Medicaid in a Time of Historic Change:

Prescription Drugs and Costs – A Medicaid Perspective

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Agenda

National Medicaid Pharmacy Policy Framework

Medicaid Budget Pressures

State Medicaid Drug Cost Control Strategies

The Challenges of High Cost Specialty Drugs

Possible Strategic Directions
Key is the national Medicaid Drug Rebate Agreement
Agreement is between CMS and each drug manufacturer
It assures coverage of a manufacturer’s outpatient prescription drug products by state Medicaid programs
Medicaid programs get “best price” through a fairly complex set of formulas no less than a statutory minimum percentage
Agreement stipulates that the manufacturer also participate in 2 other federal programs: the 340B drug pricing program and the master agreement with the Veteran’s Administration
CMS also limits state Medicaid agencies to federal upper limits in their drug pricing methodologies
Medicaid Budget Pressures

U.S. HEALTH CARE SPENDING AS % OF GDP

PROJECTED
Medicaid Budget Pressures

- Medicaid programs account for about 25% of a state’s total budget and 19% of state general fund budgets
- State revenue growth averaged 3.3%/year for the last 15 years
- State revenues are projected to grow at 2.5% in 2017
- Healthcare costs in the U.S. continue to exceed state revenue and GDP growth rates
  - In 2014, U.S. healthcare spending increased 5.3% and is estimated to increase by 5.5% in 2015
  - CMS projects health spending growth at 5.8% thru 2025
Medicaid Budget Pressures - Pharmacy

• The pharmacy component of health care costs averaged double digit growth from 1980 through 2006
• Drug cost increases were very modest from 2007 thru 2013
• In 2014, national prescription drug spending increased 12.2%
• Medicaid drug costs grew 24.3% in 2014 “as a result of increased enrollment and spending for drugs that treat hepatitis C”
• National prescription drug spending is projected to grow 8.1% in 2015 and 6.3% in 2016
Medicaid Budget Pressures

Projected 2017 % Increases

- State Revenues: 2.5%
- U.S. Health Spending: 5.1%
- U.S. Pharmacy Spending: 6%
Drug Cost Control Strategies – Purchasing Pools

- Multi-state purchasing pools began in 2003
- Currently slightly more than half of the states belong to one of four purchasing pools
- In combination with this purchasing power, states adopt preferred drug lists to leverage price
- Pharmacy manufacturers offer supplemental rebates in addition to the federally required rebate
- Federal and supplemental rebates are now estimated to be approximately 50% of initial payments
Drugs Cost Control Strategies – Other

• Beneficiary contributions to the cost of care primarily in the form of co-payments
• Co-payments are often tiered but are generally very modest because of federal requirement to be nominal
• More nuanced approaches vary by value (e.g., no co-pay for high value drugs)
• There is considerable emphasis on fraud, waste, and abuse issues that affect cost and population health
• Opioids are currently a major focus for Medicaid as well as the general population
Drug Cost Control Strategies – Carve Ins and Outs

- States are expanding their managed care footprint to cover additional eligibility groups and previously excluded services
- Whether drugs should be carved in or carved out is debatable
- Current practices vary considerably including mixed models where some classes are carved in and others out
- Common formularies simplify practice for physicians and hospitals in various ways including beneficiary transitions
- Carve-in argument: Drugs are an integral part of the overall plan of care and the overall cost of care (health plan “secret sauce”)
- Carve-out argument: While drugs are integral to the plan of care they are fundamentally a commodity where leveraging price should be a driver in the value proposition
Challenges of High Cost Specialty Drugs

- State Medicaid populations often are disproportionate users of these new and very expensive drugs.
- Of the 3.5 million persons in the U.S. believed to have Hepatitis C, about 1 million are estimated to be on Medicaid.
- A Milliman analysis concluded that the Hepatitis C prevalence rate in Medicaid is 7.5 times higher than for commercially insured populations.
- Breakthrough drug pricing started at $84,000 for a treatment course.
- California estimated that they could spend as much as $6.7 billion if all Medicaid beneficiaries and prisoners were treated with the new drugs.
An Oversimplified Reaction

Michigan General Fund (GF) Budget = $10 billion
2017 Revenue Increase Estimated at 2.5% = $250 M new money
Estimated 1 million Medicaid beneficiaries with Hepatitis C
Michigan’s proportion of national estimates is typically 3.3%
1 million times 3.3% = 33,000 MI Medicaid beneficiaries with Hep C
Hep C drug cost @ $84,000 per course X 23% discount = $64,680
Maximum potential cost = 33,000 x $64,680 = $2.1 billion
Not everyone will be treated so let’s say 20% = $420 million
State GF cost is 35% (65% Federal match rate) = $147 million
Medicaid and State Assistance Programs cover 44% of persons with cystic fibrosis (CF) and recent breakthrough drugs are costly.

Medicaid covered 4 in 10 persons with HIV/AIDS and financed almost half (47%) of those estimated to be in regular care and this was prior to implementation of the Medicaid expansion.

Last year, Turing Pharmaceuticals acquired a 62 year old drug that treats AIDS and other patients with compromised immune systems and raised the price from $13.50 to $750 per tablet.

Medicaid covered about one-third of persons with hemophilia before ACA expansion; clotting factor is very expensive.

Human growth hormone is disproportionately covered by Medicaid/CHIP due to high coverage of children and EPSDT.
Challenges of High Cost Specialty Drugs

- High cost specialty drugs pose challenges to state contracts with managed care organizations (MCOs) with no good solution.
- One approach is to take no action and let the MCOs deal with it, but this is a short-term strategy with risks.
- Or the state can adjust rates, but that is tricky especially in the initial rollout period.
- The state can make the health plans whole for the unexpected large expense outside rates, but the costs still accrue to the state.
- States can carve out the particular drug or group of drugs that treat the specific condition and manage directly.
- Finally, the state can adopt uniform treatment standards since the expense ultimately falls to the state.
Possible Strategic Directions

• Continue and enhance current efforts with purchasing pools and preferred drug lists
• Leverage price by carving drugs out of managed care contracts but require PBM functionality to inform integrated care planning
• Carve drugs into managed care contracts but require common formularies to leverage volume at the state level
• Policy focus to reduce abuse of opioids and other drugs
• Restrictive drug coverage policies (not recommended)
• Lobby Congress to change the rules of the game for legalization of drug imports or other new approaches to drug pricing
Discussion