2009 WL 1867146 (Ala.) (Appellate Brief)
Supreme Court of Alabama.

ASTRAZENECA PHARMACEUTICALS LP and Astrazeneca LP, Defendants/Appellants,
v.
STATE OF ALABAMA, Plaintiff/Appellee.

Nos. 1071439, 1071440.
March 6, 2009.

On Appeal From The Circuit Court Of Montgomery County, (CV-2005-219.10 & .11)

Brief of AARP As Amicus Curiae Supporting State of Alabama/Appellee

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*1 STATEMENT OF INTEREST

AARP is a nonpartisan, nonprofit membership organization for people 50 and over, with 40 million members, including 513,000 members in Alabama. AARP works to ensure that all Americans have access to affordable, quality health and long-term care, and to control health care costs without compromising quality.

AARP supports Alabama's efforts to protect its Medicaid funds because strengthening Medicaid is an essential foundation of the nation's health care system, serving approximately 59 million vulnerable persons, or one in six of the nation's population. Medicaid is also the largest payer for long-term care and is critical in redirecting care to the often more cost-effective home and community-based settings that older Americans prefer. Thus, although older and disabled persons make up just one-quarter of Medicaid enrollees, they account for 70 percent of Medicaid spending.

Medicaid provides essential assistance to more than six million “dual eligible” low-income Medicare beneficiaries who tend to have greater health care needs. Accordingly, AARP encourages states to exercise available options for ***2** expanding Medicaid eligibility and services and to ensure the highest level of Medicaid participation among all health care providers.

In addition, AARP has a strong interest in this case because ensuring that prescription medications are affordable is especially important to older people who have the highest rate of prescription drug use as a result of their higher rate of chronic and serious health conditions. Because prescription drug spending has skyrocketed over the last fifteen years, thereby limiting access to medically necessary medicines for many people, AARP advocates for policies, laws, and other efforts that broaden access to affordable prescription drugs.

SUMMARY OF ARGUMENT

The Medicaid program plays a critical role in our country's health care system since it provides health care coverage and long-term care assistance to about 45 million people in low-income families, and about 14 million elderly and disabled people.

In Alabama, Medicaid is a critical safety net and the main source of health care insurance for approximately one million Alabamans. Alabama's Medicaid program provides ***3** life saving and sustaining services to many of the state's most vulnerable and needy persons. For example, 38 percent of Alabama's children depend on Medicaid for healthcare coverage; 71 percent of Alabama's nursing home residents living in participating facilities are Medicaid eligible; more than 14,000 older and disabled individuals receive long-term care assistance through one of six Alabama home and community-based waiver programs; and, Alabama Medicaid pays for over seven million prescriptions a year.

Besides ensuring care for individuals, the Medicaid program is essential to the economy in that it pays for one-sixth of all health care spending in the U.S. In Alabama, for example, Medicaid expenditures support thousands of jobs, including physicians, nurses, office staff, and others.

Notwithstanding the expansiveness of Alabama's program, the State is not able to provide needed services to thousands of people.

Therefore, Alabama, along with many other states, is striving to preserve its precious Medicaid funds in order to fulfill its obligation to ensure that the State's most vulnerable population receive essential health and longterm ***4** care services. This is especially true today because the need for Medicaid coverage is growing nationwide due to the current economic crisis and the competing demands on states' budgets.

Alarmingly, the difficulties states face today from budget shortfalls are likely to worsen in the near future because Medicaid enrollment and expenditures are expected to accelerate through 2009. When the economy falters, demand for Medicaid grows as individuals lose their jobs and job-based health coverage and incomes decline. Consequently, many states are considering slashing components of their Medicaid programs to fill the gap. Cutting Medicaid services, however, will have dire consequences for the nation's poorest and most chronically ill children and older persons.

Prescription drugs with their skyrocketing prices are contributing to the strain on states' Medicaid budgets, while simultaneously creating access challenges for other non-Medicaid individuals. Alabama Medicaid has experienced a sharp increase in the amount it pays for prescription drugs in recent years. Before 1990, Alabama's Medicaid ***5** drug cost was $60 million, whereas in 2007, the State paid $409 million.

