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A Tax on Drug Price Increases Can Offset Costs

States could discourage manufacturers from large price hikes

The federal government does not regulate the list prices of drugs—set by the manufacturer before discounts and rebates—and states are generally prohibited from regulating drug prices.¹ At the same time, list prices have grown faster than the rate of inflation. In 2015, average drug list prices increased by 6.4 percent, while general inflation increased by 0.1 percent.²

Price concessions, primarily in the form of rebates paid to pharmacy benefit managers, can offset much of this price growth, but drug spending has continued to increase each year and contributes to rising health care costs.³ This particularly affects some consumers' out-of-pocket spending, since their cost-sharing for prescription drugs is often based on the product's list price.

While the federal and state governments have limited control over drug prices, a state can levy taxes on drugs sold within its borders. By taxing any drug price increases greater than the rate of inflation, states could discourage large increases and generate revenue to offset rising costs.

How states should tax price increases above inflation

Private insurance companies often include price protection clauses in their contracts with drug manufacturers, requiring them to provide discounts to offset price increases over an agreed-upon threshold.⁴ Medicaid has a similar protection, established through federal law, that requires manufacturers to pay a rebate on price increases greater than inflation.⁵ Both approaches can serve as a guide for how states could tax such price hikes.

The Medicaid Drug Rebate Program requires manufacturers to compare their current average drug price with their initial average drug price, adjusted for inflation. If the current price is greater than the inflation-adjusted price, the manufacturer must issue the state Medicaid program a rebate for the difference.⁶ For example, if a manufacturer increases the price of a drug from \$100 to \$115, but inflation is only 2 percent, the inflation-adjusted price is \$102 and the manufacturer must pay Medicaid a \$13 inflation rebate. A state tax on drug price increases could be designed to mirror the calculations that determine the Medicaid inflation rebate, reducing the compliance burden on drug manufacturers.⁷

Under this policy, a tax would be paid on the first sale of the drug within the state, generally from the manufacturer to a wholesaler or from a wholesaler to a pharmacy. The party selling the drug would be required to separately pay the tax to the state at the time of sale and include documentation of the payment to the party purchasing the drug. This documentation would be transferred to the purchaser with each subsequent sale of the drug to demonstrate that the tax was paid; otherwise, the next seller would also have to pay the tax. This system can build off existing state infrastructure, such as sale-for-resale certificates, which indicate liability for a state tax and are used to prove that the tax has been paid.⁸

To calculate the tax, the responsible manufacturer or wholesaler would subtract the inflation-adjusted initial price of the drug from its current sale price. The documentation accompanying the sale, such as a standardized form filed to the state, would include the sale price, the launch price of the drug, the current inflation-adjusted launch price, and the tax paid. The launch price used would be the same baseline average manufacturer price included in the Medicaid inflation rebate calculation, adjusted for inflation using the monthly update issued by the federal Bureau of Labor Statistics.⁹

Policymakers could design the tax to be triggered only when inflation reaches a certain threshold. For example, the tax could kick in when the price of a drug exceeds that of inflation plus 10 percent. Alternatively, rather than completely offset the amount by which the price growth has exceeded inflation, the tax could be levied on only a percentage of the price increase above inflation. New York state, for example, previously proposed but did not advance a 60 percent tax on price increases greater than inflation.¹⁰ No state has implemented a tax on drug sales, but this approach would likely withstand the legal scrutiny that has thwarted other state attempts to restrain drug spending by regulating prices. For example, Maryland's 2017 "price gouging" law was found unconstitutional in federal appeals court on the basis that it linked prices paid in state with those paid out of state, violating the Commerce Clause.¹¹ The opinion clarified that the ruling does not imply that states are barred from enacting legislation that lowers drug costs through other means.

The tax would count toward a state's general revenue. One option for this resale tax would be to fund a statewide pool that could be used to offset patient pharmacy costs and reduce insurance premiums. Insurers could be eligible to access the pool if they agreed to reduce patient cost-sharing for drugs subject to the tax. Uninsured patients could also apply to the fund for assistance in purchasing medications or insurance premiums.

Considerations for state policymakers

Policymakers should consider the administrative costs of implementing the system—including personnel required for oversight and audits, and managing the insurer and patient assistance pool—as well as the policy's potential to encourage higher launch prices.

It is unclear how this policy might affect the discounts and rebates that drug manufacturers offer pharmacy benefit managers. The tax could reduce list price growth, but manufacturers might respond by offering lower rebates. This may increase net prices paid by some payers in the near term, but a significant reduction in list price growth would mean that, over time, purchasers would no longer need to obtain the same level of rebates to keep overall drug spending in check.

In addition, drug manufacturers are already required to pay Medicaid a rebate for price increases greater than inflation. For drugs ultimately used by Medicaid patients, manufacturers would effectively pay the tax twice: once in the form of a Medicaid rebate and once in tax. Policymakers could consider developing a system to reduce the tax that manufacturers must pay by the amount of Medicaid inflation rebates they have already paid.

Levying a tax would create a source of state revenue to offset large drug price increases while also discouraging manufacturers from raising prices too much. In response, manufacturers may choose to rein in future list price increases on their products, which would result in lower state revenue but would also reduce drug spending.

Endnotes

- 1 Association for Accessible Medicines vs. Frosh et al., 17-2166 (4th Cir. 2018), <http://www.ca4.uscourts.gov/opinions/172166.P.pdf>.
- 2 Stephen Schondelmeyer and Leigh Purvis, "Trends in Retail Prices of Prescription Drugs Widely Used by Older Americans: 2006 to 2015," AARP Public Policy Institute (December 2017), <https://www.aarp.org/content/dam/aarp/ppi/2017/11/trends-in-retail-prices-of-prescription-drugs-widely-used-by-older-americans-december.pdf>.
- 3 IQVIA Institute for Human Data Science, "Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022" (April 2018), <https://www.iqvia.com/institute/reports/medicine-use-and-spending-in-the-us-review-of-2017-outlook-to-2022>.
- 4 Stephen Kaczmarek, "Pharmacy Manufacturer Rebate Negotiation Strategies: A Common Ground for a Common Purpose," Milliman, Nov. 17, 2015, <http://www.milliman.com/insight/2015/Pharmacy-manufacturer-rebate-negotiation-strategies-A-common-ground-for-a-common-purpose>.
- 5 42 U.S.C. § 1396r-8(c)(2).
- 6 Ibid. This is in addition to other required Medicaid rebates.
- 7 42 U.S.C. § 1396r-8(c)(2).
- 8 See, for example, New York State Department of Taxation and Finance, "New York State and Local Sales and Use Tax Resale Certificate," updated June 2018, https://www.tax.ny.gov/pdf/current_forms/st/st120_fill_in.pdf.
- 9 Bureau of Labor Statistics, "Consumer Price Index," accessed June 18, 2018, <https://www.bls.gov/cpi>.
- 10 New York Senate Bill S. 2007A, § S 493, <http://legislation.nysenate.gov/pdf/bills/2017/S2007>.
- 11 Association for Accessible Medicines vs. Frosh et al.

For further information, please visit:

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