesota	255,661	50	127,831
Mississippi	273,244	24	65,333
Missouri	426,179	39	165,954
Montana	38,538	27	10,471
Nebraska	101,598	40	41,096
Nevada	46,342	50	23,171
New Hampshire	77,357	50	38,679
New Jersey	407,449	50	203,725
New Mexico	55,638	27	15,000
New York	1,570,994	50	785,497
North Carolina	597,871	39	230,419
North Dakota	39,184	30	11,806
Ohio	516,837	41	213,040
Oklahoma	181,109	30	53,554
Oregon	157,106	41	64,099
Pennsylvania	694,126	45	314,786
Rhode Island	96,297	48	45,789
South Carolina	304,415	31	93,334
South Dakota	30,969	34	10,551
Tennessee	511,058	36	185,821
Texas	1,169,642	40	465,868
Utah	46,928	30	14,078
Vermont	56,113	37	20,728
Virginia	280,686	49	136,273
Washington	264,150	50	131,098
West Virginia	104,376	25	25,812
Wisconsin	258,067	41	106,917
Wyoming	16,833	38	6,402

[a] See Appendix Table A3 at www.cmwf.org for details of the methodology underlying these estimates.

[b] Equal to 100% minus the Federal Medicaid Assistance Percentage (FMAP). FMAP for fiscal year 2002 drawn from http://www.aspe.hhs.gov/health/fmap02.htm. The weighted national average for the state share is 42.66 percent.

[c] Computed by multiplying the total Medicaid prescription drug expenditures for dual eligibles by the State Medical Assistance Percentage.

Sources: Mathematica Policy Research State Medicaid Research Files Validation Tables, Health Care Financing Review, *Medicare and Medicaid Statistical Supplement, 2000*, and CMS's Third-Party Premium Billing File.

Table 2

Projected 2002 Medicaid Prescription Drug Expenditures per Dual Eligible with Full Medicaid Benefits

	Medicaid Prescription Drug Expenditures per Dual Eligible with Full Medicaid Benefits[a]
United States Average	**$2,815**
Alabama	1,958
Alaska	2,823
Arizona*	2,814
Arkansas	1,985
California*	2,563
Colorado*	2,735
Connecticut*	3,851
Delaware*	3,267
District of Columbia*	2,137
Florida	3,003
Georgia	2,058
Hawaii*	2,841
Idaho	3,321
Illinois*	2,724
Indiana*	3,558
Iowa	2,702
Kansas	3,024
Kentucky	2,916
Louisiana*	3,054
Maine	3,082
Maryland*	2,677
Massachusetts*	2,571
Michigan	2,379
Minnesota	3,116
Mississippi	2,196
Missouri	3,393
Montana*	2,948
Nebraska*	3,012
Nevada*	2,929
New Hampshire	3,327
New Jersey	3,037
New Mexico	1,896
New York*	2,814
North Carolina*	2,839
North Dakota	3,087
Ohio*	3,338
Oklahoma*	2,814
Oregon*	2,435
Pennsylvania	3,280
Rhode Island*	2,943
South Carolina*	2,707
South Dakota*	2,729
Tennessee*	2,814
Texas*	3,119
Utah	3,094
Vermont*	2,862
Virginia*	3,054
Washington	3,556
West Virginia*	2,961
Wisconsin	2,756
Wyoming	2,866

[a] Prescription drug expenditures per dual eligible drawn from 1998 data from Mathematica SMRF Validation Tables; where SMRF data were not available, costs per dual were estimated from Medicaid prescription drug spending per beneficiary (from the Health Care Financing Review, *Medicare and Medicaid Statistical Supplement, 2000*), the ratio of the number of dual eligibles to Medicaid prescription drug beneficiaries, and the percentage of the state's Medicaid population and dual population that was blind or disabled. (See Appendix Table A.2 at www.cmwf.org.) 1998 expenditures per dual eligible were projected to 2002 using the growth in per capita prescription drug spending according to CMS's National Health Expenditure Projections.

* Prescription drug expenditures were estimated for this state, since actual SMRF data were not available.

Table 3

Estimated National Number of Enrollees Who Could Be Covered with $1 Billion in State-Dollar Medicaid Savings, 2002

Program	Estimated Total Annual Per-Person Costs (National Average)	State Share of Total Annual Per-Person Costs (National Average)	Number of Enrollees Who Could Be Covered ($1 Billion Divided by Column 3)
(1)	(2)	(3)	(4)
Medicaid		**(43% state share)**	
Children	$1,497	$644	1.55 million
Adults	$2,514	$1,081	925,000
Elderly	$13,724	$5,901	170,000
Disabled	$12,187	$5,240	190,000
CHIP		**(28% state share)**	
Children	$1,497	$419	2.4 million
State-Funded Health Insurance		**(100% state share)**	
Adults	$2,514	$2,514	400,000

Source: Estimates of total annual per-person costs for 1998 were obtained from Health Care Financing Review, *Medicare and Medicaid Statistical Supplement, 2000*, Table 97, p. 320. These per-person costs were inflated to 2002 levels by multiplying each amount by 1.34 percent, the estimated increase in Medicaid and CHIP per-capita expenditures between 1998 and 2002 in CMS *National Health Care Expenditures Projections: 2001–2011*, Table 4. The state share of Medicaid and CHIP expenditures in 2002 varies from state to state, averaging 43 percent nationwide for Medicaid and 28 percent for CHIP.

Methods

Medicaid prescription drug expenditures per dual eligible vary substantially from state to state, depending on how comprehensive the state's prescription drug benefit is, how the state reimburses pharmacies for drugs, how successful the state is in encouraging the substitution of generic for brand-name drugs, how stringent the state's eligibility criteria are for dual eligibles, what percentage of dual eligibles are in nursing facilities, and other factors.

Our state-by-state estimates implicitly capture these variations by combining data on (1) the number of people dually eligible for Medicare and full Medicaid prescription drug coverage in each state, and (2) annual Medicaid prescription drug expenditures per dual eligible in each state. We multiplied these two components to compute the total prescription drug expenditures for dual eligibles in each state. For 23 states, the Medicaid prescription drug expenditures per dual eligible were based on 1998 claims data from the State Medicaid Research Files (SMRF). For the other states, expenditure estimates for dual eligibles were based primarily on available data for Medicaid expenditures per beneficiary for prescription drugs (adjusted to account for the higher average prescription drug costs of aged and disabled dual eligibles), the share of total Medicaid beneficiaries represented by dual eligibles, and the share of dual eligibles that are disabled. Details of our data sources and methodology are in the Appendix, available through The Commonwealth Fund website at www.cmwf.org.

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