



Secretary of State Audit Report

Department of Human Services: Medicaid Fee-For- Service Prescription Drug Costs Savings Analysis

Summary

PURPOSE

The purpose of the audit was to determine whether opportunities exist to reduce the cost of Oregon's Medicaid fee-for-service prescription drugs.

BACKGROUND

The increased cost of prescription drugs has been a subject of national concern. For the Medicaid program, prescription drug benefits are one of the fastest growing segments of the program. Growth in Medicaid costs in general is fast outpacing the growth of state budgets. In 2002 alone, Medicaid costs increased by 12.8 percent whereas states' budgets grew an average of only 1.2 percent.

In Oregon, nearly 30 percent of Medicaid clients are served through the fee-for-service program, at a budgeted cost of approximately \$1.3 billion in total federal and state funds for the 2003-2005 biennium. Of the \$1.3 billion, \$512 million was budgeted for prescription drug payments, and nearly 50 percent of prescription drug costs were for mental health drugs.

In the past few years, preferred drug lists and prior authorization requirements for non-preferred drugs have emerged nationally as a prominent policy to control the growth of Medicaid prescription drug costs. Through the use of preferred drug lists, states seek to shift drug use toward less-costly preferred drugs. Prior authorization requires prescribers to obtain approval before a non-preferred drug can be dispensed.

In 2001 the Oregon Legislature passed Senate Bill 819, which created the Practitioner Managed Prescription Drug Plan. Under this plan a list of evidence-based, preferred prescription drugs, called the Plan Drug List, was created for some non-mental health drugs. However, this legislation excluded mental health drugs from the list and subsequent legislation prohibited prior authorization of non-preferred drugs.

RESULTS IN BRIEF

Our analysis of a portion of the Medicaid fee-for-service drugs paid for by the Department of Human Services (department) found that from January 1, 2003 through March 31, 2004, the department could have saved approximately \$11.7 million in total funds on prescription drugs. This saving could have resulted by using a preferred drug list and prior authorization. Of this amount, the department could have saved approximately \$2.3 million on the four original Plan Drug List therapeutic drug classes, and approximately \$9.4 million had antidepressant and antipsychotic class drugs been included on the Plan Drug List. During this time, the four original Plan Drug List therapeutic drug classes accounted for eight percent of all fee-for-service prescription drug costs, and antidepressant and atypical antipsychotic class drugs accounted for 41 percent. Additional savings could be achieved from supplemental rebates from drug manufacturers. However, we were unable to estimate these additional savings.

RECOMMENDATIONS

We recommend the Department of Human Services work with the Oregon Legislature, the Office of the Governor, and other interested parties to introduce legislation that:

- Allows the addition of antidepressant and atypical antipsychotic class drugs to the Plan Drug List.
- Requires prior authorization of medically appropriate or necessary drugs not on the Plan Drug List.

AGENCY'S RESPONSE

The Department of Human Services agrees with the recommendations.

Introduction

The increased cost of prescription drugs has been a subject of national concern. For the Medicaid program, prescription drug benefits are one of the fastest growing segments of the program. Growth in Medicaid costs in general is fast outpacing the growth of state budgets. In 2002 alone, Medicaid costs increased by 12.8 percent, whereas states' budgets grew an average of only 1.2 percent.

In Oregon, the Office of Medical Assistance Programs administers Oregon's Medicaid Program, which provides healthcare services to approximately 368,000 low-income families with children, expecting women and their newborns, seniors, and people with disabilities. For the 2003-2005 biennium, the Oregon legislature budgeted \$3.4 billion to cover Oregon Health Plan client payments, with approximately \$1.3 billion (38 percent) to be paid from the State's General Fund and other funds, and the remaining \$2.1 billion (62 percent) paid from federal matching funds. Medicaid clients enrolled in the Oregon Health Plan receive coverage through either a Managed Care Plan or the fee-for-service program.¹

The fee-for-service program, which serves nearly 30 percent of Medicaid clients at a budgeted cost of approximately \$1.3 billion in total funds for the 2003-2005 biennium, was the focus of our audit. Of this amount, \$512 million in total funds was budgeted for prescription drug payments. Nearly 50 percent of prescription drug costs between January 1, 2003 and March 31, 2004 were for all mental health drugs for clients enrolled in

either the Managed Care Plans or the fee-for-service program.

