

CENTER FOR STUDYING HEALTH SYSTEM CHANGE

ACCESS TO PRESCRIPTION DRUGS: NOT JUST A MEDICARE PROBLEM

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MR. LEN NICHOLS: Well good morning. My name is Len Nichols. I'm the Vice President at the Center for Studying Health System Change, which is an independent, non-partisan policy research organization funded by the Robert Wood Johnson Foundation.

And I'd like to first welcome our phone callers as well as those who are watching over kaisernetwork.org. And I want to thank all of you for joining us this morning to discuss the findings of a new national study about Americans' access to prescription drugs.

This research is based on data from the 2000-2001 Community Tracking Studies Household Survey, a nationally representative survey of 60,000 people and 33,000 families.

Now, recent state and federal debates have focused on the prescription drug needs of the elderly in Medicare. That's a very important and vulnerable part of the population, of course. But, our new study has found that many other Americans, including Medicaid beneficiaries, are also having trouble affording the prescriptions their doctors write for them.

The study's findings about Medicaid beneficiaries are surprising, perhaps even startling. More than 1 in 4 of Medicaid beneficiaries age 18 to 64 reported they couldn't afford to fill a prescription in the previous year, despite the fact that in all 50 states drug coverage is offered as part of the Medicaid benefit package.

The prescription drug access problems experienced by Medicaid beneficiaries, in fact, are virtually the same as those experienced by the uninsured. Twenty-six percent of adult Medicaid beneficiaries said they couldn't afford to fill a prescription, compared to 29 percent of the uninsured, and this difference is statistically insignificant.

Now, Medicaid was designed to provide affordable healthcare to millions of the sickest and poorest Americans and, generally speaking, it does a good job of providing access to most health services, including hospital and physician care. So why is it that Medicaid is falling short in this one critical aspect of care?

What we found is that Medicaid beneficiaries in states that have implemented many different prescription drug cost containment policies were twice as likely to report they can't afford medications, as were Medicaid beneficiaries in states with fewer restrictions on Medicaid prescriptions.

Now we fully recognize the states are in a difficult situation. Medicaid spending has been increasing rapidly and growing as a share of state budgets. Many states have budget shortfalls, they're constitutionally constrained to balance their budget and they're trying desperately to tighten their belts any way they can.

And it's true that increased prescription drug spending is a major driver of Medicaid spending just as it is for overall healthcare spending. So it's a natural target for policy action.

But, while many private insurers have adopted similar restrictions to reign in drug costs, our study suggests that policy makers really should keep in mind that aggressive cost containment policies are likely to have a greater impact on Medicaid beneficiaries because they have poorer health and lower incomes than privately insured people.

Now I'd like to turn it over to Peter Cunningham, the HSC researcher and the author of the study, who's going to go over the findings in more detail. After Peter, we'll hear briefly from Leighton Ku, a senior health policy fellow at the Center on Budget and Policy Priorities and one of the nation's leading experts on Medicaid and then Joan Hennenberry, who's Director of Health Policy Studies at the National Governors Association for their reactions to our study.

Peter?

MR. PETER CUNNINGHAM: Thank you, Len, and good morning to everyone.

I'd like to summarize the main findings from the study before discussing them in greater detail.

First, affording prescription drugs is a problem for many American adults, not just for the elderly. And among non-elderly adults, the uninsured and those enrolled in Medicaid experienced the greatest problems affording prescription medications. In fact, one in four Medicaid beneficiaries were unable to fill a prescription last year, despite the fact that all state Medicaid programs provide prescription drug coverage.

And state efforts to control Medicaid prescription drug spending appear to be decreasing access to prescription drugs.

More people today than ever before use and depend on prescription medications for the treatment of their health problems. But, as the use of prescription medications and our ability to treat health problems with drugs have increased, so have the costs.

The drug needs of senior citizens has been a focus of a great deal of federal and state policy because Medicare does not generally cover prescription drugs.

Data from our survey of 60,000 Americans show that it's not just the elderly who have problems affording prescription medications. Twelve percent of all adults age 18 and over reported that they did not get at least one prescription drug in the previous year due to cost. That's about 23 million Americans who couldn't afford to get prescription medications.

