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CMS Misdirection: Two Troubling Decisions Damage Market Competitiveness

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In well-functioning healthcare markets, governmental regulatory policies ensure access, safety, quality and privacy. The government's most important role is creating level-field competition through balanced regulation, targeted enforcement actions and price/outcomes transparency. Unfortunately, many healthcare markets do not function efficiently.

The Centers for Medicare and Medicaid (CMS) is not uniformly supporting pro-market reforms. Two recent CMS decisions diminish competitiveness and hurt consumers in key healthcare market segments.

- On June 27th, **CMS denied** a Section 1115 Amendment Request from the Massachusetts Office of Health and Human Services to grant Massachusetts Medicaid the right to create its own drug formularies.
- On July 6th, **CMS suspended** risk-adjustment payments that support the individual market on the Obamacare exchanges.

However on July 24th, CMS announced a final rule that it will resume paying $10.4 billion in risk-adjustment payments to insurance companies with plans on the individual market.

Markets thrive when there is level-field competition, pricing transparency and predictability. These recent CMS decisions will inhibit efficient market function, create friction and trigger unnecessary price increases in the branded drug and individual health insurance markets.

At issue is whether the Trump administration supports market-based solutions for improving U.S. healthcare services. Based on the first two of these CMS decisions, it appears that patronage and political considerations carry equivalent or greater weight in shaping the administration's healthcare policy decisions.

VALUE-RESISTANT DRUG PRICES

Last September, the Massachusetts Office of Health and Human Services filed its CMS waiver request seeking relief from skyrocketing drug prices in its Medicaid Program (MassHealth). The waiver requested permission to incorporate provisions that would enable MassHealth to negotiate drug formularies like commercial insurers and pharmacy benefit managers (PBMs).

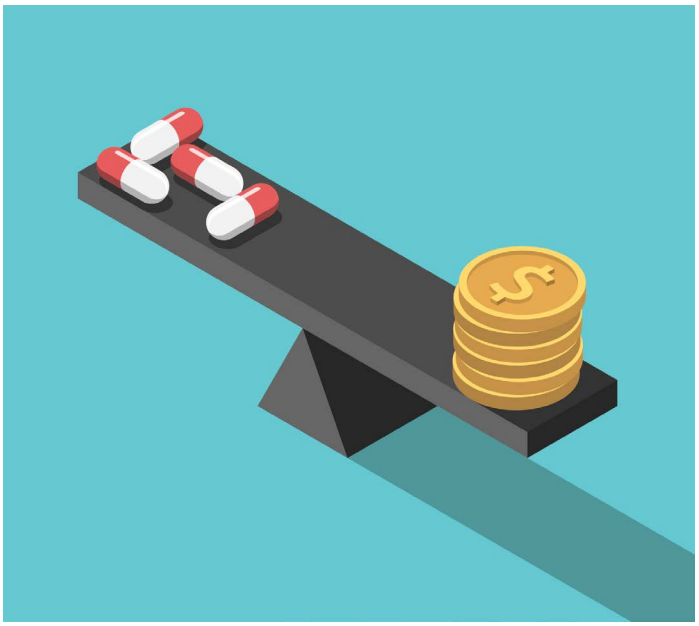
Medicaid is the largest and fastest growing component of Massachusetts' state budget. It currently represents nearly 40% of total state expenditures. Increasing drug prices contribute disproportionately to spending growth.

MassHealth's prescription drug costs more than doubled between 2010 ($917 million) and 2016 ($1.94 billion) with no relief in sight. This translates into a 13% compounded annual growth rate that threatens to "crowd out" other vital social and health care spending.

In essence, Republican Governor Charlie Baker's administration wanted CMS to grant MassHealth the ability to apply proven market-based practices (pioneered by commercial insurers and PBMs) to stabilize drug prices.

Had CMS approved the waiver, other states would have followed Massachusetts' lead and drug prices would have "come a-tumbling down." Specifically, MassHealth wanted CMS to grant it the authority to implement the following new policies.[1]

- Adopt closed formularies with at least one drug available for each therapeutic class (i.e., disease).
- Exclude drugs from formularies "with limited or inadequate evidence of clinical efficacy."



These provisions may seem "wonky" but they strike at the heart of Big Pharma's ability to force state Medicaid programs to pay sky-high prices for branded drugs. Current law requires Medicaid to offer beneficiaries all branded drugs for which pharma manufacturers provide discounts.

Adopting closed formularies for a limited number of drugs would have allowed MassHealth to negotiate better discounts based on larger volumes for preferred drugs. The proposed waiver included provisions for patients to receive alternate drugs when medically necessary.

MassHealth also wanted the ability to decide whether or not to cover drugs that have not yet been proven clinically effective. Commercial insurers already enjoy this discretion.

In denying the waiver, CMS made an offer (the ability to negotiate directly with manufacturers for all drugs) it knew Massachusetts would not accept. To do so would require MassHealth to forgo rebates altogether. This would constitute fiscal suicide.

