

The Menges Group

Strategic Health Policy & Care Coordination Consulting

Assessment of Louisiana Medicaid's Prescription Drug Carve-Out Option

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I. Executive Summary and Introduction

A. Overview

Louisiana's Medicaid Managed Care Organizations (MCOs) currently pay for approximately 95% of the state's Medicaid prescriptions. Louisiana currently includes its drug benefit into its Healthy Louisiana Medicaid MCO contracts. When states include prescription drugs within health plans' capitation payments, it is commonly referred to as "carving-in" prescription drug benefits. As of April 2018, of the 38 states and the District of Columbia use Medicaid MCOs to manage the medical benefit, 33 (85%) currently use this carve-in approach, which integrates the pharmacy benefit with other covered services in the coordinated care program. Five states with Medicaid MCO contracts currently retain the prescription drug benefit in the fee-for-service (FFS) program, "carving-out" prescription drugs from the capitated medical benefits contract. Legislation has been proposed to carve-out Louisiana's Medicaid prescription drug benefit and cover it under the FFS program. We have been engaged to assess the impacts of this potential programmatic change.

B. Key Findings

The most significant findings from our analyses are summarized below.

1. Louisiana is a very high-performing state in the management of its Medicaid prescription drug benefit – and this is attributable to the MCOs and PBMs currently serving its Medicaid program.

- As noted above, over 95% of Louisiana's Medicaid prescriptions are paid by MCOs, thus Louisiana's Medicaid prescription drug expenditure and utilization statistics essentially depict the health plans' collective performance. During FFY2017, the most recent year for which full Medicaid prescription drug data are available, Louisiana had the nation's most favorable Medicaid generic dispensing rate (GDR) at 90.9%. The GDR is derived as the generic prescriptions divided by total prescriptions.
- Net cost per prescription is a significant statistic that indicates how effectively the drug benefit is being managed in Medicaid. This statistic captures the mix of drugs the Medicaid population is utilizing, the upfront pricing of these medications, and the back-end rebates received. During FFY2017, Louisiana had the nation's 8th lowest net cost per prescription at \$32.72. Louisiana's FFY2017 net cost per prescription was 18% below the US average of \$39.94.
- Louisiana's net cost per prescription ranking is highly favorable despite the mix of its Medicaid population. Our statistics suggest that more than 30% of Louisiana's Medicaid prescriptions are attributable to Medicaid expansion enrollees. To estimate the impacts Medicaid expansion appears to be having on net cost per prescription, we assessed FFY2011 and FFY2016 net cost per prescription in 12 states that have

always had 100% of prescriptions paid in the FFS setting (in order to control for impacts of MCO management on pharmacy benefit management). Among these 12 states, 8 states did not adopt Medicaid expansion and these states collectively experienced an 18% increase in net cost per Medicaid prescription from FFY2011-FFY2016. Among the 4 states (within the 12 continuous FFS states) that did adopt Medicaid expansion, net cost per prescription increased by 37% from FFY2011-FFY2016. This suggests that Medicaid expansion has a 19 percentage point upward impact on Medicaid net cost per prescription. Expansion enrollees, the majority of whom are adult males, typically experience relatively high utilization of many high-cost medications, such as drugs treating HIV and Hepatitis C infections, which has increased net cost per prescription in expansion states. The net cost per prescription differential between expansion and non-expansion states suggests that Louisiana's already favorable net cost per prescription is understated since we have made no explicit adjustment for Medicaid expansion's upward impacts on Louisiana's drug costs.

- In summary, Louisiana's Medicaid program and its MCOs (with the support of their PBM partners) are delivering excellent pharmacy benefits management by steering volume to the lowest, cost-effective drug available.

2. Carving out the pharmacy benefit would be costly to Louisiana's Medicaid program and its taxpayers—the state would experience a cost increase of \$69.3 million in FFY2019 and \$394.8 million across the five-year timeframe (FFY2019 - FFY2023).

