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VERMONT'S PLAN TO CONTROL DRUG PRICES FOR SENIORS: A BAD PRESCRIPTION

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States that are considering ways to improve seniors' access to prescription drugs should not be quick to follow Vermont's lead. Last November, Vermont obtained a waiver from Medicaid law that allows it to set prices for prescription drugs, using Medicaid payment levels, for all seniors without private coverage and certain other low-income uninsured non-Medicaid people. Seniors whose incomes make them ineligible for Medicaid and who have no other drug coverage face paying high prices for the drugs they want or need because Medicare does not cover prescription drugs. Vermont is trying to remedy this gap by changing eligibility and access requirements in current medicaid law.

The goal may be good, but instituting price controls is bad policy. It ultimately will limit seniors' access to prescription drugs, displace private-sector prescription drug coverage, and decrease the incentive to reform Medicare to provide prescription drug coverage. Limiting access to drugs, moreover, will restrict the resources of the industry to bring better drugs to market. A better approach to improve seniors' access to prescription drugs would be to reform Medicare to offer prescription drug coverage through a system similar to the Federal Employees Health Benefits Program (FEHBP) covering Members of Congress and federal workers.

Limiting Access. Vermont received its waiver from Medicaid rules and regulations in November 2000 from the Health Care Financing Administration (HCFA), which oversees the Medicaid and Medicare programs for the U.S. Department of Health and Human Services. The state's Pharmacy Discount Program began in January 2001 and will set drug prices for all seniors over 65 without private coverage, regardless of income. It will also fix prices for uninsured people of any age who are not eligible for Medicaid but whose incomes are less than three times the poverty level ($26,877 for individuals, $34,593 for couples, and $52,389 for a family of four).

This approach may sound good to eligible Vermonters, but it will not guarantee these individuals have access to all the drugs they need, and it will create new problems. State Medicaid programs, like most private health plans, pick and choose the drugs they reimburse in their "formulary." Under a formulary, drugs are chosen not by the doctors who treat the patients, but by "outside experts" who have no direct knowledge of individual patient needs.

Though efficacy is a factor in selecting drugs for these formularies, so is cost. In some cases, formularies offer economic incentives to patients to

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discourage them from using new, expensive, and patented drugs that may be only marginally more effective than generic ones. Private insurers have more flexibility with formularies and often establish tiered co-pays to tie how much patients pay to whether a drug is generic, brand name on-formulary, or brand name off-formulary. Such a policy guarantees broader access and coverage for seniors who, for whatever reason, want or need a particular drug.

Medicaid beneficiaries, on the other hand, have access to only those drugs that state Medicaid authorities choose to reimburse and list on their formularies. And because Medicaid is perennially strapped for cash, older cheaper generic drugs tend to appear on formularies *in lieu* of newer drugs that are more effective but more expensive. In other words, seniors relying on Medicaid are at the mercy of the state's Medicaid budget. Some drugs are excluded in private formularies as well. But Medicaid programs have among the most restrictive formularies, and its beneficiaries have no access to alternative formularies in private plans.

Reducing Private Coverage. Besides being far less comprehensive, and more restrictive, than beneficiaries probably assume, there are deeper problems. The Vermont price-control approach, if widely adopted in the states, will likely crowd out private insurance such as Medigap and employer retirement plans. Seniors may be tempted to drop their private drug coverage, even if it is superior, if they believe they can pay cheaper prices for drugs they use. Private firms and large corporations concerned with the bottom line may succumb to the powerful incentive to dump retirees into the expanded Medicaid eligibility system. Thus, because private coverage is usually superior to Medicaid coverage, the quality of care for seniors would decline.

Market Consequences. The Pharmaceutical Research and Manufacturers of America (PhRMA), believing Vermont's approach violates numerous Medicaid provisions in the Social Security Act, has filed a complaint in the U.S. District Court for the District of Columbia. It charges that Vermont's plan requires beneficiaries to pay more than the "nominal co-payment" for prescription drugs mandated by Medicaid law and forces manufacturers to pay the remainder as a rebate. PhRMA fears that manufacturers that refuse to pay the rebates could be excluded from a state's Medicaid program. This could keep important drugs out of its formulary and out of the hands of seniors. Regardless of how the court rules, such concerns and the problems noted above should be taken seriously by HCFA and states that are considering such a waiver.

Price controls may be politically expedient, but they distort markets, shift costs to consumers via reduced quantity or quality of controlled products, and reduce investment in technological advances in the controlled sector of the economy. Seniors make up one-third of the prescription drug market. If the market comes under price regulation, the amount of money available for research and development will decline. This would push back the day when better treatments and cures are found for such ailments afflicting seniors as Alzheimer's disease, cancer, heart disease, strokes, and osteoporosis.

A Better Solution. The best way to ensure seniors have access to affordable prescription drugs is to overhaul Medicare so that it offers prescription drug coverage in a system similar to the FEHBP. In the FEHBP, all plans offer drug coverage, and most cover 80 to 90 percent of drug costs. Anyone not satisfied with their plan for any reason—poor service, limited doctor networks, or restrictive formularies—can switch to another plan once each year. This generates competition among plans to provide maximum access to high-quality service and prescription drugs to avoid losing market share and paying for far more expensive surgical procedures down the road. Such incentives do not exist and cannot exist to the same degree in the current Medicaid program.

Conclusion. America's seniors deserve the same quality of care and access to prescription drugs that their elected representatives in Washington enjoy. States should not emulate Vermont's new drug-pricing policy. Regardless of how the federal court rules on the legality of its approach, this is bad policy that ultimately could restrict seniors' access to drugs of choice and reduce private drug coverage.

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