Why Medicare's Maximum Fair Price Is Not a Model for State Drug Pricing

States are under increasing pressure to respond to concerns about prescription drug affordability. In that search for solutions, Medicare's Maximum Fair Price (MFP) has begun to surface as an attractive model for state efforts. MFP is highly visible and branded as "negotiation," giving it the appearance of a tested and defensible pricing tool.

That appeal is understandable. But it is also misleading. Medicare's MFP does not function as a standalone benchmark. It works only because it is embedded in a federal program with national scope, statutory carve-outs, and the ability to redesign coverage and payment rules around the negotiated price. Those features are not transferable to state markets and MFP has the same problems as any other upper payment limit (UPL) benchmark.

This issue brief builds off the Rare Access Action Project's (RAAP's) 2025 paper, "Solving for Access and Affordability: PDABs are Not the Answer" and explains why borrowing the MFP benchmark price for state prescription drug affordability boards (PDABs) would recreate the same legal, operational, and access problems already observed with any use of upper payment limits (UPLs). When removed from Medicare's statutory framework, MFP functions as a reimbursement ceiling (the same as any UPL), with consequences that show up in patient access and care delivery.

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Where MFP Comes from and What It Is Designed to Do

Medicare's MFP is not a common "fair price" that can be lifted and dropped into any market. It is a federal program tool. It works because Medicare can attach a price to Medicare payment, and because the Centers for Medicare & Medicaid Services (CMS) can redesign coverage and payment rules around that price.

Under the Inflation Reduction Act (IRA), CMS selects a limited number of drugs and sets an MFP for Medicare. That number is intended to function as an acquisition price for beneficiaries and pharmacists. The leverage point is the part state policymakers tend to miss. MFP is not "negotiation" in the abstract. It is negotiation with the single largest purchaser in the country, and with real consequences attached. Manufacturers are not simply choosing whether to accept a lower price for a product in one corner of the market. They are deciding whether they are going to participate in Medicare at all. In practice, they either participate under Medicare's rules, or all their drugs are not covered by Medicare and there are severe financial penalties.

Why States Cannot Replicate MFP

Medicare's ability to negotiate an MFP rests on leverage that states simply do not have. States regulate only portions of the prescription drug market, and often only indirectly.

ERISA preemption alone removes large segments of the commercial market from state authority. Even within fully insured plans, state reach is fragmented across payers, benefit designs, and employer arrangements. Manufacturers can decline a state imposed pricing requirement without exiting the national market or jeopardizing coverage across an entire federal program. They are still likely able to sell to most of their patients in the state, just not those subject to a PDAB-imposed-imposed limit.

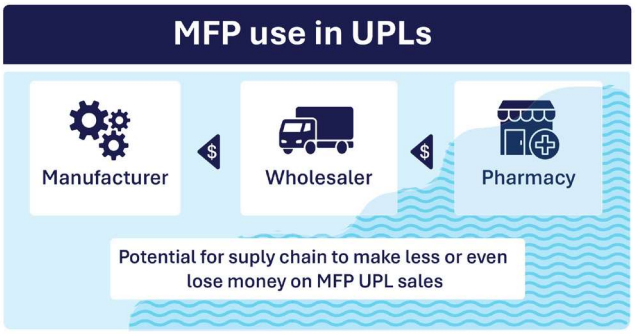
When one party can walk away with limited consequence, the interaction begins to resemble rate-setting rather than bargaining. The leverage that makes MFP function at the federal level does not scale down to individual states.

States Cannot Set Acquisition Prices, Only Reimbursement Ceilings

There is a second, more fundamental mismatch between Medicare's MFP and state drug pricing authority. Medicare negotiation changes the acquisition price of the product for pharmacies and beneficiaries. Manufacturers can choose to go below that price, but that Medicare negotiated price sets the bar for the system. State PDABs do not have that authority; they cannot require manufacturers to sell their product at the MFP price to wholesalers and pharmacies. This is the same problem PDABs face with any UPL benchmark; states can say they will only reimburse at that price, but it does not mean that supply chain stakeholders will be able to acquire the drug at a price that enables that reimbursement level to be viable.

