

Pharmacy Benefit Management Can Save Medicaid Drug Programs over \$110 Billion

Medicaid programs increasingly rely on Pharmacy Benefit Managers (PBMs) to manage drug benefits for Medicaid beneficiaries, whether they have health plan or fee-for-service (FFS) coverage.

PBM-Driven Medicaid Pharmacy Savings: Retrospective and Future Estimates

Nationally, PBMs saved Medicaid \$22 billion from 2013 to 2018 combined. These savings represent only a portion of the potential savings achievable if all states were to fully utilize PBM tools and capabilities, including:

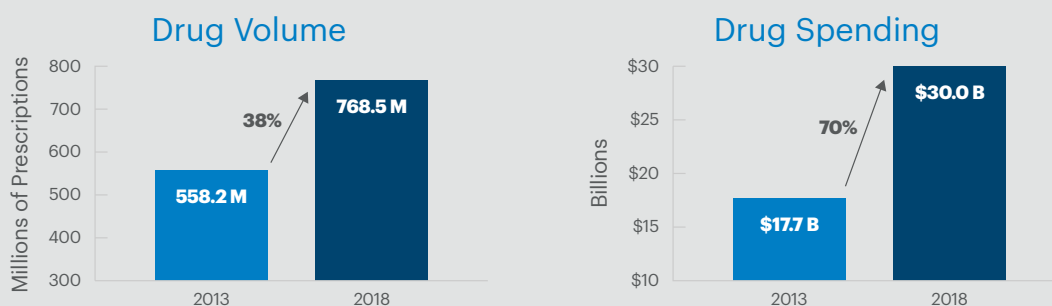
- Driving the use of the highest therapeutic quality, lowest-cost drugs and shifting utilization from brands to generics as clinically appropriate;
- Developing preferred pharmacy networks;
- Advancing evidence-based, clinically effective utilization; and
- Leveraging data analytics to detect and prevent fraud, waste, and abuse.

The optimal use of PBM tools and capabilities for all Medicaid prescriptions would yield new savings of \$8 billion in 2020 and \$112 billion over 10 years (2020-2029). The \$8 billion in savings would represent a 24% reduction in Medicaid drug spending and an average of \$130 saved per beneficiary. Over 10 years, \$112 billion in savings would result in a 25% reduction in total Medicaid drug spending. During this period, states would save \$43 billion and the federal government would accrue \$69 billion in savings.

Medicaid Drug Utilization and Spending Trends

From 2013 to 2018, Medicaid prescription drug volume grew by 38% – ultimately accounting for 18.2% of all U.S. prescription volume – and, simultaneously, spending increased by 70% to over \$30B. In response, more states are turning to PBMs and their Medicaid health plan partners to manage drug spending. PBM-administered prescriptions for Medicaid health plans increased from 52% to 72% of all Medicaid drugs between 2013 and 2018.

Medicaid Prescriptions, 2013-2018



Pharmacy benefit management has resulted in a robust increase in the use of lower-cost generic drugs in Medicaid – in 2018, generics represented over 87% of all Medicaid prescriptions, up from 83% of all Medicaid prescriptions in 2013. Collectively, the transition to PBM-administered prescription benefits, with an accompanying focus on increased generic use, has limited Medicaid’s net price per prescription growth over the same time period to an average of 4.3% per year – more than one-fifth less than the national average annual increase in net drug prices of 5.5% – despite the rapid increases in drug prices and the introduction of several new, high-priced specialty drugs.

Pharmacy Benefit Management is Pivotal to Lowering Medicaid Drug Spending

PBMs perform operational and clinical services for Medicaid drug programs to lower net cost per prescription while promoting appropriate and safe drug utilization.

