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Subscription Models for Prescription Drugs

The Motivation, Potential, and Limitations of a New Payment Model

Some new prescription drugs—for example, the new generation of hepatitis C drugs initiated by the introduction of Sovaldi and Harvoni—offer substantial improvements in health outcomes and reductions in future health care spending. However, new drugs offering significant benefits may have a large demand and thus the potential to strain the budgets of state Medicaid programs and other public payers, reserves of private payers, and resources of patients who pay out of pocket. Medicaid programs in Louisiana and Washington and federal programs in Australia have turned to a subscription model—instead of the more traditional negotiation of a per-unit price—as a way to pay for hepatitis C drugs. The Louisiana and Washington models captured the attention of the media and policymakers,[1] but, to date, there have not been other U.S. applications of prescription drug subscription models.

It remains unclear whether the potential benefits of subscription models are specific to hepatitis C drugs for public payers or have broader potential. In this Perspective, we argue that, conceptually, the main advantage of subscription models

Subscription models are a new type of payment arrangement between payers and drug manufacturers.

over traditional prescription drug payment arrangements is that they could reduce some sources of uncertainty in spending for payers and in revenue for manufacturers. But compared with traditional prescription drug payment arrangements, the ability of subscription models to lower prescription drug spending is limited. Reducing uncertainty does not seem to have been the main driver of Louisiana's and Washington's use of a subscription model to purchase hepatitis C drugs. Instead, these states appear to have turned to subscription models to circumvent barriers to price negotiation imposed by the Medicaid Drug Rebate Program.

In what follows, we define subscription payment models, examine the underlying mechanisms and the motivations of model participants, describe scenarios in which subscription models may be applicable, and discuss potential challenges in their implementation.

What Is a Prescription Drug Subscription Model?

Subscription models are a new type of payment arrangement between payers and drug manufacturers. The defining feature of a subscription model is a negotiated fixed amount paid by a payer to a manufacturer in exchange for access to one or more specific drugs for a specific patient population and use over a predefined period.

Other features could be incorporated into variants of the subscription model to adjust the negotiated payment based on prespecified contingencies. For example, payments could be adjusted based on patient outcomes realized or the amount of health care cost avoided. To protect manufacturers from an unexpectedly large volume of demand, a maximum volume of drugs provided by manufacturers could be established. To protect participants from misestimating expected spending or revenue, triggers could be embedded for contract renegotiation when predefined conditions are met.

What Are Existing Subscription Models?

There are three existing prescription drug subscription contracts for hepatitis C treatment initiated by a public payer—the Australian Government, the state of Louisiana, and the state of Washington (see Box 1).

Box 1. Examples of Subscription Models in Practice

Australia

The Australian Government started a program for hepatitis C treatment in March 2016, nearly two and half years after Gilead Sciences, Inc., obtained approval from the U.S. Food and Drug Administration (FDA) for the first drug in the class—Sovaldi. The Australian Government[a] agreed to pay up to US$766 million for hepatitis C treatment of all affected citizens during a five-year contract period.[2] It was estimated that the total number of patients treated would increase by 550 percent, from 10,180 (the status quo ante) to 60,000 under the new arrangement, with an expected total price of US$12,460 for a three-month treatment course (the list price at the time of negotiation was $84,000 in the United States, and the negotiated price among Medicaid agencies was about 40 percent of the list price,[3] or US$33,600). Based on the first two years of data after the program's implementation, researchers projected that the government would save US$4.9 billion during the entire contract period. In the meantime, the patient cost-sharing under the new arrangement is US$89 per course of treatment.[4]

Louisiana Medicaid

Louisiana is one of the two U.S. states to experiment with a subscription model. In January 2019, the state released a request for proposals to pharmaceutical manufacturers regarding hepatitis C treatment in the population covered under its Medicaid program and correction facilities.[5] The state selected Asegua Therapeutics—a subsidiary of Gilead Sciences, Inc.—for the contract, which became effective for five years starting in July 2019. Asegua Therapeutics is providing the covered population with an unlimited supply of Epclusa—a combination of sofosbuvir and velpatasvir—and services aimed to promote screening and linkage to care. The annual total payment from the state for the drug shall not exceed the $35 million[6] it spent on 1,100 patients[7] in the 2018 state fiscal year for the new generation of hepatitis C drugs. This translates to $31,818 per course of treatment. If all the targeted 31,000[8] patients to be covered by the contract were treated in 2019–2024 and a total fixed payment of $175 million for the same period was paid to Asegua Therapeutics, the state would pay an average price of $5,645 per course of treatment. If successful, this mechanism would allow Louisiana to provide the medication to many more patients than it did before while limiting the state's total payment.