- Based on our analysis, transitioning the Medicaid prescription drug benefit back to the FFS setting would represent a significant and costly step backwards for the Healthy Louisiana program. We estimate that by transitioning to a pharmacy carve-out model, Louisiana would experience a cost increase of \$69.3 million in State Funds during FFY2019, and a cost increase of \$394.8 million across the five-year timeframe (FFY2019 - FFY2023).
- These adverse State Fund impacts are a mix of overall Medicaid cost increases caused by forfeiting the highly effective management of the prescription drug benefit described above, and a loss of net tax revenue related to Louisiana's 5.5% MCO premium tax.

3. National analyses of Medicaid prescriptions demonstrate the favorable impacts of MCO drug benefit management under the carve-in model.

- Medicaid's net cost per prescription has consistently been far lower for MCO-paid prescriptions than for those paid in the FFS setting, driven primarily by the drug mix management efforts of MCOs and their PBM partners. Nationally, MCOs' net cost per Medicaid prescription was 32.5% below FFS during FFY2017.

- Of the 13 states that used the pharmacy carve-out model in FFY2011, nine of these states switched to a carve-in approach¹. We compared the progression of costs and utilization across the group of four states that retained their pharmacy carve-out model versus the nine states that moved to a carve-in model during the 2012-2014 timeframe and continued to carve-in the drug benefit during FFY2017. The states that switched to a carve-in model have far outperformed those retaining their carve-out model. A key metric demonstrating this performance is that the states that carved-in the drug benefit experienced only a 0.9% increase in net cost per prescription across the entire FFY2011-FFY2017 timeframe, while the states that continued to carve-out the pharmacy benefit experienced a 16.1% cost increase. This 15.2 percentage point difference in net cost per prescription between these 2 state groupings reflects the MCOs' favorable impact on drug spending management, despite the fact that MCOs in two of the carve-in states did not have latitude over the preferred drug list to drive the most cost-effective drug mix. The MCOs paid for 86.5% of prescriptions during 2017 in the nine states that switched to a carve-in model (and the remaining 13.5% of prescriptions in these states were paid under FFS during FFY2017). Prorating this net cost per prescription differential (to quantify MCOs' impact on only MCO-paid prescriptions in the states that carved-in the drug benefit) widens the net cost differential from 15.2% to 17.6%. Further, none of the four states that continued to carve-out the drug benefit adopted Medicaid expansion, whereas seven of the nine states that switched to a carve-in model did expand Medicaid. With all other factors being equal, given the drug cost and utilization dynamics associated with the Medicaid expansion population (such as, much greater use of high-cost drugs for conditions such as HIV and Hepatitis C) we would have expected the group of nine states that switched to a carve-in model to have experienced a higher cost trend than the carve-out states that did not expand Medicaid.
- Several states that carved-in the drug benefit limited or altogether eliminated the MCO/PBMs' latitude to determine the most appropriate preferred drug list (PDL) content, including Delaware, Iowa, Texas, and West Virginia. These states did not draw upon the full skill set of the MCOs in managing the prescription drug benefit.
- Despite collectively serving a large Medicaid expansion population and facing many limitations on their PDL latitude to manage drug mix, the nine states that carved-in the drug benefit improved their GDR by 15.66 percentage points from FFY2011-FFY2017, more than twice the increase (7.67 percentage points) that occurred in the four states that continued to carve-out the drug benefit throughout this timeframe.

¹ West Virginia recently switched back to a carve-out model as of FFY2018, resulting in eight carve-in states and five carve-out states in FFY2018.

