The use of tiered formularies and co-payments by state Medicaid programs was the most controversial provision in the mammoth five-year, federal budget-cutting bill—called the reconciliation bill—that Congress started to work on in December. One would think that the use of tiered formularies and the requirement for prior authorization for higher-priced drugs would be “no-brainers” these days, in terms of tried-and-true drug utilization policies—but apparently not in the Capitol.

Congress ultimately rejected the House provision, which would have allowed states to establish various formularies for different Medicaid populations. Medicaid currently serves people other than only the poorest of the poor. House members thought that some of the better-off Medicaid recipients should pay more for drugs in order to reduce the growth of Medicaid costs to the federal government and the states.

Medicaid provides medical care to 53 million Americans at a cost exceeding $300 billion in federal and state expenditures. The federal government, using a formula based on average per capita income in each state relative to national per capita income, matches between 50% and 76% of state expenditures, depending on the state. However, Medicaid costs are eating through state budgets like a virus.

In a report accompanying its reconciliation bill, the House said that if the system were left “unreformed,” analysts predict that Medicaid would “bankrupt every state in as little as 20 years—absorbing 80% to 100% of all state dollars.”

The House formulary cost-sharing provision would have saved about $2.25 billion over five years in federal spending on a total federal Medicaid outlay that will soon exceed $200 billion per year. With total House Medicaid savings at $11.9 billion, it was not exactly a radical measure in terms of cost-cutting. The provision would have required all Medicaid recipients below the poverty level to pay a nominal $5 co-pay for nonpreferred drugs, up from the minimum $3 co-pay, which was established in 1982 and which most recipients do not pay anyway.

Medicaid recipients above the poverty level could have been charged nominal-plus co-pays at a state’s discretion. Beginning in 2009, all nominal co-pays would have risen, according to the annual percentage increase in the medical care component of the Consumer Price Index for all urban consumers, and this sum would have been rounded up in an appropriate manner.

The provisions of the formulary design are standard for other federal agencies, not to mention the private sector. States would have had to designate as “preferred” all drugs listed as preferred under the TRICARE pharmacy benefit program. If a prescribing physician determined that the preferred drug would not be effective, would have had adverse health effects, or both, the patient could have gotten the nonpreferred drug without paying a co-pay.

As non-radical as these provisions sound, the Senate rejected them. Most of the Senate members listened to various groups who complained that the cost-sharing provisions in the House bill would put drugs beyond the reach of many Medicaid recipients, for whom even a $5 co-pay would be unaffordable.

“These cuts will force millions of low-income seniors and families to pay higher premiums and co-payments, thereby making health care unaffordable,” said Ron Pollack, executive director of Families USA.

But the final bill does allow states to use different benefit packages for different populations. Part of the problem with bringing the Medicaid drug program fully into the 21st century lay in the political perception. Medicaid benefits are being decreased to reduce the federal deficit at the same time that Congress is extending tax cuts that would add $50 billion to the deficit, with a significant proportion of those savings going to higher-income taxpayers.

That is why a House–Senate conference committee rejected the House formulary provisions. Again, the Senate bill did not have those provisions; it received most of its Medicaid drug savings (which amounted to about half the House’s $11.9 billion) by finally changing the long-criticized formula by which the states reimburse pharmacies for drugs provided to Medicaid recipients. That formula has been based on the average wholesale price (AWP), which, according to numerous Government Accountability Office reports, has led to severe overpayments to pharmacies because pharmaceutical manufacturers essentially exaggerate their inputs into the AWP formulas.

The Senate established a new average manufacturer price (AMP) basis for reimbursement of pharmacies. The House bill came up with a retail average manufacturer price (RAMP), which is based on the AMP. The AMP is even more draconian than the RAMP.

Based on the final Medicaid provision Congress approved on December 21, relatively significant Medicaid changes will hit pharmacies and drug manufacturers, who will face lower prices and alternative benefit structures too. However, both pharmacies and drug companies were comforted that things didn’t turn out quite as poorly as they thought they would.