Washington Medicaid

The state of Washington has adopted a similar model for hepatitis C treatment and selected AbbVie Inc. as the sole provider.[9] This is part of an effort to eliminate the hepatitis C virus in the state by 2030. AbbVie will work with the state to increase awareness, educate health care workers, identify untreated individuals with the condition, and address barriers to access to the treatment. The state did not disclose more information on specific terms of the contract.

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[a] We do not discuss the Australian Government's case later in this Perspective for two reasons. First, we focus on the U.S. context. Second, we were unable to find published evidence to support a meaningful discussion about whether Australia's model was primarily motivated by reducing the country's prescription spending versus the uncertainty in spending.

How Do Subscription Models Compare with Traditional Prescription Drug Payment Arrangements?

Traditional Payment Arrangements Between Manufacturers and Payers

Under a traditional payment arrangement for prescription drugs between manufacturers and payers, payment is on a per-unit basis (e.g., per pill or vial). Payers make an initial payment on a per-unit basis to pharmacies that dispense drugs covered by the payer and receive rebates from the manufacturer based on negotiated discounts. The net payments after rebates typically scale with the volume of prescriptions dispensed for that drug. Payers and manufacturers may negotiate arrangements that include nonlinear pricing (i.e., pricing tied to the volume used), outcomes-based adjustments, and other provisions that layer additional sophistication and strategy on top of the basic per-unit payment approach. The net prices—after all rebates and discounts—paid by payers for drugs hinge on many factors, including the existence of one or more competing drugs, the drug volume used, negotiated pharmacy payments, clinical outcomes achieved, and the ability of a payer to direct patients to preferred drugs with larger discounts.

In the United States, payers often use tiered formularies to ensure access to effective pharmaceutical therapies and to manage prescription drug spending because prescription drug pricing is largely unregulated. Tiered formularies charge patients different cost sharing for different drugs based on the tier in which they are placed. Payers select drugs for different tiers based largely on their cost[10] and use patient cost sharing to steer patients to preferred drugs on lower tiers. Typically, generic drugs are in the lowest tier. For brand-name drugs, payers negotiate discounts off of list prices with manufacturers in exchange for favorable placement on formularies. A large discount from a manufacturer may be associated with a preferred formulary placement that could result in a shift of a major market share of a prescription drug among the beneficiaries covered by a payer to the product of the manufacturer in the deal. Payers may have the option to use either an open formulary that reimburses all drugs in a therapeutic class or a closed one that limits reimbursement to a subset of prescription drugs available in the market. Payers may reimburse noncovered prescription drugs for a small number of beneficiaries with medical necessity for an alternative product (hereinafter *closed formularies*).[11]

Constraints on Price Negotiation Under Traditional Payment Arrangements

There are, however, statutory and/or regulatory limits in the use of drug formularies and price negotiations between payers and manufacturers. For example, for drugs covered by Medicaid, manufacturers participating in the Medicaid Drug Rebate Program are required to pay a rebate to Medicaid programs that is equal to the greater of 23.1 percent of the average manufacturer price or the difference between the average manufacturer price and the best price—the lowest unit price at which manufacturers sell a drug to commercial payers.[12] In return, Medicaid programs are obligated to cover all the drugs produced by participating manufacturers and approved by the

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FDA. Most states negotiate with drug manufacturers to obtain supplemental rebates, in some cases by forming a multistate purchasing pool, but they are not allowed to use closed formularies unless they withdraw from the Medicaid Drug Rebate Program completely.[13]

Medicare Part D prescription drug plans are not subject to the Medicaid best-price rule but are required to cover at least two chemically distinct drugs in each nonprotected therapeutic category or class. In an effort to ensure broad access among Medicare beneficiaries, all of the FDA-approved drugs in six protected therapeutic classes are required to be covered by these prescription drug plans: immunosuppressants, antidepressants, anti-psychotics, anticonvulsants, antiretrovirals, and antineo-plastics.[14] For private payers, the Medicaid best-price rule essentially creates a floor on how much pricing discount manufacturers can offer to commercial payers; a low unit price may trigger more rebates to Medicaid programs.

