Medicaid Drug Use Data Show High Costs and Wide Variation for Dual Eligibles

by James M. Verdier and Myoung Kim

The drug coverage provided to over 6 million Medicare-Medicaid “dual eligibles” shifts from Medicaid to Medicare in January 2006 under the Medicare Modernization Act of 2003 (MMA). Mathematica has prepared new state-by-state data and a chartbook on Medicaid prescription drug use and reimbursement for 1999 that highlight dual eligible drug use. These resources raise issues for health plans providing the new Medicare Part D prescription drug benefit, states, and the Centers for Medicare & Medicaid Services (CMS). The data and chartbook, funded by CMS, provide the most comprehensive information now available on dual eligible drug use and costs.

Why Focus on Dual Eligibles?

Dual eligibles, who currently receive full prescription drug benefits from Medicaid, represent over 6 million of the 43 million Medicare beneficiaries who will be eligible for drug benefits under Part D starting in 2006. After this date, Medicaid will no longer cover their drugs. Dual eligibles accounted for 19 percent of Medicaid fee-for-service (FFS) beneficiaries and 55 percent of total FFS Medicaid pharmacy reimbursement in 1999. They will represent a very large share of the initial enrollees in Part D prescription drug plans (PDPs), since they will be automatically enrolled in these plans if they do not choose a plan themselves before January 1, 2006. Stand-alone Medicare PDPs, Medicare Advantage prescription drug plans (MA-PDs), and Medicare Advantage Special Needs Plans (SNPs) must be prepared to deal with dual eligibles, whose drug use and costs may be sharply higher than those of other Medicare beneficiaries and who have a wide range of complex and serious health care needs.

Mathematica’s new data (available online at www.cms.hhs.gov/researchers/projects/Medicaid_rx/) provide an important resource to help assess and respond to the widely varying prescription drug needs of dual eligible beneficiaries. The data show the differences in drug use between under-age-65 disabled dual eligibles (“disabled duals”) and those age 65 and over (“aged duals”), the wide variance in dual eligible drug use and costs across states, the types of drugs used by dual eligibles, and the extensive use of drugs by dual eligibles in nursing facilities.

While comparative plan-by-plan and state-by-state data on drug use and reimbursement in Part D plans for 2006 and later years may be available publicly in the future, the data outlined in this issue brief can provide important insights in the interim. (See box on page 4 for details on the chartbook and tables.)

Spending Higher for Disabled Duals

Average per-person Medicaid reimbursement for prescription drugs for disabled dual eligibles under age 65 was $2,143 in 1999, almost 50 percent higher than the average reimbursement for those age 65 and over, which ranged from $1,247 to $1,447, depending on age (Compendium, Supplemental Tables 1A-1D).
As shown in Figure 1, 12 percent of disabled duals had annual Medicaid prescription drug costs that exceeded $5,000 per person, while less than 4 percent of aged duals had annual costs that high. Because disabled duals are eligible for Medicare and Medicaid by virtue of their serious physical and/or mental disabilities and chronic illnesses, as well as their low income and asset levels, it is not surprising that their prescription drug use is higher than that of aged duals, who are eligible because of their age and income (although they may also have disabilities and chronic illnesses).

CMS has developed a system to adjust the rates it will pay to PDPs, MA-PDs, and SNPs to reflect the expected drug costs for different kinds of beneficiaries. This system will result in higher payments to plans that enroll a disproportionately large share of high-cost disabled and aged dual eligibles. Although data limitations may result in some imprecision in these adjustments in the first year, the MMA contains other risk-sharing provisions that should help offset losses that some plans may incur as a result of enrolling a large number of dual eligibles with high drug costs.

Wide State-by-State Variation

Per-person Medicaid prescription drug costs for dual eligibles varied widely across states in 1999, ranging from $857 in Colorado to $2,225 in Missouri. The national average was $1,629 (Chartbook, Exhibit 23). For under-65 disabled duals alone, per-person reimbursement ranged from $1,099 in Colorado to $2,916 in Florida, with a national average of $2,143 (Chartbook, Exhibit 24).

CMS has established 34 PDP regions, 9 of which include more than one state. PDPs must serve all beneficiaries in a region with the same drug benefit packages, beneficiary premiums, and CMS payment rates. Consequently, variation within multistate regions in per-beneficiary dual eligible drug costs could result in plans being paid more or less than their costs, depending on their mix of enrollees. In developing the multistate regions, CMS sought to minimize variation in average state prescription drug spending, but relied primarily on estimates of spending for individuals age 65 and over in 2006, thus excluding under-65 disabled duals. The state-by-state variation among disabled duals (and aged duals) may turn out to be substantially greater or less than that among all Medicare beneficiaries age 65 and over.

