



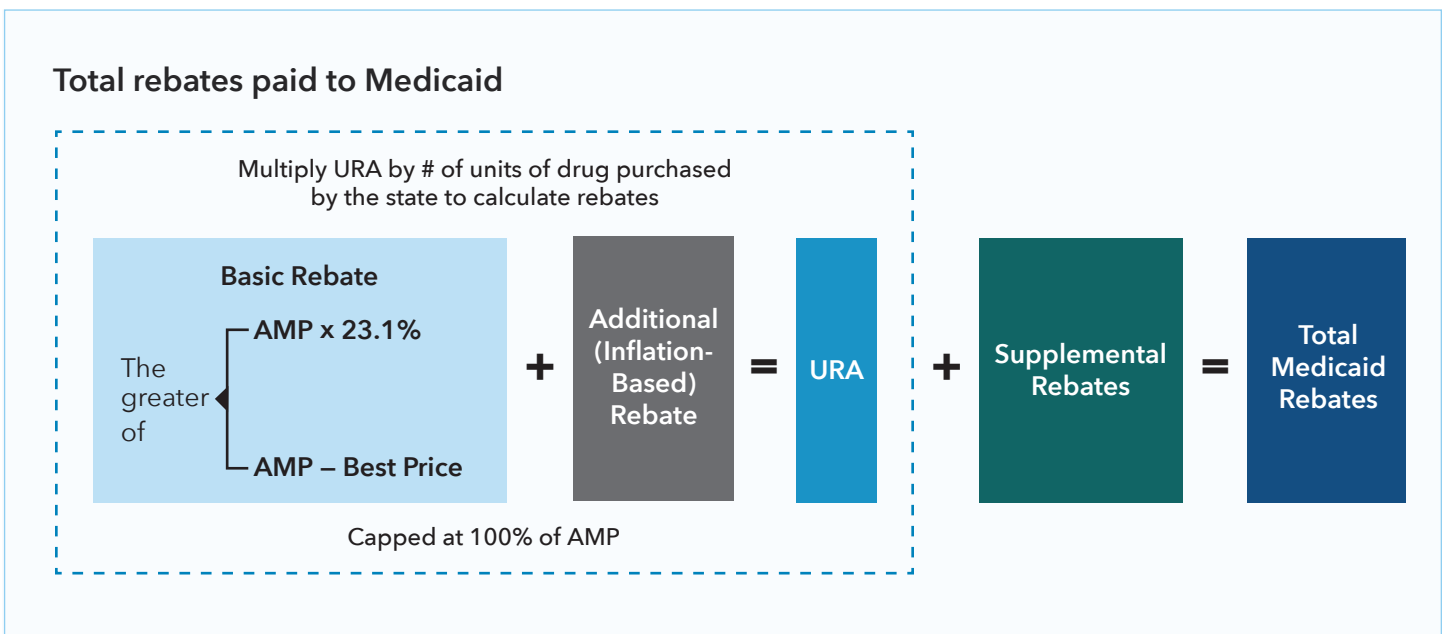
The Medicaid Drug Rebate Program and the impact of “best price” rules

The Medicaid Drug Rebate Program (MDRP) requires pharmaceutical manufacturers to issue rebates to Medicaid for covered outpatient drugs. When they offer prescription drug benefits, Medicaid programs must cover nearly all drugs, potentially reducing Medicaid’s leverage to negotiate discounts. Policymakers created the MDRP in response to rising drug costs and to help ensure Medicaid receives comparable discounts to other payers in the market. However, the way the MDRP calculates rebates may discourage manufacturers from offering deeper discounts to private purchasers, limiting potential cost savings for millions of patients covered by their employers or private health plans.

How the rebate program works

Congress created the MDRP as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). Under the program, a manufacturer that wants its drugs covered under Medicaid must enter into a national rebate agreement with the U.S. Department of Health and Human Services that commits them to paying rebates to Medicaid on their products. In exchange for the rebates, state Medicaid programs agree to cover all the manufacturer’s outpatient drugs. About 600 manufacturers have entered into rebate agreements, meaning that nearly all outpatient drugs approved by the U.S. Food and Drug Administration are subject to the MDRP.¹

To comply with MDRP, manufacturers must report drug pricing information to the government. HHS uses the price data to calculate each drug’s per-unit Medicaid rebate, known as a unit rebate amount (URA). A drug’s URA is determined by a formula that calculates the “basic” rebate and then adds an additional inflation-based rebate amount. States then multiply the number of units of a drug they purchase by the drug’s URA to determine the rebates a manufacturer owes them.