Subscription Models

Fixed Payment

Under subscription models, payers are responsible for a fixed payment regardless of the number of patients treated or the volume of a drug dispensed. In other words, unlike traditional payment arrangements, payment does not scale with volume. A lump sum upfront payment may be used, but an alternative is to leverage the existing prescription drug payment process. Thus, from a cash-flow standpoint, the process could be somewhat similar to traditional payment arrangements: Payers make an initial payment on a per-unit basis without rebates, but after the total predetermined fixed payment from the payer is reached, the manufacturer would fully rebate payments from that point on.

Preferred Treatment

The financial incentive for payers to steer patients to the contracted product under subscription models is similar to but potentially stronger than that under traditional

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payment arrangements to shift utilization to preferred drugs. Under a fixed payment, the marginal cost of additional volumes of the contracted product is zero, so payers are incentivized to use the contracted product for all indicated patients except those who have medical needs for noncontracted products, and manufacturers expect payers to do exactly that. This exclusive use of the contracted product or preferred treatment, similar to a closed formulary in traditional pricing arrangements, is therefore inherent in a subscription model. When negotiating a fixed payment, both payers and manufacturers have to incorporate the exclusive use of contracted products by payers. This is reflected in both Louisiana's and Washington's subscription models, in which only one manufacturer's drug—Gilead Sciences' and AbbVie's, respectively—was selected as the preferred treatment for all patients covered by each state's Medicaid program.

Note that the exclusive use of the contracted product is not a requirement of subscription models, because once a subscription contract is signed, the contracting manufacturer is guaranteed a fixed payment and therefore does not care if the payer uses noncontracted products. From a pricing standpoint, a closed formulary under traditional payment arrangements, if allowed, could achieve a similar level of pricing as subscription models do.

Uncertainty in Spending or Revenue

Utilization of a prescription drug (hereinafter *patient utilization*) is a function of many factors, including the number of patients with an indicated medical condition; the health consequences of the condition; the drug's cost and clinical effectiveness; the perceptions of health care providers, patients, and payers about the drug's effectiveness; patients' economic status; and insurance coverage for the drug.[15] The uncertainty in patient utilization is therefore derived from the uncertainty in the factors that determine that utilization. For example, the prevalence and incidence of a disease may not be known precisely by either payers or manufacturers. Similarly, while the FDA requires extensive clinical trials prior to approving new drugs for marketing, there may be uncertainty regarding the effectiveness of a drug when it is first marketed to the patient population outside clinical trials.

Uncertainty in utilization is an important consideration for both payers and manufacturers. Both face strong incentives to develop projections of utilization that are as accurate as possible. Despite these efforts, when the uncertainty in patient utilization is significant, payers may face a risk of potentially much higher than expected

spending on the drug if they initially underestimate prevalence or overestimate effectiveness because they are paying on a per-unit basis. Similarly, manufacturers may face a risk of potentially much lower revenue than expected if they initially overestimate prevalence or underestimate effectiveness because they realize less revenue if fewer units are sold.

Subscription models mitigate these risks for both parties by setting a fixed payment up front, therefore trading one risk (substantial spending for payers or risk of little revenue for manufacturers) for another (misestimating patient utilization when setting the fixed payment amount) (Figure 1). A fixed payment under subscription models offers the complete certainty that reduces risks to both parties: Manufacturers are guaranteed the negotiated level of revenue, while payer spending is capped.

