Mike Braun, Governor
State of Indiana

Indiana Family and Social Services Administration

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E. MITCHELL ROOB JR., SECRETARY

Report on Executive Order 25-23

Date: December 30, 2025
To: Legislative Council, State of Indiana
From: E. Mitchell Roob Jr., Secretary, Family and Social Services Administration
Subject: Executive Order 25-23 (Increasing Opportunity for Hoosiers and Businesses by Improving Price Affordability in Healthcare

This report is submitted in response to Indiana Executive Order 25-23 ("EO 25-23"), issued by Governor Braun. Under this order, the Indiana Family and Social Services Administration (FSSA) is tasked with:

1. **Review Strategies to Lower Prescription Drug Prices**
    - Conduct a comprehensive assessment of alternative policies or strategies to reduce prescription drug costs for Hoosiers.
    - Explore options such as direct-to-State drug price negotiations with pharmaceutical manufacturers and other innovative cost-control mechanisms.
2. **Develop Legislative and Regulatory Recommendations**
    - Based on the review, propose actionable legislative and regulatory changes to implement these cost-lowering strategies.
    - Recommendations should aim to enhance affordability without compromising access or quality of care.

WRITTEN REPORT

FSSA's Office of Medicaid Policy and Planning (OMPP) conducted an assessment of alternative policies and strategies aimed at reducing the cost of prescription drugs that have been implemented or considered by other states, as well as federally led initiatives to contain costs. OMPP examined the efforts of states neighboring Indiana, including: the preliminary results of alternative PBM contracting recently employed by Ohio and Kentucky; legislation recently enacted in Massachusetts and New York; and recommendations from the National Academy for State Health Policy (NASHP).

Review of Best Practices for the Medicaid Pharmacy Program

Enhanced Negotiating Authority

State Medicaid pharmacy programs are governed by Section 1927 of the Social Security Act [42 U.S. Code 1396r-8].[i] This law mandates that manufacturers must participate in the federal Medicaid Drug Rebate Program (MDRP) for state Medicaid programs to be able to cover their drugs. In essence,

- Drugs *not included* in the MDRP *cannot be covered* by state Medicaid programs
- Drugs *included* in the MDRP *must be covered* by state Medicaid programs

States benefit from the MDRP by sharing in the federal rebate and having the ability to seek additional ("supplemental") rebates from participating manufacturers. Conversely, states are bound by the MDRP, requiring coverage of all drugs in the MDRP, regardless of cost.

Drug costs have always been a concern for Medicaid programs. However, over the past decade new drug therapies, costing hundreds of thousands to even millions of dollars per Medicaid beneficiary, have been added to the MDRP. State Medicaid programs are struggling with the financial implications of covering these agents. Two states have enacted laws, establishing novel approaches to address the costs of these agents. In both cases, the state Medicaid program must follow a particular course of action when established drug cost thresholds are reached.

Massachusetts[ii]

- In 2018, Massachusetts established a Health Policy Commission (HPC) that holds public hearings when a sufficient supplemental rebate agreement cannot be reached by MassHealth. The HPC criteria for pricing reviews occurs when Massachusetts' Medicaid program and the drug has a post-rebate cost to MassHealth of more than $25,000 per utilizer per year or $10 million in aggregate annually.[iii]

    - As of 2024, MassHealth has active agreements on supplemental rebate contracts with 27 manufacturers for 72 drugs with a total annual incremental savings of approximately $450 million.[iv]
- Once the drug is referred to HPC for MassHealth, HPC may conduct pricing reviews, including a public assessment to determine whether the price is deemed unreasonable or excessive, in relation to HPC's proposed value for the drug. While explicit data on manufacturers formally being forced to lower list prices through this review process is limited, the HPC's work has led to increased transparency and informed negotiations, as the drug price is subject to public scrutiny and the manufacturer is required to justify the price.[v]

New York[vi]

- Uses an independent pricing benchmark organization, the Institute for Clinical and Economic Review (ICER), to guide supplemental rebate negotiations.
- New York's Medicaid program has used ICER's independent value assessments to inform target supplemental rebate amounts and guide negotiations with manufacturers, generating hundreds of millions in additional rebate revenue.
    - According to ICER, New York has saved nearly $500 million for the period of 2018-2020 through the process of negotiating supplemental Medicaid rebates using ICER's cost-effectiveness price benchmarks.[vii]

It should be noted that Indiana Medicaid drug utilization review processes include several similar practices to those of New York and Massachusetts, such as:

- Implementation of a Policy Change Review Committee, instituted in 2025, that performs quarterly high impact drug reviews, including cost review estimates, to establish drug coverage policy upon the drug being approved by the US Food and Drug Administration.
- Active supplemental rebate agreements with 39 manufacturers for 68 drugs with a total annual savings of approximately $180 million in calendar year 2024.
- Available ICER price benchmarks are provided to the Therapeutics Committee for their consideration when determining preference status of drugs on the Statewide Uniform Preferred Drug List (SUPDL).

