



MEMORANDUM IN OPPOSITION

FOR IMMEDIATE RELEASE: FEBRUARY 29, 2016

Re: A.9271 (Gottfried) – AN ACT to amend the social services law and the public health law, in relation to extending the preferred drug program to Medicaid managed care providers and offering the program to other health plans; and to repeal certain provisions of the social services law relating thereto.

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This legislation, A.9271, would mandate Medicaid managed care (MMC) plans adopt the State Medicaid Fee-for-Service (FFS) Preferred Drug Program (PDP) formulary. The New York Health Plan Association (HPA) opposes this legislation as it will significantly increase the cost of the Medicaid pharmacy benefit and have a direct impact on the Medicaid global cap.

With the equalization of federal rebates and MMC plans' ability to utilize management tools that are unavailable under the Medicaid FFS program, the Medicaid Redesign Team (MRT) proposed carving the pharmacy benefit back into the MMC benefit package. This carve-in was enacted as part of the 2011-12 NYS budget and the savings associated with it were critical in avoiding other cuts to beneficiaries and providers. According to the State's Medicaid Director the transition of the pharmacy benefit from the State-administered FFS program to the MMC program has achieved a state budget savings of between \$400 million and \$500 million a year.

The bill's sponsor of reasons a uniform state-run FFS Medicaid drug benefit would do a better job negotiating down drug prices than individual MMC plans and expand the benefit to allow MMC recipients access to more medications. The sponsor also believes this approach will attract commercial plans to the Medicaid FFS approach and lower the cost of drugs in New York. Unfortunately, this is just not true. The fundamental flaw in this claim is that individual MMC plans contract with national prescription benefit managers (PBMs) who use their cumulative contracts (MMC plans, commercial insurers and employer sponsored plans, at a state and national level), which results in their negotiating power covering tens of millions of members. Express Scripts, a national PBM, for example has a negotiating power of 85 million insured lives, compared to the negotiating power of the 6 million Medicaid recipients covered by this proposal. The sponsor's argument also fails to acknowledge that due to the inefficiencies and high cost of the Medicaid PDP no other commercial plan since 2008 has chosen to emulate its approach.

A uniform formulary approach modeled after the Medicaid FFS PDP is a huge step backwards for New York's Medicaid program. This legislation would effectively reverse many of the tools plans use to manage the pharmacy benefit and improve care coordination for Medicaid beneficiaries. The net result would be a serious erosion of the savings associated with the MMC pharmacy benefit carve-in. New York's history using the PDP has shown that it is an inefficient and a more costly approach of managing the Medicaid pharmacy benefit. At a time when NY needs to aggressively seek measures to reduce the cost of prescription drugs this proposal moves in the wrong direction. It is important to note that any increased costs associated with this legislation will also have a direct impact on the Medicaid global cap to the tune of between \$400 million and \$500 million dollars annually.

HPA opposes A.9271 as it will significantly increase the cost of the Medicaid pharmacy benefit, while negatively affecting care quality and threaten the Medicaid global cap.

The New York Health Plan Association represents 25 managed care health plans that provide comprehensive health care services to nearly 7 million New Yorkers.