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# MEMORANDUM IN OPPOSITION

**FOR IMMEDIATE RELEASE:** JANUARY 17, 2017

Re: A.700 (Rodriguez) – AN ACT to amend the social services law and the public health law, in relation to prescription drugs in Medicaid managed care programs; and to repeal certain provisions of the social services law, relating to payments for prescription drugs.

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This legislation, A.700, would: require Medicaid managed care (MMC) and Child Health Plus plans to adopt the procedures of the Medicaid Fee-for-Service (FFS) Preferred Drug Program; restore "prescriber prevails" for all drugs; and allow any MMC plan to opt out of the delivery of the Medicaid pharmacy benefit. The New York Health Plan Association (HPA) has concerns regarding this legislation as it may significantly increase the cost of the Medicaid pharmacy benefit and have a direct impact on the Medicaid global cap and threatens hospital and physician reimbursement in Medicaid. This bill is a boon to pharmaceutical manufacturers at a time when in the MMC reimbursement rate of pharmacy costs are greater than inpatient hospital costs.

With the equalization of the federal rebates and MMC plans' ability to utilize management tools that are unavailable under the Medicaid FFS program, in 2010 the Medicaid Redesign Team (MRT) proposed reinstating the pharmacy benefit back into the MMC benefit package. The transition of the pharmacy benefit from the state-administered FFS program to the MMC program was intended to achieve a state budget savings of $100 million annually. In reality, it has achieved greater savings than was projected. According to the state Medicaid Director, in 2011 the savings from the carve-in of the pharmacy benefit into MMC resulted in a $200 million savings over FFS costs.

In addition to generating savings that were unavailable under the FFS pharmacy program, the reinstatement of the pharmacy benefit in the MMC benefit package allowed the state to improve coordination of care. When the pharmacy benefit was carved-out of the MMC package, plans did not have the ability to monitor whether members were actually taking their medications. To provide true coordinated care for enrollees, it is necessary to monitor both the medical and pharmacy benefit—especially for enrollees with chronic conditions such as diabetes where adherence to the medication regime is as important as being seen by a health care provider. This improved care coordination results in increased care quality as MMC plans work with enrollees to ensure that they go to their primary care physicians and take necessary medications, thus reducing expensive emergency room visits.

The sponsor's assertion that there are **no** fiscal implications or costs associated with implementing this legislation— is simply not true. Effectively reversing many of the tools plans use to manage the pharmacy benefit and improve care coordination for Medicaid beneficiaries, would result in a serious erosion of the savings associated with the MMC pharmacy benefit carve-in. Moreover, expanding "prescriber prevails" to all drug classes and creating new looser prior authorization process would directly result in additional costs to the Medicaid program. While the exact cost of this expansion of benefits is unknown, this legislation fails to appropriate funds for these increased services. It is important to note that any increased costs associated with this legislation will also have a direct impact on the Medicaid global cap.

HPA has concerns that A.700 will significantly increase the cost of the Medicaid pharmacy benefit, while negatively affecting care quality and threatening the Medicaid global cap.

*The New York Health Plan Association represents 29 managed care health plans that provide comprehensive health care services to nearly 8 million New Yorkers.*