How Medicaid and Prescription Drug Spending Impact the State Budget

Executive Summary

Medicaid, through the state Health Care Authority (HCA), now provides health insurance for almost two million Washington state residents, and makes up over 16 percent of the state budget. Historically high prescription drug spending growth across America in 2014 and 2015, driven in part by new, expensive specialty drugs, became a focus of attention in the state Legislature as HCA submitted a substantial supplemental budget request in 2016. However, in the 2015-17 biennial budget, only 2 percent of maintenance level changes came from HCA.

Seventy percent of the drug cost increases nationwide from 2010 to 2015 were from specialty drugs. PricewaterhouseCoopers does not expect specialty drugs nationally to have the same impact in 2017 that occurred in previous years. Hospitalization is still the primary cost driver, consuming about 50 percent of national Medicaid outlays, while prescription drugs are at 17 percent. All states provide drug coverage as part of their Medicaid programs, and therefore cannot limit distribution of a medication when it is deemed medically necessary.

The state negotiates drug prices with manufacturers, from a starting point set by federal law that includes a federal rebate off the retail price before individually negotiated state rebates can further reduce those prices. Nationwide in 2015, a 12 percent increase in list brand drug prices was reduced to under 3 percent net costs. For managed care, these negotiated drug prices, which are proprietary information, are folded into a per patient managed care rate, put together by a private actuary, Milliman, Inc.

HCA has transitioned over 80 percent of Medicaid recipients into managed care and utilizes a number of other cost containment measures. For prescription drugs, these include requiring prior authorization for certain drugs, a preferred drug list, and periodic reviews to screen drug claims for errors, waste, fraud, unnecessary care, or gross overuse. These efforts coincide with a huge Medicaid expansion, with nearly 600,000 new recipients entering the system under the Affordable Care Act. The federal government has funded this added population to date, but beginning in 2017, the state will pay 5 percent, with the percentage increasing to 10 percent in 2020 and thereafter.

Limitations on prescribing high-cost specialty drugs to treat hepatitis C in Washington state were overturned by a federal court. Fortunately, over the last two years the cost of these expensive specialty drugs has dropped significantly. Competitors entered the picture, causing manufacturers to lower retail prices and increase rebates. The new hepatitis C drugs can cure patients in months, eliminating ongoing treatment outlays for hospitalizations or expensive transplants.

Rising drug prices in the American marketplace, reflected in the Medicaid system, have prompted proposals for reducing costs that are likely to produce unintended consequences. The Federal Trade Commission stated additional transparency rules for Medicaid drug price negotiations could encourage collusion between manufacturers, a detrimental outcome for consumers. Mandatory disclosure of production and R&D costs only fuels a politicized argument over profits, providing no clear path to positive outcomes.

The International Trade Administration noted that a third proposal, price controls, discourages cost-lowering competition from entering the market. Price controls reduce financial incentives and funds for critical research and development. We need to foster, not inhibit, the discovery of new drugs that improve health care outcomes, reducing the need for costly hospitalizations and procedures.
Medicaid makes up a significant share of state budgets, but the ability for states to control costs in the program is limited. State Medicaid programs have been strained in recent years by new, high-cost prescription drugs. These pressures are present in Washington’s Medicaid program.

**Health Care Cost Trends**

Health care spending in the U.S. increased by 5.3 percent in 2014 to $3.031 trillion, or $9,523 per person. Meanwhile, national spending on prescription drugs increased by 12.2 percent in 2014 (to $297.698 billion, or $936 per person) after growing only 2.4 percent in 2013. From 2005 to 2014, total national health expenditures increased by 49.7 percent and prescription drug spending increased by 45.1 percent. (Meanwhile, hospital expenditures increased by 59.7 percent.) For more than a decade, prescription drug spending in the U.S. has accounted for about 10 percent of total health care spending. (Hospital spending has accounted for about 30 percent of total health care spending over the same time frame.) (CMS 2015a)

Prescription drug spending continued to increase in 2015. According to the IMS Institute for Healthcare Informatics (IMS), net spending (after adjusting for rebates the manufacturer gives the purchaser) on medicine in the U.S. increased 8.5 percent in 2015, to $309.5 billion. Of that, net spending on specialty drugs was $121 billion, an increase of 15 percent. (Aitken 2016a)

According to IMS, prescription drug spending growth was “historically high” in 2014 and 2015, and “driven by wider use of hepatitis C treatments, less patent expiry and higher price increases” (Aitken 2016a). But, IMS found that in 2015, list prices for brand drugs grew 12.4 percent but net prices grew only 2.8 percent, reflecting “the heightened competition among manufacturers and more aggressive efforts by health plans and pharmacy benefit managers to limit price growth” (Aitken 2016a). Still, IMS expects that for drugs, “The U.S. will see a 46% increase in spending over the next five years” (Aitken 2016a). (Note that this expected spending increase is on a list price basis and does not account for rebates.)

Total health care spending will also increase. The Centers for Medicare & Medicaid Services (CMS) estimates that from 2016 to 2025, total national health expenditures will increase by 68.1 percent. CMS estimates that spending on prescription drugs will increase by 79.6 percent over the same period, but prescription drug spending as a share of total spending is expected to remain relatively stable (from 10.2 percent in 2016 to 10.9 percent in 2025. (CMS 2016i)

The importance of specialty drugs (for example, treatments for hepatitis C and autoimmune diseases) on spending has grown: “Spending on specialty medicines doubled in the past five years, contributing 70% of overall medicine spending growth between 2010 and 2015.” (Aitken 2016a). The Milliman Medical Index argues that this trend will continue:

**Fifteen years ago, specialty drug costs were a small sliver of the healthcare cost pie. Although increases in total drug costs may spike or moderate in the short-term as new drugs are introduced or as patents expire, long-term expectations are that these very expensive drugs will continue to be a growing proportion of total healthcare costs.** (Girod et al. 2016)

That said, PricewaterhouseCoopers does not expect specialty drugs to have the same impact in 2017 that they have had in previous years, “because there are no specialty blockbusters expected in 2017, and the impact of the Hepatitis C drugs has ebbed” (PwC 2016).

