



Georgetown University  
Health Policy Institute  
CENTER FOR CHILDREN  
AND FAMILIES

# Helping State Medicaid Programs Better Address Rising Drug Costs

Edwin Park  
Research Professor  
Georgetown University Center for Children and  
Families

October 16, 2018

# Why Rising Drug Prices and Costs Matter for Medicaid

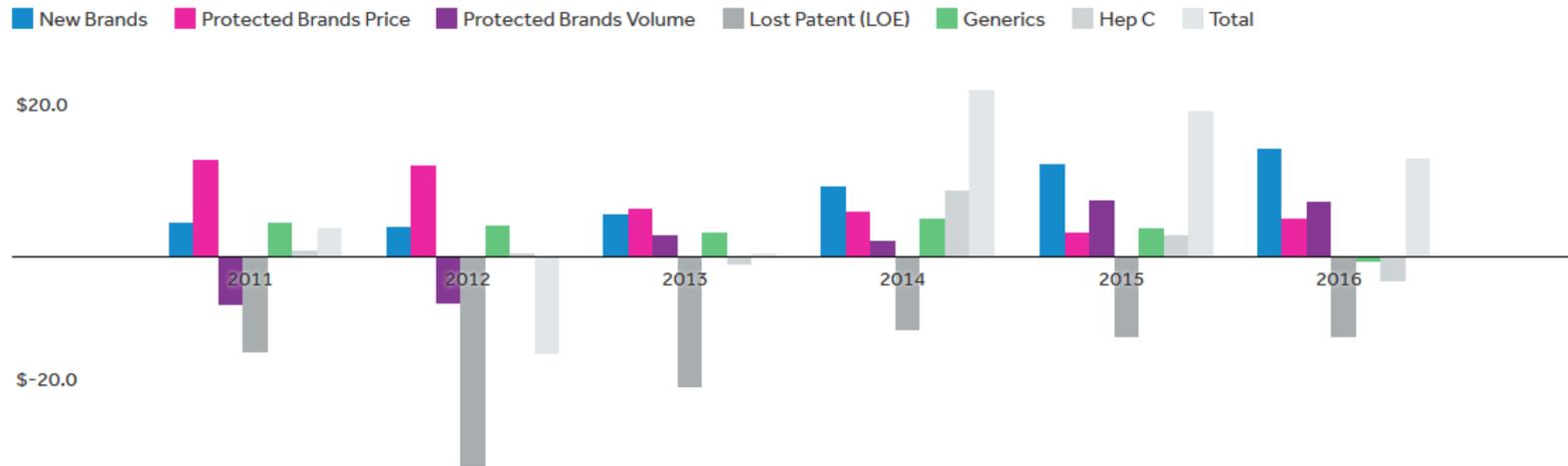
- Medicaid drug spending relatively small share of total Medicaid spending (5.6% in 2016)
- But prescription drug spending growing faster than other Medicaid benefits (MACPAC)
- Places greater fiscal pressures on states which could lead to cuts that reduce access to needed drugs as well as overall program cuts (eligibility, benefits and provider payments)
- Need for proactive action in face of future drug pricing trends

# Webinar Outline

- Overall drug pricing trends
- Current beneficiary access protections
- Effectiveness of Medicaid Drug Rebate Program
- State strategies to address rising Medicaid prescription drug costs while maintaining access to needed drugs

# Recent Drug Pricing Trends

Contribution to growth in drug spending, by spending growth drivers, in \$US billions, 2011 -2016