Alternative Pharmacy Benefit Models

NASHP has published criteria that is beneficial to State Medicaid programs regarding contracting with PBMs that can lower prescription costs.[viii] Upon the discovery of PBMs making large profit margins from spread pricing, Ohio took steps to limit this practice by

utilizing a single contracted PBM.[ix] This change is estimated to save Ohio up to $200 million per year. Ohio realized net savings of approximately $140 million over the first two years after moving to a single PBM. [x]

Similarly, West Virginia saved $54 million in the first year by carving the pharmacy benefit out of Medicaid managed care organizations and into the fee-for-service program, where drug reimbursement is based on the ingredient cost of a drug plus a professional dispensing fee.[xi] Per NASHP: "This reimbursement methodology limits spread pricing because PBMs operating under Medicaid fee-for-service programs must abide by federal and state rules regarding drug reimbursement, whereas PBMs acting on behalf of Medicaid managed care organizations can negotiate individual prices with pharmacies, which may or may not be transparent to the state." New York also enacted this change in 2023, with cost savings analysis still forthcoming.[xii]

Table 1 includes a reference to the different Preferred Drug List (PDL) approaches from this report, which were surveyed in a 2020 report on Medicaid PDL options for states:[xiii]

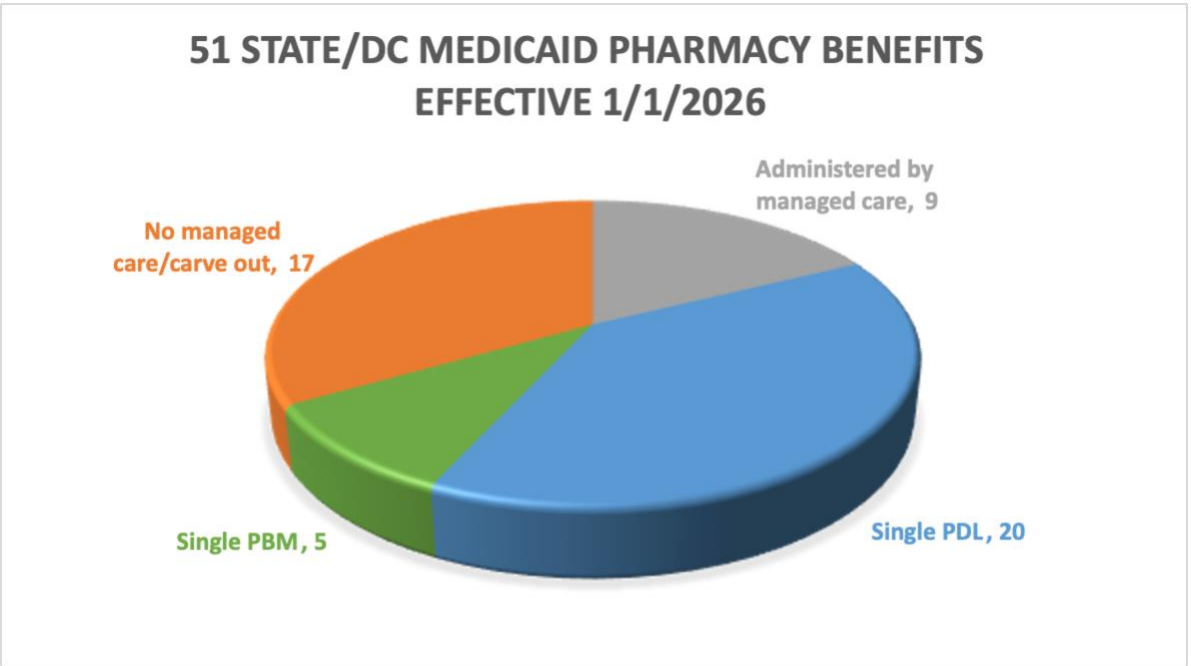
Table 1

Multiple PDLs Carved In to MCOs	Aligned PDLs Carved In to MCOs	Single PDL Carved In to MCOs	Single PDL Carved Out of MCOs
• Each MCO and the FFS program set their own PDLs • Pharmacy is included in MCO Risk	• MCO PDLs are aligned with FFS on a class-by-class basis or % of classes basis. • May be a "floor"— MCO variation allowed that is not more restrictive (e.g., generic substitution) • Pharmacy is included in MCO risk	• MCOs and FFS program use the same single PDL set through state's P&T and DUR processes • Pharmacy is included in MCO risk	• MCOs and FFS program use the same single PDL set through state's P&T and DUR process • Pharmacy is carved out of MCO risk

Abbreviations. DUR: drug utilization review; FFS: fee-for-service; MCO: managed care organization; P&T: Pharmacy and Therapeutics; PDL: preferred drug lists.

Chart 1 shows the current landscape of Medicaid pharmacy benefit models.

Chart 1



Outcomes-Based Contracting

Per NASHP, nine states have state plan amendments (SPAs) that enable outcomes-based contracts with drug manufacturers based on a specific drug and agreed-upon outcomes.

However, some manufacturers may not be willing to enter into these agreements with state Medicaid programs, especially single-source drugs. These contracts are labor-intensive and require resources and time to design, creating a need for cost effectiveness in implementation. Additionally, a costly drug could be made available at very low cost or no cost if it fails to perform as promised against outcome measures, leading to hesitance from manufacturers.

A recently finalized federal rule would allow manufacturers to report multiple best prices to avoid this scenario.[xiv]