With the high price of prescription drugs, a significant number of people, including Medicaid eligible recipients, did not fill prescriptions, skipped doses, or cut pills in half because they could not afford to pay for their medications. Even nominal co-payments, such as Alabama requires, discourage some Medicaid beneficiaries from filling their prescriptions. Lower utilization of needed medications among chronically ill persons results in increased hospital and nursing home admissions, and increased mortality rates. As the devastating effects of explosive prices and spending increases have ravaged Medicaid funds and the chronically ill, the pharmaceutical corporations have reaped significant financial benefit.

In sum, spiraling pharmaceutical price inflation has a devastating effect on not only state Medicaid budgets and recipients, but also countless people who rely on prescription drugs for their survival and well-being.

*6 ARGUMENT

I. MEDICAID PROVIDES ESSENTIAL HEALTH AND LONG-TERM CARE SERVICES TO MILLIONS OF LOW-INCOME AND OLDER AMERICANS, INCLUDING ONE MILLION PEOPLE IN ALABAMA.

The Medicaid program plays a critical role in our country's health care system. [1] Most importantly, it provides health care coverage and long-term care assistance to about 45 million people in low-income families, and about 14 million elderly and disabled. Vernon Smith, et al., Kaiser Commission on Medicaid and the Uninsured, *Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2008 and 2009* (2008), *available at* http://www.kff.org/medicaid/upload/7815.pdf (referred to as "Smith, *Headed for a Crunch*"). The Medicaid statute and implementing regulations require that medical services be provided to beneficiaries at least to the extent that those services are available to the ***7** general population living in the same geographic area. 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.204; see *Clark v. Kizer*, 758 F. Supp. 572, 575 (E.D. Cal. 1990), *aff'd in relevant part, rev'd on other grounds*, 967 F.2d 585 (9th Cir. 1992). [2]

Medicaid is also vital in sustaining long-term care for the nation's elderly and disabled. Although older and disabled persons make up just one-quarter of Medicaid enrollees, they account for 70 percent of Medicaid spending. Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance*, fig. 2 (2008), *available at* http://www.kff.org/medicaid/upload/7235_03-2.pdf. Older people are the primary users of long-term services and supports because functional disability increases with advancing age creating this enrollment spending disparity.

Medicaid pays for more than half of all nursing home care. Smith, *Headed for a Crunch, supra*. In addition to providing long-term care in institutional settings such as nursing homes, Medicaid pays for long-term care services in ***8** home and community-based settings. For instance, in 2005, spending for home based health care totaled $77 billion, of which Medicaid provided 55 percent of the funding. Ari N. Houser, AARP Public Policy Institute, *Long-Term Care Research Report* (2007), *available at* http:// assets.aarp.org/rgcenter/il/fs27r_ltc.pdf. Because older and disabled persons overwhelmingly prefer to receive long-term care in their own home or a community setting, spending on Medicaid funded home and community-based services (HCBS) has been growing. Thus, from 2001 to 2006, Medicaid spending for HCBS increased by $6.1 billion. Enid Kassner, et al., AARP Public Policy Institute, *A Balancing Act: State Long-Term Care Reform Research Report* (2008), *available at* http:// assets.aarp.org/rgcenter/il/2008_10_ltc.pdf.

Medicaid is responsible for paying a variety of Medicare related expenses for low-income persons age 65 years and older, such as premiums and cost sharing expenses. Furthermore, Medicaid provides coverage during the waiting period for low-income individuals with disabilities under age 65 who must wait 29 months from the date of disability onset before receiving Medicare. Kaiser ***9** Commission on Medicaid and the Uninsured, Policy Brief, *Short Term Options for Medicaid in Recession*, 3 (2008), *available at* http:// www.kff.org/medicaid/upload/7843.pdf (referred to as "Kaiser, *Short Term Options for Medicaid in Recession*").

