NEW HAMPSHIRE
Prescription Drug Affordability Board

PDAB Policy Brief: Leveraging Medicare Maximum Fair Prices in New Hampshire

Executive Summary

The New Hampshire Prescription Drug Affordability Board (PDAB) recommends that each public payor (excluding Medicaid) use Medicare Maximum Fair Prices (MFPs) to establish a reimbursement ceiling on those drugs identified by the Medicare negotiation program annually. Estimated saving across the relevant public payors is expected to be in a range of $1.5m to $2m per year. Medicare is expected to add to the list of pharmaceuticals that they negotiate, establishing further saving to New Hampshire public payors.

Further, the PDAB will publicly publish the status of the recommendation implementation and estimated savings. This information may potentially be used by commercial payors to reduce their pharmaceutical spend.

Key Opportunity for New Hampshire

The Medicare Drug Price Negotiation Program presents a historic opportunity for New Hampshire to lower prescription drug costs. The Centers for Medicare & Medicaid Services (CMS) has announced Maximum Fair Prices (MFPs) for ten high-cost prescription drugs, including Enbrel, Stelara, and Eliquis. If these prices had been in effect in 2023, Medicare would have saved $6 billion, an average savings of 22% per drug.[1]

- The PDAB's 2024 Annual Report found the state would have realized $6 million in net savings in 2023.[2]
- State and local employee and retiree health plans are approximately 20% of the analyzed commercial market data, resulting in a range of $1.5 - $2.0 million in net savings on the first 10 drugs selected by Medicare for negotiation. This number would increase annually as more high-cost prescription drugs are negotiated.
- Policymakers interested in leveraging the negotiated Medicare drug prices for broader savings will need to consider how they will impact the state's market weighing existing drug rebates. The National Academy for State Health Policy (NASHP) developed model legislation designed to enable referencing MFPs to establish upper payment limits that could be a tool for interested states.[3] Though the model is designed to work across payers, state employee health plans may also be interested in referencing MFPs individually.
- Other states, like Minnesota, have already required that public and private plan spending align with MFPs—offering a roadmap for New Hampshire.[4]

[1] https://www.cms.gov/newsroom/press-releases/negotiating-lower-drug-prices-works-saves-billions
[2] https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/2024pdabannualreport.pdf
[3] https://nashp.org/model-legislation-and-contracts-prescription-drug-pricing/
[4] https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/57/#:~:text=Sec.%2030.%20%5B62J.87%5D%20PRESCRIPTION%20DRUG%20AFFORDABILITY%20BOARD.

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The New Hampshire PDAB is exploring a variety of recommendation that would leverage federal price negotiations to generate millions in state savings.

Problem Statement

State employee health plans, local government plans, and Medicare Part D plans all operate within the same pharmaceutical benefit structure, relying on Pharmacy Benefit Managers (PBMs) to negotiate rebates and manage formularies. Until 2022, Medicare was prohibited from negotiating drug prices directly and had to depend on PBMs to control costs. However, the first round of Medicare negotiation revealed that the government can secure better prices than PBMs for high-cost drugs.[5]

PBMs have been ineffective at making certain high-cost, single-source, brand-name prescription drugs and biologics more affordable, instead contributing to rising costs by:

- Favoring high-cost, high-rebate brand-name drugs over lower-cost alternatives like biosimilars and generics.
- Creating opaque rebate structures that inflate net prices.
- Failing to pass savings directly to patients and public payors.

Despite the best cost containment efforts to date, prescription drug spending continues to rise, placing a strain on state budgets, employers, and families. The top 10 Medicare Part D drugs selected for price negotiation accounted for nearly $50.5 billion in gross spending in 2023—yet prices remain far above reasonable levels due to:

1. Lack of Competition – These drugs lack generic or biosimilar equivalents and have maintained monopolies for up to 28 years.

2. Misaligned Incentives – PBMs and insurers profit from higher prices due to rebate-driven incentives.

3. State-Level Impact – New Hampshire's public payors spent tens of millions on these same high-cost drugs, without access to MFPs.

If New Hampshire continues to rely solely on PBMs for its prescription drug cost containment efforts and does not take advantage of Medicare's negotiated rates, it risks significant overspending without realizing potential savings. This risks widening the current budget deficit and decreasing necessary investments in other areas of the economy like workforce development, child care, and infrastructure.