4. The programmatic advantages of the carve-in model are compelling.

- Prescription drugs play a central role in health care treatment. Moving this benefit out of the MCO contract runs directly counter to the goals of achieving integrated, whole-person focused coverage and care coordination for the Medicaid population.
- In the carve-in model, prescription drug data are available to support care coordination in real time and in the specific format each MCO desires. Conversely, in the carve-out model, the prescription drug data are available only according to the state's information dissemination schedule and in the state-preferred format, which may be challenging for MCOs to utilize for clinical decision making.
- A common misconception regarding a presumed advantage of the carve-out model is that the state gains purchasing power by bundling all Medicaid prescriptions together. The PBMs and MCOs currently supporting the Healthy Louisiana program are national organizations with far more covered lives and purchasing power than Louisiana's Medicaid population represents (even if Medicaid lives were combined with state employees or other Louisiana populations). We have also not seen a correlation showing that increasing the number of Medicaid lives will lower the net cost per prescription. Purchasing power fosters greater rebate negotiations and lower initial prices at pharmacies, however our analyses indicate that rebate-focused behaviors constitute "playing the wrong game." The path to successful Medicaid pharmacy benefits management lies first and foremost in effective management of the front-end mix of drugs. Hence, we anticipate that Louisiana would neither gain purchasing power (relative to what the national MCOs and PBMs already have) through a carve-out approach, nor would a gain in purchasing power, even if it could be achieved, translate to lower costs given Louisiana's MCOs' excellent drug mix and spending management performance to date.

C. Summary of Approach

Our assessment of Louisiana's Medicaid prescription drug costs included the following key components:

- a) States' Net Cost Per Prescription: Data were available that allowed for an accurate comparison between Louisiana's average cost per Medicaid prescription on a net (post-rebate) basis and every other state. These analyses are presented in Section II.
- b) Generic Dispensing Rates: We were also able to quantify the degree to which a drug mix-focused strategy (e.g., promoting use of generics) versus a rebate-focused strategy yields the most favorable net cost per prescription within state Medicaid programs.

- c) Prescriptions per Beneficiary: We obtained data on Medicaid enrollment in each state to assess relative access to medications in Louisiana’s Medicaid program. Focused analyses were also conducted on selected high-cost drugs, like those treating HIV and Hepatitis C.

The net cost per prescription statistic is a useful measure of how cost-effectively the pharmacy benefit is being managed, reflecting the mix of medications filled.² This is important since a given health condition may be treatable by clinically effective drugs with widely varying net (post-rebate) prices. This statistic also captures all statutory rebates for each drug, as well as the states’ and Medicaid MCOs’ and PBMs’ efforts to negotiate supplemental rebates from drug manufacturers.

We ranked all states and the District of Columbia on the key statistics above, and we have presented Louisiana’s rankings in Section II. As noted earlier, we also tabulated drug selection and spending statistics for MCO-paid prescriptions and compared them to statistics for Medicaid prescriptions paid under the FFS program. In addition, we compared the progression of costs and utilization in nine states that were carved-out in 2011 and subsequently switched to a carve-in model sometime between 2012 and 2016, to the four 2011 carve-out states that have continued to carve-out the drug benefit from 2011 through 2017.

Key Data Sources: CMS publishes the State Drug Utilization Files, which contain quarterly data by national drug code (NDC) for each state and for every Medicaid prescription. This source conveys the volume of prescriptions and the corresponding Medicaid amount paid, separately indicating drugs paid under the FFS program and those paid by MCOs. A separate CMS data source, the CMS 64 Report, captures the Medicaid prescription drug rebates each state receives in each federal fiscal year. The reported rebates include both the ACA’s statutory rebates as well supplemental rebates the states and MCOs/PBMs negotiate with manufacturers. Together, these data sources permit tabulation of each state’s Medicaid initial (pre-rebate) cost per prescription, rebates per prescription, and the net (post-rebate) cost per prescription.

The FFY2017 CMS 64 reports were not yet available for this analysis. Average brand rebate percentages in each state from the FFY2016 CMS 64 Report were applied to FFY2017 drug utilization data to estimate net brand costs. All generic drugs receive a 13% rebate, and thus FFY2017 generic rebates were tabulated rather than estimated. MCOs/PBMs’ supplemental rebates are not available in the CMS 64 report for most states. The MCOs/PBMs’ average percentage of supplemental rebates in the states where this information was reported was used to estimate MCOs’ supplemental rebates in the other states in which Medicaid MCOs operate.

