NATIONAL CENTER FOR POLICY ANALYSIS

Reforming Pennsylvania's Medicaid Drug Program

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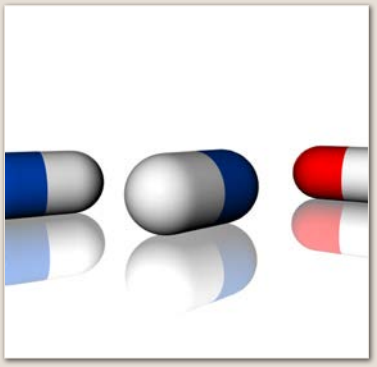
In order to reduce rising health care costs, many states are forging ahead with plans to move Medicaid enrollees into managed care plans. Pennsylvania has been more aggressive than most states, enrolling more than 80 percent of Medicaid participants in managed care.[1] Pennsylvania is also integrating Medicaid drug benefits with enrollees' health plans rather than carving out drug benefits and administering them separately on a fee-for-service basis.[2]



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Pennsylvania should continue its move away from a less efficient fee-for-service drug program. However, stakeholders and pharmacy interests have called on the state to impose new layers of unnecessary regulations on drug plans and on firms that manage drug benefits. Arguably, advocates of increased regulation aim to protect local pharmacies from competition by interfering with drug plan managers' attempts to negotiate better prices with pharmacies.[3] Though purportedly created to protect consumers, these regulations weaken health plans' ability to efficiently manage prescription drug benefits.

Managing Medicaid Drug Benefits. The Lewin Group, a public policy consultancy, found that managed drug plans are more efficient than plans that administer drugs separately from health benefits.[4] Virtually all state Medicaid programs distribute some drugs on a fee-for-service basis, but Pennsylvania ranks among the few states that distribute only a small portion this way.[5] For example, as shown in Figure I:

- Pennsylvania distributes about one-fourth of Medicaid drugs on a fee-for-service basis.
- About half of states distribute one-third of drugs that way.
- Forty-two percent of states distribute nearly all of their drugs that way.

The health plans that provide medical care to Medicaid enrollees are the logical entities to manage drug benefits, given that drug therapies often substitute for more expensive surgical treatment and can reduce the need for hospitalizations. Private-sector health plans and state-funded Medicaid managed care plans frequently contract with pharmacy benefit managers (PBMs), private firms that act as third-party administrators. Private health plans employ a variety of techniques to control drug costs, including drug formularies, required use of mail-order drug suppliers, negotiated prices with drug companies and drug distributors, and exclusive contracts with pharmacy network providers.[6]

Regardless of how a drug program operates, Medicaid enrollees generally obtain their prescriptions at local pharmacies, which are

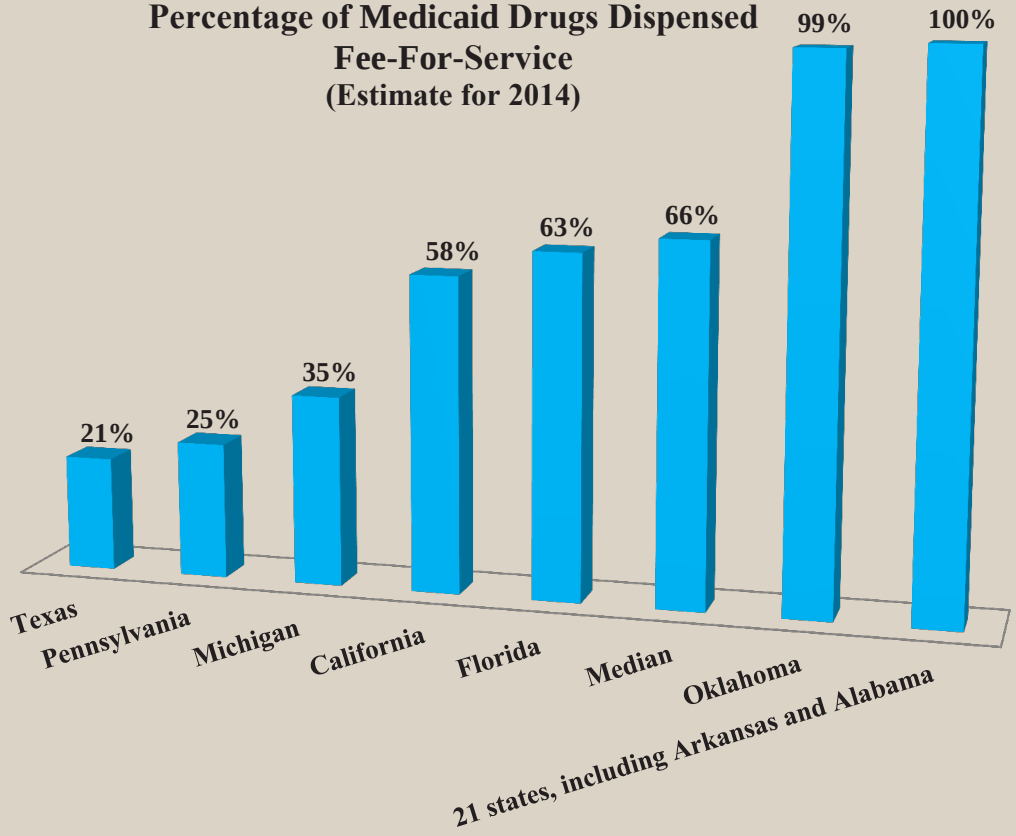
reimbursed for each prescription filled.[7] PBMs process and reimburse claims, and negotiate drug prices and rebates with drug manufacturers. They also negotiate the dispensing fee paid to pharmacies for the service of filling a prescription.[8]

