**Relationship of Commercial, ERISA, Medicare Part D and State Employee Plans to Upper Payment Limits (UPL)**

States are considering enactment of Prescription Drug Affordability Boards (PDAB) that would have authority to establish upper payment limits (UPL) for certain high-cost drugs.

The UPL would apply statewide to payers and purchasers such as health plans, hospitals, pharmacies, as well as the state-licensed distributors that supply drugs to those in-state dispensing entities. As a result, the UPL would make a drug more affordable for state consumers and state public and private health systems because a lower, transparent, cost travels through the supply chain.

All health plans that pay for pharmaceuticals using a claims payment approach (rather than bundled payments) will achieve cost savings with a statewide UPL.

In general, all public and private health plans offer a pharmacy benefit that reimburses pharmacists and other providers for the cost of drugs dispensed or administered. Most if not all health plans collect rebates from manufacturers on the back end – months after the health plan has reimbursed the provider. The net cost to a health plan for any drug is the provider reimbursement minus the rebate.

There are two aspects of savings for health plans. One aspect is the amount a health plan/PBM reimburses providers for the provider’s cost to acquire/stock a drug (the acquisition cost). That reimbursement for retail drugs is typically based on some percentage of wholesale acquisition cost (WAC) or average wholesale price (AWP). If a UPL for a drug lowered provider acquisition costs to say to WAC-30%, that would be a significant reduction in the amount of money plans spend to reimburse providers (“claims payment”).

The second way to think about plan savings to compare a plan’s net cost of a drug (after rebates) to the UPL. If a plan’s net cost for a drug before a UPL is WAC-10% and WAC-30% after the UPL, there is a savings there too. If the health plan was already netting WAC-30% after rebates, there is no additional net savings for the plan. The plan savings moved from rebates to savings on pharmacy reimbursement. The move from rebates to on-invoice discounts also help consumers and pharmacists in ways that rebates do not.

So, if the UPL cost is greater than the plan’s net cost after rebates, the health plan would still pursue manufacturer rebates, but the cost of paying pharmacy claims would be reduced to the level of the UPL. If the UPL lowers the plan’s net cost after rebates on a drug, the health plan benefits even more. Enrollees benefit when the coinsurance or deductible cost for a UPL drug decreases or when a health plan drops a UPL drug to a lower formulary tier.

Health plans that consult with the state PDAB in establishing UPLs could derive significant net savings.

The UPL for a drug will be informed by its current manufacturer discounts and other price concessions estimated to be in the market. This market awareness should help create a UPL that improves a health plan’s net cost for a drug. (see endnote[[1]](#endnote-1))

Below is more analyses to address the complexities of Medicare Part D, ERISA, and Medicaid.

**Medicare Part D Prescription Drug Plans:** Medicare Part D plans are dually regulated by state insurance departments and the federal Centers for Medicare and Medicaid Services within the US Department of Health and Human Services. By federal law, Part D plans are state licensed; their premiums and solvency are reviewed by state Insurance departments. Like ERISA plans, Medicare Part D plans could choose to reimburse pharmacies more than the UPL that a pharmacy would bill it, but that seems unlikely.

**ERISA:** The recent US Supreme Court decision in Rutledge v PCMA found state laws regulating payment rates are not preempted by federal ERISA law. The UPL created by a Prescription Drug Affordability Board (PDAB) fits squarely within the Court decision the citing state payment regulations as an example of state authority that is not preempted by federal law.

The PDAB model act was developed *before* the Rutledge decision and is designed to avoid a violating ERISA preemption. If ERISA were not affected by PDAB state law, ERISA enrollees would still be protected because the UPL applies to state-licensed pharmacists or physicians who bill for a drug dispensed -- regardless of insurance type. The ERISA plan could choose to reimburse physicians and pharmacists more than the UPL amount they were billed.

**Medicaid:** State upper payment limits would not change federal law that requires manufacturers to provide rebates. A UPL will reduce claims payment costs in both fee for service and Medicaid managed care programs for prescription drugs to which a UPL is applied. Supplemental rebates might not be available if a manufacturer retaliates.

1. An example of UPL savings based on current market price concessions would be, Humira and Enbrel -- two widely prescribed treatments for rheumatoid arthritis and other autoimmune disorders. The retail price for these drugs was about $65,000/year two years ago. At that time, the average rebate in the private market was estimated to be between 30-40% and is probably higher today. If the UPL could be 35% off the list price ($42,250), health plans could estimate potential savings using two calculations: cost of claims paid calculation and net cost calculation. First, to estimate savings on cost of claims paid, state employer plans could calculate pharmacy claims payments for these drugs and assume a 35% reduction. To estimate net cost savings, the employee plan should compare its net (post rebate) cost of these drugs relative to a UPL of WAC-35%.

   Consider also possible savings for the newer diabetes insulins, Lantus and Levemir, which retailed at about $200 and $400/pen two years ago. The average private market rebate was estimated to be 60-70%. If the UPL dropped the acquisition cost of these products by 70%, that would be a significant savings in claims payments, a significant savings in the supply chain and a significant savings for consumers at the pharmacy counter. A UPL at this level could be a significant net cost savings to state employee plans.

   A UPL of even 10%-12% below WAC for newer cancer drugs would be significant when manufacturer rebates are scarce in the market. A UPL of WAC-25% for costly multiple sclerosis drugs could make a large impact on state employee plans and consumers. A PDAB could also decide to capture deeper price concessions as needed to expand patient access. A PDAB could be well positioned to evaluate the range of discounts in setting UPLs to manage affordability and increase access to costly drugs in the state. [↑](#endnote-ref-1)