In 2006 Medicaid paid a 26 percent share of prescription drug costs.[3] Kaiser Family Foundation, *Prescription Drug Trends* fig. 3 (2008), *available at* http://www.kff.org/rxdrugs/upload/3057_07.pdf. All state Medicaid programs provide coverage for prescription drugs, although there are many differences in how the states implement the programs. *Id*. States also finance a portion of Medicare coverage for prescription drugs for individuals who are dually eligible for Medicare and Medicaid through a payment to the federal government referred to as the "clawback." *Id*.

In Alabama, Medicaid is a critical safety net and the main source of health care insurance for approximately one ***10** million Alabamans. In fiscal year 2007, Alabama Medicaid paid $4.4 billion to healthcare providers. In addition, Alabama's Medicaid program continues to make available life saving and sustaining services to many of the state's most vulnerable and needy persons. For example:

• Nearly half of all births in the state, or approximately 30,000 births each year, are paid for by Medicaid;

• 38 percent of Alabama's children depend on Medicaid for healthcare coverage;

• 12.8 percent of Alabama's elderly residents are Medicaid eligible;

• 71 percent of Alabama's nursing home residents living in participating facilities are Medicaid eligible;

• More than 14,000 elderly and disabled individuals receive long-term care assistance through one of six Alabama home and community-based waiver programs; and

• Alabama Medicaid pays for over 7 million prescriptions a year.

Testimony of Carol H. Steckel, AL Medicaid Commissioner, before the Joint AL Leg. Budget Comm., *AL Medicaid Budget Presentation* (Jan. 15, 2009), http:// www.medicaid.state.al.us/documents/News/Special_Presentations/Budget_ Presentation_1-15-09.pdf (referred to as "Steckel, *AL Medicaid Budget Presentation")*.

***11** In fiscal year 2008, Alabama Medicaid paid over $8.4 million in Medicare Part A premiums for approximately 1,839 individuals; and over $218 million in Medicare Part B premiums for approximately 214,762 individuals. Alabama Medicaid Agency, *A Medicaid Primer* (2009), *available at* http:// www.medicaid.alabama.gov/documents/apply/2A-General/2A-4_What_is_Medicaid_2-13-09.pdf.

Besides ensuring care for individuals, the Medicaid program is essential to the economy in that it pays for one-sixth of all health care spending in the U.S. Smith, *Headed for a Crunch, supra*. For example, the impact of the Medicaid program in Alabama extends to Medicaid certified providers who depend on the Medicaid program to pay staff and overhead. Medicaid expenditures in Alabama support thousands of jobs - physicians, nurses, office staff, and others. Steckel, *AL Medicaid Budget Presentation, supra*. The federal government matches Alabama's Medicaid expenditures at approximately 68 percent, and these funds pay the salaries of thousands of health care workers who buy goods and services and pay taxes in Alabama. Kaiser Family Foundation, *Alabama: Waiting Lists for Medicaid* ***12** *1915(c) Home and Community-Based Waivers, at* 17 (2007), *available at* http://www.statehealthfacts.org/profileind.jsp? ind=247&cat=4&rgn=2 (referred to as "Kaiser, *Alabama: Waiting Lists for Medicaid Waivers"*).

II. ALABAMA MEDICAID NEEDS FUNDS NOW MORE THAN EVER IN ORDER TO PROTECT THE STATE'S MOST VULNERABLE POPULATION.

Notwithstanding the expansiveness of Alabama's program, the State is not able to provide needed services to thousands of people. For example, there are approximately 2000 elderly and disabled persons in Alabama waiting for services under the state's Medicaid-funded home and community-based waiver programs. *Id*.

Therefore, Alabama, along with most other states, is striving to preserve its precious Medicaid funds in order to fulfill its obligation ensuring that the State's most vulnerable population receives essential health and long-term care services. This is especially true today because the need for Medicaid coverage is growing nationwide due to the current economic crisis and the competing demands on states' budgets. Specifically, as tax revenues are continuing to decline, scores of states, including Alabama, are currently reporting budget shortfalls. Kaiser ***13** Commission on Medicaid and the Uninsured, *Few Options for States to Control Medicaid Spending in a Declining Economy* 7, fig. 6 (2008), *available at* http://www.kff.org/medicaid/upload/7769.pdf.