How Medicare's Maximum Fair Prices (MFPs) Address the Problem

MFPs limit the maximum price that Medicare will pay for negotiated drugs, using transparent criteria based on market exclusivity, drug effectiveness, and statutory price ceilings. The Inflation Reduction Act (IRA) authorized the federal government to negotiate these prices, breaking decades of restrictive policies

[5] https://www.brookings.edu/articles/impact-of-federal-negotiation-of-prescription-drug-prices/

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and runaway spending. The first MFPs go into effect January 1, 2026, with 15 more drugs to be added annually. This year, Medicare is negotiating Ozempic and other anti-obesity medications that are straining plan spending and risks insolvency for municipal risk pools.[6]

The Link Between MFPs and PDABs

States are grappling with controlling the cost of the same high-cost drugs targeted by Medicare's negotiations. Colorado's PDAB determined that Enbrel[7] and Stelara[8] are unaffordable, moving toward implementing upper payment limits that have Medicare negotiated prices. Minnesota's PDAB law mandates that any upper payment limit must align with MFPs, setting a national precedent for New Hampshire to follow.[9]

New Hampshire PDAB Estimated Savings at Negotiated Maximum Fair Prices Relative to Estimated Plan Negotiations

For price year calendar 2023, dollar amounts in millions

Drug Name	Year Approved	Gross Drug Spending, 2023	Estimated Manufacturer Rebates	Estimated Net Spending, 2023	IRA Price Ceiling Category	MFP Discount off List Price	Estimated Net Spending at MFP, 2023	Spending at MFP vs. Spending at Estimated Net Prices, 2023
Eliquis	2012	$8,058.00	0.45	$4,431.90	Short Monopoly	0.56	$3,545.52	-$886.38
Jardiance	2014	$5,514.50	0.63	$2,040.37	Short Monopoly	0.66	$1,874.93	-$165.44
Xarelto	2011	$2,495.40	0.53	$1,172.84	Short Monopoly	0.62	$948.25	-$224.59
Januvia	2006	$2,096.60	0.7	$628.98	Long Monopoly	0.79	$440.29	-$188.69
Farxiga	2014	$1,649.90	0.68	$527.97	Short Monopoly	0.68	$527.97	$0.00
Entresto	2015	$1,050.00	0.27	$766.50	Short Monopoly	0.53	$493.50	-$273.00
Enbrel	1998	$1,667.70	0.51	$817.17	Long Monopoly	0.67	$550.34	-$266.83
Imbruvica	2013	$2,215.40	0.11	$1,971.71	Short Monopoly	0.38	$1,373.55	-$598.16
Stelara	2007	$13,604.60	0.41	$8,026.71	Long Monopoly	0.66	$4,625.56	-$3,401.15
Novolog/Fiasp	2000	$696.00	0.76	$167.04	Long Monopoly	0.76	$167.04	$0.00
Total		**$39,047.80**		**$20,551.18**			**$14,546.95**	**-$6,004.24**

Estimated Savings for New Hampshire Public Payors (excluding Medicaid) Relative to Plan Negotiations. This analysis relied on methods and rebate estimates from "Interpreting the First Round of Maximum Fair Prices Negotiated by Medicare for Drugs" (Hernandez, 2024) and gross spending for four (4) New Hampshire public payors using CHIS data.[10]

New Hampshire's Path Forward

The PDAB is exploring several recommendations to leverage MFPs, for example:

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[6] https://www.cms.gov/newsroom/press-releases/hhs-announces-15-additional-drugs-selected-medicare-drug-price-negotiations-continued-effort-lower

[7] https://drive.google.com/drive/folders/1xdHNz_KHSB5uL6o2DDSqcKOZbCsmRXq2

[8] https://drive.google.com/drive/folders/1UHaYvwQzBQgon9D28X9o5heaZUgk-fPx

[9] https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/57/#:~:text=Sec.%2030.%20%5B62J.87%5D%20PRESCRIPTION%20DRUG%20AFFORDABILITY%20BOARD.

[10] https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/2024pdabannualreport.pdf

1. *Reference MFPs in State and Local Employee Health Plans*

This policy would apply MFPs as a benchmark for maximum reimbursement on select high-cost drugs. It would ensure MFPs extend across state employee health plans and other public payors. Additional vetting is required to analyze payer-by-payer impact to ensure alignment with New Hampshire's rebate structures.

2. *Expand Authority to Additional Drugs*

This policy would review additional drugs selected for future MFP negotiations and recommend state and local employee health plans work with PBMs and insurers to ensure compliance with cost-saving measures. The PDAB will monitor Medicare's annual updates to maintain alignment with best pricing models.

3. *Strengthen Data Transparency and Coordination*

This policy would require public reporting on prescription drug spending for public payors. The PDAB could leverage the state's all-payer claims databases to track pricing and savings realized from MFP implementation. Under this policy, the PDAB would continue to collaborate with other state PDABs to ensure best practices in applying MFPs.

Estimated Impact for New Hampshire

- The 2024 Annual Report projected $6 million in savings annually for the first 10 drugs selected for Medicare negotiation.
- Stronger negotiating power for state employee health plans and other public payors.
- A fairer and more sustainable prescription drug market in New Hampshire.

Recommendation

The PDAB recommends that each public payor (excluding Medicaid) use Medicare maximum fair price to establish a reimbursement ceiling on those drugs identified by the Medicare negotiation program. Increased data-sharing, particularly net spending inclusive of rebates, by each payer to verify the magnitude of savings and implementation of Medicare negotiated prices as a ceiling for reimbursement would strengthen the PDAB's ability to monitor and refine this approach. Additionally, the PDAB recommends the legislature continue supporting the PDAB's efforts to thoughtfully vet policies to align state prescription drug spending with Medicare MFPs, leveraging federal efforts to bring immediate and lasting savings to the state.

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