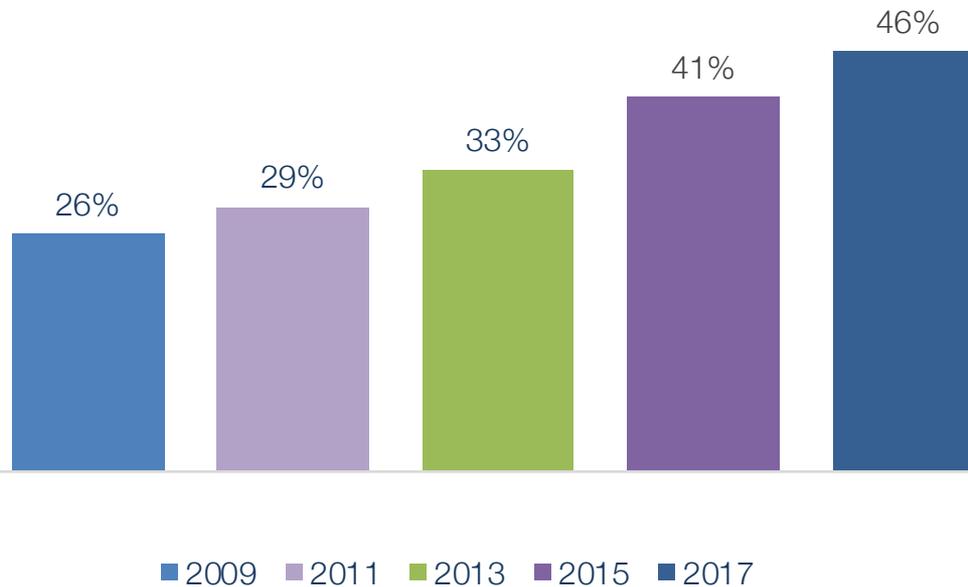


New brands are protected branded products on the market less than 24 months during the year reported. Protected brands are products which are no longer "new" and have yet to reach patent expiry. Loss of Exclusivity (LOE) are brands which were once protected and have since lost patent protection. Generics include both unbranded and branded generics. All segments exclude hepatitis C treatments. Hepatitis C spending growth is reported separately from the other segments in the chart as unusually there are declines in spending in both the new and protected segments for these drugs.

Source: IQVIA, National Sales Perspectives, Dec 2016; IQVIA Institute of Human Data Science • [Get the data](#) • PNG

Peterson-Kaiser  
**Health System Tracker**

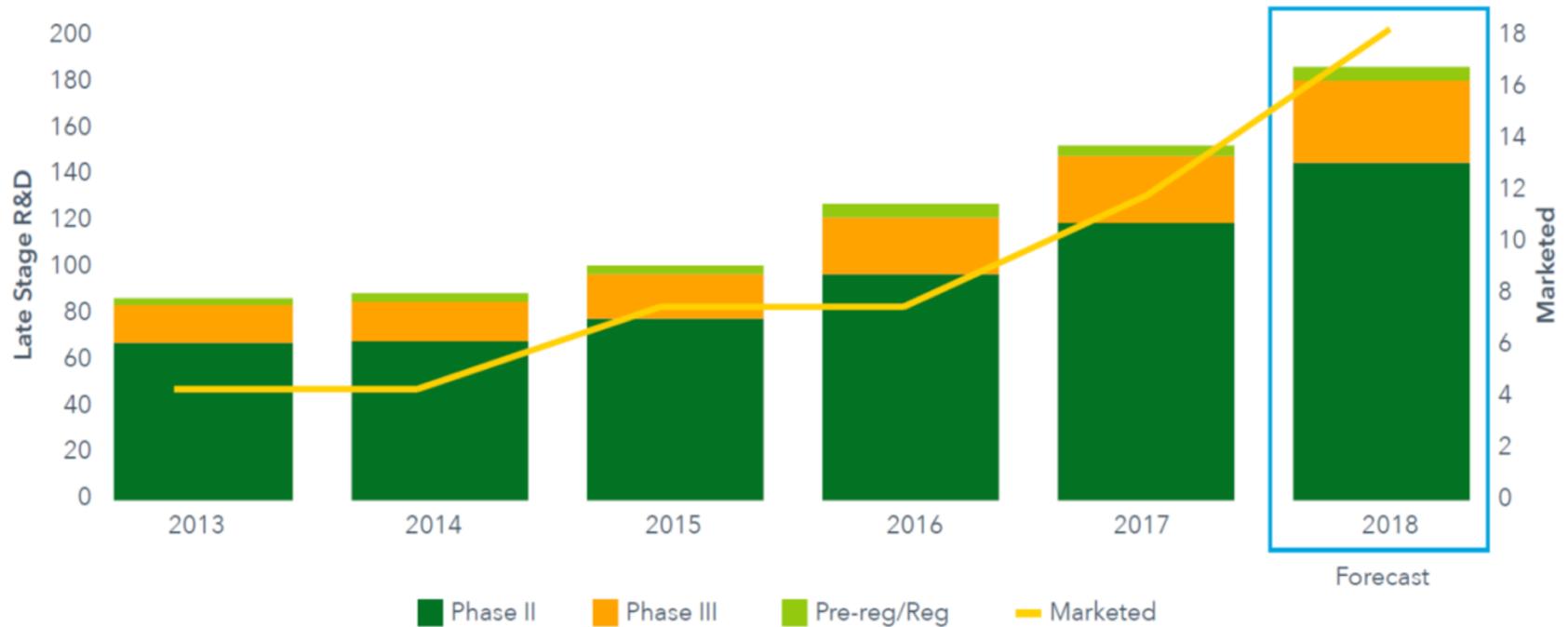
# Specialty Drugs as Share of Total Rx Spending