"States are facing fiscal conditions not seen since the Great Depression -- anticipated budget shortfalls are expected in excess of $200 billion." News Release, *National Governors Association Statement Regarding American Recovery and Reinvestment Plan* (Jan. 27, 2009), http:// www.nga.org/portal/site/nga/menuitem.6c9a8a9ebc6ae07eee28aca9501010a0/?vgnextoid=fa7903271071f110VgnVCM1000005e00100aRCRD&vgnextchannel=759b8f2005361010VgnVCM1000001a01010aRCRD. In the months between November 2008 and January 2009, more states have identified gaps in their budgets and the amount of the cumulative gap for all states grew to $47.4 billion. National Conference on State Legislatures, *Update on State Budget Gaps: FY 2009 & 2010* (2009), *available at* http:// www.ncsl.org/programs/pubs/statebudgetgaps.pdf.

Alarmingly, the difficulties states face today because of budget shortfalls are likely to worsen in the near future because Medicaid enrollment and expenditures are ***14** expected to accelerate through 2009, as is typically seen in a recession. Andrea Sisko, et al., Ctrs. for Medicaid and Medicare Servs., *Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook*, Health Aff. 28, no. 2, (2009), *available at* http:// content.healthaffairs.org/cgi/reprint/hlthaff.28.2.w346v1. This trend was recently observed when 16 of 40 states surveyed reported that they had at least a five percent increase in enrollment over the past 12 months and that the growth rate has doubled in many states from what it was in the previous year. Kevin Sack & Katie Zezima, *Growing Need for Medicaid Strains States*, N.Y. Times, Jan. 21, 2009, http://www.nytimes.com/2009/01/22/us/22medicaid.html.

"Medicaid enrollment and spending rise during economic downturns just as state revenues fall. Estimates show that a one percentage point increase in the national unemployment rate translates to a one million person increase in Medicaid . . . enrollment as individuals lose jobs and job-based health insurance." Kaiser, Short *Term Options for Medicaid in a Recession, supra* at 3. When the economy falters, demand for Medicaid grows as individuals ***15** lose their jobs and job-based health coverage, and incomes decline.

Because Medicaid represents 17 percent of most states' budgets (second only to education budgets), many states have discussed slashing components of their Medicaid programs to fill the gap.[4] Julie Appleby, *States Forced To Cut Health Coverage For Poor*, USA Today, Oct. 29, 2008, *available at* http:// www.usatoday.com/news/health/2008-10-28-health-cuts_N.htm.

Cutting Medicaid services, however, when the number of people living in poverty in the U.S. is growing, will have dire consequences for the nation's poorest and most chronically ill children and older persons. In 2007, 4.4 million more Americans were poor, the median income of non-elderly households was $1,100 lower, and nearly six million more Americans were uninsured than in 2001. Ctr. on Budget ***16** and Policy Priorities, Statement by Robert Greenstein, Ex. Dir., *On the New Census Bureau Data on Poverty, Income, and Health Insurance* (Aug. 2008), *available at* http://www.cbpp.org/8-26-08pov-stmt.pdf. The expectation for the coming years is increasingly bleak, "and poverty is almost certainly higher now -- and incomes lower -- than in 2007." *Id*.

With so much pressure to balance state budgets and meet the needs of newly unemployed people in each state, there is great need for states, including Alabama, to ensure that the Medicaid program is protected from fraud, waste, and abuse.

III. BRAND NAME PRESCRIPTION DRUG PRICE INFLATION EXCEEDS THE GENERAL INFLATION RATE WHILE PHARMACEUTICAL INDUSTRY PROFITS SOAR.

Brand name prescription drug prices have skyrocketed in recent years. For example, in the first half of 2008, the average wholesale price of 17 brand-name drugs increased 100 percent or more in a single cost adjustment. Madeline Ellis, Cost *of Prescription Medications Rising*, Health News (2008), *available* at http://www.healthnews.com/alerts-outbreaks/cost-prescription-medications-rising-1560.html. Consequently, spending in the U.S. for prescription drugs ***17** was $216.7 billion in 2006, more than five times the $40.3 billion spent in 1990. Kaiser Family Foundation, *Prescription Drug Trends* 1 (2008), *available at* http://www.kff.org/rxdrugs/upload/3057_07.pdf.