Pharmacy Board Regulation. As is the case in most states, the state insurance commissioner regulates insurance sold in Pennsylvania, including health and drug plans. However, pharmacy interests are seeking to transfer some of the regulatory authority over drug plans to the State Board of Pharmacy. Pharmacists and their allies typically dominate the membership of such boards.[9] Such a law would also grant the Board of Pharmacy the power to demand sensitive information on PBMs' business practices, which could be disclosed to pharmacy trade groups, boosting their power in negotiations with the PBMs.

Indeed, when the Mississippi House of Representatives debated this issue in 2013, the Federal Trade Commission questioned claims that increased regulation would benefit consumers — concluding that more restrictive controls would harm competition and raise costs for consumers.[10] The Pharmaceutical Care Management Association, the trade association representing drug plan managers, worded it more succinctly, warning the legislation was like "letting the fox guard the henhouse."[11]

Inflexible Contract Model. Some regulation advocates want to dictate business models and contract negotiations between drug plans and their employers/clients. But these restrictions inhibit innovation and flexibility in plan design. Some have suggested that drug plan administrators should be licensed as "risk-bearing organizations" like insurance companies (which they are not). The Pennsylvania Department of Insurance already sets standards for drug plan administrators; thus, consumers would gain little from even more regulation.

Figure I
Percentage of Medicaid Drugs Dispensed Fee-For-Service
(Estimate for 2014)



Source: Joel Menges, "Menges Group, "Medicaid Pharmacy Savings Opportunities: National and State-Specific Estimates," Menges Group, May 2013.

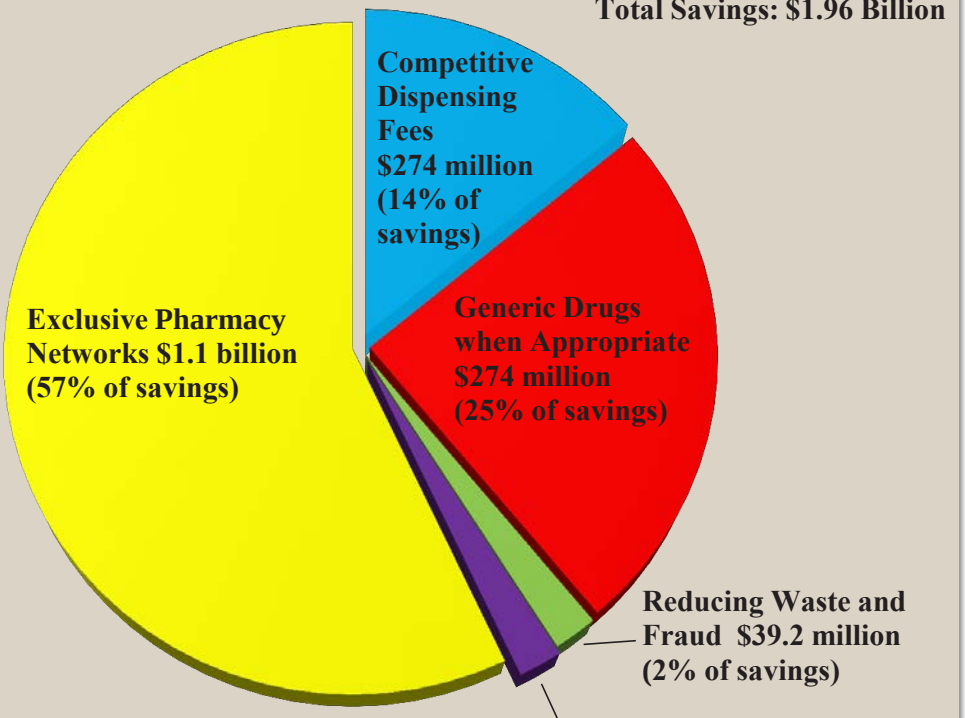
Competitive Dispensing Fees. Most state fee-for-service Medicaid drug programs pay dispensing fees that are about double the negotiated rate paid by private Medicare Part D drug plans. Community pharmacies often specialize in serving Medicaid beneficiaries and as a result lobby to maintain higher dispensing fees and the status quo.