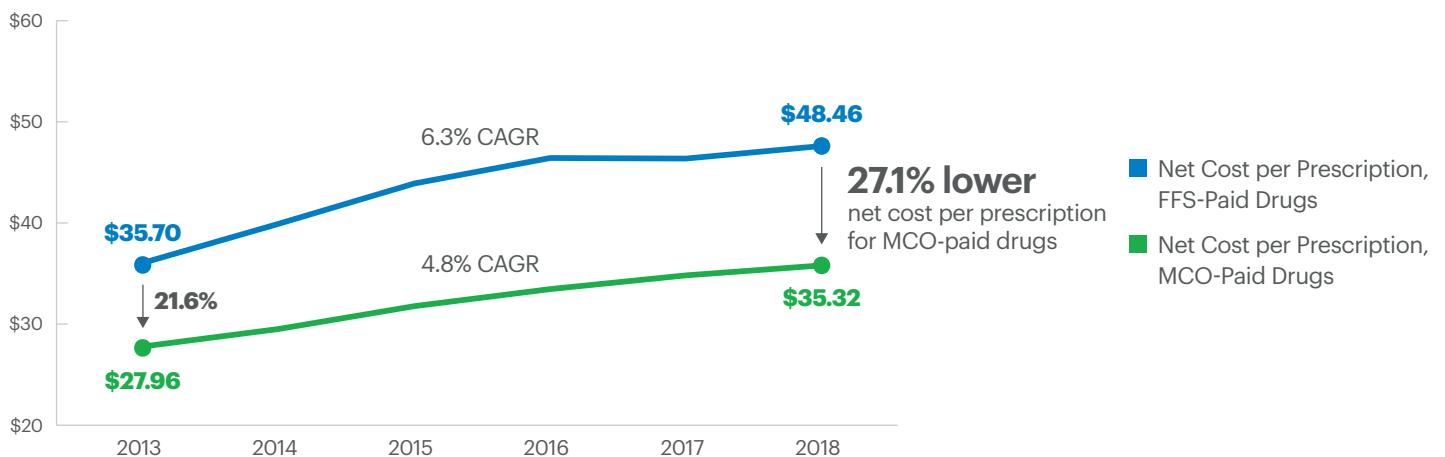
These services leverage PBMs’ expertise, data analytics capabilities, and negotiating capacities to drive cost savings, while simultaneously improving care quality, safety, and appropriate drug use – all of which make PBMs essential to lowering Medicaid drug spending through effective medical and drug benefit management. While PBM cost-saving tools are available to Medicaid programs, not all states use PBMs to manage their Medicaid prescription drug benefits.

The breadth of tools PBMs can implement and the corresponding magnitude of pharmacy savings realized are driven by states’ decisions regarding 1) whether the drug benefit is incorporated into Medicaid’s medical benefits and 2) whether the PBMs have latitude over the development and implementation of the preferred drug list (PDL).

States that integrate their drug and medical benefits experience a lower net cost per prescription and slower rate of drug cost growth.

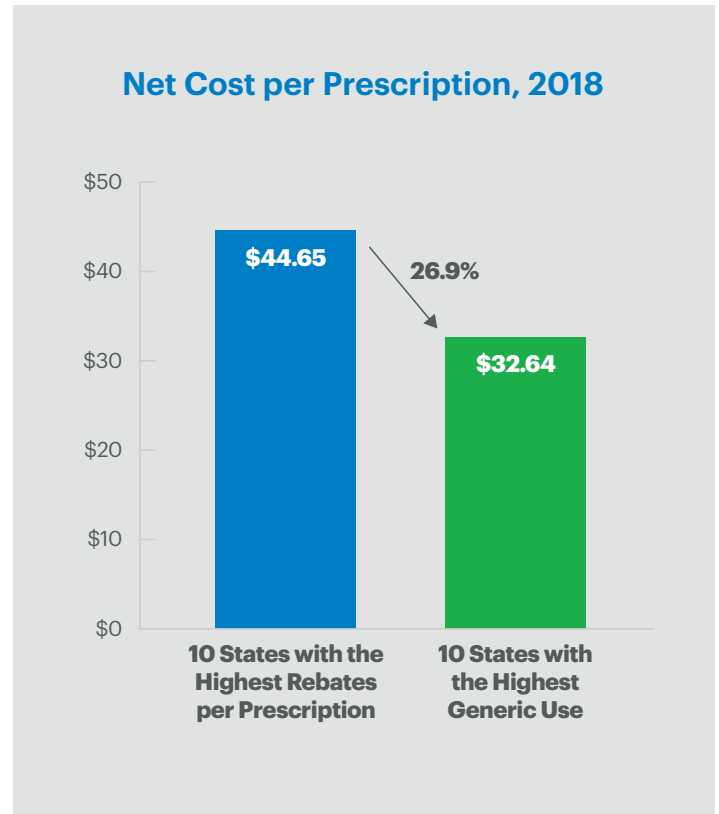
In 2018, the net cost per prescription for Managed Care Organization (MCO)-paid drugs was 27.1% lower than FFS-paid drugs. The difference between the net cost per prescription for MCO- vs. FFS-paid prescriptions increases over time (it was 21.6% in 2013) because states that utilize MCOs and their PBM partners to integrate their drug and medical benefits experience slower annual drug price growth.