II. Detailed Data Analyses Findings

A. Louisiana’s Rankings on Key Metrics

We tabulated data on various prescription drug performance metrics for FFY2015-FFY2017 for each state and the District of Columbia. Louisiana’s ranking among these 51 jurisdictions are shown in Exhibit A. Louisiana has performed favorably – and increasingly favorably – on each statistic shown. Louisiana’s

² Given that multiple medications are often clinically effective, but that these alternative drugs often have significantly different costs, managing the “mix of medications” involves steering volume towards the lowest-cost, clinically effective drug through the PDL and related utilization management processes. This includes using generics in lieu of brands where appropriate, but also includes using relatively low-cost brands (when a brand drug is most cost-effective) and relatively low-cost generics (when a generic drug is most cost-effective).

MCOs pay for nearly all of the state’s Medicaid prescriptions (95.2%) as of FFY2017, and this high percentage of managed drug benefits has been a key factor in Louisiana’s favorable prescription drug performance across all key metrics below.

Exhibit A. Louisiana’s Ranking on Key Medicaid Prescription Drug Performance Measures

Performance Measure	State Ranking Order	Louisiana Ranking Among 50 U.S. States and D.C.			Louisiana FFY2017	U.S. FFY2017
		FFY2015	FFY2016	FFY2017		
Generic Dispensing Rate (GDR)	Highest GDR Ranked #1	16th	5th	1st	90.9%	86.9%
Net Cost Per Prescription	Lowest Cost Ranked #1	9th	12th	8th	\$32.72	\$39.94
Rebates Per Prescription	Largest Rebate Ranked #1	37th	50th	50th	\$27.62	\$43.20
Rebates as Percentage of Initial Amount Paid to Pharmacies	Largest Rebate Percentage Ranked #1	17th	48th	48th	45.8%	52.0%
Percentage of Prescriptions Paid by MCOs	Highest Percentage Ranked #1	20th	11th	10th	95.2%	71.9%

Louisiana’s net cost per prescription was pushed upward by its adoption of Medicaid expansion and its large Medicaid expansion enrollment– nearly 30% of Medicaid beneficiaries in Louisiana are expansion enrollees. This population, primarily comprising of low-income adult males, has a high prevalence of conditions treated by expensive drug therapies, such as those for Hepatitis C and HIV infections. This dynamic likely explains why Louisiana had the nation’s most favorable GDR during FFY2017 but was ranked 8th in net cost per prescription.

B. Comparisons of Key Medicaid Drug Benefit Performance Metrics

Analyses of national Medicaid drug benefit performance metrics across several hundred million prescriptions indicate the significant degree to which MCOs outperform FFS drug programs on prescription drug costs.

The drug cost and spending differences are primarily driven by the drug mix management efforts of the MCOs and their PBM partners. Given that multiple medications are often clinically effective, but that these alternative drugs often have significantly different costs, managing the “mix of medications” successfully involves steering volume towards the lowest-cost, clinically effective drug through the preferred drug list (PDL) and related utilization management processes. This includes using generics in lieu of brands where appropriate, and also includes using relatively low-cost brands (when a brand drug is most cost-effective) and relatively low-cost generics (when a generic drug is most cost-effective). Exhibit B shows the following differentials for FFY2017:

- MCOs’ GDR at 105.2% was 4.4 percentage points greater than FFS;
- Within brands, MCOs’ net cost per prescription was 17.0% less than FFS; and
- Within generics, MCOs’ net cost per prescription was 18.8% less than FFS.

The collective result of the drug mix management activities resulted in MCOs’ overall net cost per Medicaid prescription being 32.5% less than FFS during FFY2017.

