We Can Win Affordable Medications for All

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on Prescription Drug Costs

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As always, we write and speak only for ourselves, not for the Boston University School of Public Health, or for organizations that provide financial support.

Senator Kerry, Representative Olver, other honored participants and community advocates—

Thank you for inviting our testimony today. We are grateful for the chance to discuss methods of winning affordable prescription drug coverage for all Americans while protecting vital pharmaceutical research.

I. THE PROBLEM

A. Coverage

We estimate that between one million and 1.2 million citizens of Massachusetts lack insurance for prescription drugs today, or roughly one-fifth of the state's population. The two-page fact sheet appended to this testimony offers more detailed numbers for Massachusetts on this and other subjects.

Nationally, some 70 million lack drug insurance, of one American in four.[1]

Many Medicare enrollees who now have drug insurance have only meager coverage, with low dollar limits and high co-payments or co-insurance. Indeed, recent testimony from the Director of the Congressional Budget Office showed that fully 45 percent of the cost of drugs bought by Medicare enrollees was paid out-of-pocket.

And many Medicare enrollees with insurance through a former employer's retiree health plan, a Medi-gap policy, or a Medicare HMO have reason to worry if they will be able to keep that protection. These plans can be expected to cut back on coverage in the face of skyrocketing prescription drug costs, and more and more people will not be able to afford the premiums.

B. Costs

We estimate that U.S. prescription drug spending this year will rise to some $160 billion, or roughly $570 for the average American. Spending is doubling about every five years at current rates of increase.

Drug spending rose roughly three times as fast as overall health spending between 1995 and 2000, as the chart on the following page shows.

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[1] U.S. and state by state data are available in our October 2000 report, *A Prescription Drug Peace Treaty: Cutting Drug Prices to Make Prescription Drugs Affordable for All and Protect Research*, available at **http://dcc2.bumc.bu.edu/hs/ushealthreform.htm**

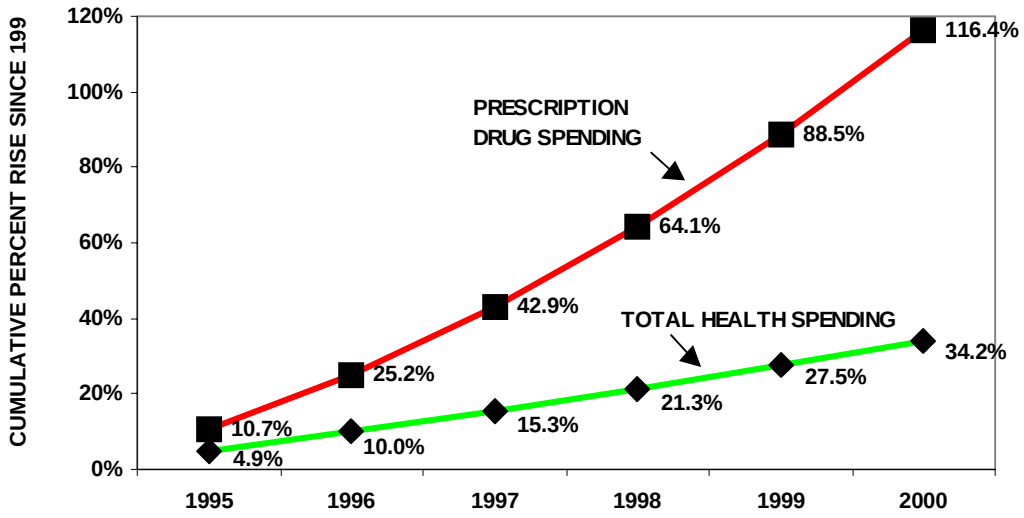
C. Choices

In the face of rising numbers of Americans without insurance for prescription drugs, and of rising costs of drugs, our state and federal governments face four alternatives:

- let our people suffer and die for lack of needed medications, but that is intolerable,
- increase spending even faster, but that is unaffordable (and would bestow unprecedented windfall profits on drug makers),
- slash drug prices and profits angrily and recklessly, but that could harm research, or
- secure all needed medications at an affordable cost, and without bestowing windfall profits, while protecting drug makers' profit margins at current levels—and while boosting research and cutting wasteful marketing costs.

