

# States Try to Control Medicaid Pharmaceutical Costs

## Numerous, Diverse Cost Pressures Force Myriad Reform Efforts

Stephen Barlas

**H**ealth plans of all stripes are struggling with the costs of specialty drugs such as Gilead Sciences' Sovaldi, but none more than state Medicaid programs and their managed care plans. The managed care organizations insure about 70% of the 70 million adults and children who receive Medicaid benefits, including about half of the 3.2 million Americans who have hepatitis C; the remaining Medicaid enrollees receive fee-for-service coverage. The costs for Sovaldi (sofosbuvir), other hepatitis C drugs such as Harvoni (ledipasvir/sofosbuvir, Gilead) and Viekira Pak (ombitasvir/paritaprevir/ritonavir plus dasabuvir, AbbVie), and other drugs such as Kalydeco (ivacaftor, Vertex Pharmaceuticals) are putting heavy pressure on state Medicaid budgets. Those specialty drugs, however, are only the leading edge of expected, expensive treatments for multiple sclerosis and Alzheimer's disease, individually sequenced cancer regimens, and others—all billed as cures for illnesses that justify gold-plated price tags.

These costs are especially hard on Medicaid managed care plans, which get fixed amounts from a state to care for each patient. For any number of reasons, the states are limited in the amount they can allocate to hepatitis C patients and to others who need costly drugs. "This one drug [Sovaldi] would double the pharmacy budget in Medicaid if everyone with hep C received it," says Matt Salo, Executive Director of the National Association of Medicaid Directors.

In February, the Arkansas Medicaid program reached a legal settlement with three cystic fibrosis patients who alleged the state had denied them access to Kalydeco, which has an annual wholesale price of \$311,000. The Arkansas patients had all met the eligibility criteria established by the FDA when it approved Kalydeco in 2012. But Arkansas officials had placed additional restrictions on Kalydeco's use, including a requirement that patients couldn't receive Kalydeco unless their health had worsened after taking older treatments. Arkansas had already changed its Medicaid criteria prior to the settlement to enable more cystic fibrosis patients to get Kalydeco. Dawn Zekis, the Arkansas Medicaid Director, did not answer an email asking how that expansion had affected the state Medicaid budget.

Some managed care plans, limited by previously contracted capitated rates, swallowed big hepatitis C medication costs when the expensive drugs entered the market in 2014. Jenny Michael, Director of Public Relations and Corporate Communications for CareSource (one of the largest nonprofit Medicaid plans in the U.S. with 1.4 million members in Ohio, Indiana, and Kentucky), says CareSource was among the first health plans to offer Sovaldi to its members. "In 2014, more than 500 CareSource members received hepatitis C medications—Sovaldi, Olysio, and/or Harvoni—at a cost of nearly

\$50 million to the company. All 500 were Medicaid members in Ohio or Kentucky and neither state provided additional funding for the cost of these drugs."

### Rising Medicaid Costs Squeeze U.S. and States

Salo says the spiraling cost of specialty drugs is one of the key factors straining state Medicaid budgets. The Centers for Medicare and Medicaid Services (CMS), which oversees Medicaid, says that prescription drug costs in the current fiscal year are expected to be about \$6 billion out of a total of \$343 billion, according to fiscal 2016 budget documents of the Department of Health and Human Services (HHS). But that accounts only for outpatient costs. Prescription drug costs are not broken out within other categories where they are undoubtedly factors, such as outpatient hospital costs, \$9.3 billion, and physician costs, \$14.8 billion (some doctors buy and bill for in-office infusion drugs). Nor are the pharmaceutical costs in institutional settings broken out. The lion's share of the Medicaid budget



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goes to health insurance payments—\$165.7 billion, which for the most part is distributed to managed care plans. Payments to hospitals for fee-for-service patients and to nursing homes come in at around \$33 billion each.