Public policy has played a role in prescription drug spending. IMS estimates that 15.7 million more people had health insurance in 2014 than had it previously, thanks to the expansion of Medicaid un-
der the Affordable Care Act (ACA), health insurance exchanges, and an improving economy (Aitken 2015). By increasing health insurance coverage—and demand for health care—the ACA has “been the leading driver of prescription growth in the past two years” (Aitken 2016a). Further, “The Affordable Care Act will continue to impact medicine spending over the next five years largely due to expanded insurance coverage, greater coordination of care and a shift to value based payment contracting” (Aitken 2016).

Still, as PricewaterhouseCoopers notes, about half of medical costs are hospital spending, while prescription drugs account for 17 percent. Further, “individual drug costs can be high enough to garner national media attention but, as a whole, are a relatively small portion of total health spending” (PwC 2016).

**Medicaid Administration in General**

Medicaid was enacted in 1965 “to provide health coverage for low-income people” (CMS 2016b). States have broad authority, within federally-set parameters, to administer their Medicaid programs as they see fit—“resulting in variations in Medicaid coverage across the country” (CMS 2016b).

Medicaid is funded by the federal governments and the states. The amount the federal government contributes is determined by state per capita income and is called the Federal Medical Assistance Percentage (FMAP). It must be at least 50 percent (meaning that the federal government pays for 50 percent of expenditures). For federal fiscal year 2017 (beginning Oct. 1, 2016), Washington’s FMAP is 50 percent. Mississippi has the nation’s highest FMAP, 74.63 percent. (CMS 2016c)

Under the ACA, states may expand Medicaid to cover all individuals with incomes less than 138 percent of the Federal Poverty Level. Washington chose to expand its Medicaid program as of January 1, 2014. Medicaid enrollees who are newly eligible because of the expansion are funded with a higher FMAP, so the state spends much less on their care than traditional Medicaid enrollees. From 2014 through 2016, the FMAP for this group is 100 percent, for 2017 it is 95 percent, for 2018 it is 94 percent, for 2019 it is 93 percent, and for 2020 and after it is 90 percent. (CMS 2013) In Washington, Medicaid enrollment is about 1.9 million (of which about 595,000 are newly eligible under the ACA expansion) (HCA 2016f).

Some individuals are enrolled in both Medicaid and Medicare (including low-income seniors and people with disabilities)—they’re called dual eligible beneficiaries. For example, they may get full Medicaid benefits and Medicare Parts A (hospital insurance) and B (medical insurance). If a service is covered by both programs, Medicare pays first. Also, “In some States, dual eligible individuals receive Medicaid through Medicaid managed care plans, and in other States, Medicaid coverage may be Fee-For-Service” (CMS 2016e). Since Jan. 1, 2006, Medicare has been responsible for prescription drug coverage for dual eligible

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**Definitions**

*Average manufacturer price.* The “average price paid to the manufacturer for the drug in the US by wholesalers for drugs distributed to retail community pharmacies and retail community pharmacies that purchase drugs directly from the manufacturer” (MACPAC 2015).

*Best price.* The “lowest price available to any wholesaler, retailer, provider, or paying entity excluding certain governmental payers” (MACPAC 2015).

*Single source innovator drug:* A drug that “is under patent protection and is produced by only one manufacturer” (Rehnquist 2002).

*Specialty drug:* According to the Medicaid and CHIP Payment and Access Commission, “there is no standard definition of specialty drugs” (MACPAC 2016). For example, definitions vary by cost threshold—a specialty drug may be defined as such if it costs more than $600 or more than $1,000 per month. Some also define specialty drugs as those “that treat complex conditions or require special storage, handling, and administration” (MACPAC 2016). According to the Health Care Authority, specialty drugs “generally include biologics or medications with novel mechanisms of action” and cost more than $600 per member per month (HCA 2016b).
beneficiaries (HCA 2014b). The Department of Social and Health Services (DSHS) has noted that the “dual eligible population is costly and has complex health needs” (DSHS 2011). Indeed, in 2009, dual eligible beneficiaries cost “four times the average state Medicaid cost for non-dual Medicaid enrollees—even before accounting for additional costs to the Medicare program” (DSHS 2011).

Medicaid programs may use fee-for-service (FFS) and managed care delivery systems. Under FFS, providers of medical care are paid by the service. States set their FFS payment rates based on how much the service costs to provide, how much commercial payers pay for the service, and how much Medicare pays for similar services (CMS 2016h). Under managed care, Medicaid programs contract with a managed care organization to deliver benefits for a set per member per month payment.

**Medicaid and Managed Care**

Serving Medicaid enrollees via managed care is a way for states to control spending—if costs are above the rate set in the contract, the managed care organization (MCO) bears the risk instead of the state. Under federal law, states can determine whether clients must be enrolled in managed care or whether they may have the option of managed care or fee-for-service (GAO 2015). In recent years, “many states have either expanded managed care to new populations or implemented new risk-based managed care programs” (MACPAC 2016). Nationally, in 2004, managed care spending represented 13 percent of federal Medicaid spending. By 2014, that number had increased to 38 percent (GAO 2015). Of federal spending in Washington, managed care accounted for 18.2 percent in 2004 and 51.2 percent in 2014 (GAO 2015). According to the Health Care Authority (HCA), managed care spending accounts for about 55 percent of total budgeted spending (state, federal, and other) within the HCA in 2015–17 (Johnson 2016). As of July 1, 2014, 60.5 percent of Medicaid enrollees nationally were in comprehensive managed care (MPR 2016). (As of July 1, 2013, that figure was 56.0 percent (MPR 2015).) In Washington, of all Medicaid enrollees, 82.8 percent are in managed care (Johnson 2016). The national increase in managed care enrollees reflects that

> *Many of the people newly eligible under a Medicaid expansion were expected to be enrolled in managed care. . . . In addition, states are increasingly moving new populations of Medicaid beneficiaries into managed care, including individuals with disabilities and those with complex health care needs who require long-term services and supports.* (GAO 2015)

According to the Government Accountability Office (GAO), “as of December 2014, 39 states were using comprehensive, risk-based managed care in their Medicaid programs” (GAO 2015).

