The Value of Medicaid Managed Care:

Making Prescription Drugs More Affordable for States and Taxpayers

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Medicaid MCOs cover the bulk of Medicaid prescriptions nationwide. **More than 70% of all Medicaid prescriptions nationwide** were covered by Medicaid managed care plans in 2018, compared to only 28% in 2011.

Medicaid MCOs' net costs per prescription were approximately 27% below net costs per prescription paid in Medicaid fee-for-service[1] (FFS) programs. This differential yielded **$6.5 billion in net savings for states and taxpayers during FFY[2] 2018.**

MCOs consistently control costs more effectively than FFS programs. Over the five-year period 2013 to 2018, **net costs per prescription increased 13% more in FFS programs than in MCOs.**

More than 75 million Americans – 1 in 5 people – are covered by Medicaid and the Children's Health Insurance Program (CHIP) including millions of children, older adults, people with disabilities and two million veterans. That makes Medicaid the largest health care program in the country and an essential safety net for people with low incomes.

Two-thirds of Americans enrolled in Medicaid are served by Medicaid managed care, a public-private partnership between federal and state governments and health insurance providers. These Medicaid managed care organizations (MCOs) work closely with states to improve quality and control costs – enhancing care and bringing innovative services to enrollees while saving billions of taxpayer dollars.

Medicaid must work for the people who rely on it – and the hardworking taxpayers who pay for it. Medicaid MCOs meet and exceed the high standards set by state and federal regulators and deliver real results for the people they serve.

So how do we know that Medicaid managed care delivers? America's Health Insurance Plans (AHIP) turned to experts at The Menges Group to conduct in-depth research to help us find out. A well-respected analysis and consulting firm, The Menges Group is committed to evaluating the highest quality and most cost-effective strategies to deliver care to high-risk, high-need populations. The result is a series of research studies AHIP will release throughout 2020.

From quality performance to innovation to prescription drug delivery, Medicaid managed care is proof that when the public and private sector work together, Americans get the quality and value they deserve.

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1 "Fee-for-service" refers to payment models that pay health and service providers directly for services they provide to patients.

2 FFY: federal fiscal year; i.e., October 2017 to September 2018

Medicaid Managed Care and Prescription Drug Coverage

MCOs manage drug costs more effectively than FFS

Americans with Medicaid have access to free or low-cost prescription drugs to get them healthy when they're sick and keep them healthy when they're well. Prescription drugs are often the most effective tools for managing chronic conditions and acute illnesses, so drug coverage is an essential part of the continuum of care. While people with Medicaid are protected from the high costs of many prescription drugs, the cost of covering drug benefits for Medicaid participants has increased significantly in recent years, due largely to the rising cost of specialty and generic drugs.

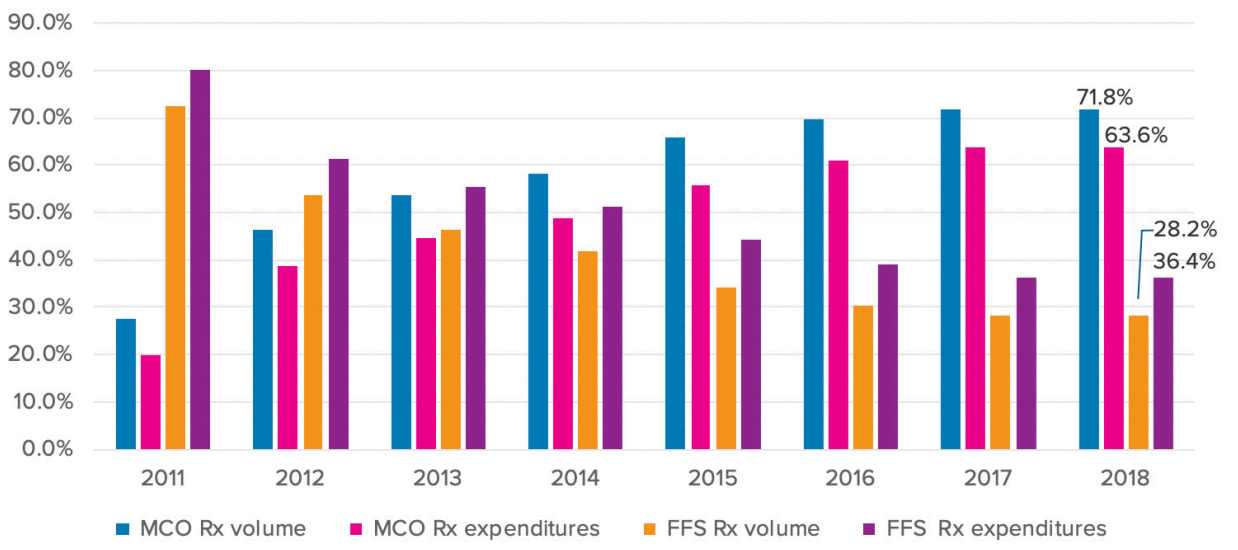
Medicaid spending on prescription drugs is driven both by drug pricing dynamics that impact the whole health care system, and Medicaid-specific issues. Rising drug costs – driven by prices set by pharmaceutical companies – have serious consequences for Medicaid enrollees, state Medicaid programs, and the Americans who support those programs with their state and federal taxes. This spending growth is a point of concern for Medicaid MCOs, state Medicaid programs and the federal government.