Under Medicare, MFP operates as an acquisition price for supply chain stakeholders tied to manufacturer participation. The price is enforced upstream, at the manufacturer level, and integrated into how plans, pharmacies, and providers are paid.

When statutes allow PDABs to establish UPLs like using MFP as a benchmark UPL price, those limits apply to what plans or payers may reimburse. They do not change the price at which manufacturers sell drugs into the distribution MFP reimbursement and hoping the rest of the system absorbs the difference.



Medicaid Best Price Ties with MFP

Medicaid Best Price also shows why Medicare negotiation is not a price benchmark states can simply copy. For drugs selected for Medicare negotiation, federal law ties the MFP into Medicaid rebate calculations by treating Best Price as inclusive of the Maximum Fair Price. That is a reminder that MFP is not just a "deal price." It is part of a larger federal legal structure that coordinates how a low price flows across programs.

States cannot recreate that structure, and they cannot control the ripple effects of trying to pull an MFP-level number into state markets. Manufacturers price and report nationally, not state by state. So, extending MFP-like pricing outside Medicare is not a clean, local decision. It is the kind of low price that can create broader obligations and consequences.

The practical result is that "borrowing MFP" is unlikely to produce a manufacturer price concession in the state market.

Patient Access and Care Delivery Impacts

The structural mismatches described above show up in how patients access care and how providers decide whether they can continue to offer certain treatments.

When pricing policies operate as reimbursement ceilings rather than acquisition prices, financial pressure moves downstream. Access effects often emerge first in settings where care delivery is already complex. Treatments requiring buy-and-bill arrangements, specialized handling, or site-based administration leave providers exposed to upfront costs. If reimbursement does not reliably cover acquisition and overhead, providers may limit stocking, restrict scheduling, or stop offering a therapy altogether. Patients then experience delays, referrals, or changes in where and how care is delivered.

Geography compounds the issue. Many patients receive care at regional centers or specialty clinics that serve multiple states. When reimbursement rules differ by state, providers face uneven financial exposure for the same treatment delivered at the same site. Over time, that misalignment can influence referral patterns, network participation, and willingness to accept patients from certain states, even when clinical need is identical.

Administrative responses also play a role. Plans facing reimbursement caps may rely more heavily on utilization management, prior authorization, or network design to manage exposure.

These tools do not reduce the underlying cost of treatment. **They manage access**. For patients, this means additional steps, longer timelines, and greater uncertainty about whether prescribed therapies will be covered and where they can be received. These dynamics are not limited to any single category of drugs. They arise whenever reimbursement constraints are imposed without corresponding changes to acquisition pricing and payment mechanics. The result is a system that manages affordability by shifting risk and friction onto patients and providers rather than resolving cost at the source.

What States Should Do Instead

States are right to focus on affordability. The mistake is trying to borrow a federal pricing tool that depends on federal leverage. There are practical state options that reduce patient cost exposure without creating downstream access risk.

- Target patient out-of-pocket costs directly. States can use benefit design levers that address affordability where patients feel it, including caps on cost sharing, smoothing mechanisms, and limits on coinsurance for high-cost therapies.
- Improve PBM and plan transparency and pass- through. States can focus on whether negotiated savings and fees are flowing to patients or are being retained elsewhere through pass-through requirements, standardized reporting, and point- of-sale transparency.
- Use risk pooling and reinsurance for high-cost, low-volume therapies. These approaches treat budget volatility as a financing challenge rather than a reimbursement-cap problem.

States have real options to address affordability, especially when the focus is patient cost exposure and system transparency rather than upstream price controls. The key is discipline. Medicare's MFP works inside a closed federal system, and outside that system it turns into a reimbursement ceiling with predictable access consequences.

Sources

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Support for this paper was provided by Apteka.