WAIT! THAT DRUG COSTS HOW MUCH?

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It is no secret that pharmacy unit costs and utilization keep rising, driven in part by very high-cost specialty drugs. In May 2019, the FDA approved a new specialty drug, Zolgensma®, that provides hope of improved quality of life for infants born with Spinal Muscular Atrophy (SMA). This drug is the world's most expensive with a $2.125 million price tag for a one-time infusion. As treatment patterns for medical conditions evolve, more and more often we are seeing high-cost drug therapies enter the market. While many of these therapies have proven to be cost-effective in the long run (as with Hepatitis C treatment), and in several cases the new drugs replace in part or in whole other high-cost drugs and medical treatments, health plans and state Medicaid agencies often look for ways to mitigate or better manage the risk associated with high-cost drugs.

RECENT DEVELOPMENTS

State Medicaid agencies and other risk-bearing entities use different approaches to manage the cost and utilization of these drugs. Three recent developments include:

- Drug Benefit Budget Cap: In 2017, the New York Legislature enacted a pharmacy cost control law that limits annual Medicaid drug spending growth and provides additional authority for the state to negotiate with pharmaceutical companies. If New York's drug spending is projected to exceed the annual spending limit, the law gives its Medicaid program authority to negotiate with drug companies for supplemental rebates. If the state is unable to reach an agreement for supplemental rebates, certain drugs may be referred to the New York Drug Utilization Review Board (Board), which conducts a "value assessment" of the product. Based on that assessment, the Board could recommend a target amount for a manufacturer's "supplemental rebate" to reduce the drug's cost. If a supplemental rebate agreement is still not reached, the drug could be removed from the managed care program formulary.

- "Netflix-Style" Model: Two states (Washington and Louisiana) have adopted what the industry is terming a "Netflix-Style" payment model for Hepatitis C treatment. Under the arrangement, a state makes an upfront payment, either a fixed amount of money or a guaranteed unit price, with a pharmaceutical manufacturer for unlimited access to a supply of medication, in this case for Hepatitis C. Industry analysts are predicting these types of programs will continue to spread. The arrangement helps manage the risk and cost of the treatment for the states and is also attractive to the pharmaceutical manufacturer, as it guarantees minimum sales. It was reported that three companies bid on the state of Washington's contract to provide

universal Hepatitis C treatment access, and the state is currently in contract negotiations with AbbVie, the maker of a Hepatitis C treatment. The Washington state program will cover Medicaid, the Public Employees Benefits Board program Labor and Industries, state hospitals and the Department of Corrections, covering an estimated 30,000 Washington residents who receive state-purchased health care.[1]

- Budget-Neutral Risk Pool: A mandatory "premium" is applied to all plans through a capitation rate reduction that funds a risk pool arrangement. Then, based on actual expenditures, the risk pool is distributed among the plans based on the terms and conditions of the contract. This provides a mechanism to increase revenue to the health plans that attract the targeted risk while limiting the state's financial risk to the size of the risk pool. Disadvantages to this approach are that it requires additional administrative effort and may slightly lessen the incentive to manage care effectively and efficiently.

OTHER RISK MITIGATION APPROACHES

Other more traditional approaches to high-cost drug risk and cost containment strategies include:

- Risk Corridors: A corridor is established around a target amount or expense ratio. Risk is shared if expenses fall above or below the corridor.
- Carveout (Full or Partial): A specific drug or group of drugs is removed from the managed care program and payment is provided through fee-for-service (FFS).
- Stop-Loss Risk Sharing: A risk sharing arrangement is established between the state and the plan where the plan pays a "premium" for the state to assume partial or full risk for a certain drug or drugs.
- Supplemental Payment Approach: The cost of treatment is carved out of the underlying rate setting and paid through separate payment. Utilization risk is eliminated for the plan, but unit cost risk remains.
- Disease-Specific Rate Cells: A specific population is placed in a stand-alone rate cell, such as for HIV/AIDS.
- Non-Risk Arrangement within a Risk Contract: Plans are reimbursed similar to how payment is made under FFS, based on actual utilization.

[1] Radar on Drug Benefits, "States Plow Ahead on 'Subscription' Models for Hep C Therapy", June 27, 2019

A PATH FORWARD

States should carefully consider the direction set by any policy action taken for high-cost drugs, as it is expected that many gene therapies and cancer-fighting drugs, among others, will be introduced to the market over the next several years. While these treatments are very costly, there is also promise they may improve the quality of life and even reduce overall health care and other societal costs in the future. Appropriately controlling and managing the use of high-cost drugs is a wise investment.

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