New Economic Analysis zeroes in on low generic utilization and waste in Medicaid

By Dalia Buffery, MA, ABD

A recent report from the American Enterprise Institute suggests that better utilization of generic drugs in the Medicaid population could save that federal program and the states much-needed funds, by eliminating unnecessary utilization of the more expensive brand-name drugs for which appropriate generic substitutes are available.¹

For this report, Alex Brill, MA, former senior adviser and chief economist to the House Ways and Means Committee, examined the database of the 2009 Medicaid Drug Rebate Program, focusing on drug utilization of 20 "popular prescription drugs for which both brand and generic versions are available." The study was limited to oral medications and demonstrated that significantly more drug sales in Medicaid involve brand-name drugs than their generic equivalent products.¹

Mr Brill calculates that if the trends outlined in his report continue, unnecessary drug spending in Medicaid could reach up to "$430 million in 2012 as a direct result of states not utilizing more generic drugs."¹

The key findings of this analysis, based on 2009 data, show that:

1. For the 20 popular (oral) drugs prescribed for Medicaid patients, the program overspent $329 million by reimbursing for brand-name products when less expensive therapeutic alternatives existed.

2. Of these 20 drugs, Medicaid wasted, on average, $95 per prescription.

3. As much as 85% of the unrealized savings was related to only 8 compounds, totaling $279 million.

4. The following states had the greatest waste in drug spending in the Medicaid program:
   • California, $102 million
   • Texas, $32 million
   • Georgia, $25 million
   • Ohio, $21 million
   • New York/Pennsylvania, $19 million each
   • Iowa, $15 million
   • Illinois/Florida, $11.5 million each
   • North Carolina, $6.8 million

5. Projections based on the 10 brand-name drugs that are expected to lose patent in 2011 and 2012 for which Medicaid reimbursement was high in 2009—assuming similar overspending patterns—would range from $289 million to $433 million.

In support of his findings, Mr Brill cites a 2005 study that identified potential savings from generic substitution across all patient categories, with overspending in Medicaid and other public programs estimated at $388 million in 2000.²

Mr Brill suggests that an “important and relatively simple approach to reducing wasteful spending is to maximize the use of less costly generic drugs in the Medicaid drug program.”¹ This, however, is anything but “relatively simple.” In the current economic state of affairs, cutting costs is on the mind of all healthcare stakeholders. However, before any firm conclusions can be reached about waste in utilization of brand versus generic drugs, a thorough investigation is needed to demonstrate the reasons for what appears to be overutilization of the more expensive options, when therapeutically equivalent and less expensive options are available.

The potential for cost-savings from generic substitutions is self-evident and potentially quite significant, but clinical experience and the medical literature have shown that individual variations in patients’ responses to medications, as well as patient variation in susceptibility to adverse events, must be considered, both of which are directly related to medication adherence and patient outcomes. These issues must be factored in when cost-effectiveness analyses are conducted. They were not included in this analysis.

It is no longer possible to consider pure economic analyses when discussing cost-effectiveness and utilization-based waste of medications; the issues raised by personalized medicine must be considered in this area. Indeed, Mr Brill makes a small concession in that direction: after saying that “to ensure the highest possible cost-effectiveness, it is important that Medicaid programs not reimburse for a more expensive version of a drug when a less expensive, therapeutically equivalent product is available,” he adds in a footnote that “there may be situations, albeit rare, in which a patient requires a brand product.”¹

Whether these situations are rare needs to be further elucidated in evidence-based studies. Perhaps some answers would soon come from those involved in personalized medicine.

References