Other States Using Preferred Drug Lists With Prior Authorization Requirements and Inclusion of Mental Health Drugs as Cost Containment Strategies

In the past few years, preferred drug lists and prior authorization requirements for non-preferred drugs have emerged nationally as a prominent policy to control the growth of Medicaid prescription drug costs. Through the use of preferred drug lists, states seek to shift drug use toward less-costly preferred drugs. Prior authorization requires prescribers to obtain approval before a prescription for a non-preferred drug can be dispensed. The National Governor's Association has recognized the value of preferred drug lists, calling them "the most effective tool" in controlling Medicaid prescription drug costs. Preferred drug lists and prior authorization requirements are used by private healthcare organizations, the U.S. Department of Veterans' Administration and each of the Managed Care Organizations providing healthcare services to the remaining 70 percent of the clients enrolled in the Oregon Health Plan.

As of September 2003, more than 30 states had implemented legislation, or had announced plans to implement legislation that requires a Medicaid preferred drug list. As part of our audit, we contacted several states to confirm preferred drug lists with prior authorization requirements were effective cost containment tools.

State Medicaid officials reported significant savings had resulted from implementing preferred drug lists with prior authorization requirements. For example, Washington reported a savings of \$12 million during fiscal year 2003,

and Michigan reported a savings of \$32 million in 2003. State officials we contacted also said that the savings achieved far outweighed the resources needed to administer a preferred drug list and a prior authorization program.

Several states have added or are in the process of adding mental health drug classes, such as antidepressants and antipsychotics, to their preferred drug lists in an effort to further reduce Medicaid prescription drug costs. For example, Massachusetts Medicaid officials reported a savings of over 12 percent on antidepressant drug classes in fiscal year 2004. Preferred drug lists that include mental health drugs provide additional benefits by helping inform physicians, not as familiar with mental health drugs, of the effectiveness of drugs used to treat specific mental health conditions.

Safeguards to Protect Medicaid Clients

The debate over preferred drug lists and prior authorization requirements centers on client access to all available drugs. Concerns over access to non-preferred drugs, especially mental health drugs, are being addressed by implementing safeguards designed to protect Medicaid clients. Examples of client safeguards include the following:

- Offering several preferred drugs within a therapeutic drug class,
- Selecting preferred drugs based on effectiveness first and cost second,
- Comprehensive exception policies for non-preferred drugs,
- "Grandfather" clauses for patients stabilized on non-preferred mental health drugs, and
- Employment of pharmacists to review medical and clinical

¹ Managed Care Plans provide health services on a pre-payment basis. Oregon Health Plan clients not enrolled in a Managed Care Plan, receive health services on a fee-for-service basis.

criteria when a physician requests prior authorization for non-preferred drugs.

These safeguards have protected client interests while at the same time providing states the cost benefit of a mandatory preferred drug list. Federal Medicaid laws protect clients by requiring Medicaid agencies to respond to prior authorization requests within 24 hours. Pharmacies are required to dispense a 72-hour supply of the drug to the client in an emergency situation.

Rising Medicaid Costs Necessitate Change in Oregon

The department has taken significant program-specific measures to work within its Medicaid operating budget. In 2003, the department was directed through the budget process to eliminate the Medically Needy program, which provided mental health services and prescription drug coverage to nearly 8,700 clients. In 2004 the department took measures to reduce the enrollment of the Oregon Health Plan Standard Plan from approximately 50,000 to 25,000 clients by June 2005 by closing enrollment, limiting benefits, and tightening eligibility criteria. Oregon was one of only two states in 2004 to impose Medicaid cuts exceeding 10 percent.

Oregon's Legislature has taken action to cope with rising Medicaid costs and budget shortfalls. The 2001 Oregon Legislative Assembly found that (1) the cost of prescription drugs in the Oregon Health Plan was growing and would soon be unsustainable; (2) the benefit of prescription drugs when appropriately used decreased the need for other expensive treatments and improved the health of Oregonians; and (3) providing the most effective drugs in the most cost-effective manner benefited

both patients and taxpayers. Subsequently, Senate Bill 819 was passed, which created the Practitioner Managed Prescription Drug Program. Under this plan, a list of evidence-based, preferred prescription drugs called the Plan Drug List, was developed for some non-mental health therapeutic drug classes.

