The Best Price Requirement of the Medicaid Rebate Program

The Academy of Managed Care Pharmacy (AMCP) believes that to provide the greatest value to Americans who need prescription drugs, market forces must effectively ensure that manufacturers of similar drugs compete with one another to establish reasonable pricing levels and maintain consumer access to needed therapies. While government has a responsibility to protect consumers against anticompetitive activity, the government must not establish rules that have the unintended effect of undermining competition. AMCP believes that the best price provisions of the Medicaid prescription drug rebate program[1] represents interference by the government into the competitive marketplace that has raised costs unnecessarily by preventing the commercial market from allowing true market dynamics to emerge.

In the private market, purchasers with sufficient market power can demand that they be provided the best price for a particular item that a seller might offer to any other purchaser. Under the antitrust laws, such "most favored nation" provisions could have serious legal ramifications if they have the effect of restricting or destroying competition, whereas smaller purchasers are unable to negotiate lower prices because the seller is unwilling to offer the same price to the larger purchaser. This has the effect of reducing competition and raising prices.

This is precisely what happened with the implementation of the best price provisions of the Medicaid drug rebate program.[2, 3, 4] This law requires brand name drug manufacturers to provide the Medicaid program with the lowest price they offer in the rest of the drug marketplace. Prior to the law's enactment in 1990, health maintenance organizations (HMOs), hospital systems and other well-organized purchasers had been able to negotiate deep discounts – often greater than 50%. In the immediate wake of the law's passage, rather than extending these deep discounts to Medicaid, drug manufacturers instead terminated discount contracts to HMOs and hospitals. Manufacturers became disinclined to offer smaller purchasers discounts and incentives that would then apply to a nationwide market such as Medicaid, which represented a much larger share of the total market than any single HMO or hospital system.

Public hospitals and the Veterans' Administration (VA) suffered the same fate, experiencing major increases in drug costs.[5] As a result, in 1992 and 1993, Congress exempted discounts negotiated by the public hospitals and VA from the calculation of best price. Unsurprisingly, discounts again flowed freely to those institutions. However, other private purchasers have continued to labor under the anticompetitive effect of the best price rule. This has inflated drug costs for employers, the state and federal employees health benefits programs, privately insured patients and health care providers ever since.

This pernicious market effect has been well documented by the U.S. Government Accountability Office (GAO), the Congressional Budget Office (CBO) and academic economists. Fortunately, there are solutions to this problem. Congress could replace the best price formula with a flat percentage rebate that generates the same level of savings for the Medicaid program that they have experienced for the past 19 years. The Medicaid program could continue to benefit from the same rebates that protect against excessive inflation of drug costs, which generates a substantial portion of the rebates paid today. Congress could also repeal the best price program and allow market forces to determine pricing.

We believe that reenergizing the competitive forces in the pharmaceutical market will benefit not only private employers, public employers, and other purchasers of prescription drugs, but it will also improve the ability of Medicare Part D plans to negotiate for lower prices on behalf of Medicare beneficiaries. Because prices negotiated for Medicare Part D are not considered under the best price program, Part D plan sponsors are required to negotiate separately for their Medicare and non-Medicare patient populations in order to protect the "integrity" of the best price system. It would save Medicare significant drug costs if these organizations are permitted to negotiate on behalf of their entire consolidated patient population, unencumbered by the best price rule.

After nearly two decades of market dysfunction, and after the establishment of a massive Medicare drug benefit, it is time to ask whether an alternative approach to Medicaid drug rebates could provide Medicaid with the same (or better) economic benefit, while freeing up competitive forces that could lower drug costs both in the private market and in public programs. AMCP strongly encourages a careful re-examination of the best price program.

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See also: AMCP's *Where We Stand on the Competitive Marketplace:* www.amcp.org/positionstatements

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[1] Established by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (P.L. 101-508).

[2] GAO, *Medicaid: Changes in Best Price for Outpatient Drugs Purchased by HMOs and Hospitals* (GAO/HEHS-94-194FS, Aug. 5, 1994), available online at http://archive.gao.gov/t2pbat2/152225.pdf

[3] GAO, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain* (GAO/HEHS-97-60. June 1997), available online at http://www.gao.gov/archive/1997/he97060.pdf.

[4] CBO, *How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry*, (January 1996) available online at http://www.cbo.gov/ftpdocs/47xx/doc4750/1996Doc20.pdf.

[5] GAO, *Medicaid: Changes in Drug Prices Paid by VA and DOD Since Enactment of Rebate Provisions* (GAO/HRD - 91-139, Sept. 18, 1991), available online at http://archive.gao.gov/t2pbat7/144939.pdf.