The fourth alternative looks by far the most desirable on its face. And our analyses of the causes of prescription drug coverage and cost problems, and of the range of solutions that have been proposed, indicate that the fourth alternative is also feasible.

RETAIL PRESCRIPTION DRUG AND HEALTH SPENDING, U.S., PERCENT *RISE* FROM 1994



II. THE CAUSES

Low coverage rates and high costs are caused in large part by American unwillingness to restrict drug makers' prices—something that all other wealthy nations do. This, in turn, stems largely from three things:

- drug makers' claims that they set high prices in the U.S. to cover research costs,
- drug makers' political power and their assertions that research will suffer if governments intervene to win lower prices,
- Americans' belief that a legitimate free market allows drug makers to secure their high prices and profits.

These claims have a high myth content.

First, no industry sets prices to cover costs. Prices are set to maximize profits. Or stockholders sue.

Second, drug makers spend less on research than they claim, and much on marketing. Just consider the chart on the next page, showing how six of the biggest drug makers spent their money in 1999. (These data are drawn from the drug makers' 1999 financial reports. New analyses of year 2000 data, done by Public Citizen, show similar results.[2])

Research and development are only 11 percent of revenue, while profits are 16 percent and marketing/administration are 31 percent. These figures are supported by the drug makers' own reports on their employees' job functions.

State or federal limits on drug makers' prices are not the main threat to research. Rather, in our view, the main threat to research is the drug makers' own intransigence—their insistence on more money for business as usual, without regard to the need to make prescription drugs affordable for all Americans. We worry that soaring drug spending will put more medications out of the financial reach of more Americans. If this persists, year after year, it is likely that an angry future Congress will over-react and slash drug makers' prices without regard to the harm that might do to research. Making prescription drugs durably affordable, through price cuts in combination with protections for drug makers, is the soundest road forward.

Third, the prescription drug market is not close to a genuine free market. Consider the requirements for real free market competition, and all the ways that the drug industry departs from those requirements.

Free market's requirements

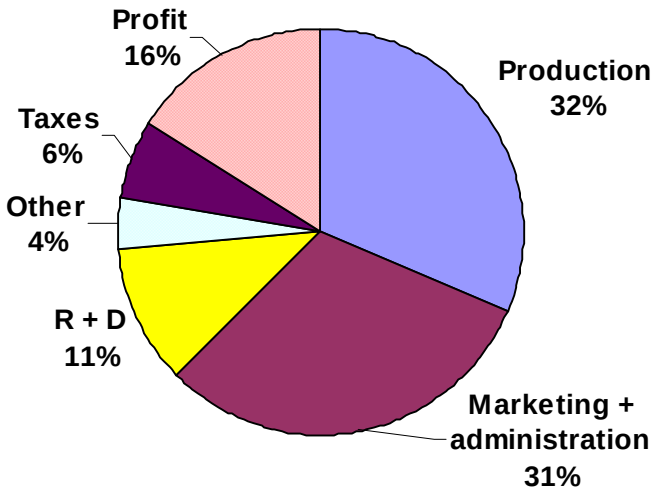
- Many small buyers and sellers
- No artificial restrictions on supply, demand, or price
- Easy entry and exit
- Good information about price and quality
- Caveat emptor—don't trust anyone!

[2] Available on the internet at http://www.citizen.org/congress/drugs/factshts/mostprofitable.htm

How drug-making departs from free market's requirements

- Market concentration: In 6 of top-selling therapeutic categories, 4 firms control more than 80 percent of all prescriptions
- Mergers among drug makers hike concentration.
- Drug makers have patents (legal monopolies) and fight to extend them, often by what Prof. Schondelmeyer of the University of Minnesota calls "increasing their investment in R&D—Republicans and Democrats."
- In a free market, everyone pays close to the same price. Today's huge price disparities display price setting that extracts as much money as possible.
- Drug makers are alleged to have worked to suppress marketing of drugs by generic manufacturers.
- Many (or most) prices are kept secret.