Barriers to Efficient Networks. Many pharmacists are small business owners. Thus, state legislators often view them sympathetically when they lobby for protection from competition. For example, PBMs and health plans are increasingly experimenting with limited or "narrow" pharmacy networks in order to negotiate lower drug prices (and dispensing

fees). Pharmacies compete to become one of the exclusive network drug providers.[12] Enrollees, insurers and employers share in the savings that result.[13]

However, many states allow *any willing pharmacy* to participate in Medicaid drug programs, preventing the development of exclusive networks. Supporters argue that open pharmacy networks offer enrollees more choices and more convenience, and promote competition. PBMs and drug plans counter that pharmacies in exclusive networks agree to deeper discounts.[14] Any-willing-provider and freedom-of-choice laws reduce the drug plans' bargaining power.[15] They prevent health plan sponsors from selectively negotiating and contracting with pharmacies.[16] They also it more difficult to detect billing fraud by unscrupulous pharmacy operators.

Figure II
Potential 10-Year Savings from Efficient Management of Pennsylvania Medicaid Drug Programs



Source: Joel Menges, "Medicaid Pharmacy Savings Opportunities: National and State-Specific Estimates," Menges Group, May 2013.

The Federal Trade Commission notes that these laws lead to higher drug prices and higher premiums by protecting less-efficient pharmacies from competition.[17] Thus, they could actually be costly to taxpayers, employers and patients.[18] The Lewin Group calculated that if government enacted a nationwide any-willing-provider mandate, prescription mail-order pharmacy costs would increase 3 percent.[19] Thus, any-willing-provider and freedom-of-choice laws typically benefit local pharmacies rather than consumers.[20]

Barriers to Mail-Order Pharmacies. Drug plans offer incentives that encourage patients to use mail-order pharmacies for medications to treat chronic conditions, such as diabetes, hypertension and high cholesterol. Most plan sponsors charge higher deductibles for retail purchases, offer lower copayments for mail-order dispensing, or only reimburse patients for mail-order maintenance medications.[21] Some plans limit the number of times a prescription may be refilled at a retail pharmacy before patients are required to use mail order.

Unfortunately, some states are enacting laws that interfere with the ability of drug plans to reward enrollees who order by mail. In 2011, New York State passed Assembly Bill 5502, which allows consumers to fill prescriptions at any pharmacy without incurring additional cost sharing or fees. The law was designed to benefit local community pharmacies — not consumers.

As one consultant described it: "Imagine that your local bookstore owner lobbied your state Senate to pass a law preventing you from buying a book less expensively via Amazon.com. You would immediately recognize that the bookstore was trying to protect its business at your expense. This is precisely what has happened for prescription drugs in New York."[22] The Federal Trade Commission stated, "By reducing competition between pharmacies, this legislation likely

will raise prices for, and reduce access to, prescription drugs…"[23]

Retail-choice laws may increase convenience for some enrollees, but they drive up costs for all health plan members and their plan sponsors. Maryland passed legislation similar to New York's. If retail choice was required nationwide, mail-order prescription costs would rise more than 5 percent, according to the Lewin Group.[24]

Unnecessary Transparency Regulations. Proponents of expanded regulations sometimes complain that drug plans lack transparency regarding costs.[25] However, a majority of employee health plan sponsors already require PBMs to disclose and "pass through" all rebates, discounts or payments.[26] Indeed, many health plan sponsors now demand price transparency from drug plan administrators in contract negotiations.[27]

Potential Savings.[28] According to Menges, better Medicaid prescription drug management could save Pennsylvania $2.0 billion over 10 years ($1.1 billion in lower federal spending and $896 million less in state spending). Specifically, as Figure II shows:

- About one-fourth (25 percent) of the savings would come from use of generic drugs where appropriate.
- More than one-half (57 percent) the savings would come from negotiating steep discounts with exclusive (limited) networks.
- Negotiating competitive dispensing fees would save a further 14 percent.

There are other ways Pennsylvania could save money, such as:[29]

- *Increased use of generic drugs*. About three-fourths (77 percent) of drug prescriptions in Pennsylvania's Medicaid program are filled with generics, whereas the national average for managed Medicaid drug benefits is about 80 percent.
- *Reduced dispensing fees*. Pennsylvania paid pharmacies $4.00 to dispense a prescription in 2011, whereas the national average for private Medicare Part D plans is half as much — about $2.00.

Conclusion. Medicaid will best serve Pennsylvania taxpayers by providing drugs to enrollees at the lowest possible cost. The state will likely find that employing the services of pharmacy benefit managers will lower costs — if they allow drug plans to use the tools to do so. However, the state will undoubtedly come under political pressure to protect local providers from the competition that could save taxpayers money.

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References and sources can be found in the online version at www.ncpa.org/pub/ib134.

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