The Plan Drug List consists of preferred prescription drugs in selected therapeutic drug classes chosen by the department's Office of Medical Assistance Programs in consultation with the Health Resources Commission (HRC).² Using evidence-based reviews performed by the Oregon Evidence-based Practice Center (OEPC)³, in conjunction with public commentary, the Office of Medical Assistance Programs identifies the most effective drug at the best possible price as the benchmark drug for each therapeutic drug class. The remaining recommended drugs with a relative cost that is less than that of the benchmark drug are added to the Plan Drug List. When compared to other Medicaid preferred drug lists, Oregon's is distinctive due to the evidence-based process by which preferred drugs are selected; however, due to current statute, Oregon cannot require prior authorization for the use of drugs not included on the Plan Drug List.

The first Plan Drug List was implemented in August 2002 and included long-acting opioids and proton pump inhibitor therapeutic drug classes. A month later, in

² The Health Resources Commission was created as a component of the Oregon Health Plan to help it achieve its goal of assuring all Oregonians access to high quality, effective health care at an affordable cost.

³ The Oregon Evidence-based Practice Center is a collaboration of the Oregon Health & Science University, Kaiser Permanente Center for Health Research, and Portland Veteran's Administration Medical Center.

September 2002, statin and non-steroidal anti-inflammatory therapeutic drug classes were added. As of December 2004, the original Plan Drug List had been expanded to include 12 therapeutic drug classes, all of which have undergone review. Therapeutic classes not included on the Plan Drug List include classes that have not yet been reviewed for effectiveness and other classes prohibited from inclusion, such as cancer, HIV, and mental health drugs. For the time period of our review, mental health drugs accounted for nearly 50 percent of fee-for-service prescription drug expenditures.

Audit Results

Our audit found opportunities exist to reduce the cost of Oregon's Medicaid fee-for-service prescription drugs by increasing utilization of the state's Plan Drug List and by including some mental health drugs on the list. Even though the state has a Plan Drug List, low utilization of the list, due to the lack of prior authorization requirements, and exclusion of mental health drugs is costing the state millions. Increased utilization of the Plan Drug List could result in further savings from supplemental rebates available from drug manufacturers.

Key to Lower Costs is an Enforceable Plan Drug List That Includes Mental Health Drugs

Prior authorization requirements for non-preferred drugs, and the inclusion of mental health drugs on the Plan Drug List could lower Medicaid fee-for-service prescription drug costs. While other states have implemented legislation requiring preferred drug lists with prior authorization requirements, and are adding mental health drugs to their preferred drug lists, Oregon

is not. During our audit we found that, while the Medicaid fee-for-service program has a preferred drug list for non-mental health drugs, the drug list is not enforced with prior authorization requirements. A report issued in January 2004 by The Kaiser Commission on Medicaid and the Uninsured, entitled *Oregon's Medicaid PDL: Will an Evidence-Based Formulary with Voluntary Compliance Set a Precedent for Medicaid*, states, "State officials found it difficult to achieve savings targets by promoting only voluntary compliance for the Practitioner Managed Plan Drug Plan." We learned that Senate Bill 819 from the 2001 Legislative session, which created the Plan Drug List, specifically excluded mental health drugs, further limiting savings for the Medicaid program.

We found that in May 2003 the department implemented prior authorization requirements for physicians prescribing non-preferred drugs in an effort to increase savings. The department saw an increase in the utilization of the Plan Drug List from 57 percent,

in first quarter 2003, to 85 percent, in third quarter 2003. However, in August 2003 the Oregon Legislature passed House Bill 3624, which specifically prohibited the department from requiring prior authorization for non-preferred drugs. After the Plan Drug List was made voluntary again, utilization dropped down to 65 percent in fourth quarter 2003. Chart 1 shows the shift in utilization rates over the 15-month period analyzed.