And, as you can see from the chart, among adults between the ages of 18 and 64, more than one in four Medicaid beneficiaries and more than one in four uninsured people were unable to afford a prescription drug.

Now, the findings for the uninsured are no surprise. We've known for a long time that they have the greatest problems accessing virtually any type of healthcare. But the fact that people enrolled in Medicaid have such a hard time getting prescription drugs is very surprising, because all state Medicaid programs provide prescription drug coverage.

And access to other types of medical care for Medicaid beneficiaries is generally comparable to those with private insurance coverage. So why do people with Medicaid have such big problems with access to prescription medications?

One important factor is that adult Medicaid beneficiaries have lower incomes, are in poorer health, and have higher medical expenses than those who have private insurance, which is basically why they qualified for Medicaid in the first place.

Half of Medicaid beneficiaries between the ages of 18 and 64 have incomes below the poverty level and that compares to only 3 percent for those with employer sponsored coverage. Poor and low income people in general have more problems affording prescription medications.

And over half of Medicaid beneficiaries in this age group have at least one chronic condition, and 30 percent have two or more chronic conditions. This compares with only 10 percent of those with employer sponsored coverage who have two or more chronic conditions.

Perhaps one of the most troubling findings in the report is that those with the greatest need for prescription drugs are having the most problems getting them. Among Medicaid beneficiaries with two or more chronic conditions, 40 percent reported that they couldn't afford a prescription medication. And it is these two factors, low incomes and high prevalence of chronic disease, that largely explains why people with Medicaid have more problems affording prescription medications compared to those with employer sponsored coverage.

And in fact, access to prescription drugs would be far worse for Medicaid beneficiaries if they didn't have any coverage for prescription drugs.

But, it's important to remember that Medicaid is supposed to eliminate or greatly reduce disparities in access to care. And the program has clearly succeeded in doing that for many other aspects of medical care.

So why is the program falling short in terms of access to prescription drugs? One important factor is that efforts to control prescription drug spending in Medicaid appear to be contributing to the problems that people with Medicaid have in getting prescription drugs.

As Len mentioned, prescription drug spending is increasing and is a major driver of Medicaid spending. So states understandably are trying to find ways of controlling this spending, in part by controlling use and influence the way physicians are prescribing medications.

Five types of cost containment methods that states are using are co-pays, limiting the total number of prescriptions per month or per year that beneficiaries can receive, requiring prior authorization for certain drugs, requiring the use of generic brands, and requiring that physicians prove a lower cost drug as ineffective before prescribing a more costly alternative, also known as step therapy or fail first requirements.

We looked at these five methods to determine whether they have an affect on access to prescription drugs for Medicaid beneficiaries. The analysis compares people in states that have adopted these policies with people in states that have not adopted these policies.

The analysis also has extensive controls for other characteristics of Medicaid beneficiaries including income and health status as well as other county, state and regional factors. So any effective state policy on access to prescription drugs cannot be attributed to these other factors.

The results of the analysis show that, individually, these five cost containment methods did not have significant affects on access to prescription drugs among Medicaid beneficiaries. However, most states have adopted more than one of these methods. And Medicaid enrollees in states that had adopted more than one of these methods were much more likely to experience problems affording prescription medications.

In fact, people in states that had adopted four or five cost containment methods were twice as likely to report that they couldn't afford prescription medications compared to those in state with zero or one method. So, this indicates that states that adopt several of these methods are much more aggressive in trying to control Medicaid prescription drug spending and, in the process, they are also reducing access to prescription drugs.

So in other words, any one of these methods may represent only a small hurdle for Medicaid beneficiaries; but, erecting several of these hurdles can create significant barriers to access.

These results should make policy makers pause and consider how they are trying to control spending in Medicaid. Again, we recognize that the budget pressures states are facing are real and rising prescription drug costs in Medicaid are a big part of that.

And it's not just Medicaid, but private health insurance plans are also trying to contain rising prescription drug costs. But we have to remember that cost containment efforts in general are likely to have a greater impact on Medicaid beneficiaries because their poor health and lower incomes make them less able to absorb any intentional or unintentional out-of-pocket expenditures that may arise from greater restrictions.

