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Prescription Drug Payola

By Dr. Merrill Matthews Jr.

Remember the old payola scam? Radio stations and disc jockeys discovered they could boost their incomes significantly by requiring record companies to fork over some cash if those companies wanted to get their records on the air. More airtime usually meant more sales and higher profits. You might call it "pay-for-play."

Although everyone now concedes that payola was wrong, some states are trying to pull the same thing with prescription drugs. Politicians and state officials are telling prescription drug manufacturers that the only way the poor in their respective states will have access to the companies' drugs is if each drug company hands over some additional cash.

Medicaid Rebates

Under current Medicaid law, manufacturers of "innovator drugs" must pay states a 15.1 percent rebate of the Average Manufacturer's Price (AMP) or the difference between the AMP and the best price the company charges its commercial customers, whichever is greater (and it's usually the rebate).

While some states use the rebate money to fund their Medicaid program, no federal law requires them to do so. The money often goes into the general fund and can be used for virtually any purpose.

Put Up or Shut Out

Some states are now telling drug manufacturers that if they want their products on the Medicaid formulary (i.e., list of approved drugs for Medicaid recipients), they must pay a "supplemental rebate" on top of the one that drug companies already pay the states. Those drug companies that are unwilling or unable to hand over some extra cash will find most or all of their drugs left off of the state's formulary.

When Florida established the program in 2001, more than 1,000 of the 1,827 brand name drugs approved by Medicaid were not on the formulary. In effect, these politicians and state officials are telling the drug companies, "If you want the poor to have access to your product, cross my palm!" Pay-for-play, just like payola.

The Medical Problems with Rebates

While defenders of the rebate policy will claim that doctors can get special permission (known as "prior authorization") to provide a drug not on the state's formulary, their argument assumes doctors' willingness to take on more bureaucratic paper work.

Defenders also contend that doctors can prescribe close substitutes, but that response ignores pharmacotherapeutics (i.e., how drugs interact with the body).

Mental Illness:

Most drugs are effective for most people with a medical condition for which that drug is approved. Unfortunately, the same cannot be said for diseases of the mind. Drugs for such diseases as schizophrenia and manic-depressive disorder are often only effective for 50 percent of the patients, which means doctors have to try other drugs until they find one that works. Limiting drug choices means that some mentally ill patients simply won't have the drug they need.

Impact on Minorities:

Drugs affect different people differently—because we all have different genetic make-ups. For example, blacks with high blood pressure tend to respond to diuretics much better than whites, and Asians respond to some anti-psychotic drugs at one-tenth the dosage required for whites. For patients with access to virtually all drugs, doctors can switch from an ineffective one to something that works.

But formularies limit the number of drugs available, and requiring an additional rebate will exclude even more of them. Since minority representation in Medicaid is

disproportionately high, they are the ones who will bear the brunt of the reduced access to drugs.

The Economic Problems with Rebates

The justification for supplemental rebates is that they will make drugs less expensive for the states. But do they really?

Cost Shifting:

Squeezing a balloon at one end doesn't make the balloon smaller; it simply causes the balloon to bulge at the other end. Similarly, when government forces prices down for one group of customers, prices will often rise for another group. It's called cost shifting. Health policy analysts agree that there is a lot of cost shifting in the health care system; however, measuring the amount is very difficult. Some actuaries argue that those with private health insurance pay about 40 percent more for health care because those in government programs (primarily Medicare and Medicaid) pay less than the actual cost of their care.

Requiring additional rebates from the drug companies may lower prices for the government, at least temporarily, but those costs will likely be shifted to those who buy private health insurance.

Increasing the Number of Uninsured:

Cost shifting has some serious side effects. Nationwide, health insurance premiums are going up by about 16 percent this year. But those in the small group and individual markets are seeing increases of between 40 and 60 percent. Forcing additional cost shifting through supplemental rebates will only exacerbate the problem of rising premiums, and therefore increase the number of uninsured. Ironically, those priced out of the market for health insurance because cost shifting made their health insurance premiums unaffordable may find themselves turning to the state for coverage.

Reducing Research:

Supplemental rebates also reduce the amount of money available for research, since the states are taking more of it from the pharmaceutical companies. Perhaps drug companies facing the dilemma of the out-stretched political hand should funnel most of their research dollars to medical schools in states that don't require manufacturers to pay additional rebates.

The Ethical Problems with Rebates

There are two major ethical problems with supplemental rebates: they are anti-competitive and corrupting. Americans recognize that competition is the best way to keep quality high and prices low. Allowing some third party to decide who can and cannot participate limits the competition—especially when the price to compete is to pay a "rebate" to the person making the decision.

More importantly, supplemental rebates open the door for political corruption. Politicians may contend that the money goes to the state treasury rather than to them personally (as in payola), but they still can use that money for political purposes.

Looking for Ways to Cut Costs

Many states expanded Medicaid coverage when state coffers were overflowing. Now that the economy has taken a downward turn, they are scrambling to make ends meet. Supplemental rebates are simply an attempt to raise revenues without raising taxes.

Wouldn't it make more sense to let competition, rather than rebates and price controls, drive costs down? A prescription drug benefit for low-income people that worked like the food stamp program—where participants get a set amount of money and are allowed to make their own choices and benefit from being prudent shoppers—would provide the vast majority of low-income patients with an incentive to get value for their money. The small percentage with very high drug costs could have a safety net program modeled after the high-risk pools that 29 states rely on to provide health coverage for people with very high health care costs.

Conclusion

The last thing we need is politicians devising one more way to extract money for government programs. Prescription drug payola is bad medicine and it's bad politics. Everyone knows the old payola scam was wrong; when will they recognize that the new version of payola is even worse?

Dr. Merrill Matthews Jr. is a Visiting Scholar with the Institute for Policy Innovation

Direct all inquiries to:

Institute for Policy Innovation
250 South Stemmons, Suite 215
Lewisville, TX 75067

(972) 874-5139 [voice]
(972) 874-5144 [fax]

Email: **ipi@ipi.org**
Website: **www.ipi.org**