Source: IQVIA Institute for Human Data Science

# Pipeline for New Biological Drugs

**Exhibit 3: Number of Next Generation Biotherapeutics Currently Marketed or in Late-Stage Pipeline**



Source: IQVIA Institute, IQVIA R&D Insight, Jan 2018

Notes: Reg = Registered.

# How Medicaid Ensures Beneficiary Access to Needed Drugs

- Generally covers all FDA-approved drugs with limited exceptions:
  - Not medically accepted indication
  - Certain drug classes (e.g. cosmetics, OTC, weight loss)
  - No meaningful therapeutic advantage over other drugs
  - States can manage utilization (e.g. preferred drug lists, prior authorization, generic substitution and step therapy)
  - States can impose numerical limits
- EPSDT benefit as critical “backstop” to ensure access for children
- Nominal or no co-payments

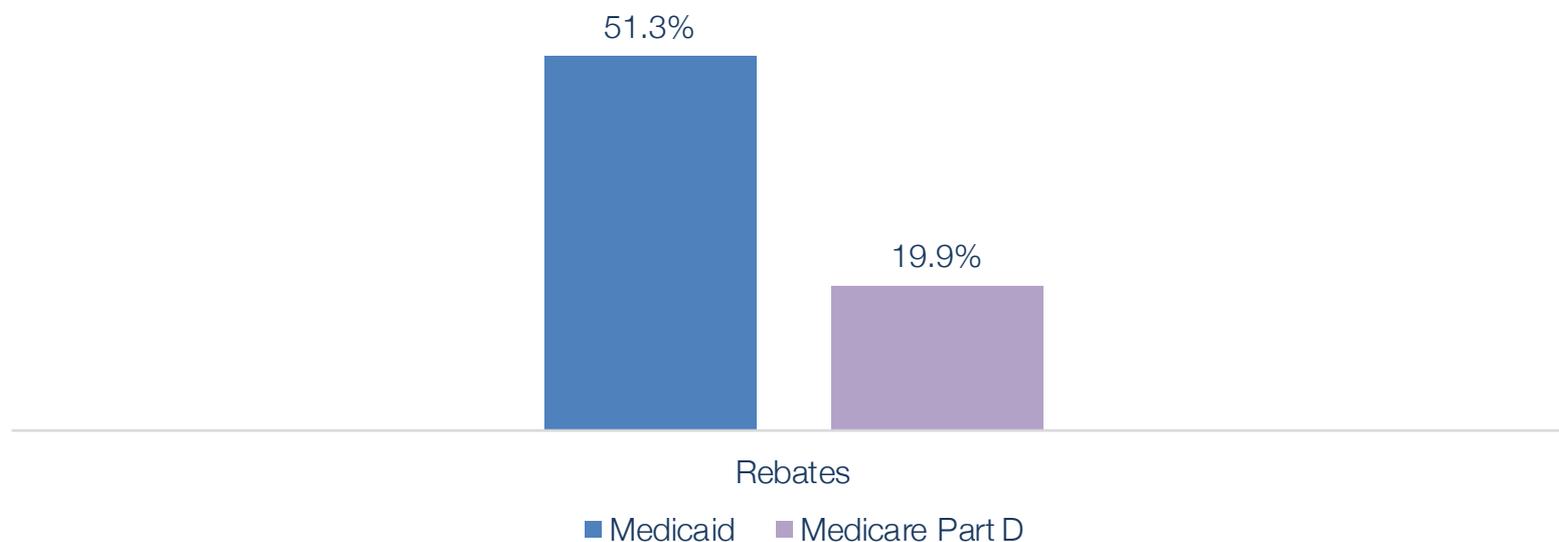
# Medicaid Drug Rebate Program

- Drug manufacturers must agree to participate in Medicaid Drug Rebate Program to have their prescription drugs covered under Medicaid