Perhaps the biggest driver of Medicaid costs is spending on institutional and community care for the physically and mentally disabled and the elderly, a program Medicaid refers to as Long-Term Services and Supports (LTSS). Not all states run LTSS programs, which are administered by the managed care plans. The National Governors Association states that in fiscal year 2009, just three million of the total Medicaid population accounted for LTSS costs of \$114 billion.<sup>1</sup> Medicaid pegged the costs at \$140 billion in 2012, out of a total of \$410.1 billion.

Rising costs for drugs, the disproportionate, fast-rising LTSS costs (many recipients are ineligible for nursing home LTSS benefits), and pressure to address other state funding priorities such as education and infrastructure have forced many state Medicaid programs up against a financial wall. However, many providers seem to be doing fine, based on financial statements and chief executive officers' salaries. That appears to be true for hospitals (both investor-owned and safety net) and managed care insurers (both for-profit and nonprofit). Doctors may be doing less well.

During the 2007–2008 recession, state Medicaid rolls swelled with the newly unemployed. Because Medicaid is an entitlement, anyone who meets its financial criteria is eligible for its benefits. During the recession, the states did not cut benefits to allow room under current budgets to accommodate new enrollees. Other nonentitlement state funding priorities such as education and infrastructure suffered as a result. While some of that financial pressure has eased as state coffers fill up again, legislatures are shifting their attention to unmet needs outside Medicaid and

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directing governors to allot new funding elsewhere. “We are starting to see some of that rebound pressure on Medicaid,” Salo says.

In Washington state, for example, a state supreme court ruling and a ballot measure voters approved last November require the state to increase education spending by 33% in 2016 and 2017 over what was spent from 2013 to 2015. In mid-February, Illinois Governor Bruce Rauner, a Republican, proposed cuts of \$1.5 billion in fiscal 2016 to his state’s Medicaid program. New York Governor Andrew Cuomo, a Democrat, won a Section 1115 waiver from CMS to significantly reform the way public hospitals do business within Medicaid. New York’s Delivery System Reform Incentive Payment (DSRIP) program “will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25% reduction in avoidable hospital use over five years,” according to the state’s website.<sup>2</sup> At least that is the plan. Savings are expected to reach \$17 billion over five years. Of that, \$8 billion will be reinvested, apparently to help keep inner-city public hospitals open.

### Specialty Drugs Fuel Costs

Almost every state is struggling, as Arkansas did with Kalydeco, with escalating prices for specialty drugs. This escalator seems to get steeper and more crowded all the time. The impact on the states is long-term, and more drastic depending on the potential number of enrollees who have each disease. There are many more people with hepatitis C, for example, than there are with cystic fibrosis.

The impact of specialty drug costs on Medicaid managed care plans is severe in the first year those new drugs are introduced, but it can be significant in the long term, too, and in a way that doesn’t come into play for Medicare or employer plans. Jeff M. Myers, President and Chief Executive Officer of Medicaid Health Plans of America, explains that Medicaid managed care plans undergo considerable patient “churn”—that is, insured people move in and out of various plans. Churn is anywhere from 40% to 60% annually per plan. “Our plans pay the entire cost of a Sovaldi in one year, even though odds are that HCV patient won’t be in [that] plan the following year,” says Myers, who calls that pricing model “unsustainable.”

Meanwhile, states, which maintain the formularies the managed care plans must work with, are feverishly trying to negotiate rebates with hepatitis C drug manufacturers. In February, Missouri said it had signed a deal with AbbVie to make the company’s multidrug regimen Viekira Pak the preferred option for low-income people covered by Missouri’s Medicaid program, in exchange for undisclosed AbbVie rebates to the state. Missouri essentially signed on to a deal negotiated by Magellan Health, mainly known as a behavioral health company. Magellan made the terms of the deal Missouri accepted available to 25 other states. It is not clear how many others have accepted that deal, but some did not. Laura Schuntermann, a Magellan media contact, declined to comment. In any case, it isn’t clear what rebate AbbVie promised. Neither the company nor Missouri would say.

