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NEGATIVE CONSEQUENCES OF THE OHIO PRESCRIPTION DRUG (or Rx) BALLOT ISSUE

Families & Children in Medicaid, Pharmacy Services Are Impacted

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The proposed initiated statute dubbed by sponsors the "Drug Price Relief Act" is bad public policy, will increase the cost of healthcare for average Ohioans, will severely disrupt the provision of healthcare services, and will cause poor children, parents, elderly, and disabled to lose access to the drugs they need to survive.

Higher Healthcare Costs for Average Ohioans

The proposed ballot issue for November 2017 will not reduce the cost of drugs for Ohioans, as proponents claim. Since the proposal only applies to state government programs, only entities with the State of Ohio would subject to the statute, if adopted. An estimated four million lives that are covered by those programs. For all Ohioans, the proposed ballot issue would force enactment of a law that is impossible to implement, resulting in administrative backlog, lawsuits and uncertainty for those who depend on state programs for medication access. For the seven million Ohioans not on state programs, including veterans who use the Department of Veterans Affairs (VA) medical services, the elderly and disabled who use Medicare, those with private insurance, and the uninsured, may see their healthcare costs go up as losses that are experienced in government programs are shifted to other payers.

The Most Vulnerable Populations Will Lose Access to Drugs

The VA operates its own pharmacies at clinics and through mail order services. Therefore, the VA needs to purchase drugs to stock those pharmacies. The ceiling price is usually the maximum the VA is paying to physically obtain those drugs and stock them on the shelves of the VA pharmacies. Most of the state programs do not operate their own pharmacies. The Medicaid program, which accounts for three million people under this proposed ballot issue, does not operate pharmacies. Medicaid pays for drugs for people on the program through retail pharmacies such as CVS, Walgreens, and independent pharmacies, and non-retail pharmacies, which are pharmacies in hospitals, nursing homes, and federally qualified health centers (FQHCs). To understand the impact of this proposed law one must first understand how drugs are reimbursed under Medicaid.

The Medicaid program by federal law must document the methodology for which it will pay providers in the Medicaid State Plan. Changes to reimbursement methodologies must be approved by the Centers of Medicare and Medicaid Services (CMS) through a State Plan Amendment (SPA). In the case of drugs, there are two components to the reimbursement: 1) the dispensing fee, and 2)

the ingredient fee. The ingredient fee is the payment for the actual drug, for example, $1.00 per pill. The state sets the ingredient fee based on averaging actual acquisition costs obtained through surveys. Because this is based on averages, it allows pharmacies to make a profit selling the drug to someone on Medicaid if the pharmacy can purchase the drug bellow that average amount. The Medicaid program can lower drug costs even further by getting the mandatory rebate from the drug companies plus negotiating supplemental rebates. It is important to note that rebates DO NOT lower the price the Medicaid program pays to the pharmacy. Those rebates are collected directly from the drug companies. A theoretical example of how this works under the fee-for-service portion of the Medicaid program is the following:

Example 1: Under Current Medicaid Reimbursement Methodology

Medicaid sets a payment of $50.00 for a one month supply of a drug. The Medicaid program receives rebates of $25.00 for a one month supply of the drug.

The pharmacy has negotiated to purchase a one month supply of the drug at $47.50.

When a person on Medicaid goes to the pharmacy to obtain their one month supply, the Medicaid program pays the pharmacy $50.00. The pharmacy makes a profit of $2.50 from the transaction.

The Medicaid program's expenditure for the drug is the payment to the pharmacy minus the rebate. In this example that would be $25.00.

Example 2: Under the Proposed Ballot Issue

The Medicaid program is still receives a rebate of $25.00 rebate for a one month supply of the drug. The VA price is $20.00 for a one month supply. Therefore, the Medicaid program would have to set the price paid to a pharmacy at $45.00 for a one month supply because that amount is equal to the VA price after the rebate.

The pharmacy has negotiated a purchase price for a one month supply of the drug at $47.50.

When a person on Medicaid goes to the pharmacy to obtain their one month supply, the Medicaid program pays the pharmacy $45.00. The pharmacy has a loss of $2.50 from the transaction.

The Medicaid program's expenditure is the payment to the pharmacy minus the supplemental rebate, which in this example would be $20.00.

	Example 1: Current Medicaid Reimbursement Methodology	Example 2: Proposed Ballot Issue
Medicaid Payments to Pharmacy for 1 Month Supply of Drug	$50.00	$45.00
Pharmacy Cost for 1 Month Supply of Drug	- $47.50	- $47.50
Pharmacy Profit/(Loss)	$2.50	($2.50)
Total Medicaid Expenditures		
Total Payment to Pharmacy	$50.00	$45.00
Medicaid Rebate for 1 month supply	- $25.00	- $25.00
Total Cost to Medicaid	$25.00	$20.00

What is clearly evident is that the savings to the state come from the cut to the pharmacy. The VA price is typically the lowest price available by law, but is only applicable to programs that serve veterans. Basic economic principles and federal rules dictate that pharmacies will not be able to purchase the drug at that price. What will happen is pharmacies will stop being providers in the Medicaid program. That will cause people to lose access to the drugs they need. Those that may lose access include the elderly, disabled, and children. If they are unable to obtain their prescriptions easily, compliance will be reduced which in many cases leads to worse health outcomes or even worse death.

If these cuts occurred, they could also apply to hospitals, nursing homes, and FQHCs that operate internal pharmacies, the cruelest being to the FQHCs, public hospitals, and children's hospitals that operate pharmacies under the 340B drug program. That program allows them to buy drugs for their pharmacy inventory at a reduced rate. The difference between the reimbursement and acquisition amounts are profits that those entities keep. Causing FQHCs to not only lose those profits, but also operate at a loss would cause the closure of FQHCs leading to even less access to primary care.