- Highly successful Medicaid Drug Rebate Program ensures Medicaid gets among the lowest prices available to any payer
- While manufacturers pay rebates to states, Medicaid does not purchase drugs directly but reimburses pharmacies for drugs they dispense
- States can negotiate additional “supplemental” rebates tied to preferred drug lists

# Key Elements of Medicaid Rebate Program

- Base Rebate
  - For brand-name drugs, higher of 23.1% of Average Manufacturer Price (AMP) or “best price”
  - For generic drugs, 13% of AMP
  - States can also seek voluntary supplemental rebates
- Inflation-Related Rebates
  - For both brand-name and generic drugs, additional rebate equal to annual price increases in excess of general inflation

# Aggregate Rebate Savings as Share of Total Drug Spending (2016)



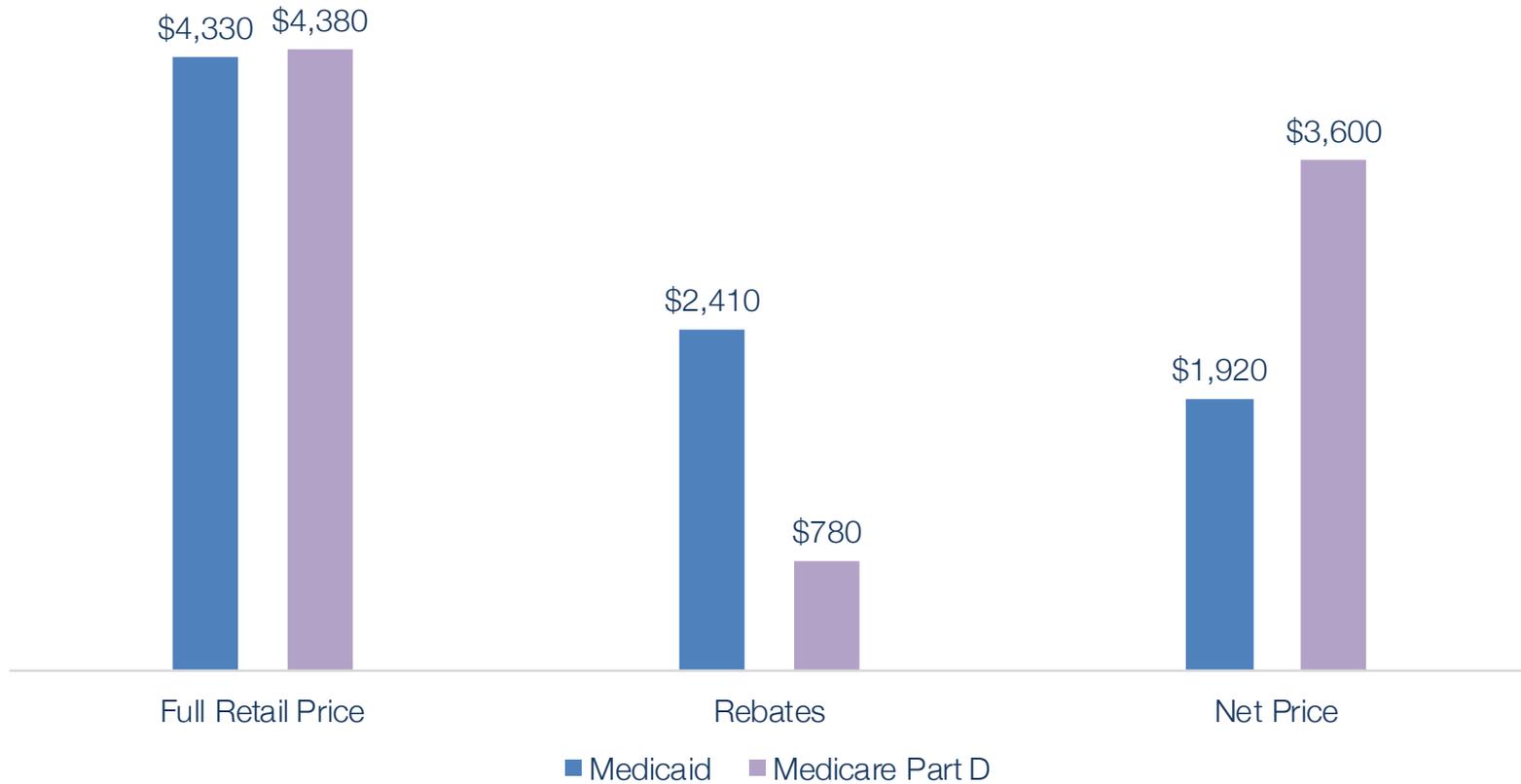
Source: MACPAC and Medicare Trustees Report

