State Opportunities to Save With Generic Drugs

Generic Drugs and Illinois Medicaid:

Although Illinois has one of the highest *generic dispensing rates* in the U.S. with 72 % of all Medicaid prescriptions filled with generic products, continued expansion of generic use saves the State $17.5 million for each additional 1% growth of generic substitution.

Generic drugs have the same active ingredients as brand name drugs and are required by the Food and Drug Administration (FDA) to have the same quality, strength, purity, and stability as their brand name counterparts. The most significant difference between generic and brand name drugs is cost. On average, the generic brand is 75% cheaper than the brand name pharmaceutical. The average cost to Medicaid for a generic prescription is $21, compared to $191 for the average brand name version of the same drug. Considering that Illinois' generic dispense rate is 72%, one can see the potential savings in the remaining 28% in light of the numbers above.

A great deal of the wasteful spending relates to drugs that recently experienced a generic launch. Nearly 75% of Medicaid's wasteful spending in 2009 (the overspending estimated to be $271 million) was tied to generic products launched in 2008 or 2009.

While generic substitution averages may be high collectively, they may be particularly low in cases concerning specific brand name drugs.

Strategies to Increase Medicaid/State Program Generic Utilization:

- **Requiring Mandatory Generic Dispensing**, which means that a generic brand must be given to the patient when available. Sixteen states already require mandatory generic dispensing. States may also choose to implement "prior approval" rules for patients as this gives patients more autonomy, but it also significantly lowers the likelihood that generics will be chosen in place of brand name drugs. Some states have eliminated the "prior approval" rule, which required the patients to agree to have a generic substitute prior to the prescription, but still allow for physicians to override a generic prescription as long as they submit a written explanation as to why the brand is medically necessary. **In 2002, Massachusetts's Medicaid program went from spending $10 to $11 million per month to $200,000 to $300,000 after implementing a generic substitution policy**.

- **Creating a Preferred Drug List (PDL)**, which means that the state creates a list of the more cost-efficient drugs, and state Medicaid only pays for drugs on the PDL unless the provider/physician seeks approval to use a non-PDL drug. **North**

Carolina's Medicaid program is expected to save over $90 million since implementing a PDL in March 2010. Other states' success varies as some states PDLs exclude certain drugs or classes of drugs, such as those to treat cancer and HIV as well as certain antipsychotics. The exclusion of these drugs, which are typically higher costing, decreases cost effectiveness a great deal in some cases.

- **Requiring Patient Copayment Differential*,*** which means that patients who choose a brand name drug in place of a generic brand without medical reason will pay out-of-pocket to cover the difference in cost. In addition, many states have significantly lowered or eliminated copayments for generic drugs—the revenue lost from the copayment was more than made by the lower total cost of generic rather than brand name drugs.

- **Requiring Brand Limits**, which is a much less significant change in that it only limits the number of brand drug prescriptions a patient can fill in a month without prior approval of generic substitutions.

- **Implementing Appropriate Pharmacy Payments**, which motivates pharmacies to dispense generic drugs more often than the brand name counterparts.

Pharmacy Education & Counseling Program Shows Better Outcomes for Patients & Lower Pharmaceutical Costs:

The Asheville Project® began in 1996 as an effort by the City of Asheville, North Carolina, a self-insured employer, to provide education and personal oversight for employees with chronic health problems such as diabetes, asthma, hypertension, and high cholesterol. Through the Asheville Project, employees with these conditions were provided with intensive education through the Mission-St. Joseph's Diabetes and Health Education Center. Patients were then teamed with community pharmacists who made sure they were using their medications correctly.

The project led pharmacists to develop thriving patient care services in their community pharmacies. Employees, retirees, and dependents with diabetes soon began experiencing improved A1C levels, lower total health care costs, fewer sick days, and increased satisfaction with their pharmacist's services.

The Asheville Project has inspired a new health care model for individuals with chronic conditions. Unlike other experiments, the Asheville model is payer-driven and patient-centered. Employers are adopting this approach as an additional health care benefit to empower their employees to control their chronic diseases, reduce their health risks, and ultimately lower their health care costs.

The Asheville Project model continues on today, not only here in Asheville but across the country.

Sources:

Much of the preceding information is drawn from *Generic Drugs and Illinois* (Aug. 2010) and *Opportunities to Reduce State Prescription Drug Expenditures: Practical, Implementable Strategies to Increase Access to Prescription Medicines While Preserving Funds for Vital State Programs* (Aug. 2010).

For a more in-depth analysis of specific drugs and their costs, see Alex Brill's *Overspending on Multi-Source Drugs in Medicaid*.

For a case study of brand name Zocor and its generic equivalent(s), see William Shrank et al., *State Generic Substitution Laws Can Lower Drug Outlays under Medicaid* (July 2010, Health Affairs).