In closing, again, I'd like to reiterate the major findings. Affording prescription drugs is a problem for many American adults, not just the elderly. Among non-elderly adults, the uninsured and those enrolled in Medicaid experienced the greatest problems affording prescription medications. One in four Medicaid beneficiaries were unable to fill a prescription drug last year, despite the fact that all state and Medicaid programs have prescription drug coverage. And state efforts to control Medicaid prescription drug spending appear to be decreasing access to prescription drugs.

Thank you.

MR. LEIGHTON KU: Thanks. I'm Leighton Ku and I'm with the Center on Budget and Policy Priorities and we're a non-partisan research and policy analysis group that deals with issues of the low income Americans.

Len and Peter both did a great job of summarizing the key aspects of the study. I want to reiterate one point that was maybe not as clearly there as I hoped it would be, which is that Medicaid does improve drug access for low income Americans, that in the study when they controlled for the fact that Medicaid beneficiaries are poor and often in poor health status, that when you statistically control for that, their access to drugs looks more comparable to those who have private insurance, and considerably better than those who uninsured.

So Medicaid is useful and makes a difference. The problem is in many cases, there are state policies that make it not as effective as it could be.

And it's worth remembering how big Medicaid is and who's on it. Right now, there about 47 million Americans on Medicaid. This includes about 24 million children, 11 million adults, and 12 million aged and disable people. Included in these ranks are some of the people who have some of the more severe problems in the US, including people with AIDS, with cancer, diabetes, serious mental health problems and so on.

So these are people who, in addition to having poor incomes, mostly well below poverty, poor health, in addition they often have other social factors that make it hard for them to maneuver in the system the way that middle class Americans can.

They have problems like limited literacy, poor transportation, and a lot of them are homeless. So some of the barriers that we erect in private insurance policies that seem like small deals for us, become much more important in the lives of Medicaid beneficiaries.

Again, they've given you a great summary of the study and, you know, pointed out again that states have serious problems containing their drug costs. And so it's perfectly understandable that there is this tension in, on one hand, trying to contain prescription drug costs because they are a serious problem in Medicaid and then, at the same time, interacting in the lives of beneficiaries.

Let me talk a little about some of the specific policies that Peter mentioned and then how they work out.

Some states limit the number of drugs that Medicaid beneficiaries can have. So if you're in Arkansas, Oklahoma or in Texas, you can't get more than three prescriptions a month. If you have a more serious problem that needs more medications, that's all that Medicaid will cover--that's it.

A majority of states have co-payments that range between 50 cents to \$2, sometimes up to \$3 per prescription. Again, that might not sound like very much but, on the other hand, if you are a low income family who's only making \$5,000 a year, then the choice becomes do I get this additional drug versus do I get dinner that day and other alternatives that make it tough.

Some states have tried to erect policies that are more thoughtful. They say, let's try to, where possible, substitute generic drugs; let's try, where possible, to choose less expensive drugs that we think are effective and that's why they develop things like prior authorization policies.

These things make some sense and I think they're thoughtful responses by states to try to deal with these situations. The problem is that, in many cases, they create administrative complications that create unintended consequences.

So for example, a patient gets a prescription by her doctor. Her doctor does not understand how the prior authorization works because they're dealing with multiple insurers, of which Medicaid is just one. They go to the pharmacist, the pharmacist says, gee, I looked at Medicaid list. You can't have this drug.

Now, what you and I might do is we can figure out well, gee, let's get on the phone to the doctor and get the right drug. Unfortunately, the Medicaid beneficiaries often aren't aware of the system, can't use the system as effectively, so what would seem like a small problem can become a greater barrier, and effectively means the patient doesn't get that prescription.

Now, we've mentioned that some of these policies are well intentioned responses by states to try to deal with some of their cost problems. And I'd like to think of--essentially this study sends up a red light saying that some of these policies really do cause serious problems for Medicaid beneficiaries and we should look for alternatives.

And let me just sort of briefly list three sorts of alternative policies states should consider. One is, particularly the study was finding problems for those who have chronic illnesses. So states ought to consider, can they set up drug policies that particularly try to consider the fact that people with chronic health problems have more serious needs.

