

# ISSUE BRIEF

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## TRENDS IN HEALTH CARE FINANCING

### Medicaid Prescription Drug Use by Dual Eligibles: Issues for Medicare Part D

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*New data, prepared by Mathematica for the Centers for Medicare & Medicaid Services (CMS), provide detailed state-by-state and national information on prescription drug cost and utilization in 2003 for Medicaid beneficiaries who are enrolled in both Medicaid and Medicare (“dual eligibles”), and whose drug coverage shifted from Medicaid to Medicare Part D in 2006. These highly detailed and uniformly formatted tables, as well as an accompanying chartbook, facilitate analysis of patterns of drug use and expenditures among dual eligibles both nationally and across states. Since dual eligibles account for over one-fourth of current enrollees in Part D, and for a disproportionate share of Part D drug utilization and costs, these Medicaid data provide an important resource for those interested in Part D. They can also provide a basis for comparison with Part D drug data for 2006 and later years when those data become available. The 2003 data and chartbook can be found online at [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08\\_MedicaidPharmacy.asp](http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp). This issue brief highlights some key data on drug use and spending in 2003 for dual eligibles, as well as Part D issues that these data can help to inform.*

#### Using Medicaid Data for Analysis

As of January 1, 2006, prescription drug coverage for dual eligibles shifted from state Medicaid programs to private Medicare Part D health plans. Part D health plans have been analyzing data on their own experience in providing drug coverage to dual eligibles and are reporting the data to CMS on a monthly basis, as they are required by law to do. CMS issued a final rule in May 2008 that authorizes federal agencies,

states, researchers, and others to obtain access to this Part D drug data for a variety of purposes, with CMS approval. However, the data for 2006 will not be available until the end of 2008, so it will not be possible to begin detailed analysis of the data before then.

In the meantime, state-by-state and national data from CMS on dual eligible drug use under Medicaid for years prior to 2006 are available, permitting analysis of pre-2006 patterns and providing a comparative benchmark for experience under Part D. Data for 1999 and 2001-2003 are now available on the CMS web site at: [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08\\_MedicaidPharmacy.asp](http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp). Data for 2004 will be available later this year and data for 2005 early next year.

This issue brief uses data from 2003 to provide answers to the following questions:

- How does drug use for under-65 disabled dual eligibles differ from that for those age 65 and over?
- What categories of drugs have been used most extensively by dual eligibles under Medicaid, and how much has Medicaid paid for them?
- What has been the pattern of drug use by dual eligibles in nursing facilities?
- To what extent is Medicaid covering drugs for dual eligibles that are excluded by statute from Part D, such as benzodiazepines? Under what circumstances might Part D plans want to work with states to include direct coverage of these drugs through Part D plans for dual eligible enrollees?

Answers to these questions can help Part D plans determine how to structure their drug formularies to best address the needs of dual eligibles and how to implement their Medication Therapy Management Programs (MTMPs) for high-cost drug users. For Medicare Advantage managed care plans that also include Part D coverage (MA-PDs), data on dual eligible drug use can help determine the kinds of staff, administrative infrastructure, and provider networks that may be needed to deal with dual eligibles' drug use and the health conditions that prompt that use. The

data can also help plans that are considering expanding into new geographic areas, or establishing new types of plans, to assess the type and level of drug use they can expect to see from dual eligibles in specific states.

The data can also help CMS perform its Part D regulatory and monitoring role, since CMS can compare the patterns of dual eligible drug use and expenditure under Part D to the patterns in Medicaid before 2006.

### **Prescription Drug Use by Dual Eligibles Under and Over Age 65**

Sixty-five percent of the 6.7 million dual eligibles who received drug coverage from Medicaid in 2003 were age 65 or older; the rest were under 65 and disabled (Supplemental Tables 1, 1A, and 1B). The average annual Medicaid prescription drug expenditure for disabled dual eligibles under age 65 in 2003 was \$3,478, substantially higher than the \$2,237 average annual expenditure for duals age 65 and over (Supplemental Tables 1A and 1B). The average disabled dual eligible had 45 prescriptions per year (including refills), while the average aged dual had just under 41 (Table D.3). As shown in Figure 1, 8 percent of under-65 disabled duals had annual Medicaid drug expenditures of over \$10,000, compared to only 2 percent of duals age 65 and over. These high-cost beneficiaries accounted for 38 percent of total drug expenditures for under-65 disabled duals, but only 10 percent of expenditures for 65-and-over duals. (See Supplemental Tables 1A and 1B for more detail.)

