Health Insurance as Innovation Incentive

Author : Amy Monahan

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Rachel Sachs, *Prizing Insurance: Prescription Drug Insurance as Innovation Incentive*, 30 **Harv. J. of L. and Tech.** (forthcoming 2016), available at SSRN.

In *Prizing Insurance: Prescription Drug Insurance as Innovation Incentive*, Rachel Sachs brings together the often disparate worlds of intellectual property theory and health insurance design, to argue that prescription drug insurance could be structured to offer a better incentive for pharmaceutical companies to develop drugs that treat conditions primarily affecting low-income Americans. Typically, health insurance design is evaluated from an access and utilization perspective. Professor Sachs suggests we should broaden that view, at least when it comes to drug coverage, to evaluate the effect insurance coverage has on research and development incentives.

To make her point, Professor Sachs works through the example of the innovation incentives for drugs that would be primarily prescribed to low-income populations in the U.S., such as those that would treat various tropical diseases. While there are many factors that influence the development of drugs, one of those incentives is financial. And when it comes to diseases that affect primarily low-income individuals, the financial analysis disfavors significant innovation investment. After all, if the population to be treated is either uninsured or covered through only Medicaid, the “prize” for developing a treatment may be insufficient to support investment. Medicaid arguably contributes to this lack of incentive given its relatively low payment rates for pharmaceuticals, which are significantly below other market payers in the U.S. The novel argument Professor Sachs makes is that insurance design could be modified to help achieve socially desirable innovation that the market would not otherwise reward.

The article begins by explaining how the patent and FDA regulatory systems do not necessarily produce socially optimal innovation. For example, she argues that exclusivity periods and clinical trial limitations can distort the incentives for innovation, favoring certain types of drugs and interventions over others. In addition, while she acknowledges that market incentives do often reward the creation of socially desirable drugs and treatments, the mechanism is imperfect because of ability-to-pay concerns and a lack of consumer salience. In the end, the types of innovations that are incentivized are not necessarily the ones with the greatest social value or those that would address the most significant disease burdens.

After establishing the current distortions in innovation incentives, Professor Sachs moves on to discuss various policy levers that might be used to address such distortions. First, she explains why reforms aimed at the current intellectual property and FDA regimes are unlikely to be wholly effective. From there, she makes the case that insurance design itself could be used to create targeted incentives for socially desirable innovations in the pharmaceutical arena, and it is here that Professor Sachs introduces a novel way of evaluating insurance. She focuses on Medicaid, given that it is the primary source of coverage for low-income Americans and she wants to concentrate on populations for whom the usual market mechanisms would fail to produce socially optimal investment. Pursuant to federal statute, state Medicaid programs are entitled to specific percentage discounts on the average manufacturer price of all pharmaceuticals. While that pricing structure makes sense from an access and cost perspective, it lowers the incentive for pharmaceutical companies to develop drugs that primarily serve the Medicaid population. She argues that Medicaid drug pricing could be tweaked to function more like a prize for innovation, without necessarily undermining cost or access concerns.

Innovation incentives in the pharmaceutical industry in the United States are complicated by our disparate insurance markets. Medicaid pays comparatively low prices for pharmaceuticals, with Medicare and private insurance paying more. As a result, all other things being equal, pharmaceutical companies should favor innovation that will have higher

utilization among the higher-paying populations – leaving the Medicaid market as the most unattractive in the U.S. While some commentators have argued that the solution is to "equalize down" – moving payment rates for non-Medicaid payers down to Medicaid levels, Professor Sachs argues that we should strategically "equalize up" – raising Medicaid rates to help achieve socially desirable innovation. She walks through possibilities for achieving this result at the federal level, and also discusses how enterprising states might implement such strategies on their own.

Professor Sachs' article deftly brings together an understanding of patent and FDA regulation, along with insurance pricing mechanisms, to give a more complete picture of healthcare innovation than is standard. As someone who spends a lot of time thinking about health insurance regulation, I valued both the explanation of why the patent and FDA regulatory systems under-incentivize certain types of innovation, as well as Sachs' position that evaluation of insurance design should go beyond cost, access, and utilization. While this article focuses specifically on the development of drugs to treat neglected diseases that affect primarily low-income populations, it could easily be applied to other areas in which insurance reimbursement structure impacts health care innovation.

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