Managed care can save money via capitated rates. These rates are generally set by private actuaries, using “either previous Medicaid MCO encounter data or claims data from the Medicaid FFS population as data sources to develop the rates” (GAO 2015). Computer modelling is also used to identify emerging trends in Medicaid usage that could indicate changes in future spending (Battersby 2016).

Also, “States build a certain percentage for administrative expenses and profit into the rates” (GAO 2015). But administrative expenses and profit are limited by medical loss ratio (MLR) standards, which “govern the proportion of capitated payments that MCOs must spend on medical care and other services” (GAO 2015).

**Medicaid and Prescription Drugs**

State Medicaid programs do not have to cover prescription drugs, but all states have chosen to do so (MACPAC 2015). Medicaid programs cover prescription drugs through the federal Medicaid Drug Rebate Program (MDRP). Before

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2010, the MDRP did not apply to managed care plans. Consequently, many states “carved out drugs from their managed care contracts” (MACPAC 2016). By covering drugs on a fee-for-service basis, states could get rebates. The ACA extended MDRP rebates to managed care plans. Now, “most states have carved in most or all of the outpatient prescription drug benefit under a capitated managed care program; six states carve out the entire outpatient prescription drug benefit” (MACPAC 2015).

When a state includes prescription drugs in its managed care contracts, it

*estimates the expected utilization and cost of drugs for the enrolled population and builds this estimate into the overall capitation rate paid to the plans.* (MACPAC 2015)

States may constrict use of drugs to an extent, but they “cannot completely exclude coverage of any products from manufacturers participating in the rebate program” (MACPAC 2016). Consequently, states do not have free rein when managing drug spending—they “must provide some level of coverage of new, high-cost drugs when they enter the market” (MACPAC 2016). The MDRP and any supplemental rebates negotiated by the states are the main way Medicaid programs control drug costs. States also use prior authorization, preferred drug lists (PDL), and drug utilization review.

**Rebates:** The MDRP allows Medicaid programs to purchase prescription drugs at “a net price that is consistent with the lowest or best price for which manufacturers sold the drug” (MACPAC 2016). In return, when a drug manufacturer and the federal Department of Health and Human Services enter into a rebate agreement, state Medicaid programs must cover the manufacturer’s drugs. (CMS 2016d)

Under the MDRP, the rebate amount depends on the type of drug. For example, the rebate for innovator drugs is 23.1 percent of the average manufacturer price (AMP) or the difference between the AMP and the best price per unit adjusted by inflation (whichever is greater). The rebate for non-innovator drugs is 13 percent of the AMP. (CMS 2016d) The AMP is not the list price of a drug; in fact, the Department of Health and Human Services (HHS) has found that it is “substantially lower” than the list price (HHS 2005). Thus, the rebate from the list price under the MDRP would be higher than 23.1 or 13 percent.

The federal government and the states share the rebate amounts—the split is determined by a state’s FMAP (MACPAC 2015). (Note, though, that the ACA increased the statutory rebate amount. Previously, the rebate for innovator drugs was 15.1 percent. The ACA also specified that the increased portion of the rebates would go to the federal government, not the states (MACPAC 2015).)

An additional rebate is required when the price of a brand drug rises faster than inflation. HHS recently looked at 200 brand-name drugs and found that 54 percent of the Medicaid rebates owed were attributable to this additional rebate (HHS 2015). As the HHS report notes,

*A major driver of the higher Medicaid rebates was the additional amount owed when prices for brand-name drugs increase faster than inflation. This rebate not only produces additional Medicaid rebates, but also helps protect the program from increased costs when manufacturers raise prices.* (HHS 2015)

States may also negotiate supplemental rebates with manufacturers (MACPAC 2016). As of June 2016, 46 states had done so, either on their own or as part of multi-state arrangements. Washington has had a supplemental rebate agreement since 2002. (CMS 2016a) Manufacturers agree to supplemental rebates in order to be included in a state’s preferred drug list, and thus avoid being subject to prior authorization (see below) (MACPAC 2015).
Prior authorization. When Medicaid requires prior authorization for certain drugs, it won’t cover them unless the prescriber contacts them first to show it is medically necessary (CMS 2015b). So, states can manage drug costs by expanding prior authorization to include more categories of drugs (Coster 2016).

Preferred drug lists (PDL). Medicaid programs list the preferred drugs within a therapeutic class. In Washington, for example, the preferred drugs are chosen “based on clinical evidence of safety, efficacy, and effectiveness” (HCA 2016g). Drugs on the PDL do not typically need prior authorization. Thus, there is “a shift in market share to the preferred drugs” (MACPAC 2015).

Drug utilization review (DUR). State Medicaid programs screen drug claims “to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy and clinical misuse or abuse” (CMS 2016f). They also review claims data on an ongoing basis “to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care and implements corrective action when needed” (CMS 2016f). In 2014, Washington reported savings of $31.9 million from its DUR (CMS 2016g).

Medicaid Spending

Medicaid spending nationally (both state and federal spending) increased by 11.0 percent in 2014, to $495.766 billion, or $1,559 per capita. Medicaid spending on prescription drugs increased by 24.3 percent—the largest increase since 1990. (It grew by 4.2 percent in 2013.) From 2005 to 2014, Medicaid spending on drugs declined by 25.2 percent, but that was due to a 47.7 percent reduction in 2006 (which was related to the transfer of prescription drugs costs to Medicare from Medicaid for dual eligible beneficiaries). From 2006 to 2014, Medicaid spending on drugs increased by 43.0 percent. (CMS 2015a) Nationally, in 2015, Medicaid spending on drugs increased by 5.7 percent. Medicaid spending on traditional drugs increased by 3.3 percent and specialty drugs increased by 10.1 percent. (Cho 2016)

Historically, Medicaid drug spending as a percent of total Medicaid spending had been similar to total drug spending’s share of total health spending. In 2005, Medicaid spending on drugs was 11.8 percent of total Medicaid spending. That figure dropped to 6.2 percent in 2006 and was 5.5 percent in 2014. (CMS 2015a)
In 2011, managed care drug spending accounted for 14 percent of total Medicaid drug spending nationally. By 2014, that figure had grown to 47 percent. (MACPAC 2016) Charts 1 and 2 (on page 6) show how Medicaid spending on drugs has changed (by net and gross prices) in managed care and fee-for-service.


