Massachusetts' Proposed Medicaid Reforms — Cheaper Drugs and Better Coverage?

Benjamin D. Sommers, M.D., Ph.D., and Aaron S. Kesselheim, M.D., J.D., M.P.H.

While health policy attention in recent months has focused on Washington, D.C., several proposals from individual states have garnered less publicity despite their potentially far-reaching implications. One such proposal comes from Massachusetts, which has applied for a waiver from federal rules in order to shift 140,000 near-poor adults — those with incomes between 100% and 138% of the federal poverty level — from Medicaid into private plans on the state's health insurance marketplace and, perhaps more important, to create a closed drug formulary for Medicaid, which would be a first for the program (see table). The administration of Massachusetts Governor Charlie Baker — a Republican who has opposed national efforts to repeal the ACA — argues that these changes are needed to manage the state's Medicaid budget and to "improve care, reduce costs, and achieve administrative efficiencies."[1]

Using private plans instead of Medicaid to cover lower-income adults is not unprecedented. Arkansas and New Hampshire implemented this approach (sometimes called the "private option" or "premium assistance") for most of their states' Medicaid-expansion population, and other states have proposed variations on this policy. Supporters of this model contend that it can improve access to clinicians as compared with Medicaid, reduce income-related churning of patients in and out of coverage, and harness private-market efficiencies to improve quality of care. However, evidence to date from Arkansas shows similar outcomes under its private option and a neighboring state's traditional Medicaid expansion, casting doubt on the notion that the Massachusetts proposal would significantly improve patient care over the status quo.[2]

Critics of the private option argue that marketplace plans feature greater cost sharing, fewer benefits, and higher administrative costs. To address concerns about the switch to a private-option model, the Massachusetts proposal includes a guarantee that enrollees would have limited dental coverage through the state's health safety-net program and at least one zero-premium plan option. In addition, the system of state-funded subsidies in Massachusetts would continue to cap out-of-pocket spending at a level lower than that required by the ACA; the state estimates that the average beneficiary would pay $200 to $300 annually, as compared with the state's current Medicaid cost sharing, which is limited to copayments of $1 to $3 per prescription and $3 per inpatient admission. Although affordability and coverage rates could potentially worsen under this model, the state is essentially proposing a return for these adults to its pre-ACA policy of "RomneyCare" (so called after Mitt Romney, the Republican former governor of Massachusetts), in which many low-income adults were covered through premium-free private exchange plans — an arrangement whose enactment in 2006 produced large improvements in access to care and health outcomes.[3]

But other aspects of this coverage shift are more uncertain — namely, how much it will cost and who will pay for it. Although the Massachusetts proposal cites "savings" to be gained from shifting patients from Medicaid to private coverage, it seems unlikely that such a move would reduce total health care expenditures, since private insurance generally costs much more than Medicaid (mainly because of higher clinician reimbursements). In fact, the Government Accountability Office concluded in 2014 that the Arkansas private option increased total and federal spending on health care as compared with traditional Medicaid, and the same result seems likely in Massachusetts.[4] Whether the federal government would be willing to foot this bill or would require Massachusetts to pay a greater share remains unclear.

The more ground-breaking policy proposal in the Massachusetts waiver addresses prescription drugs, the fastest-growing source of spending in the state's Medicaid program, MassHealth. Nationally, Medicaid faces distinct challenges in paying for new medicines: unlike private payers,

Key Features of the Massachusetts Medicaid Waiver Proposal.*

Proposal	Policy Details	Potential Advantages	Potential Concerns
Shift from Medicaid to private insurance	Affects nondisabled adults 21–64 yr of age with incomes 100–138% of the federal poverty level Transfers adults from Medicaid into subsidized private plans in the state's health insurance marketplace	Decrease reliance on public insurance among working families Higher payment rates may improve access to providers as compared with Medicaid	Cost sharing, even subsidized, will be higher in private plans than in Medicaid Future economic and political stability of the marketplace is uncertain Total costs of coverage to state and federal governments will likely increase
Creation of Medicaid drug formulary	Closed formulary in which drugs are covered on the basis of clinical effectiveness, cost, and appropriateness Coverage of at least one drug per therapeutic class	Reduce spending on drugs with limited clinical benefit Use coverage inclusion as lever to negotiate value-based prices	Formulary-setting process must be done in politically independent, evidence-based, and transparent way An overly restrictive formulary may limit some patients' access to needed medications

* Other waiver provisions not directly analyzed in the text include aligning Medicaid benefits for poor nondisabled adults with commercial coverage, implementing narrower networks in traditional Medicaid, relaxing requirements for multiple managed care options, removing barriers to behavioral health care in institutions for mental disease, and modifying cost-sharing and premium-assistance rules.

Medicaid programs must cover most new drugs approved by the Food and Drug Administration. This policy dates back to the 1990 legislation that established the Medicaid Drug Rebate Program and required manufacturers to offer rebates to the Centers for Medicare and Medicaid Services (CMS). Although the ACA increased statutory Medicaid rebates from 15.1% to 23.1% and extended them to Medicaid managed care plans, this basic framework remains in place.