In 2006, manufacturers' price increase for 193 brand-name drugs widely used by older persons, on average, was 6.2 percent -- more than one-and-a-half times the general inflation rate of 3.7 percent. The steep price increases in 2006 followed six consecutive years in which manufacturers' price increases were often double and sometimes triple the Consumer Price Index, sending cumulative increases far higher than inflation. AARP Rx Watchdog Report, Prices *of Brand-Name Drugs Continue Their Steep Rise Generic Prices Show Slight Decline* (Jan./ Feb. 2007), *available at* http://assets.aarp.org/www.aarp.org_/cs/misc/watchdog_ january_07.pdf; AARP Rx Watchdog Report, *Brand-Name Drug Prices Climb Again in 2006 List Prices of Generics Decline* (Mar. 2007), *available at* http:// assets.aarp.org/www.aarp.org_/cs/elec/watchdog_march_2007.pdf (referred to as "AARP, *Brand Name Drug Prices Climb Again"); see also* Ron Pollock & Lena O'Rourke, ***18** Families USA, Off *the Charts: Pay, Profits and Spending by Drug Companies* (2001), *available at* http:// www.familiesusa.org/assets/pdfs/offthecharts6475.pdf.

The cumulative effect of these relentless prescription drug increases is heightened due to the number of people with chronic illness taking multiple medications for many years. For example, in the above noted 2007 AARP Rx Watchdog Report, of the 153 drugs studied, providers prescribed 147 of them to treat chronic conditions. This means that millions of Americans take these drugs regularly over a long period for conditions such as high cholesterol, high blood pressure, diabetes, and osteoporosis. The average cost of a year's treatment using one of these drugs was $368 more at the end of the seven-year study period than at the beginning. But since the typical older person uses four prescription drugs to treat chronic conditions, the average cost of therapy for an individual over the seven-year period went up $1,472 (assuming the drugs were brand-name products and the manufacturers' price increases were passed on). AARP, *Brand-Name Drug Prices Climb Again, supra* at 1-2. ***19** As these explosive price and spending increases have occurred, the corporations that make brand-name prescription drugs have reaped significant financial benefits. From 1995 to 2002, pharmaceutical manufacturers were the nation's most profitable industry (profits as a percent of revenues). They ranked third in profitability in 2003 and 2004, fifth in 2005, second in 2006, and third in 2007, with profits of 15.8 percent compared to 5.7 percent for all Fortune 500 firms in 2007. Prescription drug sales were $286.5

billion in 2007, an increase of 3.8 percent over 2006. Kaiser Family Foundation, *Prescription Drug Trends*, 3 (September 2008), *available at* http:// www.kff.org/rxdrugs/upload/3057_07.pdf.

IV. SPIRALING DRUG SPENDING HAS CAUSED ALABAMA AND OTHER STATE MEDICAID AGENCIES TO IMPOSE RESTRICTIONS THAT LEAD TO WORSE HEALTH OUTCOMES AND INCREASED RISK OF INSTITUTIONALIZATION.

Alabama Medicaid, which pays for over seven million prescriptions a year, has experienced a sharp increase in the amount it pays for prescription drugs in recent years. For example, before 1990, Alabama's Medicaid drug cost was $60 million, whereas in 2007, the State paid $409 million. Steckel, *AL Medicaid Budget Presentation*, *supra*. This dramatic increase is due in part to the expansion of drugs ***20** covered in the State's program, but indisputably also due to the rapidly rising costs of drugs.

States, including Alabama, have responded to declining overall budgets and increasing Medicaid drug costs by implementing a variety of cost-saving policies. By 2007, most states implemented such cost containment policies. Kaiser, *Prescription Drug Trends*, *supra* at 4.[5] Many states have begun limiting use of expensive medications, adopting preferred drug lists (PDLs), requiring prior authorization before reimbursement of specific drugs, increasing cost sharing for Medicaid enrollees, instituting "fail first" requirements (that an alternative, inexpensive drug be tried before an expensive one), and imposing drug category reimbursement exclusions. Stephen B. Soumerai, *Benefits and Risks of Increasing Restrictions on Access to Costly-Drugs in Medicaid, Medicaid Drug Costs*, 23 Health Aff. 135-146 (2004) (referred to as "Soumerai, *Benefits and Risks of Increasing Restrictions"*).