According to the HCA, in 2014, Washington spent $291 per member per month on managed care and $344 per member per month in fee-for-service (HCA 2014a). (Note that these numbers are not a perfect comparison because managed care and fee-for-service serve different populations.) Within the HCA, in the 2015–17 biennium, managed care spending (from state, federal, and other sources) totaled $10.9 billion (55 percent of the HCA budget) (Johnson 2016). The annual cost of Medicaid per user within the HCA was $3,780 in CY 2015, up from $3,609 in 2011 (HCA 2016b).

In Washington, Medicaid spending is mostly accounted for within the “medical assistance” budgetary line item. In FY 2016, medical assistance spending within the HCA totals $7.935 billion. Of that, $1.951 billion is from state funds and $5.465 billion is from federal funds. For FY 2017, total medical assistance spending will be $8.348 billion, of which $2.054 billion will be from state funds and $5.752 billion from federal funds. In 2016 and 2017, federal funds account for 68.9 percent of medical assistance spending and state funds account for 24.6 percent. In 2012, federal funds accounted for 53.7 percent and state funds accounted for 41.1 percent. (Johnson 2016) As shown in Chart 3, state spending has remained flat over recent years while federal funding has increased substantially.

In CY 2015, the HCA spent $155.7 million for Medicaid fee-for-service prescription drugs and $926.3 million for Medicaid

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**Chart 3: HCA Medical Assistance Spending (Billions of Dollars)**

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<th>Fiscal Year</th>
<th>Federal</th>
<th>State</th>
<th>Other</th>
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<td>$2.6</td>
<td>$0.3</td>
<td>$0.4</td>
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<td>FY 2013</td>
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<td>FY 2017</td>
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In Washington, Medicaid is administered by the HCA and is called Apple Health. Some Medicaid spending occurs within the Department of Social and Health Services (including long-term care, mental health, and substance abuse). In July 2016, Medicaid enrollment in Washington totaled about 1.9 million (of which about 595,000 were newly eligible under the ACA expansion) (HCA 2016f).

Washington’s Medicaid program has used managed care since 1987. Since 2012, the blind and disabled have been required to enroll in managed care. (CMS 2014) And, since April 2016, Washington’s new Medicaid clients are auto-enrolled in managed care, rather than fee-for-service (HCA 2016a). Because of the expansion, Medicaid managed care enrollment increased from 920,158 in January 2014 to 1.3 million that December, a 41.6 percent increase (Qualis 2015). In July 2016, managed care enrollment totaled about 1.6 million (HCA 2016f).

In Washington, managed care enrollment as a percentage of total Medicaid enrollment has increased significantly over recent years. For example, in January 2011, the percentage in managed care was 57.0 percent. According to the HCA, of all Medicaid enrollees in Washington, 82.8 percent now receive most of their medical services through managed care organizations (Johnson 2016).

Additionally, for behavioral health, all Washington Medicaid enrollees are covered through Behavioral Health Organizations or the fully-integrated managed care plans in Southwest Washington. (All behavioral services in Washington will be delivered through fully integrated managed care plans by 2020.) Consequently, the Kaiser Family Foundation reports that 100 percent of Washington’s Medicaid enrollment is in managed care (Idaho, North Carolina, and Tennessee were also at 100 percent). Nationally, 77.0 percent of enrollment is in managed care. (KFF 2016)


In Washington, managed care enrollment rates are set by a private actuary, Milliman, Inc., reflecting “the population characteristics, benefits and service delivery expectations placed on health plans” (HCA 2016b). The per member per month rates are based “on data and costs reported by the managed care organizations” (SAO 2014). The federal Centers for Medicare & Medicaid Services (CMS) approves the rates.

As shown in Chart 4, Washington’s managed care family rates have been fairly steady, though they increased from $153 on Oct. 1, 2015 to $162 on Jan. 1, 2016. (These are the per person rates for those in the family eligibility category, reflecting the average cost of all children and

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**Chart 4: Apple Health Managed Care Base Rates**

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<thead>
<tr>
<th>Date</th>
<th>Blind/Disabled</th>
<th>New Adults (Expansion)</th>
<th>Family</th>
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adults in the category. Family rates are so much lower than the rates for new adults who enrolled under the expansion because children are much cheaper to cover than adults.) Rates for blind and disabled enrollees also increased significantly from Oct. 1, 2015 to Jan. 1, 2016 ($876 to $994). (Johnson 2016)

Drug management. According to the HCA’s chief pharmacy officer, challenges faced by HCA in prescription drugs include unexpected price increases and new, high cost drugs—and the need to accommodate them within a balanced budget. The HCA’s drug management strategies include a preferred drug list, prior authorization, and quantity limits. (Sullivan 2016)

To help control drug costs, the HCA, DSHS, and Department of Labor & Industries have made joint pharmacy purchases since 2002. Additionally, in 2006, Washington and Oregon agreed to pool drug purchasing through the Northwest Prescription Drug Consortium. State agencies that purchase prescription drugs must do so through the consortium (unless they can get better prices elsewhere). (Hanley 2016) “Consortium prices are better than commercial rates available to other large groups in Oregon and Washington” (Hanley 2016).

Managed care oversight. As noted above, states can limit MCO profit and administrative costs through medical loss ratio (MLR) standards. According to the GAO, five of the eight states it reviewed in 2015 require MCOs to meet a minimum MLR, including Washington. Two of the states require reimbursement if the MLRs are not met, including Washington. (GAO 2015) Washington’s MLR minimum is 85 percent for the Apple Health Family program and 88 percent for Apple Health Blind/Disabled. (GAO 2015) This means that 85 or 88 percent of payments to an MCO must be spent on medical services, not profit or administration.