Currently, beyond the rebates set by law, the primary ways for states to manage drug costs include prior-authorization processes and negotiation of supplemental rebates. However, state attempts to prioritize coverage of expensive new hepatitis C drugs have been blocked by the courts, and supplemental rebates address only about 5% of total Medicaid drug spending.[5] The Massachusetts waiver would depart from this long-standing approach by creating a closed formulary: the state would select which drugs to cover on the basis of clinical effectiveness, cost, and appropriateness, ensuring that at least one drug per therapeutic class was included. Closed formularies are used by most commercial and public payers; for example, pharmacy benefit managers CVS Health and Express Scripts reportedly exclude more than 170 and 150 drugs, respectively, from their formularies. For excluded drugs, MassHealth plans to maintain an exceptions process to address requests from individual patients.

The process of developing a formulary will require MassHealth to rigorously scrutinize drugs with limited or inadequate evidence of clinical efficacy and potentially exclude them from coverage until higher-quality evidence of benefit is available. Drugs that may be excluded are those approved on the basis of surrogate measures, drugs approved despite a failure to achieve the primary end points in clinical trials, and drugs that provide no incremental benefit over existing alternatives. The scope of the proposed pharmaceutical changes in Massachusetts could be substantial, depending on implementation details. In fiscal year 2016, roughly 20% of MassHealth's drug spending was for drugs that have been excluded from either the CVS or the Express Scripts formulary or from both. In addition to reducing spending on costly drugs excluded from coverage owing to limited clinical benefit, the state may be able to negotiate better prices for some covered drugs.

Some manufacturers and patient organizations contend that the Massachusetts policy would unfairly deprive Medicaid patients of treatments. However, formularies like those already in place for other payers — if established

on the basis of cost-effectiveness and clinical benefit — can ensure evidence-based care while lowering costs. Of course, if Medicaid formularies are implemented solely with the aim of reducing costs, then patients might indeed suffer. Given the strong historical commitment to health care access in Massachusetts and the state's well-funded administrative infrastructure for health care, its proposal would arguably test a Medicaid formulary in a best-case scenario. But if the proposed formulary is approved, other states would undoubtedly follow suit (Arizona submitted a similar proposal earlier this month), and consumer protections such as those included by Massachusetts — for example, covering at least one drug per class, making formulary decisions on the basis of the best available data on drug benefits and risks, and establishing an accessible exceptions process — will be critical in each case.

The future of the waiver now depends on the verdict from CMS, and approval is far from a sure thing. The Massachusetts proposal was submitted in a highly uncertain political and policy environment. The White House's recent actions to stop cost-sharing subsidy payments and allow more loosely regulated health plans threaten the long-term stability of the ACA marketplaces, leaving proposals for transitioning Medicaid beneficiaries to private coverage precarious. The formulary proposal is sure to face opposition from powerful lobbyists such as the pharmaceutical industry. More broadly, though CMS released a letter in March 2017 encouraging state proposals related to Medicaid and the ACA, subsequent actions have clouded the outlook for such waiver applications (some of which are of the 1115 variety focused on Medicaid, while others are related to the ACA's 1332 waiver process). Given that proposals from Republican administrations in Iowa and Oklahoma faced unexpected delays and White House opposition, it's possible that even policies with a conservative orientation will get bogged down in the ACA's political quagmire. Whether the Massachusetts proposal ultimately receives approval and, if it does, how it ends up affecting coverage, quality, and costs will be important harbingers of the future direction of state health policies.

Disclosure forms provided by the authors are available at NEJM.org.

From the Department of Health Policy and Management, Harvard School of Public Health (B.D.S.); and the Program on Regulation, Therapeutics, and Law, Department of Medicine, Brigham and Women's Hospital (A.S.K.) — both in Boston.

This article was published on December 13, 2017, at NEJM.org.

1. MassHealth section 1115 demonstration amendment request [submitted to CMS]. Boston: Massachusetts Executive Office of Health and Human Services, September 8, 2017 (http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/masshealth-section-1115-demonstration-amendment-request-09-08-17.pdf).
2. Sommers BD, Blendon RJ, Orav EJ, Epstein AM. Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance. JAMA Intern Med 2016;176:1501-9.
3. Sommers BD, Long SK, Baicker K. Changes in mortality after Massachusetts health care reform: a quasi-experimental study. Ann Intern Med 2014;160:585-93.
4. Medicaid demonstrations: HHS's approval process for Arkansas's Medicaid expansion waiver raises cost concerns (publication no. GAO-14-689R). Washington, DC: Government Accountability Office, August 2014.
5. Medicaid and CHIP Payment and Access Commission (MACPAC). Medicaid spending for prescription drugs. January 2016 (http://www.macpac.gov/publication/medicaid-spending-for-prescription-drugs).

DOI: 10.1056/NEJMp1714824