This high use and cost of prescription drugs among those under age 65 is due primarily to the fact that they are on Medicare and Medicaid because they are disabled and chronically ill, while those age 65 and over are on both programs because of their age, regardless of their health condition. (Both groups must also meet state-specific income and asset standards to be eligible for Medicaid.)

Part D plans are required to have MTMPs that target enrollees who have multiple chronic diseases, are taking multiple Part D drugs, and are likely to incur annual costs of at least \$4,000 in 2008 for all covered Part D drugs. MTMPs must be designed to ensure optimum therapeutic outcomes for targeted beneficiaries through improved medication use and to reduce the risk of adverse events. They must be developed in cooperation with licensed and practicing pharmacists and physicians.

Since average Medicaid expenditures for under-65 disabled duals were \$3,478 in 2003, a very large portion of these duals are likely to incur costs of over \$4,000 in 2008 and thus be eligible for MTMPs. Part D plans can use the Supplemental Tables in the Statistical Compendium for each state to determine the likely

distribution of prescription drug costs for dual eligibles in states in which they are operating or planning to operate. They can also assess the likely demand for MTMPs in these states among dual eligibles.

### **Most Costly and Commonly Used Drugs**

Among dual eligibles as a whole, the most costly drug group was antipsychotics, accounting for over \$2.3 billion in expenditures in 2003, 13 percent of total Medicaid expenditures on prescription drugs for duals (Chartbook, Exhibits 21 and 22). Ulcer drugs were the next most costly drug group (\$1.38 billion in total expenditures), followed by antidepressants (\$1.18 billion). Twenty-four percent of duals used antipsychotics in 2003, 40 percent used ulcer drugs, and 41 percent used antidepressants. Some other drugs were used more commonly by dual eligibles (antihypertensives and analgesics), but the costs per drug were lower, so overall costs for these drug groups were lower as well (Chartbook, Exhibit 22, and Tables D.7A-D).

Under-65 disabled duals are especially heavy users of antipsychotic drugs. Among all dual eligibles, 24 percent used an antipsychotic in 2003, at an average cost per month of \$127 (Table D.7A). Among disabled duals under age 65, 39 percent used an antipsychotic in 2003, while only 17 percent of nondisabled duals age 65 and older did so (Tables D.7A and D.7D).

CMS requires Part D plans to include “all or substantially all” antipsychotics and antidepressants in their formularies. Plans may not use prior authorization and step therapy (using lower-cost drugs first) as a way of encouraging use of lower-cost and generic versions of antipsychotics and antidepressants by enrollees who are currently taking these drugs, but may do so for enrollees who are just beginning their use. Plans may also use beneficiary co-payments (set at \$1.05 to \$5.60 for dual eligibles in 2008) as a way of controlling use of these and other Part D drugs.

The other four “classes of clinical concern” in which “all or substantially all” drugs must be on Part D formularies (immunosuppressants, anticonvulsants, anti-retrovirals, and antineoplastics) were not in the top 10 drug groups in terms of expenditures for dual eligibles in 2003. Their costs are included as part of the costs of broader therapeutic categories shown in Table D.6 (anti-infective agents, central nervous system drugs, and antineoplastic agents).

### **Drug Use in Nursing Facilities**

Total Medicaid prescription drug expenditures for full-year dual eligible nursing facility residents were \$2.7 billion in 2003. Expenditures for part-year residents were another \$1.3 billion. These full-year and part-year nursing facility residents accounted for just

under 20 percent of all dual eligibles in 2003 and just under 21 percent of total Medicaid prescription drug spending on dual eligibles (Table D.2 and National Comparison Table N.1a). The average monthly Medicaid prescription drug expenditure per dual eligible for those in a nursing facility all year was \$316, compared to \$239 for duals with no nursing facility use (Chartbook, Exhibit 25). The average all-year dual eligible nursing facility resident used 6.2 prescriptions per month, compared to 4.0 for all dual eligibles combined (Table N.5).