# Comparison of Net Price of Brand-Name Drugs Across Payers



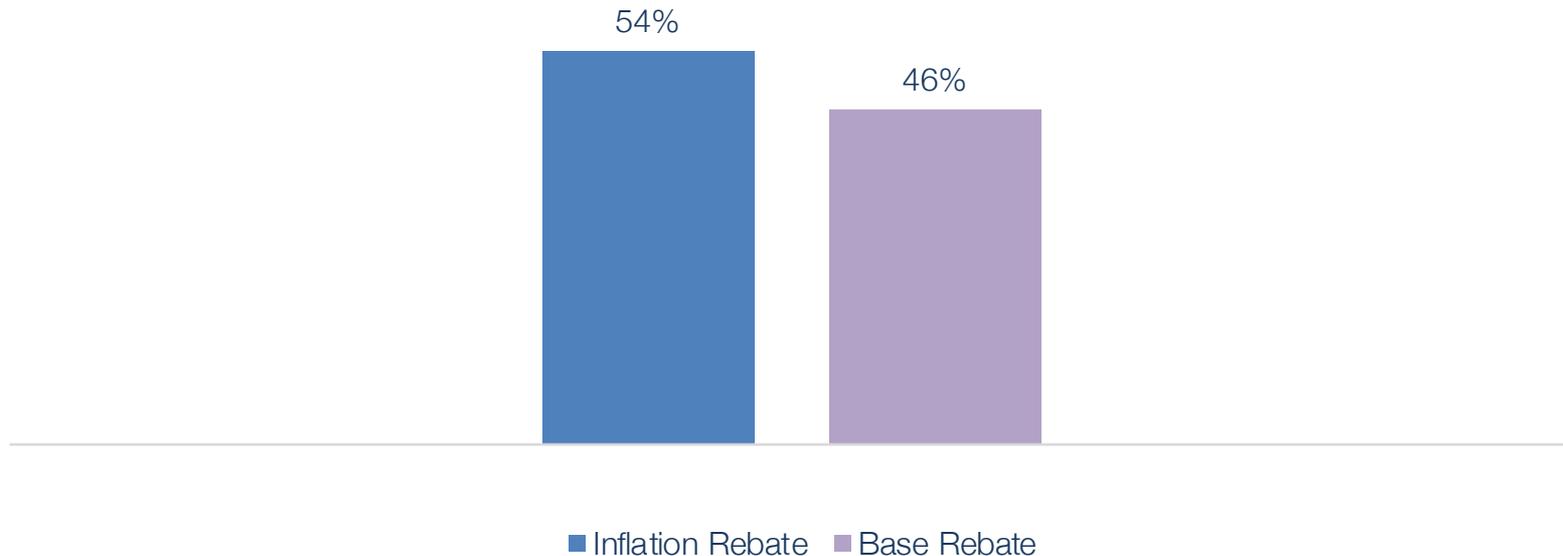
Source: Altarum

# Weighted Average Price for Top-Selling Brand-Name Specialty Drugs (2015)



Source: Congressional Budget Office

# Inflation-Related Rebates Account for Majority of Rebates (2012)



Source: HHS Office of Inspector General

# Expand Supplemental Rebates

- A few states have no supplemental rebates at all
- Large majority of states do not extend supplemental rebates to Medicaid managed care
- Many states do not extend supplemental rebates to most or all drugs/drug classes
- States could seek inflation-related supplemental rebates rather than just add-ons to base rebate

# Assess Medicaid Managed Care Plans

- Require alignment of preferred drug list across plans to enhance leverage for rebates negotiated by plans
- Ensure that rebates their PBMs negotiate are passed back to state Medicaid programs through lower capitation rates
- Prevent “spread” pricing by PBMs

# Review Multi-State Purchasing Pools

- Most states participate in multi-state purchasing pools to enhance leverage in their supplemental rebate negotiations
  - National Medicaid Pooling Initiative
  - Top Dollar Program
  - Sovereign States Drug Consortium
  - Hepatitis C Purchasing Agreement
- Assess effectiveness and determine if they are really helping get a good deal
- Maximize leverage by considering preferred drug list alignment and across other state programs

# Expand Use of Clinical Effectiveness Reviews

- Increase use of evidence-based research on new and existing drugs
- Rationalize and improve use of existing tools like preferred drug lists, prior authorization, step therapy and provider education
- Increase leverage in supplemental rebate negotiations

# Evaluate Drug Utilization Review Programs

- Federal law requires states to have retrospective and prospective DUR programs