Rebates keep drug prices in check for 90% of drugs directed to Medicaid beneficiaries. Only 10% of drugs are budget-busters. MassHealth wanted to attack prices only on high-cost drugs. These are the same high-priced drugs that Big Pharma is lobbying to protect. Denying Massachusetts' 1115 waiver request is a boon for Big Pharma.

RE-RISKING OBAMACARE

CMS decided to suspend risk-adjustment payments after a federal judge in Utah ruled CMS's formula for determining risk-adjustment payments was flawed. In a similar Massachusetts case, another federal judge upheld the formula.

The ACA eliminates the ability of participating health plans to deny coverage or charge higher prices to prospective enrollees with pre-existing conditions. It created the 3 Rs (Reinsurance, Risk Corridors and Risk-Adjustment) to stabilize market prices on public health exchanges by addressing two behaviors that bedevil health insurance markets and destabilize prices: "adverse selection" and "risk selection."

Adverse Selection occurs when disproportionate numbers of individuals with high-cost healthcare needs enroll in specific health plans. In such case, health plan premiums are insufficient to cover health expenditures and plans lose money. Absent protection from "adverse selection," health plans either stop offering health exchange products and/or raise prices to mitigate their financial risk.

Risk Selection occurs when health plans use their underwriting process and benefit design to enroll disproportionate numbers of healthy individuals in their plan offerings. A classic "risk selection" tactic is for health insurance plans to place enrollment centers on higher floors with no elevators. This discourages sick and handicapped individuals from enrolling.

The 3 Rs stabilize market prices and encourage broad-based enrollment practices in the following ways.[2]

- **Reinsurance** provides payment to plans that enroll higher-cost individuals
- **Risk Corridors** limits losses and gains to health plans beyond allowable ranges
- **Risk Adjustment** redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees

Risk adjustment is the last of the "3 Rs" still standing. Reinsurance expired in 2016. Congressional Republicans failed to fund risk corridors, so they disappeared. Their elimination is a principal reason select health exchanges have experienced

stratospheric price increases and/or declines in health plans willing to offer exchange products.

These three Rs mitigated the insurance risks associated with high-cost patients and disproportionately sick patient populations. In 2016, risk adjustment transferred funds from insurers with healthier populations to insurers with sicker populations, and shifted 11% of total premium dollars within the individual market to plans with higher-risk patients. This enabled health plans to insure the sickest patients and give them affordable access to care.

Suspending the risk-adjustment payments as insurers are submitting their 2019 Obamacare rates introduces significant uncertainty into the health insurance marketplace. This can and likely will lead to higher prices and fewer participating insurers in many marketplace exchanges.

In the absence of federal risk mitigation, some states have taken actions to stabilize health insurance prices on their public exchanges. For example, Minnesota's Republican legislature initiated a reinsurance program last year to pay a defined percentage of larger health insurance claims. As a result, 2018 health insurance premiums in Minnesota are significantly lower than they otherwise would have been. Health Partners actually reduced its prices.

It's hard not to conclude that CMS "cherry-picked" the Utah ruling to deliver another body blow to Obamacare. The agency could have fought the ruling and prevented the collateral market damage caused by suspending risk-adjustment payments. CMS announced it would resume the payments July 24th. Switching $10.4 billion in payments back on, while clearly the right decision, reinforces fears that rules and policies are unpredictable. Markets abhor uncertainty.

As President Trump himself might say, "Sad."

PRO-MARKET RIGHTEOUSNESS

Competition is hard but makes companies better. Free markets depend upon balanced regulation and effective enforcement to ensure "level-field" competition.

Preserving competitive markets is a delicate exercise that requires constant vigilance and tinkering. Too much regulation and overly vigorous enforcement burden productive companies, stifle innovation and exert a negative drag on the economy.

Too little regulation and feeble enforcement encourage negligent corporate behavior, create moral hazard and increase societal harm. This also retards innovation and economic growth.

The constant challenge for American government is to find a "Goldilocks" balance where regulation and enforcement protect societal interests, encourage innovation and stimulate economic growth.

The first two recent CMS rulings discourage pro-market healthcare reformers. The Massachusetts 1115 waiver offered the potential to apply market competition to Medicaid drug pricing. Competition works. Drug manufacturers would offer their best prices to gain inclusion of their drugs in state-based formularies.

Instead, already struggling state Medicaid agencies will continue to overpay Big Pharma for branded drugs. They will have fewer resources to fund vital healthcare needs for the vulnerable populations they serve.

Stabilizing public health insurance exchanges lowers prices for everyone. The better health insurance companies can predict and manage their financial risks, the more aggressive they can be in pricing health insurance policies. Witness Minnesota.

Playing politics with health insurance premiums is cruel and unnecessary. It hurts already-struggling Americans the most.

CMS has the power to improve market efficiency within U.S. healthcare markets. A recent Bloomberg article suggests the Trump administration "blueprint" for reducing anti-competitive behaviors, such as safe-harbor protections for drug company rebates, are picking up speed.[3] This would be most welcome news.

However, CMS's recent anti-market decisions raise the question whether the Agency will consistently employ market-based reforms to improve healthcare delivery. There's still time, but CMS's market transformation "clock" is ticking toward midnight.

SOURCES

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