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MEMORANDUM IN OPPOSITION

FOR IMMEDIATE RELEASE: JANUARY 25, 2021

Re: A.1671-A(Gottfried) / S.2520 (Rivera) – An act to amend part FFF of chapter 56 of the laws of 2020, amending the public health law relating to extending and enhancing the Medicaid drug cap and to reduce unnecessary pharmacy benefit manager costs to the Medicaid program, in relation to temporarily exempting covered entities under the federal 340B program and comprehensive HIV special needs plans

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The New York Health Plan Association (HPA), which represents 28 health plans that provide coverage to more than 8 million New Yorkers, opposes A.1671-A/S.2520, which would temporarily delay implementation of the FY 2020 budget provision to remove the Medicaid pharmacy benefit from the Medicaid managed care program – but only for the 340B program (a federal program that discounts drug costs) and comprehensive HIV special needs plans. While well intentioned, delaying the implementation for a limited number of providers does not address the overarching problem with carving the pharmacy benefit from the Medicaid managed care program and will create chaos for patients and providers, and disrupt care. A more efficient, effective solution would be to reverse this budget action in its entirety and retain the pharmacy benefit in managed care for all participants of the Medicaid program.

In the FY2020 enacted budget, the state chose to carve pharmacy benefits out of the Medicaid managed care plan benefit package. In addition to not achieving savings the state anticipates, the change will result in more fragmented care for Medicaid patients, particularly those with chronic health conditions, who rely on having their care integrated and coordinated across the continuum. A major advantage of the carve-in model is that it insulates the state budget from the volatility in prescription drug costs. Currently, drug cost volatility risk is assumed by the managed care organizations and the state is guaranteed a predictable drug cost budget during the year. Under a carve-out model, the state would be at risk for prescription drug cost volatility, which has been as high as 11.5% in the past five years.

Carve-in models support integrating care for the whole person under one umbrella. A study published by Prime Therapeutics showed that an integrated care model combining pharmacy and diagnosis data produces better care at lower cost.[1] **Key results showed 11% lower medical costs, 9% lower hospitalization events, and 4% lower emergency department visits when using an integrated care carve-in model versus a carve-out model**. These savings were obtained by improved health plan care coordination through integrated data resulting in more timely and targeted health interventions, including enhancing care management and disease management programs. Proven evidence shows that maintaining prescription drug benefits as a carve-in with managed care organizations drives cost savings and delivers highly effective and quality integrated care. While a pharmacy carve-out would increase rebate revenue and decrease ingredient costs for the Medicaid program, the additional costs from dispensing fees, a single preferred drug list medical utilization, and further bifurcating the quality of care received by beneficiaries would far exceed this.

[1] Value of Managed Care Organizations and Pharmacy Benefit Managers in Managing the Medicaid Prescription Drug Benefit, The Menges Group, October 2019.

The state's actions to move the pharmacy benefit will also drastically affect 340B providers, greatly hindering their ability to use these savings for essential services. It could decimate safety net providers, stripping critical resources they need to support programs including housing, food assistance and HIV assistance that they provide to the state's most under-served communities.

There are numerous public health and fiscal reasons for discontinuing the Medicaid pharmacy carve-out initiative, including that it will destabilize many safety net providers who rely on 340B funding, will reduce critical services now provided to minority and underserved populations and is likely to increase costs to the State. However, recognizing the potential damaging effect of this policy for one subset of the health care continuum and moving to protect these providers does not confront the larger issue: that this is bad policy that will result in less care coordination for patients and should be reversed for all Medicaid patients.

For these reasons, HPA urges you to oppose A.1671-A/S.2520.