- Intended to identify issues like fraud and abuse, inappropriate prescribing and drug-drug interactions
- Could be used to a much greater degree to support other Medicaid drug cost control initiatives

# Price Transparency

- Rebate pricing information reported to federal government is confidential and is not shared with state Medicaid programs
- Use licensing authority for drug supply chain to require drug pricing information from manufacturers, wholesalers, PBMs, group purchasing organizations, pharmacies and others
- Negotiate for pricing information as part of preferred drug list decisions
- Ensure Medicaid also benefits from broader drug pricing initiatives at state level

# New “Value-Based Purchasing” Strategies

- States are looking at other rebate and pricing strategies but would or would likely require federal approval
- Not clear how much savings these strategies could produce

# Improve Access to Needed Drugs

- Ensure EPSDT protections available for children, including in managed care
- Evaluate whether managed care plans are inappropriately excluding drugs
- Review how current utilization management strategies are implemented (e.g. prior authorization and step therapy)
- Check compliance with prior authorization requirements in FFS and managed care (e.g. 24 hour decisions, 72 hour emergency supply)

# Other Medicaid Rx Proposals Raise Serious Concerns

- Trump Administration 5-state demonstration project
  - States would have to opt out of rebate program entirely
  - Current beneficiary protections likely would not apply
- Closed formulary waivers
  - What is basis for drug exclusions?
  - What protections/appeals process apply?
- Using current tools solely to cut costs

# Edwin Park

Research Professor

Center for Children and Families

Health Policy Institute

McCourt School of Public Policy

Georgetown University

Email: [Edwin.Park@georgetown.edu](mailto:Edwin.Park@georgetown.edu)

Twitter: [@EdwinCPark](https://twitter.com/EdwinCPark)