The Department Could Have Saved \$11.7 Million

Our analysis of a portion of the Medicaid fee-for-service drugs paid for by the department found the department could have saved approximately \$11.7 million in total funds on prescription drugs paid for the Medicaid fee-for-service program during January 1, 2003 through March 31, 2004 by using a preferred drug list and prior authorization. Of the \$11.7 million in total funds, the department could have saved approximately \$2.3 million on the four original Plan Drug List therapeutic drug classes had the state achieved a 90 percent

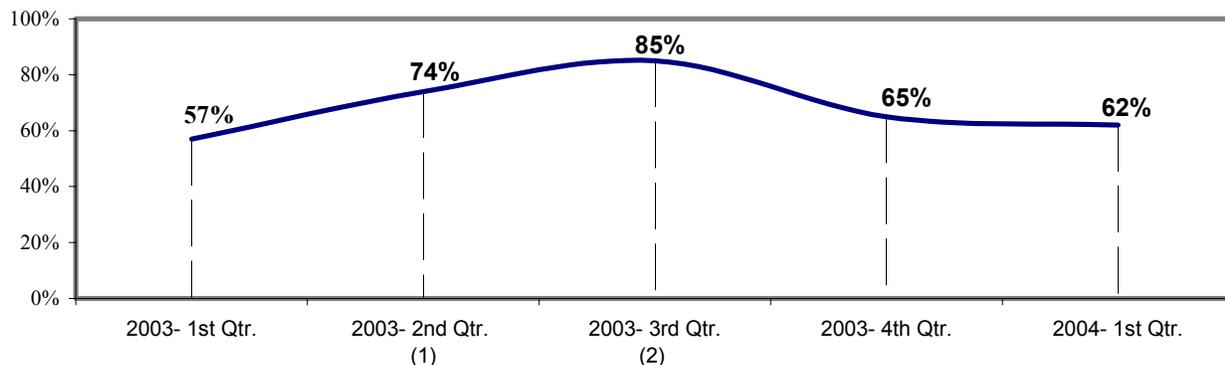
utilization rate with its Plan Drug List. In addition to the \$2.3 million we found the department could have saved approximately \$9.4 million had antidepressant and antipsychotic class drugs been added to the Plan Drug List, and had the state achieved 90 percent utilization for antidepressant class drugs and 85 percent utilization for atypical antipsychotic class drugs. Based on utilization rates achieved by other states with mandatory preferred drug lists, we concluded that these utilization rates are achievable. Using cost data provided by the department, this estimated savings could have paid all the medical costs, including prescription drugs, for approximately 2,600 additional Medicaid clients.

\$2.3 Million in Savings Identified For Non-Mental Health Drugs

Our analysis identified approximately \$2.3 million in total funds that the department could have saved between January 1, 2003 and March 31, 2004 had the state achieved a 90-percent utilization rate with its Plan Drug

**Chart 1:
Average Plan Drug List (PDL) Utilization of the Four
Original Therapeutic Classes (By Quarter)**

(January 1 2003 - March 31, 2004)



(1)-DHS implemented a prior authorization (PA) requirement for the PDL in May 2003.
 (2)-The PA requirement ended in September 2003 as a result of House Bill 3624.

List for the following therapeutic drug classes: long-acting opioids, non-steroidal anti-inflammatory drugs, proton pump inhibitors, and statins. We selected these classes for our first analysis because they were the only therapeutic classes on the Plan Drug List until May 2003. During the 15 months analyzed, the department paid approximately \$18.5 million in total funds, after all required Medicaid rebates, for over 330,000 prescriptions in these four therapeutic drug classes. These drugs accounted for eight percent of all fee-for-service prescription drug costs during this time period. Our analysis found that had drugs included on the Plan Drug List (preferred drugs) been purchased 90 percent of the time, the total cost could have been reduced to approximately \$16.2 million in total funds, generating a savings of \$2.3 million in total funds (12.4 percent) for these four therapeutic drug classes.

On Average, Non-Preferred Drugs are More Expensive Than Preferred Drugs

For the four classes analyzed during our audit period, we noted that while non-preferred drugs represented 32 percent of the claims they accounted for 47 percent of the cost (See Appendix A for details.)

Specifically, we found for the four classes analyzed the average cost of non-preferred drugs was significantly higher than the average per-class cost of preferred drugs. Because drugs on the Plan Drug List are selected based on effectiveness first and then cost, some of the preferred drugs for the four therapeutic classes analyzed were more expensive than some of the non-preferred drugs. However, when compared using a weighted average for all preferred and non-preferred drugs within their class, non-preferred drugs were

significantly more expensive than preferred. For example, during the 15 months analyzed, the average cost for non-preferred proton pump inhibitors was approximately \$100, compared to \$57 for preferred, and the average per-class cost for non-preferred non-steroidal anti-inflammatory drugs was approximately \$53, compared to \$8 for preferred. When combined, the average cost of non-preferred drugs for the four classes analyzed was almost twice that of preferred drugs. Appendix A shows the significant differences in average prices for the four classes analyzed between preferred and non-preferred drugs, paid for between January 1, 2003 and March 31, 2004.