***21** In Alabama, the state Medicaid program requires beneficiary co-payments ranging from 50 cents to $3.00 per prescription, uses a Preferred Drug List, and requires prior authorization for certain drugs. Steckel, *AL Medicaid Budget Presentation*, *supra*. Even moderate drug cost sharing, however, reduces use of essential medications among low-income and elderly populations, increases hospital and nursing home admissions, and increases mortality. *Id.; see also* Kaiser Commission on Medicaid and the Uninsured, Policy Brief, *Medicaid and the Prescription Drug Benefit Cost Containment Strategies and State Experiences*, 11 (2002), *available at* http://www.kff.org/medicaid/loader.cfm?url=/ commonspot/security/getfile.cfm&PageID=14138 (finding that even nominal co-payments might discourage some poor Medicaid beneficiaries from filling their prescriptions, particularly patients taking several drugs).

Policies restricting access to particular medications or capping the number of medications people can receive have especially detrimental effects on the chronically ill and disabled population. Soumerai, *Benefits and Risks of Increasing Restrictions*, *supra* at 136. For example, limits ***22** on the number of Medicaid prescriptions reimbursed for chronically ill and disabled people resulted in a 35 percent reduction in the use of clinically essential drugs (such as insulin), increased illness, and led to a 200 percent increase in the use of services such as nursing homes, whose costs exceeded the cost of drugs. *Id.*

Thus, there are unintended harmful consequences that result when states, including Alabama, must implement pharmaceutical usage restrictions as a mechanism to reduce the burden of spiraling prescription drug costs on state budgets.

V. HIGH PRICES FOR PRESCRIPTION DRUGS HAVE SERIOUS, HARMFUL CONSEQUENCES FOR MILLIONS OF AMERICANS.

Countless Americans, who are not Medicaid recipients, also have difficulty paying for their prescription medication. More than 54 percent of Americans say they currently take prescription medicines, including 50 percent who take them daily. One in five or 19 percent say they take four or more prescription drugs daily. Not surprisingly, prescription drug use is most common among the elderly and those in poor health. Testimony of Donald B. Marron, Acting Director, Cong. Budget Office, before U.S. the Senate Special Comm. on Aging, *Medicaid Spending* ***23** *Growth and Options for Controlling Costs* (July 13, 2006), *available at* http://www.cbo.gov/ftpdocs/73xx/doc7387/07-13-Medicaid.pdf (referred to as "Marron, *Medicaid Spending Growth*").

The number of children and working-age Americans who went without a prescribed medication because they could not afford to fill their prescription increased from 10.3 percent in 2003 to 13.9 percent in 2007. Because having at least one chronic condition more than doubles the likelihood of individuals not obtaining their needed prescription drugs, the most sick suffer the harshest consequences. Laurie E. Felland & James D. Reschovsky, Center for Studying Health System Change, *More Non-elderly Americans Face Problems Affording Prescription Drugs*, 1-3 (2009), *available at* http:// www.hschange.com/ CONTENT/1039/. A number of factors contributed to this trend including rising drug prices, expensive new specialty drugs, physicians prescribing more drugs, and less drug coverage. *Id*. at 1-4.

In 2006, the Congressional Budget Office (CBO) reported that a significant number of people were having difficulty paying for prescription drugs. Many did not fill ***24** prescriptions, skipped doses, or cut pills in half because they could not afford to pay for their prescribed medications. Marron, *Medicaid Spending Growth*, *supra*. Problems paying for prescription drugs are most common among those who take larger numbers of medications, those who do not have insurance, and those with lower incomes. *Id*.