So, for example, on co-payments they might say we'll cap the level of co-payments you have to pay every month or, alternatively, people who have chronic diseases, need more prescriptions--give them prescriptions that last for a longer time period than just one month so that, essentially, that co-payment goes longer or so that it's less of a hassle to get to the pharmacy to fill up the refills.

Another policy issue is, in general, focus on drug prices, not issues that limit the access to beneficiaries. There is lots of data right now that indicate--Medicaid has a fairly complicated system in terms of how states are supposed to set payment policies that they pay pharmacies and, on the other hand, rebates that come back from manufacturers for drugs.

The principal is that Medicaid should pay the best price. Unfortunately, drug manufacturers have often manipulated these prices and so, in many cases, there's studies that show that Medicaid is paying far more than expected.

For example, HHS's Office of the Inspector General just last year published a study. They looked at 216 pharmacies in 8 states and they found that Medicaid consistently was paying far more than they should have been paying for drugs. And if Medicaid had set a slightly different formula for how it was paying, Medicaid could have saved \$1 billion a year by paying less for the drugs--same drugs, no limitations on access, by changing their pricing policies could have saved \$1 billion a year.

Similarly there are other cases of where drugs or manufacturers have essentially fraudulently manipulated prices. There have been a number of investigations by State Attorney Generals across the country, by the Department of Justice and other places.

Just last year, for example, the federal government settled a suit with the manufacturers of Lupron, which is a breast cancer drug. For this one drug there was a settlement of \$875 million. This was the largest fraud settlement for a claim of this type in history. This is just for one drug.

So again, there are things that can be done to bring drug prices down to make it cheaper for the public to purchase drugs without limiting the access to those drugs.

And the third option is a bigger one, which is realizing that there's a temporary fiscal problem that states have right now. States are under serious problems. Congress has brought up the possibility of temporarily helping out states during this economic downturn.

And one important ingredient is, essentially speaking, temporarily increasing the amount of money the federal government pays to help out with Medicaid. This concept was supported by the National Governors Association, by a number of other organizations, got a vote of 62 Senators last--just a couple of months ago, so it has a fairly broad range of support but isn't law now.

Again, this is a time when we can help the states out so they don't need to be doing things like limiting access to drugs.

Thanks.

MS. JOAN HENNENBERRY: Good morning. I'd like to thank the Center for the opportunity to comment and for receiving the brief in advance.

Let me just start by saying that no one wants to deny access to appropriate and necessary pharmaceuticals to Medicaid enrollees. It's in no one's best interest to do that. In fact, there is pretty good evidence that when required medications are under utilized by individuals, which they sometimes are, it then increases healthcare cost in other parts of the system.

So we want people to get the appropriate and necessary medications that they need at the time they need them, and to manage that benefit in a comprehensive way so it's coordinated with the other healthcare services that people are receiving.

As Leighton and the study pointed out, there really are two enormous driving forces that are occurring right now: a greater reliance on prescription drugs, that's part of our medical care treatment and a very important part of our medical care treatment for everyone, whether you're a Medicaid enrollee or not, and the rising cost of that very same treatment.

Medicaid now accounts for 20 percent of state budgets. Those costs are going up, 9, 10, 11 percent per year. The pharmaceutical benefit portion of Medicaid is going up 18 to 20 percent per year.

So states have no choice but to aggressively manage this benefit and manage it in a way that does not compromise access to necessary benefits like pharmaceuticals, but to eliminate all fraud, abuse, waste, misuse that they can in that benefit. And that's really what you're seeing happen here.

I did have some methodological questions about the study, some concerns that I'm sure the researchers can address.

One question I had--if you look on table one and look at the way that the question was asked to the population, it asks the question about during the past 12 months was there any time you needed drugs but didn't get them because you couldn't afford them?

One question I would have, which is an important policy decision, is whether these individuals were on actually Medicaid beneficiaries that whole 12 months. And I don't know of any states--Leighton, you might know this better than I do--where there is continuous eligibility for adults unless it's done under a waiver, but it's not as common as it is among children.

So, it does make a difference if people were enrolled in Medicaid one month, their income changed, they're not enrolled the next month or the next quarter. Then they're back on. And that is a problem when people are in and out of a benefits plan like Medicaid--or an insurance plan like Medicaid.