Subscription models, however, are not able to resolve the payment or revenue risk completely. The remaining risk appears in a different form: Both parties may misestimate volume and effectively over- or underpay relative to what they likely would have paid under the traditional payment approach. More specifically,

- The payer may pay more per treatment under a subscription model than it would have otherwise if the volume of the drug used by patients is lower than what was expected under a traditional payment arrangement.
- The manufacturer may receive less payment per treatment under a subscription model than it would have otherwise if the volume of the drug used by patients is higher than what was expected under a traditional payment arrangement.

FIGURE 1

Risk in Traditional Payment Approach Versus Subscription Model
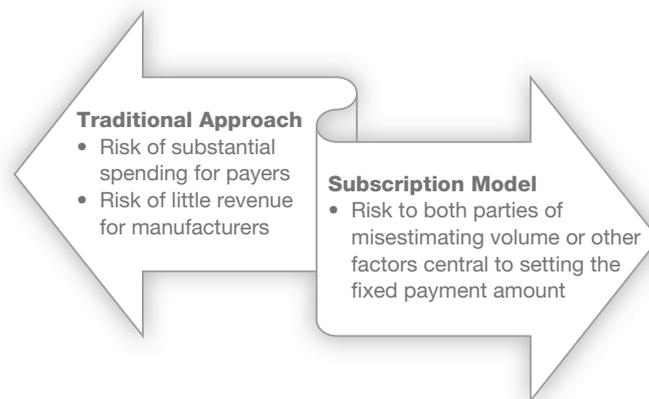
These scenarios are much more likely when the payer or manufacturer has imperfect information on the volume of the drug that will be used. For that reason, negotiation leverage in the subscription model may rest with the party with more-accurate information on expected utilization.

The level of uncertainty in patient utilization affects the utility of subscription models. If there is no uncertainty in patient utilization and both parties know exactly how much of a drug will be used, a subscription model does not have an advantage over a traditional approach (i.e., a closed formulary). As a result, absent other such factors as public relations or marketing that might favor a subscription model, there is no difference in the total payment or price per treatment between the two approaches. But if the uncertainty in patient utilization is large (e.g., when there is a serious acute infectious disease that may or may not break out) compared with traditional payment approaches,

a subscription model would benefit both parties by reducing a payer's risk in spending and a manufacturer's risk in revenue.

By negotiating a fixed payment, payers and manufacturers essentially agree to pay to guard against risks in spending and revenue, respectively, similar to insurance premiums that people pay to protect their properties. A manufacturer may be willing to receive a slightly smaller revenue if it is guaranteed a minimum payment from a payer; the difference between its expected revenue and the guaranteed amount is the price the manufacture pays for such a guarantee (i.e., an insurance policy). By the same token, if a payer is guaranteed that all its patients will be treated with a cap on spending on the drug, it may be willing to pay slightly more than the expected payment so that unexpected utilization of the drug will not adversely affect the payer's ability to provide other health care services under a fixed budget.

The amount that one party needs to pay to another depends on its exposure to the risk, but both parties have tools to influence patient utilization of prescription drugs. On one hand, payers can influence patient utilization and control spending through such tools as tiered formularies, step therapies (programs that require a patient to try a preferred treatment before eligibility for nonpreferred treatment regimens), and prior authorization (a program that requires a patient to obtain approval from insurance before a prescription drug is reimbursed). Manufacturers, on the other hand, can influence patient utilization via such strategies as prescriber detailing and direct-to-consumer advertising. But whether payers are more exposed to the risk in spending than manufacturers are to the risk in revenue remains unclear. As a result, we do not know which party would pay more to protect from the risk of higher spending or lower revenue than expected. That is, compared with traditional payment arrangements, subscription models may not necessarily reduce the per-unit price paid by a payer.