Exhibit B. National Medicaid Costs Per Prescription and Generic Dispensing Rate, FFY2017

Timeframe	Performance Measure	MCO	FFS	All Medicaid	Differential	MCO as a Percentage of FFS
FFY2017	Generic Dispensing Rate (GDR)	88.1%	83.7%	86.9%	4.4% pts	105.2%
	Net Cost Per Brand Prescription	\$172.58	\$208.02	\$184.91	-\$35.44	83.0%
	Net Cost Per Generic Prescription	\$17.77	\$21.87	\$18.88	-\$4.10	81.2%
	Overall Net Cost Per Prescription	\$36.00	\$53.33	\$40.42	-\$17.33	67.5%

C. Comparisons Between Carve-In and Carve-Out States

During 2011, 13 states used a prescription drug carve-out model within their Medicaid MCO program. Nine of these states – Delaware, Illinois, Indiana, New York, Ohio, Texas, Utah and West Virginia³ – subsequently switched to a carve-in approach and continue to carve-in their drug benefit in FFY2017. Four of the states that had a carved-out drug benefit in FFY2011 have retained their carve-out approach – Missouri, Nebraska, Tennessee and Wisconsin. The four states maintaining their carve-out model represent a “control group,” and their drug cost and utilization progression from FFY2011-FFY2017 was compared with the group of 9 states that used a carve-out model during 2011 but has switched to a carve-in model. These comparisons are shown in Exhibit C.

Exhibit C. Performance Progression Among States Switching to Carve-In as Compared with States Retaining Carve-Out Model

Performance Measure	9 States Carved-Out in 2011, Switched to Carve-In Thereafter			4 States Carved-Out in 2011, Retaining Carve-Out Through 2017		
	FFY2011	FFY2017	Change, FFY2011-2017	FFY2011	FFY2017	Change, FFY2011-2017
Generic Dispensing Rate	70.96%	86.63%	15.7% pts	76.92%	84.59%	7.7% pts
Initial (pre-rebate) Cost Per Prescription	\$76.40	\$81.38	6.5%	\$68.77	\$92.37	34.3%
Net (post-rebate) Cost Per Prescription	\$38.59	\$38.93	0.9%	\$38.11	\$44.25	16.1%
Rebates Per Prescription	\$37.81	\$42.45	12.3%	\$30.66	\$48.12	56.9%
Rebates as Percentage of Initial Pharmacy Payments	49.5%	52.2%	2.7% pts	44.6%	52.1%	7.5% pts
Percentage of Prescriptions Paid by MCOs	0.0%	86.53%	86.5% pts	0.0%	0.0%	0.0% pts

Many of the statistics in Exhibit C contribute to the overall net cost per prescription, as highlighted in the third row. While the two groups of states had similar net costs per prescription during FFY2011, states that carved-in the drug benefit achieved a much lower net cost per prescription trend than states that retained the carve-out model. The four states maintaining their carve-out model through FFY2017

³ West Virginia has carved-out its drug benefit effective FFY2018.

experienced a **16.1% increase** in net cost per prescription from FFY2011-FFY2017.

In contrast, the nine states switching to a carve-in approach experienced just a 0.9% increase in net cost per prescription from FFY2011-FFY2017. Seven of these nine states implemented Medicaid expansion during this timeframe, which typically has the effect of driving up net cost per prescription. None of the four carve-out states implemented Medicaid expansion, so these states did not experience those cost-increasing dynamics as seven out of the nine states in the carve-in group experienced. MCO/PBMs in several of these states also faced PDL latitude restrictions that impaired their ability to optimally manage drug mix. The MCOs' essentially flat trend line across the carve-in states during a seven-year period is a significant accomplishment in the face of Medicaid expansion, state-imposed PDL latitude restrictions, the introduction of so many high-priced specialty drugs, and the rapid increase in drug prices.

