Learning From Novel Approaches to Paying for Hepatitis C Virus Medications in State Medicaid Programs

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In the absence of notable action by the US Congress to address rising prescription drug prices, many states have moved to fill the gap.1 State Medicaid programs, which finance 10% of outpatient prescription drug spending, have recently adopted innovative approaches to paying for prescription drugs.

Since 1990, Medicaid programs have purchased outpatient prescription drugs under the Medicaid Drug Rebate Program. Medicaid rebates are substantial, reducing gross Medicaid drug spending (based on list prices) by more than 50% in 2017.2 The program has also prevented states from establishing restrictive formularies, although states may impose other cost-containment measures, such as caps on the number of prescriptions.3

The introduction of medications to treat hepatitis C virus (HCV) exposed the limits of the Medicaid rebate program for balancing the goals of cost containment and adequate access to effective medications. Direct-acting antivirals for HCV are considerably more effective than existing therapies, but they come with extraordinarily high prices—up to $95 000 per treatment course.4 The burden of these high prices falls disproportionately on Medicaid, which covers a large share of individuals with HCV.

In this issue of JAMA Health Forum, Auty et al5,6 examine 2 approaches that state Medicaid programs have taken to address the high costs of HCV medications while ensuring access. One study5 examines policies in Indiana, Michigan, New Hampshire, and West Virginia to carve out HCV medications from managed care contracts, paying for them instead under the states’ fee-for-service programs. In the US, approximately 70% of Medicaid enrollees are in managed care plans that are typically at risk for all prescription drugs. The study finds that carve outs were associated with a relative increase of 86.3% in HCV medication volume in the 4 states compared with similar Medicaid enrollees in the comparison group, but with 7-fold variation in the estimates across the 4 states.

Another study examines subscription-based payment models adopted by Louisiana and Washington state.6 Each state negotiated with a single manufacturer to provide the state with a preferred HCV medication at lower cost. Each state pays a reduced price per prescription through supplemental rebates up to a specified threshold, beyond which the price falls substantially through additional rebates. Findings differed substantially between the 2 states. The subscription-based payment model in Louisiana was associated with a 5-fold increase in HCV prescription volume in the 4 states compared with similar Medicaid enrollees in the comparison group, but with 7-fold variation in the estimates across the 4 states.

Both studies draw on timely data on Medicaid prescription volume from the Centers for Medicare & Medicaid Services to provide evidence on these novel Medicaid policies. Both studies use synthetic control models, which require fewer assumptions than traditional difference-in-difference analyses. The authors conducted a series of tests to ensure the robustness of their findings.

Looking ahead, researchers can build on these important findings to improve our understanding of state Medicaid policy effects on costs, quality, and outcomes. First, it will be important to conduct similar analyses using alternative data sets that permit examination of policy effects on patient-level outcomes, as well as disparities in policy outcomes in key subgroups based on race and ethnicity, gender, or comorbidity. Second, the study of carve outs5 reminds us of the vital role played by Medicaid managed care organizations. Owing to historical gaps in availability of Medicaid encounter data, understanding of best practices in state contracting with managed care organizations is
profoundly limited. Researchers can take advantage of new and improved Medicaid data available from Centers for Medicare & Medicaid Services and partner directly with states to fill this important gap. Third, these articles underscore the need for policy analysts to focus on policy implementation. Both articles point to notable state-level variation in the estimated associations between policy and outcome, and little is known about the mechanisms through which these policies may have changed the use of HCV medications. Researchers and funders should prioritize the collection and analysis of data on how state Medicaid agencies implement policies. Only then can we generate a robust evidence base to inform the Medicaid programs that now cover 80 million people in the US.

REFERENCES


