Medicaid

Health Policy Brief |

Despite the success of the Medicaid drug rebate program, it is clear that more needs to be done to lower the prices states pay for drugs.

THE ISSUE

The Medicaid program provides prescription drug coverage to low-income adults, children, pregnant women, and individuals with disabilities. Manufacturers are required to pay a base rebate to Medicaid as well as an additional rebate that accounts for price increases greater than inflation.[1] The rebate requirements in Medicaid have been very successful at lowering drug prices and generated rebates over three times greater on average than those in Medicare Part D. However, the federal government does not share all of those rebates with states.[2] Additionally, states do not have as many tools as the private sector to manage the Medicaid drug benefit, which gives them limited ability to rein in costs for new high cost specialty drugs.[3]

THE EVIDENCE

Medicaid spending on outpatient drugs grew more than 50 percent over the 2012 to 2017 period.[4] In total, the federal government and states spent about $30 billion on drugs in 2017 net of rebates.[5] Net spending on specialty drugs in Medicaid doubled between 2010 and 2015, reaching $9.9 billion in 2015, an average annual increase of 16 percent.[6] Although brand name specialty drugs accounted for just 1 percent of prescriptions, these prescriptions comprised about a third of net drug spending in Medicaid in 2015.[7] In fact, the shift in use towards higher priced drugs, especially new launches, explained much of the increase in average net price for brand name specialty drugs between 2010 and 2015.[8] The average net price per specialty prescription in Medicaid rose from $700 in 2010 to $1,220 in 2015, an average annual increase of 11.7 percent.[9]

THE SOLUTIONS

- Congress should give states the flexibility to exclude certain drugs from coverage, while maintaining access to the statutory rebate. This legislative change would ensure that states like Massachusetts and Arizona could pursue the more flexible benefit designs they proposed to CMS.[10,11] This policy would be accompanied by beneficiary protections that could include requiring coverage of a minimum number of drugs per class, a well-designed appeals process, and access to off-formulary drugs when clinically indicated.
- The total rebate liability owed by brand manufacturers is capped at 100 percent of a drug's Average Manufacturer Price (AMP). After a drug reaches its rebate cap, the inflationary component of the rebate no longer provides an incentive to slow price growth.[12] Congress should increase the statutory cap on the brand rebate, which would lead to lower prices and further penalize manufacturers for raising prices.
- Current law requires a brand manufacturer to include the price of its lower cost authorized generic (AG) drug in the calculation of its brand drug's AMP. Because inclusion of the AG price lowers a brand drug's AMP, and because rebates are paid off of AMP, brands with AGs are paying less in rebates than they otherwise should. The Medicaid and CHIP Payment and Access Commission (MACPAC) proposed excluding the AG price from the calculation of a brand drug's AMP. This would require brands with AGs to pay higher rebates, which would lower the prices states and the federal government pay these drugs.
- Congress should require that the inflation rebate of an AG drug be the higher of the brand inflation rebate or the AG drug's inflation rebate. This can be constructed in a similar manner to the Medicaid line extension rebate formula that passed in the Bipartisan Budget Act of 2018.[13]

[1] https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html
[2] https://www.cbo.gov/sites/default/files/presentation/44366academyhealthpresentationcook0.pdf
[3] *Ibid.*
[4] Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, Table 16 Retail Prescription Drugs Expenditures.
[5] https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-28.-Medicaid-Gross-Spending-and-Rebates-for-Drugs-by-Delivery-System-FY-2017.pdf
[6] Congressional Budget Office Presentation for Congressional Staff March 19, 2019 March 19, 2019 Anna Anderson-Cook, et al Prices for and Spending on Specialty Drugs in Medicare Part D and Medicaid The information in this presentation is based on two CBO publications. See Congressional Budget Office, Prices for and Spending on Specialty Drugs in Medicare Part D and Medicaid (March 2019) and Prices for and Spending on Specialty Drugs in Medicare Part D and Medicaid: An In-Depth Analysis (March 2019).
[7] *Ibid.*
[8] *Ibid.*
[9] *Ibid.*
[10] https://www.mass.gov/files/documents/2018/04/26/masshealth-1115-waiver-hearing-slides.pdf
[11] https://www.azahcccs.gov/shared/Downloads/News/FlexibilitiesLetterFinal_11172017.pdf
[12] https://www.macpac.gov/wp-content/uploads/2018/06/Improving-Operations-of-the-Medicaid-Drug-Rebate-Program.pdf
[13] https://www.macpac.gov/wp-content/uploads/2018/06/Improving-Operations-of-the-Medicaid-Drug-Rebate-Program.pdf