The 15.2 percentage point differential in net cost per prescription between the two groups of states amounts to a 17.6 percentage point differential in net cost per prescription when prorated for the 86.5% of Medicaid prescriptions that were paid by MCOs in these states during FFY2017. The MCOs were not able to influence costs for 13.5% of prescriptions paid under FFS in these carve-in states.

Another interesting comparison in Exhibit C involves rebates per prescription, which were greater in the four states that retained the carve-out model throughout this timeframe when compared to the nine states that switched to a carve-in approach (\$48.12 vs. \$42.45). The fact that this wide of a rebate differential did not yield a net cost per prescription advantage in the states retaining the carve-out model demonstrates the failure to achieve lower drug spending through adoption of a rebate-focused, drug cost management strategy. The four carve-out states achieved a higher rebate per prescription because they utilized higher-cost drugs than the nine states that switched to the carve-in model, as witnessed by their initial pre-rebate cost per prescription comparison—\$92.37 for the four carve-states vs. \$81.38 for the nine states that carved-in. Our analyses in Exhibit C demonstrates that driving greater generic use, as witnessed in the nine states switching to a carve-in, is a more successful strategy at lowering net cost per prescription than maximizing rebates by utilizing higher-cost brand drugs.

III. Cost Impacts of Louisiana Moving to a Carve-Out Model

We estimated impacts on Louisiana's Medicaid costs of adopting a carve-out model for its Medicaid prescription drug program through the following process.

Establishing Baseline Estimates: Louisiana's current program structure, cost and utilization dynamics, as depicted in its actual drug benefit performance during FFY2017, were used to estimate baseline costs through FFY2023.

The key assumptions used to trend the FFY2017 figures forward each year were derived based on observed national Medicaid prescription drug trends and are shown below:

- Overall prescription volume was increased by 1.5% per year.
- The GDR was increased by 0.5 percentage points each year, subject to a ceiling of 92.5% (which Louisiana would reach in FFY2021). The ceiling assumption reflects the expectation that the opportunity to continue increasing the GDR may "top out" given that the effect of patent expirations may be offset by the introduction of new brand products.

- Average cost per prescription was increased by 3.6% per year for generics and by 9.1% for brands. The higher trend rate for brands reflects the ongoing stream of high-priced specialty drugs being introduced. A very small proportion of drugs could not be categorized as brand or generic (roughly 0.2% of all Medicaid prescriptions). The average annual price increase for this group of drugs was assumed to be 5%.

Cost Impact Factors: Using the state groupings in Exhibit C, we derived the following cost impact factors by comparing the average differential between the 9 states that have carved-in their drug benefit and the 4 states that continue to use the carve-out model. The increased cost of Louisiana’s proposed move to a carve-out model were estimated using cost impact factors derived in Exhibit C and the following assumptions:

- Net cost per prescription was assumed to be reduced by 17.6% in the carve-in setting based on our analyses in Section II. We therefore applied a net cost per prescription factor of 1.176 to yield estimated costs of Louisiana switching to a carve-out model.
- Prescription drug volume is estimated to be 2.8% lower in the carve-in model than the carve-out model. We derived this 2.8% utilization factor based on recent work in which we estimated that a 2% prescription volume reduction occurs in the MCO setting relative to FFS due to the health plans’ utilization management (UM) efforts, and a 0.8% volume reduction occurs in the MCO setting relative to FFS due to the health plans’ efforts to detect and eliminate fraud, waste and abuse (FWA). These prescription volume reductions from UM and FWA efforts yield a net overall savings as they eliminate unnecessary volume in the carve-in setting. We therefore applied a 1.028 factor to estimate the increase in Louisiana’s prescription volume under a carve-out model.
- We have also applied a 4.0% cost savings factor in moving to a pharmacy carve-out model to account for reduction in capitation payments that include both a risk/profit margin for the health plans and an administrative allocation to manage the drug benefit under a carve-in model. The 4.0% cost savings factor is a combination of the 2.5% fee for additive services provided by PBMs to MCOs⁴ and a 1.5% aggregate operating margin earned by Medicaid MCOs across 2011-2016 on their Medicaid line of business.