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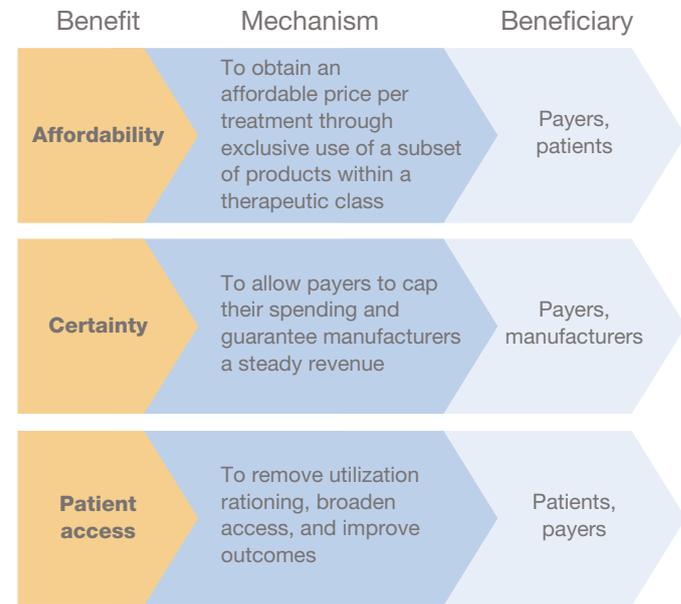
Ability to Lower Prescription Drug Spending

To summarize the key points just stated, in a market without any constraints on price negotiation (such as the Medicaid best-price rule) or restrictions on the use of formularies, subscription models do not necessarily lead to a lower unit price than traditional payment arrangements do. Both payers and manufacturers are subject to the remaining risk of misestimating patient utilization, and inaccurate assumptions on utilization may actually result in higher payments from payers. Additionally, it is unclear whether one party in a subscription model has to pay more for guarding against risk than the other does.

Why Would Medicaid Agencies and Manufacturers Prefer a Subscription Model?

A subscription model could potentially generate three major benefits for Louisiana and Washington: (1) Payers and patients could better afford prescription drugs that would otherwise impose a larger budgetary impact (affordability), (2) patient access is potentially broadened, and (3) there is increased certainty with regard to payer spending and manufacturer revenue (Figure 2). Importantly, a subscription model allows the states to selectively cover a subset of prescription drugs available, which is not feasible without special regulatory approval because of the Medicaid Drug Rebate Program, and such selective coverage of prescriptions is associated with the first two potential benefits.

Potential Benefits of Existing U.S. Subscription Models

Benefit	Mechanism	Beneficiary
Affordability	To obtain an affordable price per treatment through exclusive use of a subset of products within a therapeutic class	Payers, patients
Certainty	To allow payers to cap their spending and guarantee manufacturers a steady revenue	Payers, manufacturers
Patient access	To remove utilization rationing, broaden access, and improve outcomes	Patients, payers

The subscription model has allowed Louisiana and Washington to gain access to a hepatitis C treatment for a fixed payment that is within their budgets. The increased affordability benefits payers, who do not need to spend beyond their budget, and patients, who can access a treatment that would otherwise not be available to them. For example, Louisiana is expected to pay $35 million per year in 2019–2024 for Epclusa for about 31,000 patients,[16] with an expected unit price of $5,645 (equal to $35 million × 5 ÷ 31,000)—7.6 percent of the $74,760 list price. Typically, Medicaid agencies receive a 60-percent discount off the list price because of the Medicaid Drug Rebate Program and

supplemental rebates negotiated between states and manufacturers—that is, a unit price of $29,904 (equal to $74,760 × 40 percent).[17] Louisiana's expected unit price, $5,645, is thus about 18.9 percent of the typical discounted price obtained by other Medicaid agencies. We were not able to estimate Washington's expected unit price from public sources.

Why is the expected unit price so low in Louisiana's case? Theoretically, as we discussed in the previous section, we would expect traditional payment arrangements, such as a closed formulary, to achieve similar price discounts. The discrepancy can largely be explained by regulatory constraints: Medicaid programs are not allowed to use closed formularies because their participation in the Medicaid Drug Rebate Program requires them to cover all FDA-approved drugs of participating manufacturers. But both Louisiana and Washington have obtained approval from the Centers for Medicare and Medicaid Services (CMS), which oversees Medicaid programs at the federal level, to use the subscription model to contract with only one manufacturer for one product—essentially a closed formulary.[18] As a result, the state has much more leverage in negotiation with manufacturers, which largely explains the price decline from $31,818 to $5,645 per treatment. To circumvent barriers to price negotiation imposed by the Medicaid Drug Rebate Program, the state of Louisiana appears to have turned to a subscription model to obtain a low expected unit price for hepatitis C treatment.