So access. If you're not continuously enrolled and continuously covered, that absolutely could have an impact on access. And I think that's an important question to ask.

I also had a question about, again, whether all of these individuals--there are lots of ways to become eligible for Medicaid. It's a very complicated program. And a number of states have waivers, demonstration waivers.

So it wasn't clear to me whether the population surveyed were what we would call categorically eligible for Medicaid or were they eligible because of some sort of waiver that the state hasn't received, which again means the rules are different. That's all it means.

And to lump everybody together under one umbrella of Medicaid, because one population of benefits and rules in Medicaid is not the same as another. So I think it's important that we know what those are.

And I have a equal concern on table one, if I understand it correctly. And again, there may be an explanation for this. But it's Medicaid/other state coverage. Well, I don't know what that means. Does that mean a state only program?

Half of the states in this country have started pharmaceutical benefits programs, primarily for the elderly, but some also for the disabled and the uninsured. So if they're, again, grouped together with people who are in a categorically required Medicaid program, the rules are different in a state only program than in a Medicaid program. There may be higher co-pays. There may be more restrictive access.

So I just--I, my question is to then say this is only a Medicaid problem when there may be different populations being surveyed here I would like addressed.

As Len said in his quote in the paper, the results are somewhat surprising and I, too, was somewhat surprised, especially because of the emphasis on co-pays. Because the co-pay requirements in Medicaid have been the same for about 20 years. They're--for a population, especially in this income group, co-pays are nominal. For most of the people that you're talking about in this group, state policy would require probably \$1 co-pay per prescription and, in some cases, especially if a generic was substituted, no co-pay. And even if there is a co-pay, pharmacists are not allowed to deny the service because of an inability to make that co-pay.

So they often time forfeit their co-pay anyway because the clients can't pay. So I think this--it raises a question of separating out the impact of something like a co-pay versus some of the other interventions. And I think that was an important question to ask, and I agreed with Len that it was a little surprising.

I think, all in all, the study and Leighton's comments really suggest the importance of having really good management information systems and tracking when you implement new policies like this, whether it's in Medicaid, or Medicare, or in a state employee benefits plan, that it's important to know the impact of what a specific policy is going to have on the people enrolled in that plan.

In recent state experiences in both Maine and Michigan, where they have implemented more aggressive prior authorization programs and preferred drug lists, they have actually seen very significant savings in Medicaid without harmful affects to consumers.

Maine last year has saved \$15 million in their Medicaid program with no consumer complaints, no harmful outcomes that have been documented.

All of these programs have options for review, for clients to come back and say I do want a drug that's not on the preferred drug list, or I do want something that--or their clinician wants to prescribe something that isn't prior authorized.

And in Michigan, for instance, they're allowed to get 30 days of that medication while their appeal is being heard. So there are avenues for people to go back and question those policies.

But, it is very important and I would completely agree that, when the policy is put in place, to pay attention to it, to track the outcome and make sure that it's achieving the results that it was meant to achieve, and not harmful outcomes.

And it also--I think the study suggests the importance of better education to providers about their clients and what their needs are and better consumer education.

If part of what was happening here with these Medicaid enrollees is that they were being prescribed brand name drugs, where indeed there was a higher co-pay and there was a generic alternative that could have been prescribed with no co-pay, then that's an important education component for the provider and the consumer and important behavior to take a look at.

Thank you.

MR. NICHOLS: Thanks, Joan.

We certainly want to get to your questions as soon as we can but I thought, given the initial sort of factual questions Joan raised, we'll let Peter address them and then we'll turn to your questions.

MR. CUNNINGHAM: Yeah, on this--on the first question Joan had about whether the findings pertain to people who are on Medicaid all 12 months, or whether some of what we're seeing is based on people who are switching on and off coverage, we looked at it both ways and basically it doesn't have any impact.

We looked at just those who were on Medicaid the whole previous months, basically the reference period for the question, and the results are basically the same--both in terms of the proportion, having problems, and then the differences we're seeing by state policy.