Negotiating state supplemental rebates is an example of direct-to-manufacturer drug price contracting. The FSSA Indiana Medicaid FFS pharmacy benefit has been negotiating supplemental rebates for preferred status on its preferred drug lists (PDLs), directly with pharmaceutical manufacturers, since 2002.

To gain further savings on drug prices, the FFS program and the managed care programs aligned their PDLs in July 2023, allowing the state to receive supplemental rebates on

preferred drugs utilized by managed care members and FFS members. This alignment was called the Statewide Uniform Preferred Drug List (SUPDL). The Indiana Medicaid SUPDL program saved taxpayers a total of almost $161 million in drug costs in its first year.[xv]

Indiana's Medicaid Pharmacy Benefit Program

The Indiana Medicaid pharmacy benefit was consolidated under the FFS program ("carve out") until 2015, when pharmacy benefits were returned to managed care plans with the implementation of the revised Healthy Indiana Program (HIP 2.0). With the implementation of the Indiana PathWays for Aging program in 2024, almost 90% of Indiana Medicaid member's pharmacy benefits were provided by managed care.
However, the pharmacy benefit has continuously sought to optimize drug cost savings and the quality of its pharmacy benefits. The following is a list of actions Indiana Medicaid has taken to lower the prescription prices for Medicaid members:

- 2016 - Carve out of select classes of drugs
- 2020 - Began adding PBM spread-pricing prohibition language into managed care entity contracts
- 2023 - Single PDL, called the Statewide Unified Preferred Drug List (SUPDL)
- 2023 - Obtained CMS authorization to enter into outcomes-based contracts

Indiana Medicaid's evaluation of pharmacy benefit models and recommendations

- FSSA's recommendation is to engage an independent third party to perform a more robust evaluation, specifically tailored for the Indiana Medicaid program, of the financial and non-financial impacts of implementing a single PBM or carving out the pharmacy benefit. In the interest of urgency on the matter, FSSA has already initiated work with an independent third party to begin this analysis. The FSSA team will update the Governor's Office once the evaluation is complete and further recommendations will be shared in the next couple of months.

- FSSA is proposing a state plan amendment to modify the eligibility of outpatient prescription drugs prescribed to Medicaid recipients by 340B covered entities. The proposal entails excluding these drugs from eligibility for rebates under the 340B drug pricing program. Instead, FSSA will receive rebates through the Medicaid Drug Rebate Program. This strategic exclusion of 340B claims is expected to yield significant cost savings to the State. This will also eliminate confusion regarding Indiana's 340B policy for providers and create a consistent process for all providers.

- FSSA recommends participation in CMS's GENEROUS program, as it will facilitate additional opportunities for FSSA to review prescription drug cost savings in the program.