\$9.4 Million in Savings Identified For Mental Health Drugs

Our analysis also found the department could have saved approximately \$9.4 million in total funds between January 1, 2003 and March 31, 2004, had antidepressant and atypical antipsychotic class drugs been added to the Plan Drug List in a form similar to West Virginia's evidence-based approach, and had the state achieved 90 percent utilization for antidepressant class drugs and 85 percent utilization for atypical antipsychotic class drugs.

All mental health drugs accounted for nearly 50 percent of Medicaid fee-for-service prescription drug costs between January 1, 2003 and March 31, 2004. During the 15 months analyzed, the department paid for 1.1 million prescriptions for antidepressant and atypical antipsychotic class drugs. These included prescriptions for both the fee-for-service program and the Managed Care Plans, since antidepressant and atypical antipsychotic therapeutic class drugs are "carved out" of the

Managed Care Plans. The total cost for these prescriptions, after the required Medicaid rebate was approximately \$91 million in total funds. These mental health drugs accounted for 41 percent of all fee-for-service prescription drugs costs during this time period.

Because Oregon currently excludes mental health drugs from its Plan Drug List, we used the preferred antidepressant and atypical antipsychotic class drugs listed on West Virginia's evidence-based, Medicaid Preferred Drug List (dated September 1, 2004) to calculate potential savings. West Virginia's preferred drug list included a total of 12 preferred antidepressant class drugs, and four atypical antipsychotic class drugs.

Our savings calculation was based on the average price paid in Oregon for those same drugs. Had preferred antidepressant class drugs been paid for 90 percent of the time, and had preferred atypical antipsychotic class drugs been paid for 85 percent of the time Oregon's total cost could have been reduced to approximately \$81.6 million in total funds, generating a savings of nearly \$9.4 million in total funds (10 percent).

On Average, Non-Preferred Mental Health Drugs are More Expensive Than Preferred Drugs

In applying West Virginia's preferred drug list to Oregon's claims, we found for our audit period that non-preferred mental health drugs represented just 29 percent of the claims but 42 percent of the costs. (See Appendix B for details.)

Specifically, we found that for two of the three mental health class drugs analyzed, the average cost of non-preferred drugs was significantly higher than the average cost of preferred drugs. For example, as shown in Appendix B,

the average cost per claim for non-preferred atypical antipsychotics was approximately \$233, whereas the average cost per claim for preferred atypical antipsychotics was \$123. When combined, the average cost of non-preferred antidepressant and atypical antipsychotic class drugs was almost twice that of preferred.

Supplemental Rebates Provide Additional Savings

In addition to direct savings resulting from utilization of preferred drug lists with prior authorization requirements, several states have reported additional savings from supplemental rebates offered by drug manufacturers. Supplemental rebates are in addition to the required Medicaid rebate, and generally involve the inclusion of the manufacturer's drug in a state's preferred drug list in exchange for the manufacturer's provision of a supplemental rebate to the state. Currently, Oregon cannot guarantee a significant market shift to preferred drugs because the Plan Drug List is voluntary. Thus, Oregon's ability to negotiate additional supplemental rebates is diminished.

In September 2002, the Centers For Medicare and Medicaid Services (CMS) endorsed the use of prior authorization programs as a means to encourage drug manufacturers to enter into separate or supplemental rebate agreements for covered drugs purchased by Medicaid recipients.⁴ CMS officials said that a prior authorization program used to negotiate drug discounts for the Medicaid program is consistent with the paramount purpose of Medicaid's drug rebate provision, which is to reduce the costs to the Medicaid program for prescription drugs.

⁴ CMS is the federal agency that works in partnership with the states to administer Medicaid.

