Medicaid Pharmacy Savings Opportunities: National and State-Specific Estimates

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Executive Summary

This study examines whether the full range of pharmacy benefit management (PBM) tools are being allowed and used in Medicaid and whether additional savings are possible if PBM tools were employed to a greater extent. Based on a comprehensive analysis of CMS Medicaid data, we conclude that the entire range of PBM tools are generally not being fully allowed and used and that substantial savings are possible from their broader application.

Read the study.

In recent years, factors such as rising drug costs and the Affordable Care Act (which expanded Medicaid and enabled states to retain drug manufacturer rebates even when Medicaid managed care plans cover prescription drugs) have encouraged greater use of PBM cost-saving tools in Medicaid. Nonetheless, the broad adoption and full application of PBM tools has evolved more slowly in Medicaid than in the commercial market. For example, in many states, traditional Medicaid pharmacy payment rates are still not negotiated with pharmacies but set by state officials, often at rates much higher than those of other large payers.

This study explores how using the full range of PBM tools—without making changes to federal and state supplemental drug manufacturer rebates—could save Medicaid an additional $51.1 billion over the next decade. That's $33.4 billion in federal savings and another $17.7 billion in savings for the states.

It's important to note that the use of PBM tools is not synonymous with simply contracting with Managed Care Organizations (MCOs) or Pharmacy Benefit Managers (PBMs). Many state governments—even those that retain MCOs to manage major medical costs or PBMs to manage pharmacy benefits—still restrict the use of basic cost-savings tools. For example, some states require MCOs to administer a state-developed formulary rather than allowing them to manage their own formularies as do most commercial-sector plans. At the same time, other states use a traditional administrative approach but do allow other PBM tools to be used to manage costs and quality.

Experience suggests that Medicaid programs could allow the use of PBM tools to a greater extent while quality is maintained or improved for the unique and vulnerable populations that Medicaid serves. Likewise, there is no compelling evidence that restricting the use of PBM tools benefits patients. In short, this is a budgetary opportunity for policymakers seeking to reduce overall costs or find savings to re-apply toward more robust and sustainable Medicaid benefits.

Savings options include:

- **$26.5 billion saved by optimizing the use of generic drugs**: Generics are typically (but not always) the lowest net cost products for state Medicaid programs. In aggregate, each percentage point increase in the generic dispensing rate yields roughly a 3% reduction in net prescription drug costs.
- **$2.4 billion saved by encouraging the use of more affordable, preferred brands**: State Medicaid programs that continue the antiquated practice of exempting entire classes of drugs from Preferred Drug List reviews make it more difficult to use Prior Authorization (PA) protocols that encourage both safe and cost-effective drug utilization.
- **$1.9 billion could be saved over the next ten years in reduced 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.
- **By using a competitive process and negotiating better discounts from drugstores that wish to participate in more selective pharmacy networks, Medicaid could save $11.4 billion over the next ten years.** State Medicaid programs could achieve greater savings by implementing competitive pharmacy contracting processes that characterize Medicare Part D and commercial-sector programs. In Medicare Part D, preferred pharmacy options have demonstrated savings of 6.1%.
- **$9 billion saved by aligning pharmacy reimbursements with competitive levels in the commercial sector**: CMS has recently required that states adopt an Actual Acquisition Cost (AAC) methodology for paying pharmacies. The AAC approach may result in higher pharmacy reimbursements than the already higher-than-average reimbursements characteristic of traditional Medicaid programs.