A 2014 state performance audit pointed out a potential problem with Washington’s managed care program. The State Auditor’s Office (SAO) found “inadequate oversight of the managed care program and limited controls over expenditures” (SAO 2014). The rate-setting process relies on data from managed care organizations and was not verified by HCA. If the MCOs over pay providers, “they put the state at risk of paying unnecessarily high premium rates in the future” (SAO 2014). Of course, MCOs have a short-run incentive to avoid overpayments. Still, based on a limited check of payments, the SAO estimated that there were $17.5 million of overpayments. (As an example, some of the overpayments found included outpatient procedures incorrectly billed as inpatient procedures.) If there were net overpayments in the entire system, the SAO estimates that “for every $1 million paid by organizations to their providers in 2010, the state would pay an additional $1.26 million in premiums” (SAO 2014). They concluded, “It is in the state’s interest to limit cost increases today if it wishes to reduce the overall cost of its Medicaid managed care program tomorrow” (SAO 2014). According to the HCA, it has completed the action items in the audit. For example, it has developed new algorithms to prevent overpayments and has strengthened contracts to require more reporting. (Johnson 2016)

The HCA contracted with Qualis Health to provide a quality review study of Washington’s managed care program in 2015. The study compares Washington to peers and state and national benchmarks, and it shows that Washington does well in some areas and has room for improvement in others. According to the study, “Limiting cost growth while maximizing health coverage is essential for the program to be sustainable. There are two important methods of controlling costs: preventing waste and reducing unnecessary inpatient admissions” (Qualis 2015). Thus,

There may be opportunities to lower costs and improve the care provided to Apple Health enrollees through
enhanced outpatient access and reduced rehospitalizations within 30 days. (Qualis 2015)

That said, Washington does fairly well in avoiding inappropriate care. According to the study, “Overall Apple Health rates are higher than national averages for all three measures of appropriate utilization (meaning MCOs did a better job at ensuring individuals did not receive inappropriate care)” (Qualis 2015). Additionally, “Total inpatient utilization is significantly below the national average, reflecting good performance by Apple Health plans at keeping enrollees out of the hospital” (Qualis 2015).

But,

Four of five MCOs performed below the national average rate on four measures, and for another 10 measures, at least three of five MCOs were below the national average. These measures can be grouped into six domains: adults’ access to care, well-care visits for children and adolescents, immunizations for children and adolescents, weight management for children and adolescents, women’s health and pregnancy care. (Qualis 2015)

Value-based purchasing. E2SHB 2572 (2014) required the HCA to increase its use of value-based contracting. When payments are value-based, they reward quality of health care instead of volume (HCA 2016d). Pursuant to E2SHB 2572, HCA has pledged that 80 percent of HCA provider payments under State-financed health care programs . . . will be linked to quality and value by 2019. HCA’s ultimate goal is that, by 2019, Washington’s annual health care cost growth will be 2 percent less than the national health expenditure trend. (HCA 2016c)

To that end, Washington “is transforming its health care ecosystem to one that delivers better care, better health, and lower costs through the Healthier Washington Initiative” (HCA 2016d). The Healthier Washington initiative is funded by a federal grant and is intended to build “capacity to incentivize value through purchasing strategies, improve the health of state residents, and deliver coordinated whole-person care” (HCA 2016d). Part of Healthier Washington is integrated care, meaning that physical and behavioral health services are purchased together. According to the HCA, “This leads to more coordinated health care for Apple Health clients, where providers are looking holistically at health needs relating to physical health, mental health and substance use disorders” (HCA 2016e). Currently integrated care is being used in Southwest Washington; all counties must use integrated care by 2020 (HCA 2016e).

This is in line with the national trend:

Traditionally, health care reimbursement has been based on the volume rather than the value of services provided, contributing to wasteful, unnecessary spending and fragmented care. . . . Over the past few years, there has been a national movement to transition away from Fee-for-Service (FFS) and adopt new payments that reward providers and hospitals for quality outcomes at a competitive price. (HCA 2016d)

The national movement includes Medicare, which has begun moving away from fee-for-service (CMS 2015c).

Comparing Washington to other states. The National Association of State Budget Officers (NASBO) notes that in Medicaid, “State actions are aimed at controlling costs, selectively increasing payments and benefits, and changing delivery methods to improve care” (NASBO 2015). This means increased use of managed care, and—like Washington—states “are also focusing on greater integration of physical and behavioral health” (NASBO 2015).

In 2014, the HCA looked at the Medicaid programs of several states (Arizona, California, Florida, Michigan, and Oregon) to
see how they compared to Washington. Medicaid is not a stand-alone agency in any of the states that responded, and only in California are all Medicaid services part of one umbrella agency. (HCA 2014a)

All the states had some enrollees in fee-for-service, but they were different groups and different services. For example, in California, dental was fee-for-service and in Washington, dual eligible beneficiaries were fee-for-service. According to the report, enrollment in managed care was 80 percent in Washington, 88 percent in Arizona, 78 percent in California, 85 percent in Florida, 74 percent in Michigan, and 85 percent in Oregon. (HCA 2014a)

Many of the states were still working on reconfiguring staffing to reflect the high percentages in managed care. In Washington, “300 positions specifically support either managed care or the FFS business” (HCA 2014a). But, “Only 13% of these positions are devoted to the managed care business” (HCA 2014a). (According to the HCA, it has since reallocated employees to better serve the managed care side of things (Johnson 2016).) In Michigan, 6 percent of positions were in the Managed Care Unit. In Florida, “Our staff levels are still a moving target—we have a disproportionate number [of staff] in customer services [and] we are moving staff from FFS to managed care functions. We are decreasing provider relations staff and increasing staff in analysis and financial oversight” (HCA 2014a).

The HCA summarized, “In general, as an organization transforms from mostly FFS to mostly MC, roles change from claims payment oversight . . . to monitoring plan capabilities, improving plan accountability and increased attention to value-based outcomes” (HCA 2014a).