It is also possible that, to improve public relations, manufacturers with high-priced drugs may use subscription models as a way to signal that their drugs are accessible to patients at a much lower than expected unit price or fixed payment amount than they would otherwise be under traditional payment arrangements. The framing of subscription models is generally positive—both payers and manufacturers could receive some credit for attempting an innovative contracting solution to address the issue of rising prescription drug spending and improve patient outcomes. Such public relations and optics drivers of subscription models may play a larger role for serious diseases and in cases where there is a considerable unmet need, such as hepatitis C or Alzheimer's disease.

The core feature of the subscription model—that the payment to manufacturers does not scale with

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volume—may broaden patient access and lead to more people getting beneficial treatments because restrictions resulting from budgetary concerns may be reduced. Increased access to effective treatments benefits patients through improved clinical outcomes, as well as payers if the cost of a treatment is less than the reduction in medical spending because of the treatment. In Louisiana's case, the number of patients treated per year is expected to increase from 1,100 in 2018 to an average of 6,200 (equal to 31,000 ÷ 5) per year from 2019 to 2024.

Certainty in payment amount is likely appealing for planning purposes for payers facing budget constraints, such as state Medicaid programs. An exact outlay estimate enables Louisiana and Washington to avoid the risk of spending beyond their budgets. Certainty in payment may also be appealing to manufacturers to guarantee a certain level of revenue in cases where utilization of a drug is uncertain. For example, the utilization of the treatment of a serious acute infectious disease that may or may not break out tends to have large variation. In this case, some risk-averse manufacturers may be willing to risk receiving a slightly smaller payment than they otherwise might receive to avoid the chance of much lower than expected revenue.

Can the Experiences of Louisiana's and Washington's Medicaid Programs Be Replicated?

Conditions for Replicating the Two States' Experiences

When there are price-negotiation constraints, the removal of such constraints is needed to use subscription models so that payers and manufacturers can negotiate a fixed payment for specific products. In the cases of Louisiana and Washington, special regulatory approval of subscription models relaxed price-negotiation constraints.

In a market without price-negotiation constraints, significant uncertainty around patient utilization is required so that subscription models are advantageous over traditional payment approaches. In addition, the following two conditions are likely needed to ensure that price negotiations between payers and manufacturers can generate sufficient economic benefits to offset subscription contract implementation costs. First, payers need to cover a pharmaceutical therapy expected to generate a large spending increase. And second, payers control a sizable market and/or there are two or more manufacturers producing products that can be substituted for each other. The first condition indicates a large gap between patient needs and the spending payers can afford, and the second condition enables payers to negotiate an affordable price. Prescription drugs that align with these two conditions and are associated with significant uncertainty in patient utilization are potential candidates for subscription models.

Medicaid Agencies

For Medicaid agencies, supplemental rebates from manufacturers are exempt from the Medicaid best-price rule,[19] and, consequently, contracting manufacturers do not need to offer the contract price to other Medicaid programs even if it is lower than the current lowest price for commercial payers. But Medicaid agencies are obligated to cover all FDA-approved drugs of manufacturers that participate in the Medicaid Drug Rebate Program. That is,

they are not allowed to use closed formularies. CMS has some flexibility and can approve waivers for state Medicaid programs. That is exactly what occurred in the cases of Louisiana and Washington. Other Medicaid agencies could follow suit. In fact, CMS seems to be encouraging states to apply for similar waivers.[20] If Medicaid agencies can gain the approval of CMS for specific prescription drugs, they may be able to replicate the experiences of Louisiana and Washington. Hypothetically, if the Medicaid Drug Rebate Program rules were changed to allow closed formularies, Medicaid programs could achieve most of what Louisiana and Washington have done using either traditional payment arrangements or subscription models (where there is significant uncertainty in patient utilization).