Net Cost per Prescription and Rate of Price Growth, MCO- vs. FFS-Paid Drugs



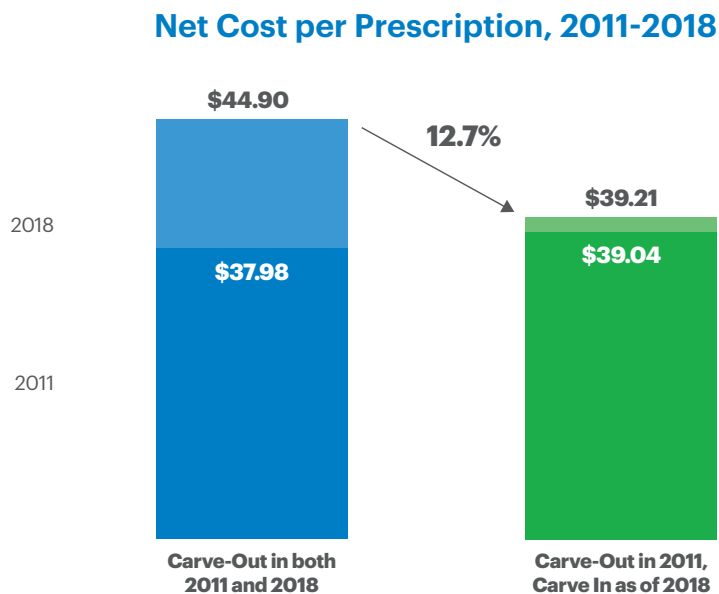
PBMs generate more savings for states from driving higher generic use than from maximizing rebates on brand drugs.

In states where the medical and drug benefits are integrated, PBMs and their MCO partners achieve a lower net cost per prescription by driving greater generic use, which results in lower rebates. However, the savings realized from increased generic use far exceed the savings garnered from rebates. In 2018, the ten states with the highest generic utilization have a lower net cost per prescription (\$32.64) than the ten states with the highest rebates per prescription (\$44.65). Notably, in the ten states with the highest generic utilization, PBMs and their MCO partners paid for 92.6% of all Medicaid prescriptions and advanced a 90% generic utilization rate, whereas in the ten states with the highest rebates, PBMs and their MCO partners paid for only 53.1% of all Medicaid prescriptions and achieved an 82% generic utilization rate for those states.



States that incorporate the drug benefit into Medicaid’s medical benefit achieve a lower net cost per prescription.

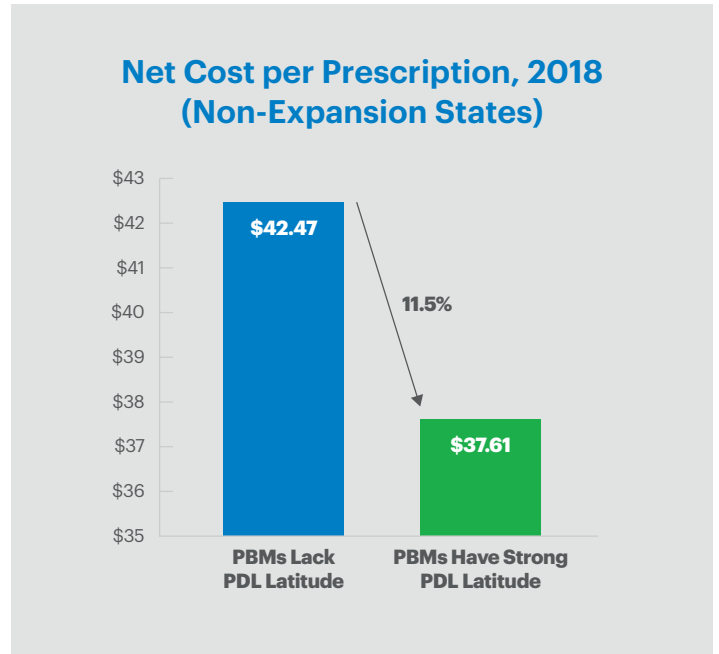
States that incorporated (“carved-in”) the drug benefit into Medicaid’s medical benefits between 2011 and 2018 realized \$0.17 increase in net cost per prescription, compared to the states that carved-out their drug benefit and paid for it under FFS Medicaid (\$6.92 increase). This suggests that carving the drug benefit into Medicaid’s medical benefit lowers net cost per prescription.



States that give PBMs latitude over the preferred drug list achieve a lower net cost per prescription than states in which PBMs lack PDL latitude.

Beyond deciding to incorporate the drug benefit into Medicaid's medical benefit, states decide how much latitude PBMs have over the development and implementation of the PDL.^a Latitude over the PDL increases a PBM's ability to manage Medicaid drug spending. Through the PDL, PBMs drive utilization of the highest therapeutic quality, lowest-cost brand and generic drugs, achieving the highest value for states and the consumers they cover.

In 2018, states in which PBMs had strong PDL latitude benefitted from competitive negotiation, achieving an 11.5% lower net cost per prescription. Higher generic utilization (87.5%) was a contributing factor to the lower net cost per prescription in states where PBMs have PDL latitude, when compared to states where PBMs have no PDL latitude (83.4%).



^a PBMs use an independent Pharmacy and Therapeutic (P&T) Committee to assess the clinical appropriateness of their formularies. After the P&T committee's clinical assessment of drugs, PBMs then use their negotiating capabilities to lower the net cost per prescription for state Medicaid programs.

Methodology and data sources are available at: www.unitedhealthgroup.com/pcs.