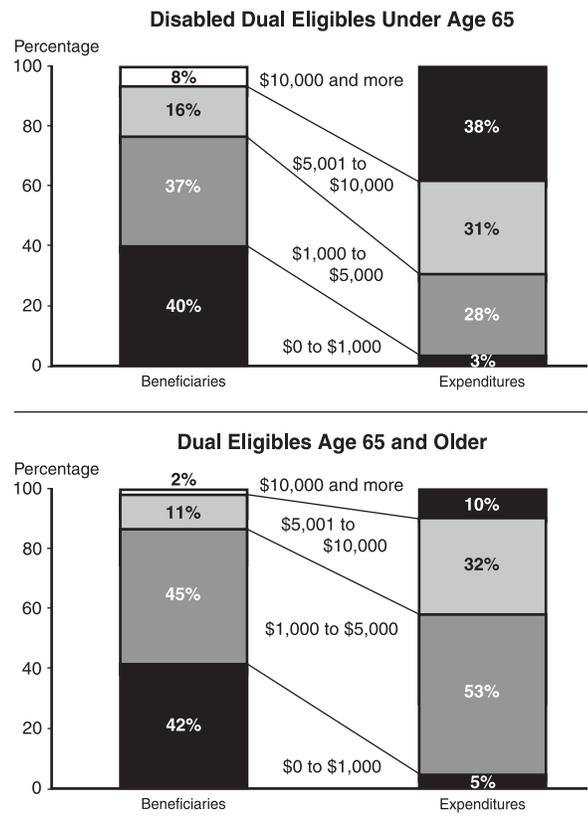
Almost 57 percent of all-year dual eligible nursing facility residents used antidepressants in 2003, 44 percent used antipsychotics, and 44 percent used ulcer drugs (Table D.10). Since antipsychotics are among the most costly drugs for all-year duals in nursing facilities (\$144 per prescription in 2003, versus \$58 for antidepressants and \$70 for ulcer drugs), total Medicaid expenditures were greatest for this drug group (\$442 million in 2003, compared to \$241 million for antidepressants and \$200 million for ulcer drugs). Full-year dual eligible nursing facility residents accounted for just over 19 percent of all Medicaid expenditures for antipsychotics for dual eligibles, over 20 percent of expenditures for antidepressants, and almost 15 percent of expenditures for ulcer drugs (Tables D.7 and D.10).

Part D plans that cover dual eligible nursing facility residents may use methods such as formularies, prior authorization, step therapy, and therapeutic or generic substitution to control drug costs in nursing facilities. Beneficiary co-pays are not permitted for dual eligible nursing facility residents. MA-PD plans that are at financial risk for Medicare nursing facility and hospital costs may be less inclined than stand-alone prescription drug plans (PDPs) to seek to limit nursing facility drug costs, since restrictions on drug use may lead to higher nursing facility and hospital expenditures.

### Cost and Use of Drugs Excluded From Part D

The 2003 statute that established the Medicare Part D drug benefit excluded from coverage several types of drugs (benzodiazepines, barbiturates, nonprescription drugs, cough and cold medications) that Medicaid has been allowed since 1990 to exclude, but that most states have chosen to cover to varying degrees. New Medicare legislation enacted in July 2008 extends Part D coverage to benzodiazepines and barbiturates, but not until 2013. CMS requires state Medicaid programs to continue providing coverage of these drugs for dual eligibles after January 1, 2006, if they are covered for any other Medicaid beneficiaries. As of 2003, all states covered most of these drugs for both duals and nonduals, except for drugs for anorexia, weight

**Figure 1: Distribution of Annual Pharmacy Reimbursement, 2003**



Source: 2003 Chartbook, Exhibit 24.

loss or gain, fertility, and cosmetic purposes, which most states either did not cover or paid for only rarely.

