A new Medicaid rule has retail pharmacies worried that lower reimbursements for popular generic drugs might cause their profits—and their business—to disappear. But the pharmacies had better not hold their breath as they wait for Congress to come to their rescue.

Published on July 6, 2007, the new rule essentially implements a congressional law in 2006 that requires Medicaid to adjust how the average manufacturer’s price (AMP) is calculated; the AMP, in turn, determines a state’s reimbursement to pharmacies. This ruling affects only generic drugs, not brand-name products. The federal government reimburses the states for patients’ drug expenditures according to an impossibly confusing formula built around a concept called “federal upper limits.” The formula, consequently, depends on the AMP.

The Deficit Reduction Act (DRA), passed by Congress in February 2006, essentially followed the recommendations of and numerous reports from the Government Accountability Office (GAO). The law declared that drug prices billed to Medicaid by the states were too high. The problem was not as much the fault of the pharmacies as that of the generic drug companies, which were using inflated prices. This practice led to excessively high AMPs and, therefore, high federal upper limits. Those GAO reports were always delivered to congressional committees, whose members voiced outrage. Consequently, the 2006 DRA contained the mandate to change the method by which the AMP is computed.

The first step took place on January 1, 2007; the federal upper limit for multiple-source drugs was set at 250% of the AMP. Prior to the 2006 DRA, the AMP had been the average unit price that wholesalers paid to the manufacturer in the U.S. for drugs distributed to retail pharmacies after customary prompt pay discounts were deducted. Effective January 1, 2007, the DRA revised that formula to exclude customary prompt pay discounts to wholesalers, and this change automatically lowered the AMP.

In addition to this congressional authorized change, the DRA gave Medicaid the latitude to make other administrative changes. In the final rule, the most important change was exempting retail business rebates and discounts from pharmacy benefit managers (PBMs) in calculating the AMP.

For several reasons, the National Community Pharmacists Association (NCPA) and the National Association of Chain Drug Stores face an uphill battle to convince Congress to revise the final rule from Medicaid. Primarily, the states, saddled with ever-higher Medicaid costs, clamored for changes in drug reimbursement, but governors are expected to vehemently oppose any changes in the AMP rule.

The only political factor in the retail pharmacies’ favor may be the Democrats’ control of Congress. When the DRA was passed, the Republicans controlled Congress, and key Republican committee chairmen strongly favored taking a buzz saw to Medicaid drug reimbursement. Now that the Democrats are running Congress, they might have more political allegiance to Medicaid recipients than the Republicans had.

Yet it is not the Medicaid recipients who would be harmed by the new AMP formula; only the pharmacies would feel the pain. However, Bruce Roberts, RPh, the NCPA’s Executive Vice President and Chief Executive Officer, says that pharmacies might drop out of the Medicaid plan; this would certainly affect the program’s beneficiaries. He says that the change in AMP would result in a total decline of $120,622 in annual profit for the average community pharmacy. This is a heavy loss, considering that the average pharmacy’s annual profit is $129,000.

Charles Sewell, the NCPA’s Senior Vice President of Government Affairs, says that his group has met with Representative Charles Rangel (D-N.Y.), House Ways and Means Committee chairman, and Senator Max Baucus (D-Mont.), Senate Finance Committee chairman. These two congressmen are the key decision-makers on Medicaid matters. Mr. Sewell says that the two would probably sympathize with the independent pharmacies and would appreciate how the Medicaid rule would hurt them. These pharmacies are located mostly in rural and inner-city areas, which the two men happen to represent.

Asked why Congress might now approve legislation that nullifies Medicaid’s rule on the AMP—when it was Congress itself in the 2006 DRA who asked Medicaid to make these changes—Mr. Sewell explained that no one knew then, before current pricing information became available, how deep the cuts in pharmacy profits would be with the new AMP formulation. He anticipates that the legislation to be introduced on behalf of the pharmacy groups will have bipartisan support and “fairly strong traction.”

However, during the past three or four congressional terms, the American Medical Association has claimed that cuts in Medicare payments to physicians would reduce the number of doctors willing to see Medicare patients. Surveys show that the number of doctors has not decreased, and Congress has not made any adjustments to physicians’ payments—even though the payments are becoming smaller.
Charles Sewell says that 2,300 community pharmacies will close if the Medicaid rule stands as is. This is only his prediction, of course. A skeptic might call it a scare tactic. In any event, this kind of warning has had no effect on Congress on the matter of physician fees.

Another Sewell prediction seems a little more solid: that pharmacies will simply find a way to dispense more brand-name drugs than generics. This would mean higher costs for states and the federal government, the opposite of what the Medicaid rule aims to achieve.