

## EXECUTIVE SUMMARY

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STATE MEDICAID PROGRAM ISSUES: PREFERRED DRUG LISTS BILL NO. 5B324  
CONDUCTING A COST-BENEFIT ANALYSIS

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A preferred drug list (PDL) is a list of selected drugs that health care providers are permitted to prescribe without prior authorization. Providers must obtain prior authorization from the state Medicaid agency (or its contractor) before any drug that is not included on the PDL can be dispensed.

PDLs primarily focus on drugs used to treat chronic illnesses, which are refilled on a regular basis. These include drugs for diabetes, gastrointestinal conditions, high blood pressure, heart disease, arthritis, asthma, epilepsy, cancer, mental illness, and high cholesterol. Elderly and disabled patients tend to feel the impact of a PDL disproportionately because they suffer from more chronic illnesses than younger and non-disabled patients.

While several states have implemented a PDL in their Medicaid program and others are considering or planning to implement a PDL in the coming year, the new Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) significantly reduces the state's potential for savings from new PDL initiatives. The MMA shifts responsibility of prescription drug benefits for dual eligible patients<sup>i</sup> from Medicaid to Medicare effective January 1, 2006. Therefore:

- Potential savings for dually-eligible patients will accrue over a diminishing period of time, and
- The number of prescriptions from which savings can be derived (subject to a PDL) will be greatly reduced.

This means that the cost of a PDL implementation is amortized over a smaller base of savings opportunities.

In addition, few states recognize the unintended and usually un-monitored costs of a PDL implementation. The mandatory switches in drug therapy associated with a PDL can result in:

- Additional physician office visits,
- Lab work for monitoring and titrating new prescriptions,
- Increased concomitant medications, and
- More treatment failures.

These costs are shown to have a substantial negative impact on the true valuation of net PDL savings.

- Recently, a white paper was prepared by the authors of this brief that provides a framework for states to estimate the potential first year return on investment from a PDL implementation, in light of the impending Medicare drug benefit. In the paper, two sample calculations illustrate that *savings from a PDL are reduced by as much as 60 percent when all implementation costs and indirect non-pharmacy costs are accounted for* (and the PDL is implemented within six months of the Medicare drug benefit effective date of January 1, 2006). A reduced savings expectation may make the decision to invest in a PDL unattractive in terms of its return on investment. *The savings may be further eroded depending upon the state's Federal Medical Assistance Percentages (FMAP)*<sup>ii</sup> since there are minimal savings to a state with a large federal match. (See Table 1.)

The sample calculations in the white paper include assumptions based on data from the literature and from other states; however, each state should input its own data in order to determine their respective return on investment. In addition to the state's estimate of return on investment, the state should also consider the following before making the decision to implement a PDL:

- There can be significant disruption to **patients** who are required to switch from a trusted, effective drug to a new, as yet untried drug. There are real quality of care and cost concerns associated with the five to six percent of drug switches that fail to achieve an acceptable therapeutic outcome.
- The return on investment for alternative cost containment strategies, such as **disease and targeted case management**, may equal or exceed the return on investment for a PDL without any of the aforementioned quality-of-care concerns.
- The cost impact of dealing with prior authorization requirements and denials is significant for

<sup>i</sup> A dual eligible is a beneficiary who is eligible for Medicaid and entitled to Medicare, the federal health insurance program.

<sup>ii</sup> The federal government and the states share responsibility for financing Medicaid. The portion of the Medicaid program paid by the Federal government, known as the Federal Medical Assistance Percentage (FMAP), varies by state with an authorized rate of between 50 and 77 percent, depending on the state's per capita income. (Financing the Medicaid Program: The Impact of Federal Fiscal Relief. Kaiser Commission on Medicaid and the Uninsured. April 2004.)

**physicians and pharmacies.**

- The cost impact to the Medicare program is significant, and indeed, dwarfs the impact on state coffers. This is because the direct and indirect cost of drug switches for dually eligible patients (including physician, laboratory, and emergency room services) are paid by Medicare, not Medicaid. While a state may save money in the pharmacy budget, the federal government may experience large increases in other medical costs to support the drug switches, as well as additional medical costs when some of the drug

switches fail.

In summary, it is important that the decision to implement a PDL not be based on over-simplified and over-sold estimates. In light of the new Medicare drug benefit, states need to look carefully at whether a PDL is an effective way to invest their time and money in order to achieve savings in Medicaid.

**Table 1 — First Year PDL Costs and Savings**

Tangible Costs	Savings for Medicaid-Only Recipients
<p>State staffing costs (to oversee P&amp;T committee and hire &amp; manage vendors, etc.)</p> <p>Vendor costs for PDL:</p> <ul style="list-style-type: none"> <li>• Development</li> <li>• Implementation</li> <li>• Prior authorization processing</li> </ul> <p>MMIS costs for duplicate claims when prior authorization results in a claim denial</p> <p>Non-drug benefit costs for physician office visits and lab work necessary to switch patients to PDL drug</p> <p>Non-drug benefit costs when new PDL drug fails to work or causes adverse results and patient must be switched back or needs emergency care services for treatment failures</p>	<p>Lower drug ingredient costs for each new PDL prescription and/or refill for 12 months of the year</p>
Intangible Costs from State Perspective	Savings for Dual Eligible Recipients
<p>Labor costs for pharmacies and physicians to handle prior authorization requirements</p> <p>Patient inconvenience and time loss to respond to prior authorization requirements</p> <p>Quality of life impact when prior authorization process results in:</p> <ul style="list-style-type: none"> <li>• Loss of symptom control</li> <li>• Treatment gaps</li> <li>• Treatment failures</li> </ul> <p>Non-drug benefit costs to Medicare</p>	<p>Lower drug ingredient costs for each new PDL prescription and/or refill for however many months before January, 2006</p>



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