In terms of which Medicaid eligibles are included in the analysis--basically it would include all of them. And again, the analysis of the affects of Medicaid state policy, we're focusing only on those in the age groups between 18 and 64, but it would include all of those and, you know, basically, virtually all of these people have prescription drug coverage.

It's only certain groups of medically needy in some states that are excluded. But if they're, in general, if they're eligible for Medicaid, they're eligible for prescription drug coverage.

And then the same question about the other state coverage. This, again, this is a fairly small group. We include it in there because there's a little bit, some times it's a little bit difficult for people to tell whether they're in Medicaid or another state program. But, if we just look only in people in Medicaid, again, we get basically the same results.

MR. NICHOLS: Okay, let me turn to your questions now and we'll certainly take them. As you ask them, I would ask you to identify yourself and your organization before you speak, okay?

MS. JUNE ROBBINS: June Robbins (sp) from CongressDaily. What accounts for the very low managed care number? We keep hearing about all the elderly who are having trouble paying for their drugs, and it's the same as for people with employer coverage.

MR. CUNNINGHAM: Well, I think, you have to--this is not a measure of financial burden or actual use or actual cost. This is based on people's perception and their self assessment of whether they can afford prescription medications, and we know that that varies based on individual circumstances as well as the importance or value that they attach to prescription medications.

So what we may be seeing with the elderly is that--we know from a lot of other research that they have very high cost, out of pocket cost, for prescription drugs. What we may be seeing for the elderly is they have a lot of financial burden but they place a lot of value and importance on prescription drugs and so they get it anyway, they incur those costs. So that's what we think is going on with the elderly.

MR. KU: Well I just had a comment, just, I mean, looking at other studies, for example, for Medicare beneficiaries, with or without drug coverage, some of the studies have shown that Medicare beneficiaries who don't have it pay twice as much out of pocket for their drugs but still only purchase about a third fewer drugs during the year.

So it's the point that Peter is making. In many cases, they still want to go get drugs. They have to pay a lot for it, but the matter of fact is they're spending more of their money and they're getting less.

MS. MARCIA CLEMENT: Marcia Clement (sp), Medicine and Health. You were saying that having administrative processes and things in place to track this, and find the impact of these various things and keep an eye on what's going on in the states is really important. But, one of the things that seems to always take a hit is Medicaid administration in terms of economics.

So how likely is it that states have these programs, and how widespread is it that states are able to really track the consequences of what they're doing?

MS. HENNENBERRY: Well, it varies. I mean--but I do think it's one of the reasons you're seeing states turn to pharmacy benefit managers in the same way they turned to managed care organizations in the past to manage the medical benefit.

They're looking at what a pharmacy benefit manager can offer them in managing this benefit, getting better prices, managing the rebates, managing access in a positive way, where you have a database and a system that can actually tell you all of the drugs and all of the providers that an individual is accessing, and can help improve quality and outcome and track what these policy--the impacts of the policy.

So some states are looking at contracting that out. Some are trying to build an in house capacity to do that.

MR. JOHN REICHARD: John Reichard with Washington HealthBeat. Joan, you mentioned a couple of states that you thought were doing a good job of controlling costs while maintaining good access. I'm wondering if the rest of the panel would agree with that assessment, in terms of states using those two specific techniques--I think it was prior authorization and the preferred list. I mean, is that a good way to go?

MR. KU: Well I think Joan's comment and the question just before about what do we know about how well the states manage these, is very much our point.

And, to be perfectly honest, I'd say that in general, most states are completely clueless with respect to how well these programs are working except from the perspective of are they saving money or not, and that is the key aspect that they monitor.

To be perfectly honest, states are doing these policies because in Medicaid they felt very pressured by cost pressures and they thought that these were reasonable policies but it is very hard, except for through use of studies like this, to see are there negative affects for beneficiaries.

And that's what makes this so important, is they couldn't have figured this out from their administrative data very easily at all. And, to be perfectly honest, I don't think most of them are looking very hard.

I mean, a good example of where in many cases states have done things--I think despite research is the area of co-payments. We have a decade's worth of research that shows that co-payments reduce utilization, have disproportionate impacts on poor people and can lead to poor health status.