The CMS Innovation Center recently announced the GENErating cost Reductions for U.S. Medicaid (GENEROUS) program model. According to CMS, "GENEROUS builds on the work the states have done to manage Medicaid drug costs through the Medicaid Drug Rebate Program (MDRP), in which states receive rebates from manufacturers in exchange for coverage of manufacturers' covered outpatient drugs. The model also builds on the Cell and Gene Therapy Access Model in which CMS-led negotiations with manufacturers have extended access to innovative cell and gene therapies to people with Medicaid."[xvi]

OMPP is currently drafting a letter of intent to submit to CMS for approval to participate in the GENEROUS program. The federal deadline to submit the letter of intent is January 15, 2026. OMPP is on track to submit the letter within this timeframe.

- FSSA recommends an audit of electronic file claims transactions to ensure PBMs are not engaging in the practice of spread pricing.

  In 2020, Indiana added PBM "pass-through" pricing requirements to managed care entity ("MCE") contracts, which effectively prohibit spread-pricing. Spread pricing occurs when a PBM charges health plans more for a prescription drug than it reimburses the pharmacy for dispensing the drug. The PBM then pockets the difference as profit, known as the "spread." This can result in higher prescription drug costs for Medicaid health plans and ultimately, patients.[xvii] The pass-through requirements implemented by FSSA in 2020 ensure that PBMs who contract with MCEs to charge MCEs the same price they reimburse pharmacies for drugs. As of March 2023, twelve (12) states have enacted legislation to prohibit spread pricing by PBMs.[xviii]

  In 2023, House Enrolled Act 1445 mandated an audit of pharmacy benefit managers utilized by Indiana Medicaid's managed care programs. The Indiana Office of the Attorney General made public the Rx Connection's audit report results which showed there had been documented spread pricing in 2021-2022 by some of Indiana Medicaid's MCE's PBMs in the September 2024 interim report.[xix] The final audit report is NOT public but was published January 2025. Health Management Associates (HMA) is examining calendar year 2024 Medicaid pharmacy claims for evidence of continued spread pricing practices by Indiana Medicaid MCE PBMs. The results of HMA's analysis will determine if a more extensive audit to include 837 and 835 electronic file claims transactions should be conducted.

[i] 42 USC 1396r-8: Payment for covered outpatient drugs. (2024). House.gov. https://uscode.house.gov/view.xhtml?req=granuleid:USC-1999-title42-section1396r-8&num=0&edition=1999

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[iii] Drug Pricing Review. Massachusetts Health Policy Commission. (n.d.-b). https://masshpc.gov/moat/drug-pricing-review

[iv] Healey, M. (2025, May 6). Drugs with Directly Negotiated Supplemental Rebate Agreements. Boston, Massachusetts; One Ashburton Place.

[v] Weisman, R. (2025, April 19). Rising drug prices are hammering patients, employers, and insurers. is there any end in sight? - The Boston Globe. BostonGlobe.com. https://www.bostonglobe.com/2025/04/17/business/drug-prices-rising-health-care-patients-employers-insurers/

[vi] *NYS Open Legislation | NYSenate.gov*. (2024). Nysenate.gov. https://www.nysenate.gov/legislation/laws/PBH/280

[vii] New York Medicaid saves $500 million. Institute for Clinical and Economic Review. (n.d.). https://icer.org/who-we-are/history-impact/impact-case-study-3/

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[xii] *State Of New York Senate -Assembly*. (2020). Https://Legislation.Nysenate.Gov/Pdf/Bills/2019/S7506b

[xiii] *Medicaid Preferred Drug List Options For States State Medicaid Alternative Reimbursement and Purchasing Test for High-cost Drugs (SMART-D)*. (2020). https://centerforevidencebasedpolicy.org/wp-content/uploads/2021/12/MEDICAID-PREFERRED-DRUG-LIST-OPTIONS-FOR-STATES.pdf

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[xv] Kiriakopoulos, A. (2024, November). *Draft Evaluation of the Indiana Medicaid Fee-For-Service Preferred Drug List Program Report #29* . Optum Rx. https://iga.in.gov/publications/agency_report/2024%20-%20Evaluation%20of%20the%20Indiana%20Medicaid%20Preferred%20Drug%20List%20Program,%20FY%202024.pdf

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[xvii] *Spread Pricing 101*. (n.d.). Spread Pricing 101. https://ncpa.org/spread-pricing-101

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