Risks to Medicaid Surface in Drug Pricing Debate

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As the debate over prescription drug pricing heats up, I have been worried for a while that some of the federal policy solutions being considered in Congress and in the Administration could adversely affect Medicaid and its highly effective rebate program, whether inadvertently or intentionally. This could result in higher Medicaid drug costs, reduced beneficiary access to needed medications, or both. Two recent developments validate those fears:

The Trump Administration issued a new proposed regulation that would eliminate the safe harbor in the federal anti-kickback law for rebates negotiated by pharmacy benefit managers (PBMs) on behalf of Medicare Part D and Medicaid managed care plans, unless the rebates are converted to “point-of-sale” discounts.

Much of the rule’s preamble and the subsequent outside analysis has focused on the merits of the rule relative to Medicare Part D, with little attention paid to the rule’s impact on Medicaid. For example, the Administration argues that the regulation would benefit individuals by lowering their out-of-pocket costs if individuals share in the benefit of rebates and pay less in co-insurance and copayments when they go to the pharmacy. While that could be true of Medicare Part D, that would not be the case in Medicaid. Medicaid beneficiaries pay only nominal copayments irrespective of the price of individual drugs.

Most states currently rely on Medicaid managed care plans to negotiate voluntary supplemental rebates, in addition to those required under federal law, on behalf of their enrollees. (The regulation would not affect the federally required base rebate and inflation-related rebate, discussed further below.)

The supplemental rebates are then passed on to states in the form of lower managed care capitation payments or are collected by states themselves. While these rebates are modest relative to the size of the federally required rebates, supplemental rebates help lower federal and state Medicaid prescription drug costs.

But according to the actuaries at the Centers for Medicare and Medicaid Services, eliminating the safe harbor would increase total Medicaid spending by nearly $2 billion over the next 10 years. While states would still be permitted to negotiate supplemental rebates with manufacturers directly (as some states do today for certain drugs or drug classes in Medicaid managed care), the CMS actuaries assume that 85 percent of current Medicaid managed care rebates would no longer be negotiated, and only half would be replaced by directly negotiated rebates.
At the same time, because managed care plans would see higher net pharmacy costs, states would have to increase their payments to plans. That is, in part, why the actuaries expect the rule to increase Medicaid spending. (The actuaries also assume that manufacturers would retain only 15 percent of the rebates they now provide to Medicare Part D and Medicaid managed care plans once the safe harbor was eliminated. If manufacturers keep a greater share, the net increase in Medicaid costs would be even larger.)

If the rule is finalized, in order to avoid facing higher Medicaid drug costs, it is critical that states directly negotiate supplemental rebates with manufacturers for drugs furnished to enrollees in managed care and obtain supplemental rebates that are as large as those currently obtained by Medicaid managed care plans. In fact, as I have written, extending directly negotiated supplemental rebates to managed care in all states for all drugs could actually result in greater discounts for state Medicaid programs overall, relative to current law.

Senator Bill Cassidy (R-LA) and Senator Mark Warner (D-VA) recently unveiled a discussion draft of a bill intended to promote the use of value-based related to prescription drugs, which generally envision adjusting the price of a drug based on its clinical efficacy and relative value to patients. Some drug manufacturers have argued that Medicaid’s “best price” requirement poses an undue barrier to innovative value-based drug pricing arrangements that insurers, states and others are exploring. Unfortunately, as currently written, the draft bill would likely result in significantly higher Medicaid drug costs.

Under the Medicaid Drug Rebate Program, manufacturers of brand-name drugs must pay a base rebate to state Medicaid programs equal to 23.1 percent of the Average Manufacturer Price (AMP) or the AMP minus the best price provided to most other purchasers, whichever is greater. (Manufacturers must also pay an additional rebate if the prices of their drugs rise faster than general inflation.)

The intent of the best price provision is to ensure that Medicaid obtains discounts at least as large as those available to other payers including in private insurance. But the draft bill would create an expansive exemption from the best price requirement for “any prices charged under a value-based purchasing arrangement” under which the price of a drug is based “in whole or in part” on achievement of patient outcomes, clinical circumstances or measures, or the relative value of multiple indications.

This would essentially allow manufacturers to add minor price adjustments based on clinical efficacy to each of their existing pricing arrangements with pharmacy benefit managers, insurers, health care providers and others and thus entirely eviscerate the “best price” requirement. As a result, certain manufacturers of brand-name drugs could end up paying considerably smaller base rebates to state Medicaid programs than they do now, driving up net Medicaid drug costs.

As one outside analysis has pointed out, many of the value-based arrangement concepts now being proposed would not even trigger Medicaid best price if they were designed carefully. And to the extent there may be some technical issues, such as the appropriate method for calculating best price under specific arrangements, any potential change to Medicaid best price should be highly targeted and narrowly tailored and not inadvertently provide an open-ended best price loophole for manufacturers to exploit. Senator Cassidy and Senator Warner are currently seeking comments on their draft bill.

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