And as Joan mentioned, there is pressure from a number of states who would say we'd like to increase co-payments and cost sharing for very poor people. And again, I don't think they're doing this because they are heartless people or because they are, you know, have bad intent. I think that they're doing it

because of severe budgetary pressures and, in many cases, because they don't see what the negative affects are.

So, with respect to the question, are prior authorization and generics useful policies, we--I get the sense when I talk to legal services attorney, patron advocates across the country, that there is some variation. All of them report some problems that are associated with prior authorizations, situations where patients don't understand what their appeal rights are, when they try to get information from their doctor, from their insurer, from the state, you know, their HMO, from the state Medicaid agency, they can't get good information and they feel trapped and have problems.

How widespread is this and what is the net affect? I don't really know and, again, I think part of the problems that we in general don't know--the policies are sensible. On the other hand, there are safeguards that could be put in that would make them better so that people--so that the sort of policy, for example, that Joan mentioned in Michigan where, when there is a prior authorization problem the patient can still get a month's worth of drugs during the time period as they're trying to sort of shift over to the other drug, that's a reasonable step.

I don't know how many states have a policy like that. My impression is that that's not the norm. That, in many cases with prior authorization, either there is no extra drugs that are given or it's a very short amount of drugs.

MS. HENNENBERRY: Well, having an appeal process, I mean, Medicaid clients are entitled to appeals under laws for all kind of things. So, I--whether they--I'm not sure either about whether they actually get a month's supply of drugs or not but they are entitled to appeal those decisions.

I would turn to states are always looking for best and promising practices. They like to copy ideas from one another and not reinvent the wheel. And one of the states they've looked at very closely is Maine.

And this is a state where the seniors and the consumers were very supportive of the approach that Maine took because, number one, it is important to save money when you can because that allows you to keep your program going and continue to serve the eligible people that are already eligible and not have to cut back on that eligibility.

And one of the reasons that Maine will tell you they have received consumer report and they have not had complaints to legal aid is because they also did very aggressive consumer education. And I think the concerns that Leighton raised are important ones but, they don't necessarily mean the policy's bad.

It means that we as consumers and perhaps even the providers aren't as well educated about how to use the system as they need to be. And it is the state's responsibility to provide that consumer education, make sure people know what they're eligible for, once they're enrolled, what they're entitled to and what their appeals process is.

MR. NICHOLS: Peter, did you want to add?

MR. CUNNINGHAM: Yes, I--just to add one thing here, again the study--when we looked at these five cost containment methods individually, they did not have a significant affect on access to prescription drugs. So individually, they didn't seem to have much of an affect or not a significant affect that we could detect.

But it's when states introduce several of these, or even four or five, as the study showed, that's when we begin to see these policies having a significant affect on access.

So it's--any one of them may be a small hurdle that may be manageable, but when they erect lots of these hurdles, that's when access seems to begin to deteriorate.

MR. BROCK HALEN: Brock Halen (sp) with CSI. I just wondered whether as you look at the structure for dealing with the cost of prescription drugs you think legislation is needed on the federal level or does the current system give the states the flexibility they need to do what they're doing what they want to do?

MR. KU: I think that federal legislation could be changed to modify some components. I mean, what happens is there's a national framework and there's particularly a rebate system that is set into national legislation. I think that could be modified and, in fact, the Administration, the Bush Administration proposed earlier this year to modify that basis of Medicaid and to save about \$17 billion over 10 years and reducing drug prices.

There are similar sorts of options that could be done at the federal level. States also have things that they could do within state legislation or state administrative action to attain some of the same results.

Obviously, the real problem with this is that there are very powerful drug manufacturers who are deeply concerned and worried about this and who fight it tooth and nail.

And so while there are policies that sound reasonable that would save--I should mention that these things not only would save the federal government money, they would also save the states roughly speaking an equal amount of money.

They're sensible, they're good for consumers. But, there are very powerful interests that oppose them.

MR. NICHOLS: Does anyone want to add anything on the need for federal legislation?

MS. HENNENBERRY: Well, the governors did endorse the Administration's proposal to change the rebate, but please don't ask me the details of that rebate proposal, because I'm not a rebate expert and it's kind of complicated.

But, they are supported of the Administration's proposal.

MR. NICHOLS: Thank you. Thanks for coming.

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