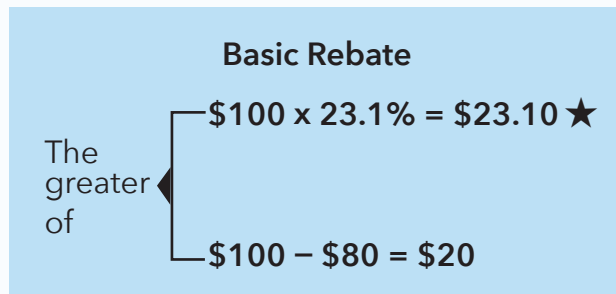
The basic rebate

The first component of the URA is the basic rebate, which helps ensure Medicaid gets comparable discounts to private payers. For brand drugs, the basic rebate is the greater of either: 1) a fixed percentage – 23.1% for most brand name drugs – of the average manufacturer price (AMP)² or 2) the difference between the AMP and the “best price.”

Best price is defined as the lowest price paid for a drug by any wholesaler, provider, retailer, HMO, government entity, nonprofit, or other health care purchaser. Discounts offered to some entities – such as the Department of Veterans Affairs, the Department of Defense, the 340B drug discount program, and private plans under Medicare Part D – are exempt from best price calculations. Discounts offered by manufacturers in the commercial market, however, are not exempt. Best price is used in the basic rebate formula to determine the rebates a manufacturer owes Medicaid; best price is not the amount Medicaid pays for a drug.

Basic rebate example

Assume the AMP for a brand drug is \$100 and its lowest negotiated price in the market is \$80, making \$80 its best price.



To determine the basic rebate, we look to see which is greater – 23.1% of the AMP or the difference between AMP and the best price for the drug. In this scenario, the greater of the two is \$23.10, which is 23.1% of AMP, also known as the “minimum rebate amount.” Therefore, \$23.10 per unit is the basic rebate paid to Medicaid for the drug.

Additional (inflation-based) rebate

The second component of the URA is the additional rebate, which requires manufacturers to pay higher rebates when a drug’s price increases faster than inflation. More aggressive price increases will generally trigger higher additional rebates.

Supplemental rebates

In addition to rebates calculated in the URA formula, nearly all state Medicaid programs negotiate supplemental rebate agreements (SRAs) with manufacturers that further offset their drug costs. Under SRAs, manufacturers pay additional rebates for preferential treatment on Medicaid formularies.

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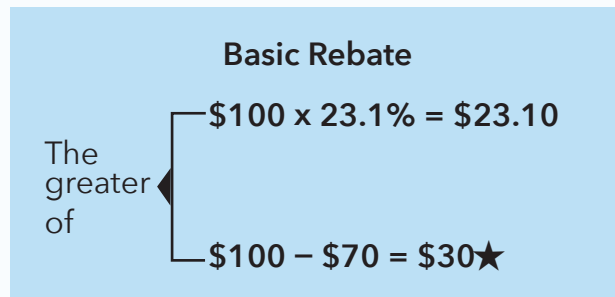
Impact of best price

The MDRP’s basic rebate helps make sure Medicaid pays a fair price for prescription drugs. However, the use of best price to determine the rebate may inadvertently increase costs on certain drugs in other markets and weaken negotiation tools available to health plans, hospitals, and other purchasers.

For example, a manufacturer that offered discounts to a private payer of greater than 23.1% of AMP would then owe a higher rebate on every unit of the drug sold in Medicaid, a program that covers over 64 million people. Indeed, the Government Accountability Office found that several years after Congress enacted OBRA 90, average best prices increased, resulting in the best price calculations for many drugs falling to about the level of the minimum rebate amount of 23.1% of AMP.³

Basic rebate example: How best price impacts the Medicaid rebate

In this example, the AMP for a brand name drug is again \$100, but its best price in the market is \$70.



Due in part to the dynamics created by using a drug’s best price in the basic rebate calculation, manufacturers are disincentivized to offer discounts below the minimum rebate level (23.1% of AMP). As a result, the minimum rebate amount often serves as a floor on discounts in the private market, restraining competition and keeping net drug prices artificially high. Modifying best price rules may help facilitate deeper discounts on some drugs in the private market, which could lead to cost savings for patients.

References

1. Medicaid Drug Rebate Program, Medicaid.gov, July 10, 2020, <https://jamanetwork.com/journals/jama/fullarticle/2720029>.
2. AMP is the average price wholesalers pay manufacturers for drugs sold to retail pharmacies, reflecting discounts and other reductions in the price paid.
3. GAO. (August 1994). Medicaid: Changes in Best Price for Outpatient Drugs Purchased by HMOs and Hospitals. Available at: <https://www.gao.gov/assets/90/89752.pdf>.