Medicare Part D beneficiaries, who are age 65 and older or who have certain disabilities, decreased their drug usage by about 14 percent per month when they lacked prescription drug coverage due to Part D's coverage gap or when they anticipated reaching the coverage gap, commonly referred to as the "doughnut hole." Yuting Zhang, et al., *The Effects of the Coverage Gap on Drug Spending: A Closer Look at Medicare Part D*, Health Aff. (2009), http:// content.healthaffairs.org/cgi/content/abstract/ hlthaff.28.2.w317. Medicare Part D beneficiaries are more likely to reach the doughnut hole when they suffer from at least one chronic illness. For example, beneficiaries with diabetes often reach the coverage gap every year. *Id*.; *see also*, Sebastian Schneeweiss, et al., *The Effect of Medicare Part D Coverage on Drug Use and Cost Sharing Among Seniors* ***25** *Without Prior Drug Benefits*, Health Aff. (2009), *available at* http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.2.w305v1 (finding that patients reaching the Part D coverage gap experienced a decrease in essential medication use ranging from 5.7 percent per month for the blood-thinning drug, warfarin, to 6.3 percent for statins, drugs that lower cholesterol).

Similarly, Medicare beneficiaries who had a $1,000 limit on what they could spend on their prescription drugs took fewer drugs over the year and had more unfavorable health outcomes compared with people whose drug benefits were not capped. In patients with chronic disease, a drug-benefit cap was associated with poorer adherence to drug therapy and poorer control of blood pressure, cholesterol, and blood sugar. In addition, beneficiaries whose benefits were capped had higher rates of visits to the emergency department, hospitalizations, and death. John Hsu, et al., Unintended *Consequences of Caps on Medicare Drug Benefits*, 354 New Eng. J. Med. 2249 (2006).

In sum, spiraling pharmaceutical price inflation has a devastating effect on not only state Medicaid budgets and ***26** recipients, but also countless people who rely on prescription drugs for their survival and well-being.

CONCLUSION

For the foregoing reasons, AARP urges this Court to uphold the lower court's judgment and verdict in this case.

Footnotes

1 The Medicaid program is administered by the states, but funded jointly by both state and federal governments. Centers for Medicare and Medicaid Services, Medicaid Program - Technical Summary (Dec. 14, 2005), *available at* http://www.cms.hhs.gov/ MedicaidGenInfo/03_TechnicalSummary.asp#TopOfPage. The general purpose of Medicaid is to "ensure adequate access and quality of care" by both institutional and non-institutional providers. *Arkansas Medical Society v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993).

2 A state's failure to provide a certain level and quality of care can result in revocation of federal funds. 42 C.F.R. § 430.35; *See also* 42 U.S.C. § 1396; *Antrican v. Odom*, 290 F.3d 178, 191 (4th Cir. 2002), *cert. denied*, 537 U.S. 973 (2002).

3 This percentage reflects the reduced state expenditures for prescription drugs that resulted after Medicare Part D coverage began in 2006, when Medicare added prescription drug coverage for beneficiaries dually eligible for both Medicaid and Medicare. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173 (Dec. 8, 2003), 42 U.S.C.A. § 1395w-101 et seq. (2004 supplement), 42 C.F.R. §423.506.

4 Although Alabama Medicaid may receive approximately $850 million dollars as part the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. 111-5 (Feb. 17, 2009), ("Stimulus Bill"), the state's ability to provide Medicaid to all who are in need will continue to be a challenge due to increasing numbers of uninsured people, fewer people with private health insurance coverage, and a larger Medicaid population. Iris J. Lav, et al., Ctr. on Budget and Policy Priorities, *Recovery Act Provides Much-Needed, Targeted Medicaid Assistance To States* (Feb. 13, 2009), *available at* http:// www.cbpp.org/2-13-09sfp.htm.

5 The Deficit Reduction Act of 2005 (DRA) gave states more authority to control Medicaid drug spending through increased cost sharing for non-preferred drugs, changes in the way Medicaid pays pharmacists, allowing pharmacists to refuse prescriptions for beneficiaries who do not pay their cost sharing, and inclusion of authorized generic drugs in the calculation of "best price" for drugs. Pub. L. No. 109-171, 120 Stat. 4 (2006).

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