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Report: Upgrading Medicaid Drug Benefits Could Save Federal, State Governments \$74.4 Billion

Most State Medicaid Programs Use Fewer Generics, Pay Higher Drugstore Fees, Make Less Use of Pharmacy Networks Than Other Programs

(Washington, DC)—As policymakers seek new ways to reduce costs in the expanding Medicaid program – which is jointly financed by state and federal taxpayers – a new report estimates that upgrading management of drug benefits in the program could save **\$74.4 billion** without cutting either benefits or enrollees. The Menges Group report shows that most state Medicaid programs make too little use of the tools Medicare, unions, and employers rely on to curb wasteful pharmacy spending.

The study, which includes a 50-state breakout, projects how much Medicaid could save by avoiding drugstore overpayments, increasing the use of generics, and promoting pharmacies that offer better rates. Currently, Medicaid consumes 11 percent of all federal spending and over 30 percent of some state budgets. With Medicaid enrollment expected to hit 84 million people in 10 years, policymakers are seeking cost-savings solutions.

“The good news is state Medicaid programs can dramatically reduce costs by simply applying best practices already used by Medicare and other large payers that offer pharmacy benefits,” said **Pharmaceutical Care Management Association (PCMA) President and CEO Mark Merritt**. “By upgrading Medicaid pharmacy management, policymakers can protect patients without cutting benefits or slashing payments to doctors, hospitals and other providers.”

According to the new research, optimizing PBM tools and strategies in state Medicaid programs nationwide could save a total of \$74.4 billion across the 10-year period 2014–2023, including \$43 billion in federal savings and \$31.4 billion state savings. Click [here](#) to read the study.

Components of these potential savings include:

- **\$23.5 billion saved by increasing the use of generic drugs:** State-administered Medicaid programs that do not already manage formularies are less effective at encouraging the use of generic medications. The average generic dispensing rate in the Medicaid FFS setting is 73%, compared to an average generic dispensing rate exceeding 80% in the Medicaid managed care organization (MCO) setting.
- **\$12.5 billion saved by negotiating market-based pharmacy dispensing fees:** Medicare Part D and commercial sector plans negotiate market-based pharmacy dispensing fees that average less than half those set by officials in most state Medicaid programs.

- **\$33.4 billion saved by using limited pharmacy networks:** In most state Medicaid programs, every drugstore in the state is entitled to participate. State Medicaid programs could achieve greater savings by using a competitive process and negotiating better discounts from select drugstores that wish to participate in a limited pharmacy network.
- **\$2.7 billion saved by encouraging the use of more affordable, preferred brands:** Unlike PBMs, state Medicaid FFS programs generally do not aggressively encourage the use of more affordable, preferred brands through active formulary management.
- **\$2.3 billion saved by reducing drug diversion, polypharmacy, fraud, and waste:** Medicaid plans that are more actively managed detect patterns of fraud through use of tools like step therapy, audits, and pharmacy lock-in programs to help detect and avoid inappropriate utilization.

Many states have already started exploring new ways to eliminate wasteful Medicaid pharmacy spending without reducing patient access to quality care. New York Governor Andrew Cuomo's decision to modernize the state's Medicaid pharmacy program using proven PBM tools saved the state \$425 million in 2012, according to a study from Special Needs Consulting Services. This is four times the savings originally projected by the New York State Department of Health.

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