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National Legislative Association on Prescription Drug Prices

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State Medicaid Programs Lead the Way on Negotiation of Drug Prices
January 11, 2007

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As Congress considers how Medicare should negotiate for lower prices on prescription drugs, it should consider the effective examples provided by states. This fact sheet provides information on how states negotiate drug prices for Medicaid through the creation of Preferred Drug Lists (PDLs).

How do states negotiate lower drug prices for Medicaid? Pioneered in California in the mid-1990s, over three-quarters of states have created some form of PDL based on the medical and cost-effectiveness of competing treatments. A PDL normally defines a list of drugs that are "preferred" for use under the Medicaid program. Non-preferred drugs may still be used and reimbursed, but normally must first receive prior approval. Most states require that the approval process be simple and efficient, and federal law mandates that state Medicaid programs cover all drugs for which the manufacturer has agreed to provide a rebate to the federal government. Nonetheless, the lists provide a strong encouragement for doctors to prescribe the preferred drugs and for drug companies to compete to have their drugs on the preferred list.

How effective have PDLs been at lowering drug prices? Michigan officials estimate that their state PDL saved $60.5 million in its first year of operation.[1] Texas saved 140 million over two years.[2] Florida saved almost half a billion dollars between 2000 and 2002 in drug purchases for its 2.2 million Medicaid recipients.[3] Overall Medicaid spending by state governments increased less than the rate of inflation in 2005, even while drug spending as a whole increased double the rate of inflation. Economists at the Centers for Medicare and Medicaid services credit "aggressive cost control" measures such as PDLs by states for this.[4]

How do PDLs work? Though each state's program is unique, Preferred Drug Lists generally work by guiding prescribers towards the most cost effective medicine for a specific illness or condition. An appointed committee evaluates existing therapies based on safety, efficacy and price to determine the most cost effective medicines. When a particular listed drug is not right for a patient, he or she may be reimbursed for a different drug after prior authorization is obtained by the prescriber from a state office set up for such authorizations. Efficient systems of prior authorization have been set up that allow patients access to off-list drugs. In Missouri, for example, three quarters of all prior authorizations are granted through an online system, and 97% of the remaining ones are granted on the first call placed by a prescriber to the state office for prior authorizations. [5]

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[1] December, 2004. The Commonwealth Fund. *Michigan: Preferred Drug List & National Medicaid Pooling Initiative.* www.cmwf.org
[2] January 2005. Texas Health and Human Services Commission. "Preferred Drug List Annual Report." www.hhsc.state.tx.us/
[3] "The Rx Factor." By Misha Sigal. Pew Center on the States. www.governing.com/medicaid/drug.htm
[4] Aaron Catlin, Cathy Cowan, Stephen Heffler, Benjamin Washington the National Health Expenditure Accounts Team. National Health Spending In 2005: The Slowdown Continues. Health Affairs, 26, no. 1 (2007): 142-153 www.healthaffairs.org/
[5] March 2005. Colorado Health Institute Policy Brief. *Medicaid Preferred Drug Lists – A Review of Three States.* Available at www.coloradohealthinstitute.org