The above cost factors (1.176, 1.028, and 0.960) were multiplied together to yield an estimated 16.07% increase in Medicaid costs due to the programmatic impacts of switching to a carve-out model. This percentage applies to both the state and federal shares of Medicaid prescription drug expenditures.

It is estimated that a policy change to a prescription drug carve-out could become effective in October 2018, the beginning of FFY2019. We applied the above factors to Louisiana’s baseline FFY2019 costs and utilization to estimate increased costs under a pharmacy carve-out in Louisiana. This new FFY2019 set of costs and utilization patterns in Louisiana was then trended forward through FFY2023 using the

⁴ Sood, N. et al. June 2017. The Flow of Money Through the Pharmaceutical Distribution System. http://healthpolicy.usc.edu/documents/USC%20Schaeffer_Flow%20of%20Money_2017.pdf. The transactional aspects of prescription drug benefits administration – for example, paying claims – will occur under both the carve-in and carve-out models and account for the remaining 2.5% of drug benefit management costs.

same trending assumptions described earlier. The increased costs of carving-out the drug benefit in Louisiana from FFY2019-FFY2023 are outlined in Exhibit D.

Under a pharmacy carve-out, Louisiana Medicaid will experience an overall cost increase of \$104.6 million in FFY2019, \$27.6 million of the cost increase will be funded by the state and its taxpayers. Over a five-year timeframe (FFY2019-FFY2023), Louisiana Medicaid will experience an overall cost increase of \$596 million, \$161.6 million of the cost increase will be funded by the state and its taxpayers. These cost increases would amount to 16.1% of FFY2017 Medicaid prescription drug spending (prior to factoring in the loss in state revenues from premium tax forfeiture which are modeled in Exhibit E).

Exhibit D. Estimated Medicaid Costs from Moving to a Pharmacy Carve-Out Model (prior to factoring in tax impacts)

Time Period	Estimated Baseline Net Cost of LA's Medicaid Prescriptions	Percentage Additional Cost of Switching to Carve-Out Model	Estimated Net Cost Under Carve-Out	Additional Costs Caused by Switch to Carve-Out	State Share of Medicaid Prescription Drug Expenditures (blending regular FMAP and Expansion Population FMAP)	Additional State Fund Costs Caused by Switch to Carve-Out (prior to tax implications)
FFY2019	\$651,198,466	16.07%	\$755,827,079	\$104,628,613	26.34%	\$27,559,177
FFY2020	\$681,567,705	16.07%	\$791,075,769	\$109,508,064	27.27%	\$29,862,849
FFY2021	\$732,201,461	16.07%	\$849,844,894	\$117,643,433	27.27%	\$32,081,364
FFY2022	\$790,757,266	16.07%	\$917,808,910	\$127,051,644	27.27%	\$34,646,983
FFY2023	\$854,563,842	16.07%	\$991,867,343	\$137,303,501	27.27%	\$37,442,665
5 Year Total	\$3,710,288,740	16.07%	\$4,306,423,994	\$596,135,254		\$161,593,038

Additionally, two tax dynamics affect the fiscal impacts of carving-in or carving-out Louisiana's Medicaid prescription drug benefit:

- The Affordable Care Act's Health Insurance Tax (HIT) assessment on Medicaid health plan premiums is estimated at 2.7% in 2019 by Oliver Wyman Actuarial Consulting.⁵ This figure is used throughout these tax projections as a cost savings factor if Louisiana switched to a carve-out model, given that Medicaid FFS expenditures are not subject to the HIT. The state would not have to pay its share of this tax under a carve-out.
- Louisiana has its own premium tax program. Medicaid MCOs pay a 5.5% premium tax to the State of Louisiana, which is offset by a commensurate increase in the capitation rates paid to the Medicaid MCOs by the state. The State of Louisiana garners large-scale revenue gains because the federal government pays for most of the increased premium payments related to the premium tax through the FMAP percentages, but the State

⁵ Giese, G and Carlson, C. (2017, October 10). *New Analysis: How the ACA's HIT Will Impact 2018 Premiums*. Retrieved from http://health.oliverwyman.com/transform-care/2017/08/analysis_HIT_impact.html.

retains 100% of the MCO premium tax collections. Under a pharmacy carve-out, the State would forfeit the federal share of the premium tax that is collected as revenue by the State.