Let’s look at PDP Region 31, which covers Idaho and Utah, for example. Annual Medicaid prescription drug spending per person in 1999 for all dual eligibles in Idaho was more than double that in Utah ($2,071 in Idaho compared to $1,008 in Utah). The difference for under-65 disabled duals was almost as great ($2,491 in Idaho and $1,286 in Utah). There were similar differences in per-beneficiary Medicaid spending on dual eligibles between the high and low states in the seven-state PDP Region 25 ($1,957 for all duals combined in Nebraska, compared to $1,576 in North Dakota).
The CMS risk-adjustment and risk-sharing systems may alleviate most problems that greater than expected state-by-state variations may present. In addition, these variations may turn out to be less in Part D than in Medicaid, since Part D benefit and payment rules will be uniform across regions, while Medicaid policies vary by state. Still, because dual eligibles will make up a large share of the initial enrollment in many PDPs, these plans are likely to be very attuned to unanticipated variations and the implications for the adequacy and equity of their Part D payments. CMS may want to monitor variation in enrollment patterns by state to assess the current methods used to adjust for risk and whether they adequately account for state differences in dual eligible enrollment and costs.

Drugs Used by Dual Eligibles

The MMA requires that Part D drug plan design and benefits not “substantially discourage enrollment” by specific types of beneficiaries. CMS has set up a process to review formularies and other plan features to help ensure access to needed drugs by Part D enrollees. States may also be under pressure to continue covering some drugs under Medicaid that are not available from Part D plans, even though federal matching payments may not be available. The following data provide insights into drugs dual eligibles may require, although the drug marketplace has changed since 1999:

- Central nervous system drugs, cardiovascular agents, gastrointestinal agents, anti-infective agents, and analgesics and anesthetics were the five highest-ranking therapeutic categories for dual eligibles in 1999, measured by total pharmacy reimbursement. They accounted for 64 percent of total pharmacy spending for duals (Compendium, Table 15).

- Antipsychotics and antidepressants accounted for over 18 percent of total Medicaid prescription drug reimbursement for dual eligibles in 1999; ulcer drugs accounted for another 8 percent (Chartbook, Exhibit 15).

- Disabled duals were much heavier users of antipsychotic drugs than aged duals. Over 37 percent of disabled duals ages 21 to 44 used antipsychotic drugs in 1999, for example, compared to less than 12 percent of aged duals between ages 65 and 74 (Compendium, Table 16A).

Drug Use in Nursing Facilities

Almost one-quarter of dual eligibles are cared for in nursing facilities. CMS has established a number of requirements for Part D plans and pharmacies serving nursing facilities to ensure appropriate levels of access, quality, and competition. In addition, the MMA authorizes SNPs to specialize in serving dual eligibles and other beneficiaries in nursing facilities. The 1999 data illustrate the magnitude of Medicaid prescription drug use in this setting and the drugs most heavily used:

- Pharmacy reimbursement for dual eligibles in nursing facilities was 14 percent of total Medicaid pharmacy reimbursement for the nation as a whole, ranging from 2 percent in South Carolina to 30 percent in Maryland, reflecting variations in drug use in nursing facilities as well as states’ broader policies on nursing facilities in Medicaid (Chartbook, Exhibit 26).

- Medicaid reimbursement for dual eligibles in nursing facilities in 1999 averaged $181 per benefit month, compared to $157 per benefit month for all dual eligibles combined (Chartbook, Exhibit 8).

- Central nervous system drugs accounted for 26 percent of total pharmacy reimbursements for dual eligibles residing in nursing facilities for the full year, compared to 21 percent of total reimbursement for all dual eligibles (Compendium, Tables 15 and 18).

Part D Prescription Drug Data

Part D plans will be accumulating extensive data on prescription drug use beginning in 2006. They will be required to submit 37 prescription drug data elements
to CMS on a monthly basis to support CMS’s Part D payment, quality monitoring, program integrity, and oversight responsibilities. Although plans will have their own drug data for 2006, only CMS will have comparative data for all plans. It is not clear at this point what portion of these data CMS will make publicly available, in what form, or at what time. Until actual data on Part D expenditures and utilization are available, the data reviewed in this issue brief will remain the best source of public information on prescription drug use by dual eligibles.

Further Reading


For more information, contact Jim Verdier, (202) 484-4520, jverdier@mathematica-mpr.com.

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