



THE BASICS

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The Medicaid Drug Rebate Program

Spending on outpatient prescription drugs accounts for a substantial share of total Medicaid expenditures—over \$26 billion in 2006. Controlling drug expenditures is a challenge for states: rising prices, high drug utilization, and increases in the Medicaid population all contribute to the growth of Medicaid outpatient prescription drug expenditures. State Medicaid programs do not purchase drugs directly; they reimburse pharmacies for covered drugs dispensed to Medicaid beneficiaries. Each state defines its pharmacy reimbursement formulas, which include the drug ingredient cost plus a dispensing fee. States are not allowed to use many cost containment tools (for example, closed drug formularies, tiered copayments, mandatory mail order) used by private purchasers to control drug spending, although they can use other tools such as prior authorization and generic substitution.

Created by the Omnibus Reconciliation Act of 1990 (OBRA 1990), the Medicaid Drug Rebate Program helps lower Medicaid spending on outpatient prescription drugs by ensuring states receive discounts similar to those provided to private purchasers. While complicated, technical, and at times controversial, the Rebate Program has generated significant revenue for the states (and the federal government) that helps offset Medicaid prescription drug expenditures.

REBATE AGREEMENTS

In order for pharmaceutical manufacturers to obtain Medicaid coverage for their prescription drugs, they must sign a rebate agreement with the Secretary of Health and Human Services (HHS) to provide rebates for those drugs when purchased by Medicaid. Manufacturers pay the rebates directly to the

National Health Policy Forum

2131 K Street, NW
Suite 500
Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

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states, and the rebates are shared with the federal government. Approximately 550 drug manufacturers currently participate in the rebate program. Once a manufacturer enters into a rebate agreement, all of its prescription drugs are covered under Medicaid, subject to certain statutory exclusions.¹

BEST PRICE AND AVERAGE MANUFACTURER'S PRICE

Rebates are calculated for every outpatient prescription drug that states cover under Medicaid fee-for-service. Manufacturers do not pay rebates for drugs provided in managed care settings. The rebate amounts pharmaceutical manufacturers must pay are based on manufacturer-reported pricing data, namely the best price and average manufacturer's price (AMP) for each drug, which are based on the prices and financial concessions (for example, volume discounts, other rebates, etc.) available to private purchasers. A drug's best price and AMP are reported to the Centers for Medicare & Medicaid Services (CMS) by the manufacturer, but they are not publicly available.

- **Best price** is the lowest manufacturer price paid for a drug by any purchaser (defined by the Medicaid statute as "any wholesaler, retailer, provider, health maintenance organization (HMO), or nonprofit or government entity" with some exceptions²). A drug's reported best price is required to reflect all discounts, rebates, and other pricing adjustments.
- **AMP** is the average price wholesalers pay manufacturers for drugs that are sold to retail pharmacies. (The statute defines AMP as "the average price paid to a manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade.") The transactions used to calculate AMP are to reflect cash discounts and other reductions in the actual price paid.

REBATES

Rebates are paid on both brand name and generic drugs. The brand name (known also as "innovator") drug rebate is equal to 15.1 percent of AMP per unit (15.1% AMP), or the difference between AMP and best price per unit (AMP minus best price), whichever is greater. The relationship between best price and

AMP determines the size of the rebate; the closer best price is to AMP, the more likely the rebate will be based on 15.1% AMP (the minimum rebate amount). If a brand name drug's AMP rises faster than inflation, an *additional* unit rebate amount is calculated based on the change in AMP compared with the consumer price index. The rebate amount for generic drugs is 11 percent of AMP per unit (11% AMP).

Rebate amounts are calculated and paid on a quarterly basis. Manufacturers must report the best price and AMP for each drug to CMS within 30 days of the end of each calendar quarter. CMS uses the pricing information to calculate the unit rebate amount for each drug and provides it to the states. Each state determines its Medicaid utilization for each covered drug in the quarter and reports this information to the manufacturer within 60 days of the end of the quarter. The manufacturer then computes and pays the rebate amount to each state within 30 days of receiving the utilization information. States report rebate amounts received to CMS and share the rebates with the federal government based on their federal medical assistance percentage (FMAP).

Rebate amounts have risen along with the increases in Medicaid drug spending. As a percentage of Medicaid drug spending, rebates increased from about 19 percent to 26 percent of Medicaid drug spending between 2001 and 2005. This increase is likely due to (i) a growing number of rebates calculated as the difference between AMP and best price, rather than the minimum; and (ii) a growing number of additional rebates due to drug prices climbing faster than inflation.

ENDNOTES

1. Section 1927(d) of the Medicaid statute identifies 11 categories of drugs that states are allowed to exclude from coverage (for example, drugs for anorexia, weight gain/loss; drugs to promote fertility; drugs for cosmetic purposes or hair growth; barbiturates; benzodiazepines).
2. Exceptions to the best price include prices that are charged to certain federal purchasers (sales made through federal supply schedule, single-award contract prices of any federal agency, federal depot prices, and prices charged to the Department of Defense, Department of Veterans Affairs, Indian Health Service, and the Public Health Service), eligible state pharmaceutical assistance programs and state-run nursing homes

ENDNOTES (continued)

for veterans, and certain health care facilities, including those in underserved areas or serving poorer populations. Prices negotiated by Medicare prescription drug plans or certain retiree prescription drugs plans are also excluded from best price. Nominal prices—prices that are less than 10 percent of AMP—also are excluded from best price.