HOW SIX DRUG MAKERS SPENT THEIR MONEY, 1999



III. THE POSSIBLE SOLUTIONS

Many possible solutions are being debated publicly. This shows how serious the problem has become, and how seriously our public officials are taking the problem.

Four ways to expand coverage

- Grants to states to subsidize drug buying by impoverished Medicare enrollees.
- Covering Medicare enrollees through HMOs.
- Covering Medicare enrollees directly through Medicare.
- Private voluntary (or state-subsidized) purchase of insurance

The grants to states will be costly and won't help many Medicare enrollees in need.

Expanding coverage through HMOs is costly and very speculative, given the problems HMOs have been having generally in the Medicare program, and the evidence that they do not save money for Medicare. Further, the drug makers would harvest substantial windfall profits from the HMOs because the latter and their agents have proven unable to contain drug costs.

A Medicare drug benefit would cover people, but it would be very costly if it relied only on feeble pharmacy benefits managers (PBMs) to contain cost. These PBMs are not effective in squeezing manufacturers, who garner three-fourths of the drug dollar. Instead, they focus more on other activities, such as squeezing pharmacies. Also, their financial transactions are far from transparent. For these reasons, the Medicare drug benefits that are now under discussion would yield enormous windfall profits to the drug makers. The drug makers' revenues would rise far faster than their costs.

Private voluntary insurance, even with state subsidies, is doomed to fail, we believe. High-cost drugs are generally those that must be taken for the long term. That means that they are a predictable cost. Insurance is not designed to protect people against predictable costs. That is because the people who are most likely to sign up for voluntary insurance programs are those who know that they will need expensive medications. This is called adverse selection. It is a recipe for soaring premiums, demands to increase state subsidies, or both.

Three ways to cut prices

- Parallel importing from other nations.
- State price controls.
- State extension of Medicaid discounts to growing shares of the population.

Parallel importing could potentially be an effective tool to win lower prices. Each nation can obtain drugs at lower prices won by other nations through regulation. But when Congress voted to legalize parallel importing in October of 2000, it did so in a way that endorsed public regulation of drug prices only under very peculiar circumstances—as long as foreign governments did the regulating, and as long as the law did not actually work effectively to get low-cost drugs over the border and into the hands of Americans who need them. Although many legislators who voted for parallel importing were well-intentioned, this law—in practice—became nothing more than political window dressing.

State action is vital to pursue, as well as Congressional action, as both face substantial resistance. Price controls are being pursued in Maine but are currently tied up in federal court, principally on Commerce Clause grounds. An alternative is to empower states as wholesalers, perhaps as sole wholesalers, to buy prescription drugs. They would not take physical possession of the drugs, and medications would continue to be distributed as they are today. But individual states could then assemble their buying power on behalf of all of their citizens. Groups of states could unite and do even better.

At minimum, each state should consider extending its present Medicaid discount, averaging 18 percent of prices, to larger groups of people who don't qualify for Medicaid itself but who often can't afford needed drugs. State Representative Patricia Jehlen has submitted a bill calling on the administration to do this in Massachusetts—as Maine and Vermont have gotten federal permission to do.

We suggest a somewhat broader approach. These are its main provisions, which could be pursued nationally, or by individual states or groups of states:

1. Win lower prices for all medications through negotiation with the drug makers or through public action. Applying Federal Supply Schedule prices would have cut year 2000 costs by some $35 billion nationally for brand name drugs alone. That would have meant a saving of about $800 million in Massachusetts.

2. But replace all the revenue lost by drug makers. Lower prices will mean higher private market volume offsetting much or most of the revenue loss. (Private volume would rise substantially. We expect that about 58 percent of the savings would go to private payors.) The rest of the revenue lost by the drug makers to lower prices should be made up by public help for all those patients of all ages who can't afford even the newly lowered prices.

3. Cover drug makers' additional manufacturing costs, which are typically very low. The real, marginal cost of making more pills averages perhaps five percent of today's retail prices. So making enough additional pills to fill ***all*** the prescriptions that all Americans need, our preliminary estimates suggest, would cost only about $3.6 to $5 billion dollars per year.