Supplemental rebates can be negotiated directly between the state and drug manufacturers, or can be negotiated on behalf of the state by a Prescription Benefit Manager or Administrator, as with the case of the Michigan Multi-State Prescription Drug Initiative. At the time of its approval by the U.S. Department of Health and Human Services in April 2004, this multi-state purchasing pool included Michigan, Vermont, New Hampshire, Alaska, and Nevada. The goal of a purchasing pool such as this one is to increase the bargaining power with drug manufacturers in order to leverage better pricing and supplemental rebate revenue. Oregon law permits the department to join a multi-state purchasing pool, but without prior authorization requirements in place Oregon cannot join a purchasing pool.

Although we were not able to estimate Oregon's potential supplemental savings, the following are examples of supplemental savings reported by other states:

- Washington Medicaid officials reported a cost savings of \$12 million during fiscal year 2003 from the implementation of their preferred drug list with a prior authorization requirement, and an additional savings of \$1.1 million, during October 2002 through March 2004, from supplemental rebates from drug manufacturers.
- Michigan Medicaid officials reported the state saved an additional \$8 million in 2003 from supplemental rebates received after beginning the Multi-State Prescription Drug Initiative. The \$8 million in supplemental savings was in addition to \$32 million saved by implementing a prior authorization process for non-preferred drugs.

We recommend the Department of Human Services work with the Oregon Legislature, the Office of the Governor, and other interested parties to introduce legislation that:

- Allows the addition of antidepressant and atypical antipsychotic class drugs to the Plan Drug List.
- Requires prior authorization of medically appropriate or necessary drugs not on the Plan Drug List.

Agency's Response:

Thank you for the review and recommendations contained in your report entitled Medicaid Fee-For-Service Prescription Drug Cost Savings Analysis. The Department of Human Services (DHS) agrees with the findings of this audit. These findings are consistent with the Department's experience in operating the Medicaid pharmacy program. The Department has included cost savings associated with these actions in the Governor's Recommended Budget (GRB). The results from this report should inform the decision making process of developing OHP prescription drug policy.

If the statutory changes needed to implement these actions do become law, it is important to keep in mind the impact of the new Medicare drug benefit, Part D, created by the Medicare Modernization Act. Beginning January 1, 2006 the Medicare drug benefit will cover dual eligible OHP clients and the state will reimburse the federal government for a portion of the cost to cover these clients using a federally determined formula. This means the state will not be able to manage the cost of providing drug coverage for these 50,000 clients, resulting in a significant reduction in the estimate of savings identified in the Secretary of State's audit report. (Note: The impact of the Medicare drug benefit is included in the GRB.)

The Department will continue to work with the Legislative Assembly and the Governor on initiatives that position the Department to achieve the cost savings you have identified.

Other Matters

Medicare Part D Will Reduce Purchasing Power For Medicaid

Effective January 1, 2006, Medicaid clients eligible for both Medicaid and Medicare (dual eligibles) will receive prescription drug coverage primarily through the new federal Medicare Prescription Drug Act. The department estimates approximately 50,000 of Medicaid clients served by both Managed Care Plans and the fee-for-service program will shift to the new federal program. As of February 15, 2005, we were unable to determine the total impact on the fee-for-service program.

Objectives, Scope and Methodology

The purpose of the audit was to determine whether opportunities exist to reduce the cost of Oregon's Medicaid fee-for-service prescription drugs.

We analyzed Medicaid fee-for-service prescription drug claims provided by the department for January 1, 2003 through March 31, 2004. We also analyzed Medicaid fee-for-service prescription drug rebates provided by First Health

Services Corporation for the same time period. Prescription drug claims and rebate data for mental health drugs were analyzed for both the fee-for-service program and the Managed Care Plans. We performed preliminary analysis of Medicaid fee-for-service prescription drug claims and drug rebates used in our analysis and determined they were sufficiently reliable for our audit purposes. We compared drug claim totals to totals from a separate reporting system and found the totals to be reasonable. We also reviewed two Service Audit Reports that concluded First Health Services' system controls were adequate to meet their control objectives.

For the cost-savings analysis of the long-acting opioids, non-steroidal anti-inflammatory drugs, proton pump inhibitors, and statin drug classes, we calculated what the department could have saved between January 1, 2003 and March 31, 2004, had physicians prescribed preferred drugs 90 percent of the time. The savings were calculated by subtracting what could have been paid with 90 percent utilization from what was actually paid.