These tax implications are quantified in Exhibit E.

Exhibit E. Tax Impacts of a Medicaid Prescription Drug Carve-Out

Time Period	Estimated Baseline Pre-Rebate Premium Cost for Drug Benefit	2.7% ACA Health Insurance Tax	State Share of ACA Health Insurance Tax	5.5% Premium Tax Assessment	Federal Share of Premium Tax Assessment
FFY2019	\$1,249,071,200	\$33,724,922	\$8,883,145	\$68,698,916	\$50,603,622
FFY2020	\$1,307,322,783	\$35,297,715	\$9,625,687	\$71,902,753	\$52,294,872
FFY2021	\$1,404,443,968	\$37,919,987	\$10,340,780	\$77,244,418	\$56,179,865
FFY2022	\$1,516,760,525	\$40,952,534	\$11,167,756	\$83,421,829	\$60,672,696
FFY2023	\$1,639,148,646	\$44,257,013	\$12,068,888	\$90,153,176	\$65,568,405
5 Year Total	\$7,116,747,122	\$192,152,172	\$52,086,256	\$391,421,092	\$285,319,460

The figures in Exhibit F take all the above programmatic and tax impacts factors into account.

We estimate that a shift to a carve-out model will have a significant adverse impact on Louisiana’s State Fund Balance. These adverse impacts are estimated to be \$69.3 million during FFY2019 and \$394.8 million across the five-year timeframe FFY2019-FFY2023.

Exhibit F. Overall State Fund Impacts of a Medicaid Prescription Drug Carve-Out

Time Period	Additional State Fund Costs Caused by Switch to Carve-Out (prior to tax implications)	Less State Savings From Paying 2.7% ACA Health Insurance Tax Under Pharmacy Carve-Out	Plus Foregone Revenue Yielded by Federal Share of 5.5% Premium Tax	Net State Fund Fiscal Impact of Moving to Pharmacy Carve-Out Model
FFY2019	\$27,559,177	-\$8,883,145	\$50,603,622	\$69,279,653
FFY2020	\$29,862,849	-\$9,625,687	\$52,294,872	\$72,532,034
FFY2021	\$32,081,364	-\$10,340,780	\$56,179,865	\$77,920,449
FFY2022	\$34,646,983	-\$11,167,756	\$60,672,696	\$84,151,923
FFY2023	\$37,442,665	-\$12,068,888	\$65,568,405	\$90,942,182
5 Year Total	\$161,593,038	-\$52,086,256	\$285,319,460	\$394,826,242

IV. Conclusions

Our analyses indicate that significant costs would be incurred by the State of Louisiana and its taxpayers if the prescription drug benefit is carved-out of Louisiana’s MCO contracts. The State Fund cost of this policy change is estimated at \$69 million in the first year (FFY2019) and \$394 million across the five-year timeframe FFY2019-FFY2023.

We tabulated a wide array of statistics comparing Louisiana with other states, and our findings consistently demonstrated that the state's prescription drug benefit is being managed exceptionally well. Louisiana had the nation's highest generic dispensing rate in FFY2017 and the nation's 8th lowest average net costs per prescription.

Any change in policy away from the existing approaches that are yielding this excellent drug benefit management performance creates an enormous risk of being a step backwards. Moving to a carve-out model would immediately and substantially increase Louisiana's net Medicaid prescription drug costs, given the collective performance of MCOs in the carve-in states and certainly given Louisiana's achievements through its current carve-in approach.