Myers points out that the cost of treating hepatitis C patients has increased about 400% over the past four years. “The fact that the manufacturers want to walk back prices for the new hep C drugs some small-amount percent doesn’t really help,” Myers says. “We are facing a true crisis.” He worries that

pharmaceutical companies may conclude the hepatitis C pricing model is the one the industry should use for other drugs needed by even more people.

### Far Beyond Its Origins

The Medicaid program has changed drastically since it was established in 1965. Medicaid was originally restricted to members of families with children and pregnant women and to persons who had disabilities or who were elderly or blind. Low-income individuals who did not fit into one of these categories, such as childless couples or adults without disabilities, typically did not qualify for Medicaid regardless of how low their income was. The establishment of new eligibility standards in the 1980s and the approval of Medicaid program waivers have provided states with opportunities to extend Medicaid services to populations beyond the traditional welfare-defined groups.

When Medicaid was first offered, about four million Americans were eligible. The HHS budget estimates that in fiscal year 2016, which begins on October 1, 2015, Medicaid will cover 30.3 million children, 10.3 million disabled people, 5.8 million elderly people, 25.5 million other adults, and 1 million people in U.S. territories.

Prior to 1982, 99% of Medicaid recipients received coverage through fee-for-service arrangements. The passage of the Omnibus Budget Reconciliation Act of 1981 and the Balanced Budget Act of 1997 made it easier for states to develop managed care delivery systems, significantly increasing the number of Medicaid recipients enrolled in managed care organizations. As of July 1, 2012, over 75% of all Medicaid beneficiaries (more than 44 million) in 47 states, the District of Columbia, and Puerto Rico were enrolled in some type of managed care plan.

### The Stress of Medicaid Growth

The quickening shift to managed care reflects an imperative on both the state and federal levels to reduce the expansion of Medicaid costs. Over the next decade the Congressional Budget Office (CBO) expects federal Medicaid expenditures to grow from \$299 billion in 2014 to \$576 billion in 2024, an average annual growth rate of about 7%.<sup>3</sup> This increase includes higher federal Medicaid spending over the decade related to the implementation of the Patient Protection and Affordable Care Act (PPACA). Under the Medicaid expansion that is part of the PPACA, the federal government pays the full price for covering newly eligible adults with incomes up to 138% of the federal poverty level (\$16,242 in 2015) through 2016 and then gradually lowers its share to 90% in 2020 and beyond. The CBO estimates that total Medicaid enrollment will grow from 72 million in 2013 to 93 million by 2024.

While the federal and many state governments are watching their nickels, many Medicaid managed care plans are watching theirs pile up. For example, Molina Healthcare announced buoyant financial results for 2014 in mid-February. The company has insurance programs outside Medicaid but was founded as a Medicaid company, and Medicaid remains its core business. It added 700,000 new members in 2014, primarily due to the Medicaid expansion. Premium revenue increased 46% over 2013, and net income jumped 35%. Centene Corporation, another major commercial Medicaid managed care provider, did even better. When it announced 2014 results in February,

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Michael F. Neidorff, Centene's Chairman and Chief Executive Officer, stated, "By any measure, 2014 was a significant year in the history of Centene. Membership grew by 1.2 million lives, revenue by almost 50%, and EPS [earnings per share] by 55%."

"You do make a healthy profit on Medicaid," Sabo says, which may be an understatement given the booming results of some companies. Even many nonprofit managed care companies are doing very well. Actually, *nonprofit* is a bit of a misnomer. These plans earn revenues that exceed expenses, but they call them margins; they are distributed to affiliated health care facilities and often, in generous amounts, to the executives of the nonprofits in the form of salaries. Pamela Morris, CEO of CareSource, earned \$2 million in 2012, according to the Form 990 CareSource filed with the IRS. The CareSource Executive Vice President of External Affairs, essentially the company's top lobbyist, earned nearly \$400,000. The company spent \$227,000 on "lobbying" and nearly \$1 million on advertising. Salaries for top executives at some safety net hospitals, which have relatively high percentages of Medicaid patients, are just as high.