For the cost-savings analysis of the antidepressant and atypical antipsychotic class drugs, we calculated what the department could have saved between January 1, 2003 and March 31, 2004 had physicians prescribed preferred antidepressant class drugs 90 percent of the time, and atypical antipsychotic class drugs 85 percent of the time. Because

Oregon law does not permit the inclusion of mental health drugs on the Plan Drug List, we used the preferred antidepressant and atypical antipsychotic drugs listed on West Virginia's Medicaid Preferred Drug List (dated September 1, 2004) for our cost savings analysis. The savings was calculated by subtracting what could have been paid had preferred drugs been paid for 90 percent and 85 percent of the time, from what was actually paid. All drug costs and savings reported include both federal and state costs and savings.

We reviewed federal regulations, and Oregon statutes and rules governing the Medicaid prescription drug program including those relating to Medicaid drug rebates. In order to identify best practices and cost saving methods, we reviewed published studies and audit reports on the subject matter. We also contacted pharmacy benefit managers in several other states, as well as Managed Care Plans in Oregon to obtain information about best practices and savings. We also interviewed department officials, physicians, and pharmacists to gain an understanding of current and best practices.

We conducted our fieldwork during the period of May 2004 through October 2004. We conducted our work according to generally accepted government auditing standards.

**Appendix A:
Comparison of Preferred and Non-Preferred Drug Claims and Costs
Oregon's Plan Drug List - Four Original Therapeutic Classes
(January 1, 2003 through March 31, 2004)**

	Total Drug Claims	Total Cost	Avg. Cost Per Claim	% of Total Claims	% of Total Cost
<u>Long Acting Opioids</u>					
Preferred Drugs	44,167	\$3,797,316	\$85.98	63%	51%
Non-Preferred Drugs	25,578	\$3,712,791	\$145.16	37%	49%
Total	69,745	\$7,510,107			
<u>Non-Steroidal Anti-Inflammatory Drugs</u>					
Preferred Drugs	75,279	\$571,670	\$7.59	66%	22%
Non-Preferred Drugs	38,576	\$2,052,420	\$53.20	34%	78%
Total	113,855	\$2,624,090			
<u>Proton Pump Inhibitors</u>					
Preferred Drugs	46,434	\$2,626,649	\$56.57	81%	71%
Non-Preferred Drugs	10,733	\$1,072,540	\$99.93	19%	29%
Total	57,167	\$3,699,189			
<u>Statins</u>					
Preferred Drugs	59,140	\$2,867,830	\$48.49	66%	62%
Non-Preferred Drugs	30,113	\$1,764,328	\$58.59	34%	38%
Total	89,253	\$4,632,158			
<u>Summary of the Four Classes</u>					
Preferred Drugs	225,020	\$9,863,466	\$43.83	68%	53%
Non-Preferred Drugs	105,000	\$8,602,079	\$81.92	32%	47%
Total	330,020	\$18,465,545			

**Appendix B:
Comparison of Preferred and Non-Preferred Drug Claims and Costs
for Atypical Antipsychotics and Antidepressant Class Drugs
(January 1, 2003 through March 31, 2004)**

	<u>Total Drug Claims</u>	<u>Total Cost</u>	<u>Avg. Cost Per Claim</u>	<u>% of Total Claims</u>	<u>% of Total Cost</u>
<u>Atypical Antipsychotics</u>					
Preferred Drugs	207,282	\$25,583,847	\$123.43	64%	49%
Non-Preferred	116,746	\$27,164,090	\$232.68	36%	51%
Total	324,028	\$52,747,938			
<u>Antidepressants, Non-SSRIs</u>					
Preferred Drugs	212,371	\$6,710,388	\$31.60	62%	50%
Non-Preferred Drugs	131,614	\$6,646,719	\$50.50	38%	50%
Total	343,985	\$13,357,106			
<u>Antidepressants, SSRIs</u>					
Preferred Drugs	386,702	\$20,919,432	\$54.10	84%	84%
Non-Preferred Drugs	75,384	\$3,960,563	\$52.54	16%	16%
Total	462,086	\$24,879,995			
<u>Summary of the Three Classes</u>					
Preferred Drugs	806,355	\$53,213,667	\$65.99	71%	58%
Non-Preferred Drugs	323,744	\$37,771,372	\$116.67	29%	42%
Total	1,130,099	\$90,985,039			



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*The courtesies and cooperation extended by the officials
and staff of the Department of Human Services were
commendable and much appreciated.*

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