Medicaid Drug Spending Trends

In fiscal year (FY) 2017, Medicaid spent approximately $64.0 billion on outpatient prescription drugs and collected $34.9 billion in rebates, bringing net drug spending to $29.1 billion (Table 1). Net spending for outpatient drugs accounted for about 5.1 percent of total Medicaid benefit spending.

Gross spending continues to rise but net spending has slowed

Gross drug spending (i.e., before rebates) reflects the number of prescriptions filled and the amount paid per prescription. The amount paid per prescription reflects the price the state or Medicaid managed care organization pays to the pharmacy to purchase and dispense any particular drug as well as the mix of drugs dispensed (i.e., the distribution of drugs across different therapeutic classes and the mix of brand and generic drugs).

Net drug spending takes into account any rebates that the state receives from manufacturers. These rebates include those that are mandated by the Medicaid Drug Rebate Program as well as any supplemental rebates that the states negotiate directly with the manufacturers.[1] Overall, rebates reduced gross drug spending by over 50 percent in FY 2017 (Table 1).

While gross drug spending has continued to rise since FY 2014, net spending has slowed and actually decreased over the past year, reflecting an increase in the amount of rebates collected. In the past two years, the dollar increase in gross drug spending has been matched by a similar or even greater dollar increase in rebates. In FY 2017, gross drug spending increased 5.2 percent from the prior year, but net drug spending decreased by 1.7 percent (Table 1).[2]

TABLE 1. Medicaid Drug Spending and Rebates, FYs 2014–2017

Fiscal year	Gross drug spending ($ billions)	Rebates ($ billions)	Net drug spending ($ billions)
2014	$43.2	-$19.9	$23.2
2015	53.5	-24.0	29.5
2016	60.9	-31.2	29.7
2017	64.0	-34.9	29.1

Notes: Includes federal and state funds. Gross expenditures are before the application of rebates. Virginia data were corrected for an apparent error in fee-for-service spending in the second quarter of 2014. Does not include Medicare Part D clawback payments.
Source: MACPAC analysis of Medicaid state drug rebate utilization data as reported by states as of July 2018 and CMS-64 Financial Management Report net expenditure data as of July 2018.

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The mix of drugs used by Medicaid beneficiaries is shifting towards generics

One way for payers to manage drug spending is to shift utilization toward low-cost generic drugs when possible. The generic fill rate increased from 80.7 percent in FY 2014 to 83.2 percent in FY 2017 (Table 2).

TABLE 2. Medicaid Drug Claims, by Brand versus Generic Status, FYs 2014–2017

Fiscal year	Brand drug claims (millions)	Generic drug claims (millions)	Total drug claims (millions)	Percent brand drug of total	Percent generic drug of total
2014	112.4	480.4	595.3	18.9%	80.7%
2015	123.2	554.1	680.0	18.1	81.5
2016	124.9	605.4	732.1	17.1	82.7
2017	125.2	630.3	757.4	16.5	83.2

Notes: Includes federal and state funds. To assign brand and generic status, we linked the state drug utilization data to the Medicaid drug product data from CMS using the National Drug Code, the universal product identifier for drugs. Excludes drugs that could not be matched to the drug product data.
Source: MACPAC analysis of Medicaid state drug rebate utilization and product data as reported by states as of July 2018.

Distribution of spending on brand drugs has increased

Despite increasing use of generic drugs, there has not been a corresponding shift in the distribution of spending between brand and generic drugs. The share of spending for brand drugs increased from 76.6 percent to 80.5 percent from FY 2014 to FY 2017 (Table 3).

TABLE 3. Medicaid Gross Drug Spending, by Brand versus Generic Status, FYs 2014–2017

Fiscal year	Brand drug gross spending ($ billions)	Generic drug gross spending ($ billions)	Total drug gross spending ($ billions)	Percent brand drug of total	Percent generic drug of total
2014	$33.0	$10.0	$43.2	76.6%	23.2%
2015	41.1	12.3	53.5	76.8	23.0
2016	47.8	13.1	60.9	78.4	21.5
2017	51.5	12.4	64.0	80.5	19.5

Notes: Includes federal and state funds. Gross expenditures are before the application of rebates. To assign brand and generic status, we linked the state drug utilization data to the Medicaid drug product data from CMS using the National Drug Code, the universal product identifier for drugs. Excludes drugs that could not be matched to the drug product data. Virginia data were corrected for an apparent error in fee-for-service spending in the second quarter of 2014. Does not include Medicare Part D clawback payments.
Source: MACPAC analysis of Medicaid state drug rebate utilization and product data as reported by states as of July 2018.