The Most Vulnerable Will Also Lose Access to Their Doctors

There are some drugs people receive directly from a doctor and not from a pharmacy. In these cases, the doctors purchase drugs directly from wholesalers and are then reimbursed by the Medicaid program once they are administered. The theoretical pharmacy example above would be the same for doctors. The Medicaid program would need to reimburse the doctors less than what the doctors pay for the drug. At some point those doctors will stop serving people on Medicaid. A few examples of people that could lose access to these doctors are patients with breast cancer, immune deficiency disease, kidney failure, rheumatoid arthritis, substance abuse disorder, and mental illness.

Ohio's Federal Medicaid Funding Will be Put in Jeopardy

Title XIX of the Social Security Act is the federal law states the requirements of the Medicaid program. Drug coverage is an optional benefit under the Medicaid program that the State of Ohio has elected to cover. If a state chooses to cover drugs, Title XIX generally requires that a state must make available to everyone enrolled in the Medicaid program virtually all drugs approved by the Food and Drug Administration (FDA). In return, drug companies must offer states rebates. The state can then attempt to negotiate additional rebates, usually using a guarantee of a preferred status and thus higher volume for a drug. The drug companies under this proposed ballot issue are ***not required*** to negotiate rebates down to the VA price. The proposal says that the state is simply limited to paying the VA price. The only way to do that will be to lower the price paid to providers because the state has no new negotiating leverage with the drug companies. The drug companies will not be compelled to give the state additional supplemental rebates. The state will have to lower reimbursement to providers. To implement that rate cut, Ohio Medicaid must submit a SPA to CMS. In order to obtain approval of the SPA, Ohio Medicaid will have to prove people on the program will have adequate access to providers. Ohio Medicaid will not be able to prove to CMS there will be adequate access to pharmacies, and therefore CMS will not approve the SPA. In that scenario, Ohio Medicaid has two options. One, Ohio Medicaid can ignore the "Drug Price Relief Act" and not pay the VA price for drugs, or two, Ohio Medicaid can violate federal law and only pay the VA price and risk losing the federal matching dollars for the Medicaid program.

People enrolled in Both Medicare and Medicaid Could Lose Their Drug Benefit

The Ohio Medicaid program pays the premiums and copays for low income people. This is done directly for some and indirectly through a payment made to CMS for others. Per the ballot issue those payments would be indirect payments for drugs limited to the VA pricing. It is not clear how the Ohio Medicaid program would comply with the proposed statute and the federal law for these payments. The state could reduce the amount it pays to the federal government, but then the federal match for the Medicaid program would be put in jeopardy. The state could also short the Medicare program on the premium payments, but that could lead to people losing their drug coverage.

Bad Deal for Taxpayers: Healthcare Uncertainty and Paying for Lawsuits

It has been reported that, should Ohio voters approve the proposed statute, it would apply to around four million lives total. This includes people on Medicaid, as well as state workers and retirees, prisoners, injured workers, participants in the Rx Ohio Collaborative, and more. Based on the very high probability outlined above that CMS will not allow the Ohio Medicaid program to implement this payment policy because it would severely limit access to pharmacies, the Medicaid program and its three million lives would not be included, which would lower the number of lives possibly impacted to one million lives. An argument can also be made that all the other state programs that do not operate pharmacies would also not be able to implement this payment policy, and thus the lives covered by those programs would be subtracted from the total also. The number of covered lives left would be in the 100,000 range, and those programs that are left will most likely not be able

to obtain drugs at the VA prices because of a lack of negotiating power. In that scenario the state will have to decide whether to violate the proposed law or close the programs and leave children unable to get vaccines and people in the state-run mental health hospitals unable to get their medications.

What could happen if the state excluded programs and/or shut down programs is the citizens of Ohio would have to pay for the proponent's lawyers if they decided to sue the state. The proposed law contains an unprecedented and extraordinary provision that dictates that the taxpayers of Ohio must cover the costs of any legal challenge to the proposed law. Given that the proposal is vague and without implementation guidance, it is highly anticipated that proponents will push lawsuits, at Ohioans' expense, to force actions on the law, should it pass. If the state decides the proposed law is not implementable, the proponents have the incentive to take the state to court because they are not responsible for the legal costs. The taxpayers must pay the legal costs. The only small disincentive in the proposed law is if the proponents ultimately lose in court they will have to pay a $10,000 penalty. That is peanuts compared to the millions that will be spent on litigation.

About the Author

John McCarthy is currently the CEO of Upshur Street Consulting, LLC. A healthcare strategy and advisory consulting firm. Most recently, Mr. McCarthy was the Director of the Ohio Department of Medicaid (ODM) for six years, Ohio's first cabinet-level state Medicaid agency. Through its network of more than 75,000 active providers, Ohio Medicaid made coordinated, person-centered care available to residents in all regions of Ohio. The department became the cornerstone of the Governor John Kasich's Office of Health Transformation (OHT). Mr. McCarthy implemented a series of innovative policy initiatives that modernized the Ohio Medicaid program by improving the quality of health services at a substantial value to Ohio's taxpayers.

Prior to overseeing Ohio Medicaid, McCarthy served as Medicaid Director for the District of Columbia for two years and as the policy Director for three years. During his time in DC Medicaid he reformed and modernized many aspects of the program including but not limited to coverage, rate setting, managed care contracts, IT systems, and home- and community-based services.

He also spent ten years with EP&P Consulting, where he worked with many states, to help reform their Medicaid programs and two years in the Arizona Governor's Office of Strategic Planning and Budgeting.

McCarthy has a master's degree in public affairs from Indiana University's School of Public and Environmental Affairs and a bachelor's degree in chemistry from Indiana University.