**Budgetary Issues in the States**

States have limited resources, and although the federal government picks up at least half the tab for Medicaid, states still spend a significant amount of their budgets on their share of Medicaid costs. According to NASBO, nationally in 2014, spending on Medicaid accounted for 25.6 percent of total state spending. It was “the single largest component of total state expenditures” (NASBO 2015). Medicaid accounted for 19.3 percent of state general fund spending nationally. (NASBO 2015) According to NASBO, ‘Medicaid spending is expected to grow by about 29.3 percent over the three-year period starting in fiscal 2015 through fiscal 2017” (NASBO 2016). (Meanwhile, national enrollment is expected to grow by 23.0 percent over that time period.)

In Washington, Medicaid accounted for 16.5 percent of total state expenditures in 2014 (up from 11.9 percent in 2013). (NASBO 2015) In 2015, Washington Medicaid spending decreased by 1.8 percent from state funds, increased by 44.3 percent from federal funds, and increased by 27.2 percent from total funds. (NASBO 2016)

NASBO notes that spending on Medicaid “has historically increased faster than the economy as a whole” (NASBO 2015). For example, the projected annual average growth rate of Medicaid spending is 6.2 percent from 2014 to 2023, while GDP is expected to grow by an average annual 4.9 percent over that period (NASBO 2015). This, combined with the high share of state spending that is devoted to Medicaid, makes it difficult for states to budget for Medicaid along with other priorities.

On that note, NASBO asked states what Medicaid issues and trends they worry about. The responses included:

- Pharmaceutical costs for specialty drugs and generics,
- Enrollment trends related to the ACA expansion and the elderly and disabled,
- Long-term care costs and higher costs for dual eligible beneficiaries,
- Federal policy changes, “including federal rules on Medicaid managed care and home health care” (NASBO 2016).

The most frequent response was pharmaceutical costs. Accordingly, in 2015, “over two-thirds of the states took actions to address higher pharmaceutical costs” (NASBO 2015). Similarly, in 2016, 13 states (including Washington) have policies to cut costs for prescription drugs. Other budgetary actions states are taking in 2016 include:

- Expanding managed care (14 states including Washington),
- Restricting provider payments (13 states),
- Increasing provider payments (24 states including Washington),
- Restricting benefits (one state),
- Expanding or restoring benefits (16 states including Washington), and
- Making enhanced program integrity efforts (for example, identifying fraud and waste) (22 states).

(NASBO 2016)

**HCA Budget Forecasting**

The budget issues that states have related to Medicaid in general and prescription drugs in particular are also at play in Washington.

As we wrote earlier this year, during the 2016 supplemental state budget process, maintenance level (ML) changes were driven by the Health Care Authority (the maintenance level reflects the costs of continuing current services). (WRC 2016)

The HCA’s maintenance level increase was 78.3 percent of the total NGFS+ maintenance level changes (as enacted). (The HCA’s ML increases were exceptionally high in the 2014 supplemental as well. For the 2015–17 biennial budget, the HCA’s ML changes were only 2 percent of the total NGFS+ ML changes. (WRC 2016))

The 2016 ML increase was due to managed care costs, not caseloads. According to the HCA at a January 20 work session of the Senate Ways & Means Committee, managed care rates ended up being set at a higher level than the HCA had predicted at the time the biennial budget was enacted. Additionally, prescription drug costs were the primary cost driver of the increased managed care rates. The 2016 rate increase was $16.56 per member per month. Of that, 65.9 percent ($10.90) was due to pharmacy costs (HCA 2016b).

At the work session Nathan Johnson of the HCA said that the issue is not that people need more drugs, but that the drugs are more expensive. It’s difficult to forecast drug costs because even though the HCA knows that there are some 80 high cost drugs that are within one year of approval, the timing of market entry and pricing are uncertain (HCA 2016b).

(The Medicaid and CHIP Payment and Access Commission also noted this issue, calling it “a challenge for states to plan for these costs as they develop their budgets” (MACPAC 2016).)

Additionally, Johnson noted that the managed care rate-setting timeline had been a problem because it occurred just before the HCA needed to make its budget forecast. He said the HCA intended to move the rate setting process earlier in the calendar year to better avoid this issue. For 2017, final rates will be set by the end of September 2016 and submitted to CMS in October. This means that the rates will be finalized a month and a half earlier than they had been previously. (Johnson 2016) Another timing problem related to forecasting is that managed care rates are set using data from the previous year. If costs go up significantly in the meantime, the forecast may not adequately reflect them.

The Legislature took steps to address the HCA’s forecasting issues in 2015 and 2016. The 2015 supplemental budget (SHB 1105) appropriated $276,000 for the Office of the State Actuary “to im-
prove the legislature’s access to independent and objective health care actuarial analysis.” Further, the 2016 supplemental (2ESHB 2376) transferred the Medicaid forecast function from the HCA to the Office of Financial Management (OFM), effective July 1, 2016, and transferred administration of the managed care actuarial rate setting contract to OFM. Additionally, the HCA must consult with the Medical Assistance Forecast work group (which includes OFM, HCA, the State Actuary’s Office, and legislative fiscal staff) “prior to accepting the actuarial contractor’s managed care rate recommendations.” Finally, the supplemental holds managed care rates flat at their 2016 levels for 2017.

**Prescription Drugs as Budget Driver**

The budgetary problems associated with high prescription drug costs are acute for state Medicaid programs, which must operate within state budget constraints. Furthermore, they are limited by federal law as to how they can control costs.

The National Association of Medicaid Directors (NAMD) notes that under Medicaid rules, states

> ... may not exclude coverage of a given product altogether. This is true even if a product lacks relevant evidence of efficacy among the Medicaid population, is comparatively effective or cost effective compared to currently available treatments, or is priced in a manner that results in budgetary pressures that impact other aspects of a state’s Medicaid program. (NAMD 2016)

Then, because all drugs must be covered, “The introduction of a high-cost, breakthrough single source innovator drug can pose unanticipated high pharmacy expenditures, inserting a significant level of uncertainty in the overall Medicaid budget” (NAMD 2016). The resulting “increased costs in one program area can lead to unintended and sometimes undesirable trade-offs in other program areas within Medicaid or other core areas of state government” (NAMD 2016).