"The suggestion that plans are making tremendous amounts of money at the expense of the state is not fair factually," Myers argues. "Managed care plans just received 9.3 million new Medicaid beneficiaries for whom the state is paying for services. If not in a managed care environment, the costs would be higher."

### Medicaid Expansion Under the PPACA

Already dealing with a population that is sicker than those of Medicare and employer health plans, Medicaid is now welcoming more relatively unhealthy Americans, some of whom have had little-to-no health care in the past and are beset by comorbidities. Medicaid expansions were implemented by Pennsylvania on January 1, 2015, and Indiana on February 1, 2015. Medicaid expansions have been controversial, especially in Republican states where governors and legislatures fear the federal contribution will diminish or even disappear in the future because of deficit and debt concerns in Congress. Republican governors may also harbor political motives (some may not want to appear to be furthering the PPACA, the root of the Medicaid expansion).

New enrollees in both Democratic and Republican states were mostly added via so-called Section 1115 waivers. For example, Indiana expects to add about 350,000 low-income adults via a Section 1115 waiver that opens Medicaid to people with incomes above the federal poverty level (\$11,770 for an individual in 2015) with the proviso that they must contribute to a health savings account or be locked out of coverage for six months. The penalty for not paying into a health savings account, which has never before been approved by HHS, reflects an important GOP health care tenet: People who receive Medicaid benefits should take personal responsibility for their care. Republican Governor Mike Pence called his plan "the first-ever consumer-driven health care plan for a low-income population."

However, some Republican governors who were able to wheedle favorable waivers from the Obama administration have found themselves with egg on their faces when state legislatures voted against expansion. In early February, the Senate Health Committee of the Tennessee legislature voted 7-4 to kill Republican Governor Bill Haslam's Insure Tennessee plan.

### Changes to Medicaid Going Forward

The Section 1115 waivers allow the states and the federal government to exert some downward cost pressure on this entitlement program. But Medicaid, Medicare, and Social Security are gobbling up ever-larger shares of the federal budget. While the Obama administration and members of Congress have tossed around reform ideas for Medicare and Social Security, they have been unusually quiet about Medicaid. There were no hearings in the last Congress on Medicaid's growing costs. One House subcommittee did hold hearings on Medicaid fraud, which is substantial and has inflated federal costs. Medicaid has been on the Government Accountability Office (GAO) list of high-risk programs for years. The program wasted more than \$14 billion on improper payments in 2013—nearly 6% of its spending, a GAO study found in July 2014.<sup>4</sup> The report said that the CMS and the states have program integrity units and auditing teams looking at Medicaid fee-for-service payments. But the federal government is not looking at managed care providers, nor are the states, to any great extent. The CMS does not require states to audit managed care payments. State officials interviewed by the GAO said they need more CMS support, such as additional guidance and the option of obtaining audit assistance from Medicaid integrity contractors, to oversee Medicaid managed care program integrity.

Medicaid reform may move up a bit on the congressional priority list now that Republicans control the Senate. In 2013, Senator Orrin Hatch of Utah and Representative Fred Upton of Michigan, both Republicans, published a broad reform plan.<sup>5</sup> Their key idea was to establish per-capita caps on enrollee spending on a state-by-state basis, adjusted for various factors. Similar to the reforms proposed in the 1990s, federal per-capita caps would be placed on the four major beneficiary groups: elderly people (age 65 years and older), blind and disabled people, children, and other adults. The Hatch/Upton plan was never translated into legislation. Neither office answered emails asking whether the legislators would introduce Medicaid reform legislation in 2015.

So the burden is apparently on the states to make Medicaid work as is. The HHS granting of Section 1115 waivers may help staunch some of the financial bleeding. But those waivers are really just so many fingers in the dike.

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