Overall Medicaid prescription drug volume expanded by 44% between 2011 and 2018. While much of this can attributed to state adoption of the Affordable Care Act (ACA) Medicaid expansion, states that did not expand their Medicaid programs have also seen significant increases. Prescription drug volume increased by 10% in non-expansion states over the 2011-2018 timeframe.

40 states and U.S. territories provide health coverage through Medicaid managed care, and Medicaid MCOs in 36 of those programs manage prescription drug coverage as part of their Medicaid responsibilities. **Figure 1 shows how Medicaid MCOs are managing greater volumes of prescription drugs:**

- The percentage of total Medicaid prescription volume managed by MCOs more than doubled from nearly 28% in 2011 to nearly 72% in 2018.
- Over the same period, MCOs' share of Medicaid prescription expenditures increased from almost 20% in 2011 to over 63% in 2018 on a pre-rebate basis.
- Overall prescription drug spending grew by 33% between 2011 and 2018.

Figure 1: MCO & FFS Medicaid Prescription Drug Volume and Expenditures, 2011-2018



Source: Menges Group analysis of CMS state drug utilization files; national MCO and FFS Medicaid prescription drug volume and pre-rebate expenditure data for federal fiscal years (FFY) 2011 – 2018.[3]

3 The Medicaid State Drug Utilization Files are a comprehensive public dataset of all Medicaid prescription drug utilization and expenditures in every state. This dataset is maintained by the federal Centers for Medicare and Medicaid Services (CMS) and updated quarterly. Medicaid prescription drug rebate amounts in the analysis are derived in aggregate from CMS's annual Financial Management Reports (FMR), which include statutory rebates for all states and supplemental negotiated rebates for all states. In some cases, supplemental rebates obtained by MCOs are not available in the FMR and are estimated based on averages across reported FMR data.

The comparison of Medicaid FFS and MCO volume and expenditure data is important for two reasons. First, it illustrates the shift to managed care over the last decade. Second, the percentage of total drug expenditures through MCOs has been consistently lower than MCOs' corresponding percentage of total prescription volume, while the FFS percentage of drug expenditures has consistently exceeded the percentage of FFS prescription volume.

Managed Care Savings Compared to FFS

In the United States, prescription drug prices start with the pricing decisions made by drug companies when a drug is first introduced, and develop subsequently over time as the drug's manufacturer decides to increase prices. In gauging the effectiveness of managing the pharmacy benefit for Medicaid programs, average cost per prescription paid to pharmacies is an important statistical measurement. But using this metric excludes the value states obtain from using MCOs to negotiate rebates. States and MCOs receive several kinds of rebates from drug makers, including rebates on prescription drugs that are required by federal law, and supplemental rebates that states and MCOs negotiate for many specific drugs. These rebates help reduce the overall costs of covering prescription drugs for people with Medicaid.