As noted above, in FY 2014, Medicaid spending on prescription drugs increased significantly. The 2014 spending increase “reflects both an increase in drug volume and an increase in the average spending per claim, particularly for brand drugs” (MACPAC 2016). Additionally, “The increase in the average spending per brand drug claim is due in part to the increase in use and price of high-cost specialty drugs” (MACPAC 2016). Indeed, “In CY 2014, these high-cost drugs accounted for less than 1 percent of claims (0.9 percent) but made up almost one-third (32 percent) of total drug spending” (MACPAC 2016).

As an example, in 2013 and 2014, the Food and Drug Administration approved new hepatitis C drugs that are very effective but also very expensive. (The list price for Sovaldi, for example, is “$84,000 for a 12-week course of treatment” (MACPAC 2016).) Their introduction “led to an increase in Medicaid spending for hepatitis C treatment from $0.4–$0.6 billion in CYs 2011–2013 to $1.8 billion in CY 2014” (MACPAC 2016). These are gross spending numbers; Gilead Sciences said last year that Medicaid rebates for its hepatitis C drugs exceeded 50 percent (Fein 2015).

The U.S. Senate Committee on Finance spent 18 months investigating the pricing of Gilead Sciences’ hepatitis C (HCV) drugs Sovaldi and Harvoni. The results shed light on prescription drug pricing in general. The committee’s report notes,

> The high cost of HCV drugs sold by Gilead Sciences, Inc., continues to put tremendous strain on these public payer systems, creating difficult decisions about how to provide medically necessary drugs to patients while staying within budgets. As a result of the high cost of these drugs, many public and private payers adopted access restrictions to control HCV treatment costs, which reduced the number of patients eligible for treatment. (Finance 2015)
Additionally, several states indicated to the committee that to deal with the high costs of these drugs within Medicaid, “they were compelled to undertake unusual financial arrangements with MCOs, seek targeted budgetary authority for the management of costs related to managing HCV treatment, and, in at least one case, enact new legislation” (Finance 2015).

Like several other states, Washington’s policy on these drugs had been to limit coverage to Medicaid clients with fibrosis scores of at least 3 (the scores range from 0—no liver damage—to 4—cirrhosis of the liver). But, in May 2016, a federal judge issued a preliminary injunction requiring the HCA to cover hepatitis C drugs for all Medicaid clients with the disease. (B.E. and A.R. v. Teeter 2016) The injunction notes that the HCA’s chief pharmacy officer had “identified fiscal concerns as the sole basis for the WHCA’s exclusionary policy” (B.E. and A.R. v. Teeter 2016). But the treatment is medically necessary and so must be covered by Medicaid.

The HCA wrote the Finance Committee that if it “were to pay for hepatitis C treatment for all Medicaid clients infected with hepatitis C, the cost would be three times the current total pharmacy budget” (Lindeblad 2015).

But, competition lowers prices. The FDA approved a competitor to Sovaldi and Harvoni—Viekira Pak—in December 2014. Just a few months later, “in February 2015, Gilead announced that its ‘gross-to-net’ deductions for HCV products increased from 22% in 2014 to 46% in 2015” (Finance 2015).

Still, the committee’s report notes that “Even as competition appears to have mitigated some of the pricing concerns discussed throughout this report, concerns about cost burden and access remain” (Finance 2015). And the short amount of time that elapsed in the case of hepatitis C drugs before a competitor was approved was unusual: “The average time between a single source innovator entering the market and a generic manufacturer producing its equivalent product and bringing it to market is 12.6 years” (Finance 2015).

In the end, the report argues that . . . federal health care programs—notably Medicare and Medicaid—have little to no policy levers at their disposal to significantly impact the price of a single source innovator drug. . . . Thus the next expensive innovator drug could potentially create significant budgetary pressures for federal payers and lead to access restrictions for an extended timeframe. (Finance 2015)

But to some extent high drug prices may be warranted. Patents provide drug manufacturers an incentive to develop innovative new drugs and bring them to market. As health economist Henry Grabowski writes,

The pharmaceutical R&D process is long and costly, with highly variable and uncertain outcomes. Scholarly studies find that returns on R&D for new drug product introductions are characterized by a skewed distribution—one with long tails in which a few entities account for a disproportionate amount of the sales and profits.

The top ranked 10 percent of new drugs generally account for more than half of all the sales and profits of the introductions in particular periods. Furthermore, the majority of new drug introductions do not cover the average cost of R&D, when one also takes account of the high risks of failure and the lengthy times associated with the biopharmaceutical R&D process. Companies are therefore dependent on the high returns from a few successfully marketed products to sustain the R&D process. (Grabowski 2016)

Moreover, there is an inverse relationship between prescription drugs and the use of other expensive medical services. The Congressional Budget Office (CBO) wrote in 2012 that when individuals had more generous prescription drug coverage
through Medicare, they “had fewer hospitalizations and used fewer medical services as a result” (CBO 2012). CBO’s conclusion was that “a 1 percent increase in prescription drug use would cause spending for medical services to fall by roughly one-fifth of 1 percent” (CBO 2012).

HCA has stated that some new drugs may be so expensive as to negate net savings in medical care costs for a patient even over the long run (Lindeblad 2015). However, the drug manufacturers’ trade organization argues that a half a million dollar course of treatment that cures hepatitis C replaced a drug regimen (interferon) that cost nearly as much over a year and had to be taken in perpetuity because it is not a cure. (It also has side effects that create new costs like hospitalization.) Competing drugs have appeared and now the cost for the course of treatment that cures hepatitis C has been reduced by about half. (Pandya 2016)

PricewaterhouseCoopers argues that “The future of PBM contracting points toward paying for results and cures, not the volume of drugs dispensed” (PwC 2016). Additionally, transparency and price controls are a few ways that have been proposed to deal with high drug costs, and thus alleviate pressure on state budgets.