Average spending per brand drug claim has increased substantially

The increase in the proportion of brand drug spending while the proportion of brand drug claims is decreasing reflects an increase in the average spending per claim (Table 4). The average spending for a brand drug has increased 40 percent since FY 2014, going from about $294 per claim to $411 per claim in FY 2017. By contrast, the average price of generic drugs decreased about 5 percent over the same time period (Table 4).

TABLE 4. Medicaid Gross Drug Spending per Claim, by Brand versus Generic Status, FYs 2014–2017

Fiscal year	Gross brand drug spending per claim	Gross generic drug spending per claim	Gross total drug spending per claim
2014	$293.85	$20.83	$72.48
2015	333.91	22.26	78.72
2016	382.30	21.68	83.23
2017	411.08	19.75	84.47

Notes: Includes federal and state funds. Gross expenditures are before the application of rebates. To assign brand and generic status, we linked the state drug utilization data to the Medicaid drug product data from CMS using the National Drug Code, the universal product identifier for drugs. Excludes drugs that could not be matched to the drug product data. Virginia data were corrected for an apparent error in fee-for-service spending in the second quarter of 2014. Does not include Medicare Part D clawback payments.
Source: MACPAC analysis of Medicaid state drug rebate utilization and product data as reported by states of July 2018.

Increases in average spending per brand drug claim reflects spending for high-cost specialty drugs

Much of the recent growth in drug spending has been attributed to high-cost specialty drugs.[3] The share of prescriptions for high-cost drugs has increased slightly, from 0.9 percent of claims in FY 2014 to approximately 1.2 percent of claims in FY 2017. However, the share of spending on these drugs has increased substantially, as they accounted for only 31 percent of total spending in FY 2014 but now account for almost 44 percent of spending in FY 2017 (Table 5).

Average spending for these drugs has increased from $2,600 per claim in FY 2014 to over $3,100 in FY 2017, reflecting price inflation for existing drugs as well as the introduction of new high-cost drugs (Table 5).

TABLE 5. Medicaid Drug Claims and Gross Spending for Drugs over $1,000 per Claim, FYs 2014–2017

Fiscal year	Drug claims (millions)	Gross spending ($ billions)	Spending per claim	Percent of total claims	Percent of total spending
2014	5.2	$13.4	$2,597	0.9%	31.1%
2015	6.5	18.4	2,822	1.0%	34.4%
2016	7.3	23.9	3,252	1.0%	39.2%
2017	8.8	27.8	3,174	1.2%	43.7%

Notes: Includes federal and state funds. Gross expenditures are before the application of rebates. To assign brand and generic status, we linked the state drug utilization data to the Medicaid drug product data from CMS using the National Drug Code, the universal product identifier for drugs. Excludes drugs that could not be matched to the drug product data. Virginia data were corrected for an apparent error in fee-for-service spending in the second quarter of 2014. Additionally, $294 million associated with only 222 claims in 2017 was considered anomalous and excluded from this analysis. Does not include Medicare Part D clawback payments.
Source: MACPAC analysis of Medicaid state drug rebate utilization and product data as reported by states as of July 2018.

Endnotes

[1] For more information on the Medicaid Drug Rebate Program, see MACPAC's issue brief: *Medicaid Payment for Outpatient Prescription Drugs*. https://www.macpac.gov/publication/medicaid-payment-for-outpatient-prescription-drugs/

[2] State-level information on gross drug spending and rebates is available in MACPAC's annual publication of MACStats.

[3] Magellan, a large, national pharmacy benefits manager (PBM), reported that for its contracted Medicaid fee-for-service (FFS) populations, net spending per claim (net of federal and supplemental rebates) decreased 5.1 percent for its traditional drug classes but increased 20.5 percent for its specialty drug classes from 2015 to 2016. The share of net spending attributed to specialty drugs increased by almost 5 percentage points during this period, from 31.8 percent to 36.5 percent (Magellan 2017). Express Scripts, another large, national PBM, reported that specialty medications accounted for 42.3 percent of total Medicaid drug spending in 2017, increasing 7.4 percent in per member, per year spending compared to 2016 (Express Scripts 2018).

References

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