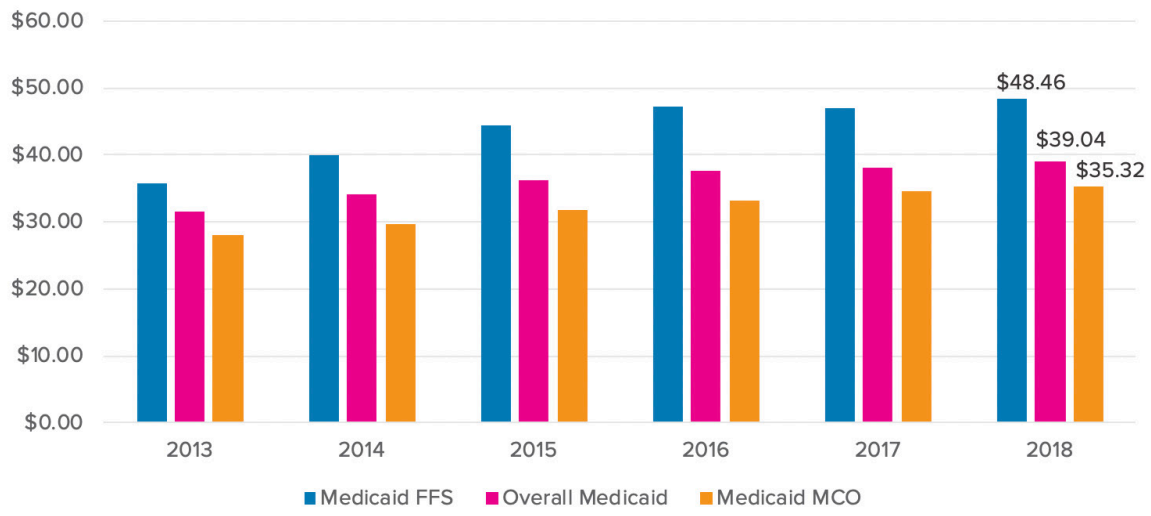
In order to reflect the effect of the MCO negotiated savings and rebates, the preferred method of assessing financial performance of drug programs is *average net* or *post-rebate cost per prescription*, the actual cost to the Medicaid program after accounting for rebates.

Figure 2 shows that factoring in rebates, MCOs achieved net costs per prescription that were 73% of net costs in FFS programs. **During the five-year period 2013 to 2018,** net costs per prescription increased 13% faster in FFS programs than in MCOs:

- **In FFS programs, the average post-rebate cost per prescription grew nearly 36%** from $35.70 in 2013 to $48.46 in 2018, accounting for more than 28% of Medicaid prescriptions in 2018.
- Across all Medicaid prescriptions in the MCO and FFS programs, the average post-rebate cost per prescription increased over 26% from $31.67 in 2013 to $39.04 in 2018.
- **In MCO programs, the average post-rebate cost per prescription grew about 23%** from $27.96 in 2013 to $35.32 in 2018, representing almost 72% of Medicaid prescriptions in 2018.

These data demonstrate that Medicaid managed care drug programs delivered 13% better control over the rate of increases in prescription drug expenditures than FFS programs.

Figure 2: Medicaid FFS, Overall & MCO Net Costs per Prescription, all drugs 2013–2018



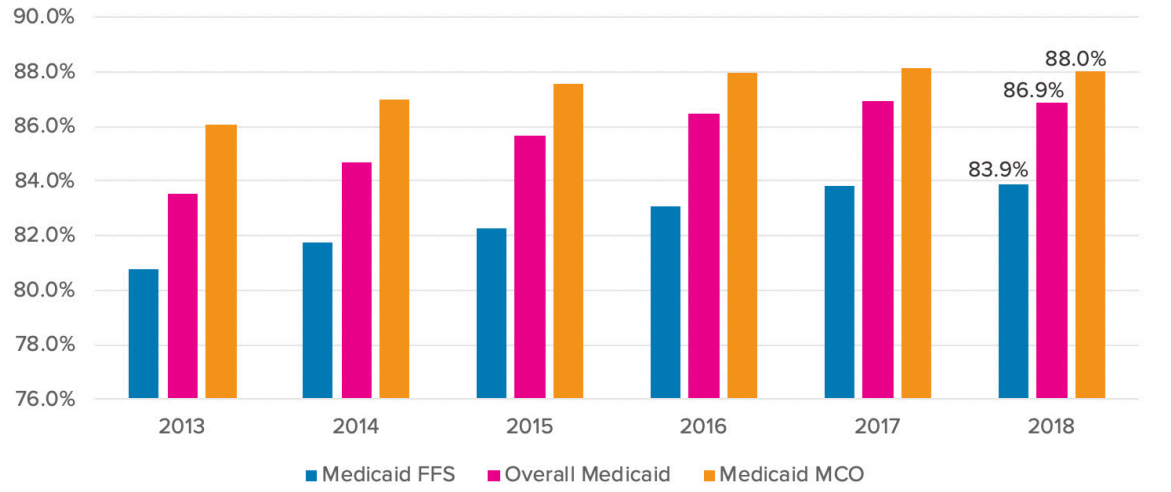
Source: Menges Group analysis of CMS 64 reports; national Medicaid FFS, overall and MCO post-rebate cost per prescription, all drugs for FFY 2013 – 2018.