Transparency. Many states have all-payer claims databases, which collect claims information from private and public payers to help states and others “understand the cost, quality, and utilization of health care” (Porter et al. 2014). The Washington Legislature passed E2SHB 2572 in 2014, requiring the Office of Financial Management to set up a statewide all-payer health care claims database (the requirements were modified by ESSB 5084 in 2015). The database is not yet up and running; it is still in the rulemaking process (OFM 2016).

Going a step farther, the U.S. Senate Committee on Finance report suggested that “The Committee should explore the degree to which transparency could put downward pressure on pricing without exposing confidential, proprietary information about a new drug’s scientific development” (Finance 2015). Such transparency proposals have been considered by many states.

In 2016, when Vermont passed Act 165, it became “the first state to require greater transparency from drug manufacturers when they increase prices of prescription medications” (Appel 2016). Legislation has been introduced in at least 11 states (including, for example, Colorado, Michigan, North Carolina, Oregon, Pennsylvania, Tennessee, Virginia, and Washington) “that would require pharmaceutical companies to justify their prices by disclosing how much they spend on research, manufacturing and marketing” (Ollove 2016). Similarly, President Obama’s proposed 2017 budget includes a provision that would require manufacturers to disclose production costs and discounts for certain high-cost drugs (HHS 2016). A proposal in Massachusetts would go so far as to cap prices (Ollove 2016).

In Washington, in 2016, HB 2363 was introduced in the state House of Representatives (but not voted on). It would have required drug manufacturers to report on several components of drug costs, including R&D and profits, if the average wholesale price of the drug is $10,000 or more annually.

Additionally, in 2017, a ballot measure that would control drug prices is expected to be voted on in Ohio (Appel 2016). It would require state agencies to pay no more for drugs than the discounted prices paid by the federal Department of Veterans Affairs” (Appel 2016). A similar measure was rejected by California voters in 2016 (Beasley 2016).

The Federal Trade Commission has argued that mandatory transparency requirements could result in collusion among drug manufacturers. While transparency always sounds like a
good policy, “Industry representatives . . . say the information being sought is proprietary and has little to do with the actual price drug companies charge” (Ollove 2016). As with any other commodity, the market determines pricing. Overhead influences the profit margin (and therefore the incentive to continue producing), as well as production decisions that can affect the market price, like additional supply.

Given that, it’s not clear what purpose disclosures of expenses would serve, except to provide political pressure to price drugs artificially low. Indeed, in August 2016, presidential candidate Hillary Clinton said, “pharmaceutical manufacturers should be required to explain significant price increases, and prove that any additional costs are linked to additional patient benefits and better value” (Clinton 2016).

Price controls. A 2004 report from the International Trade Administration (ITA) noted that in the U.S.,

. . . government action has focused on creating the environment that would best encourage further innovation and yield a constant flow of new and innovative medicines to market. The goal has been to ensure that consumers would benefit both from technological breakthroughs and the competition that further innovation generates. (ITA 2004)

Many other countries, though, rely on price controls rather than competition. Controls, ‘when applied to new drugs, reduce company compensation to levels closer to direct production costs, leaving less revenue for R&D” (ITA 2004). The ITA compared drug prices in several Organisation for Economic Co-operation and Development (OECD) countries and found that average prices of patented drugs were 18 to 67 percent lower than in the U.S. (ITA 2004).

As an example, according to the Finance Committee report,

. . . the pricing strategy for Sovaldi in non-U.S. markets contemplated significant [sic] lower prices than what would be set for U.S. consumers. For example, the senators noted that Gilead had reportedly reached an agreement with Egypt to sell Sovaldi for roughly $900 per course of treatment. (Finance 2015)

According to Gilead, it engages “in separate pricing approaches for developed- and less-developed countries,” and limits “access to the drug in other countries to citizens of those countries” (Finance 2015). IMS recently reported that net prices for hepatitis C drugs in the U.S. are similar to those in Europe (Aitken 2016b).

Economist Austin Frakt argues that the U.S. could use reference pricing, which is used in British Columbia and several European countries. In such a system,

. . . the prices of drugs with similar therapeutic effects are pegged to that of one of the lower cost drugs in the class, or an average. The insurer pays one amount (called the reference price) for any drug in a class, an approach that penalizes high-cost drugs that are no better than less expensive but therapeutically similar alternatives. However, the approach only works across drugs that are reasonable substitutes. That is, they require a degree of competition, even if only across a few brand-name drugs. (Frakt 2016)

As the ITA suggests, lower prices also mean less research and development (R&D). One literature review concluded that “price regulation has adverse effects on the cost and quality of medical care” (Kessler 2004). Although consumers may benefit in the short run from lower prices, regulation may mean “reduced R&D, delays in the launch of new drugs even after they have already been discovered, and distortion of patients’ and physicians’ choices toward compounds with lower therapeutic value” (Kessler 2004).

One study found that “R&D investment
is quite sensitive to U.S. price expectations, and policies regulating drug prices in the U.S. could lead to a significant decline in industry R&D expenditures” (Abbott and Vernon 2005). Specifically, cutting pharmaceutical prices in the U.S. by 40 to 50 percent would mean that 30 to 60 percent fewer R&D projects would be undertaken (Abbott and Vernon 2005).

Comment
Medicaid programs represent a significant share of state budgets (25.6 percent nationally and 16.5 percent in Washington, in 2014), but states’ ability to control Medicaid spending is limited. In Washington, Medicaid expansion has substantially increased enrollment. The use of managed care, which can help reduce spending growth, has also increased.

Prescription drugs are one cost driver, but Medicaid programs (if they choose to cover prescription drugs) must cover drugs that are medically necessary. Nationally, prescription drug spending growth has been historically high in recent years, due in part to high-cost specialty drugs. The cost for these drugs is reduced when competitors enter the marketplace. Hospitalization is still the principal cost driver and there is a growing number of drug therapies that have the potential to reduce in-patient costs.

The expansion of Medicaid in an era of rising health care costs puts enormous pressure on state budgets. But price controls are not the answer. In the U.S., drug companies are protected by patents to give them an incentive to produce life-saving medicines. The high prices that may be charged before competing drugs enter the market help to support R&D for future innovations. With price controls, which could upend that model, the cure could very well be worse than the disease.
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