Medicare Part D Prescription Drug Plans

For nonprotected therapeutic classes, Medicare prescription drug plans have likely already achieved a majority of the savings under traditional payment arrangements that could be gained under subscription models, because they are allowed to cover only two drugs in a therapeutic class, which in turn gives them leverage in price negotiation with manufacturers. For the same reason, if they were allowed to cover only one drug in a nonprotected therapeutic class, the gain would be larger, using either traditional payment arrangements or subscription models. For the six protected therapeutic classes, if a new drug could dramatically increase their spending, it is possible that CMS may leverage its authority

via the Center for Medicare and Medicaid Innovation to allow subscription models, similar to what it has done for state Medicaid programs on a case-by-case basis. If the rules for protected classes were relaxed, Medicare prescription drug plans would be able to replicate the experiences of Louisiana and Washington, with or without subscription models, although these plans may lack incentives to do so because they are responsible for only 15 percent of catastrophic spending—the reinsurance benefits under Medicare Part D.[21] Of course, exception rules would need to be in place to ensure access to noncontracted products deemed medically necessary.

Private Payers

Private payers may find certainty in payment appealing so they can manage reserves or target health care spending to meet medical loss-ratio thresholds. But the Medicaid best-price rule imposes a floor on the lowest price that manufacturers can offer to private payers. CMS does not have the authority to waive the best-price rule for private payers unless Congress changes the law.[22] However, when there is large uncertainty in patient utilization (e.g., in the case of a serious acute infectious disease that may or may not break out), private payers may benefit from the certainty in spending under a subscription model. In the absence of the Medicaid best-price rule, private payers would be able to use subscription models or traditional payment arrangements to replicate the experiences of Louisiana and Washington.

As the U.S. health care system is transitioning from a fee-for-service-based model to a value-based or even a capitation-based one, subscription models may have the potential to play a larger role than they do currently.

Conclusions

Characterized by a fixed payment, subscription models for prescription drugs offer a new framework for drug manufacturers and payers to negotiate prices and payments for drugs, under which patients can access beneficial treatments because utilization restrictions resulting from budgetary concerns may be reduced. Compared with traditional payment arrangements, the advantage of subscription models is that they could reduce uncertainty in spending for payers and uncertainty in revenue for manufacturers through a negotiated fixed payment, but such models do not necessarily lead to lower prescription drug spending for payers.

When there are constraints on the utilization of closed formularies (such as among Medicaid programs) subscription models, if approved by CMS, have the potential to increase patient access while limiting prescription drug spending compared with the status quo. For example, Louisiana's and Washington's Medicaid programs predict that their models will generate significant benefits, although such benefits will need to be verified when data are available. Note that both states are using

subscription models to gain additional price negotiation leverage that private payers already have. In contrast, the prospects of utilizing subscription models among Medicare prescription drug plans or private payers are less optimistic unless they gain the approval of regulatory authorities for subscription models or unless the Medicaid best-price rule or restrictions on formulary use are relaxed.

In the current regulatory environment, the use of subscription models seems to be limited to scenarios in which exceptions for such models are granted by regulatory authorities. In a market without price-negotiation constraints, subscription models are indicated only when there is significant uncertainty in patient utilization. In either case, the wide adoption of subscription models is unlikely. However, as the U.S. health care system is transitioning from a fee-for-service-based model to a value-based or even a capitation-based one, subscription models may have the potential to play a larger role than they do currently. Payers using subscription models have incentives to encourage clinically indicated utilization of prescription drugs, which is well aligned with their goal of managing and improving health at the population level.

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Acknowledgments

About This Perspective

Recent advances in biomedical research have led to new pharmaceutical therapies, such as direct-acting antivirals for hepatitis C, that could generate a large budgetary impact on payers. However, adequate access to new prescription drugs remains an elusive goal. Two state Medicaid programs—in Louisiana and Washington—have adopted a new type of contractual arrangement in which the states pay a fixed amount to a manufacturer in exchange for access to new hepatitis C treatment for all their covered beneficiaries. Known as a subscription model, such an arrangement may hold the promise of improving patient access to prescription drugs. In this Perspective, the authors describe the motivation, potential, and limitations of subscription models.

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PE-A289-1