Utilization of Generic Drugs

One of the most effective ways to decrease prescription drug spending is to encourage patients to use – and physicians to prescribe – generic drugs. Generic drugs are chemically identical to their brand-name competitors, are just as effective, and cost far less.

MCOs do a better job encouraging the use of generic drugs than FFS programs. This can be measured by comparing the generic dispensing rate, a measure of the percentage of total prescriptions that are supplied as generic drugs. **Figure 3 shows that for MCOs, the generic dispensing rate is consistently more than 4% higher than for FFS programs, leading to millions of dollars in savings for state Medicaid programs and the taxpayers that support them.**

Figure 3: Medicaid FFS, Overall & MCO Generic Dispensing Rates, 2013–2018



Source: Menges Group analysis of CMS reports; national Medicaid FFS, overall and MCO generic drug dispensing rates for FFY 2013 – 2018.

How Do Prescription Drug Carve-Outs Impact Savings?

Some states exclude or "carve-out" selected high-cost populations or certain high-cost drugs, such as curative hepatitis C drugs, from their MCO prescription drug programs. In comparing drug expenditures between MCOs and FFS programs at the national aggregate level, states with carve outs had significantly higher cost increases than those without carve outs.

To better understand this potential issue, The Menges Group focused on 12 states that have carved out prescription drugs from their MCO programs:

- **Group A:** Three states carved-out prescription drugs from their MCO programs in 2011 and retained the carve-out through 2018: Missouri, Tennessee, and Wisconsin.
- **Group B:** Nine states carved-out prescription drugs from their MCO programs in 2011 but had "carved in" or reintegrated drug coverage into their programs by 2018: Delaware, Illinois, Indiana, Iowa, Nebraska, New York, Ohio, Texas, and Utah.

As shown in Figure 4, the **Group A carve-out states experienced significantly higher growth in net costs per prescription and lower generic dispensing rates than the Group B states.** In addition, the average post-rebate cost of drugs in the Group A states was more than 14% higher than the corresponding costs in the Group B states.

Figure 4: Medicaid Prescription Drug Analysis Between Carve-Out State Groupings

State Group	Year	Net Costs Per Rx	Generic Dispensing Rate	Average Rebate Per Rx
Group A *(carve-out in both 2011 and 2018)*	**2011**	$37.98	76.8%	$31.19
	2018	$44.90	84.6%	$54.64
	Trend	**+18.2%**	**+7.8%**	**+75.2%**
Group B *(carve-out in 2011, carve-in in 2018)*	**2011**	$39.04	71.0%	$37.62
	2018	$39.21	86.6%	$46.55
	Trend	**+0.4%**	**+15.6%**	**+23.8%**

Source: Menges Group analysis of CMS state drug utilization files; national MCO and FFS Medicaid prescription drug volume and pre-rebate expenditure data for FFYs 2011 – 2018.
Note: West Virginia is excluded from both groups. Prescription drugs were carved out of West Virginia Medicaid in 2011, reintegrated into managed care, and then carved out again before 2018.

The data are clear that using MCOs to manage Medicaid prescription drug benefits yields big savings for states and taxpayers. Even though the Group A carve-out states realized higher average rebates per prescription, the Group B states that reintegrated drug coverage into their MCOs experienced much lower growth rates in their net costs per prescription.

The nearly 18% gap in net costs might even be under-stated, according to the Menges Group, and could be closer to 25%.[4]

Medicaid Managed Care Lowers Drug Costs for States

States continue to recognize the value of Medicaid MCOs in delivering affordable health care and program savings. Medicaid enrollment in MCOs more than doubled from 25.6 million people in 2010 to 56.5 million people in 2018, and that trend is expected to continue.

Medicaid health plans are responsible stewards of taxpayer dollars. They perform a significant range of provider network, care management, and administrative functions for states, demonstrating how efficiently and effectively they serve hardworking taxpayers. They achieve cost stability, improve care and outcomes for enrollees, and shoulder many administrative responsibilities for states.

MCOs are providing Americans with affordable, high quality health care. The data are clear. By working together with the public sector, MCOs are delivering people with Medicaid the prescription drug coverage they need, at the right price, and saving states billions of dollars.

4 There are two reasons for the possible savings understatement. First, not all Medicaid prescriptions were paid by MCOs in all states once the states switched to a carve-in model. Second, six of the nine Group B states adopted Medicaid expansion, whereas none of the three Group A states expanded Medicaid. The Menges analysis suggests that Medicaid expansion was associated with a 5-percentage point increase in statewide net costs per prescription.