Common Sense and Medicaid Drug Policy

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Eakinomics: Common Sense and Medicaid Drug Policy

The Medicaid Drug Rebate Program (MDRP) was created by Congress nearly 30 years ago. It requires drug manufacturers to pay a rebate for all out-patient drugs dispensed to Medicaid beneficiaries. The percentage for this rebate varies by type of drug, with brand-name drugs requiring the greatest rebate and generics the least. In addition, the rebate must rise until it ensures that the net (of rebate) price of the drug matches the best price available to anyone in the private market. (MDRP is often referred to as the Medicaid "best price" policy.) Finally, there is an inflation penalty — an additional rebate equal to the amount by which the price increase exceeds the rate of inflation, measured by the Consumer Price Index for All Urban Consumers (CPI-U).

The latter feature allows the rebate to continue to rise if the drug's price is rising. At present, however, the maximum rebate is capped at 100 percent of the drug's average manufacturer price (AMP). This cap is little comfort, if one thinks about it, as it means that the manufacturer is providing the drug for free. That's a pretty good price. It's also solely due to a coercive, confiscatory, and indefensible policy.

But wait, it could get worse. Legislation expected to be considered by the Senate (and a proposal in the President's Budget) would eliminate the cap and allow for the possibility of a rebate greater than 100 percent. Companies would, in effect, have to pay for the privilege of distributing their drugs for free to Medicaid beneficiaries. This outcome simply defies common sense.

Proponents argue that this would be a self-inflicted wound — companies have the option of not raising their prices and facing higher rebates. Eliminating the cap would reduce the incentive for inflating drug prices. That's true as far as it goes, but it misses the key

incentive: Companies could avoid the inflation-based rebate by simply launching the drug at a high price to begin with. As a policy, removing the cap is likely to be a failure.

Only in the Orwellian DC health policy world would a mandatory payment to the government be called a “rebate” (as if some poor Medicaid beneficiary saw a check in the mail), and especially still be called a rebate when it exceeds the underlying price. Let’s face it, these are taxes plain and simple. Being honest also makes it simpler to understand how the cap rose from 25 percent of AMP at the outset to 50 percent of AMP in 1992, and to 100 percent of the AMP beginning in 2010. Politically, the empirical fact is that stealth taxes have a tendency to rise. But this is also a policy failure. Taxes are a cost of doing business, and raising taxes forces drug companies to raise prices to cover their costs.

It is a good idea for Congress to improve incentives for lower-cost drugs. But lifting the 100 percent cap is not among those incentives. The MDRP is part of the problem, and making it worse will not be part of the solution.