Insight

Medicaid's Best Price: A Bad Calculation

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Executive Summary

- In an effort to reduce costs to Medicaid, the Centers for Medicare and Medicaid Services is expected to soon release its wide-ranging final rule on the Medicaid Drug Rebate Program; the rule will change how drug manufacturers calculate Medicaid's best price for medications from the current standard of the single lowest offered price to a price that includes all rebates offered to eligible entities on a single medication.
- Compounding this change, starting on January 1, 2024, the Biden Administration will, as required by the American Rescue Plan Act of 2021, eliminate the cap that prevented manufacturers paying more than a penny to Medicaid to dispense certain medications; additionally, drug manufacturers that have medicines with prices that increase greater than inflation could end up paying Medicaid to dispense their medications.
- Combined, these changes are likely to distort incentives for drug manufacturers in two ways: Drug manufacturers could end up reducing the number of rebates offered on a product and may also opt to increase list prices for new products to avoid future inflationary penalties.

Introduction

In an effort to reduce costs to Medicaid, the Centers for Medicare and Medicaid Services (CMS) is expected to release its wide-ranging final rule on the Medicaid Drug Rebate Program to change how drug manufacturers calculate Medicaid's best price for medications.

This proposed rule will require manufacturers participating in the Medicaid Drug Rebate Program (MDRP) to combine (or "stack") all rebates offered on a single product (whether to the wholesaler, pharmacy benefit manager, or provider) to reflect the lowest realized price when calculating Medicaid's best price. Manufacturers have argued that CMS' interpretation strays from the original intent of Medicaid best price, which has been traditionally understood as the single lowest price available to any eligible entity within the pharmaceutical supply chain.[i]

Compounding this change, starting on January 1, 2024, the Biden Administration, as required by the American Rescue Plan Act of 2021, will eliminate the cap that prevented manufacturers from paying more than a penny to Medicaid for certain medications as the Medicaid and CHIP Payment and Access Commission (MACPAC) reported that approximately 5 percent of claims and approximately 18 percent of gross spending were on drugs that reached the cap in 2020. Drug manufacturers that have medicines with prices that increase greater than inflation could end up paying Medicaid to dispense their medications.

These changes are intended to increase savings for states and the federal government to share to offset costs to run the program as pharmacy coverage is optional under Medicaid law. Nevertheless, all states currently provide outpatient prescription drug coverage. Most states and some Medicaid-managed care plans negotiate with drug

manufacturers for supplemental rebates. This change may incentivize drug manufacturers to reduce or modify supplemental rebates to minimize the overall financial risk to their products covered under Medicaid.

Combined, these changes are likely to distort incentives for drug manufacturers in two ways: Drug manufacturers may opt to reduce the number of rebates they offer on a product and may increase list prices for new products to avoid future inflationary penalties.

For a deeper dive into the Medicaid Drug Rebate Program, please see AAF's Primer: The Medicaid Drug Rebate Program.

Price Problems: Rebates and High List Prices

The current bipartisan drug pricing debate is centered on the government's ability to obtain large rebates from drug manufacturers on expensive medications through new legislation or regulation at the federal and state levels. Yet simply tinkering with the price delta (the difference between the list price and the discounted amount created by a rebate) for branded prescription products incentivizes drug manufacturers to set high list priced medications and offer large rebates, which are then preferred by plans—including government payers. Although lower-priced generics or competitively priced brand alternatives may be cheaper for the beneficiary or the plan, high list price products with large rebates are typically preferred by pharmacy benefit managers when placing a drug on a formulary. CMS' decision to simply change the Medicaid best price and eliminate the penny cap only reinforces the high list price and large rebate model, which ultimately increases drug costs.

Best Price: Medicaid best price was established so that manufacturers would have to offer their drugs to Medicaid at the lowest price they offered to their most-favored customers. To achieve this goal, CMS has opted to modify current Medicaid best price practices to require that manufacturers track and aggregate price concessions (including rebates) across the pharmaceutical supply chain. This is likely to disincentivize manufacturers from offering discounts to eligible entities (wholesalers or providers) to avoid non-compliance. Manufacturers will still compete on rebate offerings but, potentially, this rule could reduce the number of large price concessions tendered. What's more, currently, drug manufactures do not have the technical infrastructure to even track rebates, increasing the likelihood that manufacturers will reduce or eliminate the rebates they offer to eligible entities and inadvertently increasing the costs of medications.

Removal of the Cap: The provision protecting manufacturers from paying Medicaid more than a penny to dispense medication will end on January 1, 2024, as directed by the American Rescue Plan Act.[iii] The Biden Administration will eliminate the cap that traditionally limited mandatory Medicaid rebates to 100 percent of the drug's quarterly average manufacturer price. In 2021, the Congressional Budget Office scored the removal of the cap during the reconciliation process as saving $15.9 billion over 10 years, but which was later reduced to $14.5 billion for 2021 to 2031. When the cap finally expires, drug manufacturers that have medicines with prices that increase greater than inflation or stacked best price calculations that exceed the quarterly average manufacturer price could end up offering a sizable rebate to Medicaid that is more the cost of the product. It is likely that manufacturers will set higher list prices to avoid the risk of future substantial inflationary penalties.

Conclusion

Reducing Medicaid spending, alongside government spending in general, for prescription drugs remains a bipartisan priority. Yet CMS' decision to modify the calculation of Medicaid best price is likely to discourage drug manufacturers from offering rebates to eligible entities while encouraging drug manufacturers to use high

list prices as a mechanism to avoid inflationary penalties.

Policymakers should consider if piecemeal reforms to prescription drug pricing, such as reforming Medicaid best price, are skewing manufacturer incentives away from offering sizable discounts or lowering list prices of new and innovative products. Federal and state lawmakers should be aware that such rebate reform likely reinforces a drug pricing model that encourages very high list prices while restricting traditional market competition.

[i] Moreover, KFF found that Medicaid "…net spending [the amount after rebates and other discounts are applied] on prescription drugs remained almost unchanged, spending before rebates increased by 23 percent from 2015 to 2019." If net spend was mostly stabilized within the Medicaid program, it could be assumed that the rebates offered by branded manufacturers were competitive and sizable.

[ii] This rebate is also known as the Medicaid Unit Rebate Amount.

[iii] Public Law 117-2—Mar 11, 2021. SEC. 9816. SUNSET OF LIMIT ON MAXIMUM REBATE AMOUNT FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS. Section 1927(c)(2)(D) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)(D)) is amended by inserting after ''December 31, 2009,'' the following: ''and before January 1, 2024,''.