Requiring dual eligibles to get these excluded drugs from Medicaid, while getting all the rest of their drugs from Medicare Part D, can be confusing and burdensome for dual eligible beneficiaries, as well as their prescribers and pharmacies. To ease this burden, Medicare Part D plans may want to consider contracting with state Medicaid agencies so that direct coverage of these drugs can be provided to dual eligible enrollees through their Part D plans. Since Medicaid is generally required to cover these drugs for duals, state Medicaid agencies may be willing to make payments for these drugs to Part D plans that are willing to assume this responsibility for their dual eligible members. Alternatively, since most of these excluded drugs are low-cost and may substitute for higher-cost drugs and treatments, MA-PDs may find it advantageous to cover these excluded drugs with savings they are able to achieve by providing other Medicare services, such as in-patient hospitalization, more efficiently or at lower cost. Stand-alone PDPs would not be able to cover the cost of these excluded drugs from savings on other Medicare services, since PDPs cover only prescription drugs.

Tables ND.11 through ND.13 in the 2003 statistical compendium provide information on the utilization and cost of these drugs in each state and nationally for nonduals, and Tables D.11 through D.13 provide the same information for dual eligibles. Exhibits 31-33 in the 2003 chartbook show some of the highlights.

Over half (53 percent) of dual eligibles used at least one of these excluded drugs in 2003, with nonprescription (over-the-counter) drugs having the highest number of users (28 percent of all duals), followed by benzodiazepines (20 percent of duals) and vitamins and minerals (17 percent) (Tables D.11 and D.13). As just noted, most of these drugs are not costly, with the cost per prescription averaging \$14 for all excluded Part D drugs for dual eligibles in 2003 (Table D.13). The average cost per prescription was \$8 for nonprescription (over-the-counter) drugs, and \$17 for benzodiazepines and vitamins and minerals. Some less commonly used excluded drugs are more expensive. Fertility drugs averaged \$139, but there were only 68 dual eligible users in the entire country, and drugs for anorexia and weight loss or gain averaged \$66, but there were only 2,247 dual eligible users of these drugs nationwide (Table D.13).

## Looking Ahead

The last full year for Medicaid MAX data on prescription drug use by dual eligibles will be 2005. The MAX files for that year will be available later this year, and state-by-state and national tables on dual eligible drug use in Medicaid comparable to those prepared for 1999 and 2001-2004 will be available in the spring of 2009, shortly after the Part D data for 2006 are ready for analysis. Comparing drug use by duals in Medicaid in 2005 to their drug use in 2006 and later years under Part D should provide a wide range of insights into the impact of Part D coverage on dual eligibles, and could suggest ways of improving drug coverage for this highly vulnerable population.

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## BACKGROUND ON THE DATA

**State-By-State Data Tables.** Under contract with CMS, Mathematica has developed 51 data tables for the nation, each state, and the District of Columbia for 2003, and similar tables for 1999, 2001, and 2002. For 2003, 14 of these tables focus just on dual eligibles. There are also three national comparison tables for dual eligibles that show state-by-state comparisons based on a number of key measures included in the full set of tables. Finally, there are six supplemental tables that show Medicaid prescription drug spending in \$500 increments for disabled and elderly duals by age group. The full set of tables for both nonduals and duals, called a Statistical Compendium, is available online in both PDF and Excel formats at [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08\\_MedicaidPharmacy.asp](http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp).

**Chartbooks.** Mathematica has also developed chartbooks (available at the same website as the tables) from data in the tables for 2003 and earlier years. The chartbook for 2003 contains 54 exhibits (2 tables and 52 graphs) that highlight major features and comparisons, including 19 graphs that focus exclusively on dual eligibles.

**MAX Files.** Mathematica developed the state-by-state data tables from Medicaid Analytic eXtract (MAX) files for 2003 and earlier years prepared by CMS from Medicaid claims and eligibility data states submitted electronically through the Medicaid Statistical Information System (MSIS). The MAX files link claims data on all Medicaid services to beneficiary eligibility files, creating a “person summary file” for each beneficiary. The tables include data for all months in which beneficiaries had fee-for-service Medicaid coverage in each year. They do not include data for months that beneficiaries were in capitated managed care programs, since claims data were generally incomplete or unavailable for those months. However, fewer than eight percent of dual eligible beneficiaries were in capitated managed care for all of 2003, and they were concentrated in a small number of states, so the data on drug use by dual eligibles is quite complete in most states. Appendix Table A.6 in the Statistical Compendium provides state-by-state detail on managed care penetration rates for dual eligibles.

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