4. This means that ***all*** prescriptions written by physicians are filled, but there is only a small increase in total spending. This will keep drug makers financially whole. Their profits are intact, as is their capacity to finance research.

5. Provide additional incentives for breakthrough research, and provide disincentives for wasteful marketing spending.

Together, these five steps protect all parties-- patients, payors, and drug makers-- from the crises caused by exploding drug spending.

And they do so before an angry future Congress becomes so furious at the drug makers that it eviscerates their prices and profits—something that truly would harm research. Indeed, these steps protect and expand the resources committed to innovative research.

Thank you for the chance to offer this testimony. We are available by phone (or email) to discuss any questions.

CUTTING MASSACHUSETTS PRICES TO MAKE PRESCRIPTION DRUGS AFFORDABLE FOR ALL

Fact Sheet from "A Prescription Drug Peace Treaty" (Oct. 2000)

Americans can win much lower drug prices and make all needed medications affordable for people of all ages without cutting drug makers' revenues and without spending substantially more. State action to achieve these goals is feasible—and necessary if Congress fails to act. If government fails to cut prices, more and more citizens will go without life-saving drugs.

- **In Massachusetts, an estimated 1.0 to 1.2 million people—or 1 out of 5—have no coverage for prescription drugs.** This figure includes uninsured people, many seniors, and many people whose private insurance lacks drug coverage. But in addition to that total are the many Medicare recipients with disabilities under age 65 who lack coverage (perhaps 2 million nationwide), and still more people who have inadequate drug benefits.

Residents Lacking Insurance for Prescription Drugs, 1998 *(thousands)*

Age 65+ lacking Rx coverage	Lack Any Health Insurance	Privately Insured With No Drug Coverage	***TOTAL*** **Lacking Drug Coverage**	***PERCENT*** **Lacking Drug Coverage**
303	639	284	**1,226**	**19.8%**

CUTTING PRICES

- Americans spend more per person on drugs than any other nation, yet high prices here mean we get less for our money. And higher private insurance spending and huge public subsidies would be unaffordable solutions. Cutting drug makers' prices is vital to make needed drugs affordable for all.

- In the year 2000, Massachusetts residents paid manufacturers some $2,236 million ($2.2 billion) for brand name prescription drugs.

- **Cutting brand name prescription drug makers' prices by up to 42%—from undiscounted factory prices to Federal Supply Schedule (FSS) prices—for all drugs sold in Massachusetts in 2000, would have saved about $801 million.**

- With these price cuts, the state's payments to brand name drug makers would have dropped from $2.2 billion to $1.4 billion, saving 35.8% of actual year 2000 payments. (The savings would be less than 42% because some buyers already receive discounts.)

Estimated Massachusetts Payments to Brand Name Prescription Drug Makers, Before and After Federal Supply Schedule Discounts, 2000 *($ millions)*

Estimated Current Payments to Brand Name Drug Makers	*Minus* Additional **Savings** If All Pay FSS Prices	*Equals* **Payments** to Brand Name Drug Makers If All Pay FSS Prices
$2,235.5	**$801.1**	**$1,434.3**

Note: FSS prices are those that certain federal agencies routinely pay for prescription drugs.

(continued)

- Of the year's **$801 million in new savings for Massachusetts**, 57% would go to people with private third party insurance, and 19% to people who pay out-of-pocket. Medicaid and hospitals and nursing homes would split the rest of the savings.

Estimated Savings on Brand Name Prescription Drugs by Payor, If Federal Supply Schedule Prices Prevailed, 2000 *($ millions)*					
cash	3rd party	Medicaid	non-retail	Total	Savings as % of current spending
$148.9	$457.7	$99.4	$95.0	$801.1	35.8%
19%	57%	12%	12%	100%	--

A DRUG PRICE PEACE TREATY

The state could act to assure that all residents get the medications they need, while keeping drug makers financially whole. Prices could be cut but drug makers' total revenue restored. They could be paid the cost of making more drugs to fill many more prescriptions. Several things combine to make this possible:

- Americans spend enough already to cover the cost of all needed medications.
- The state's buying power about equals that of Australia, which has far lower drug prices.
- Cutting brand name prescription drug prices to FSS levels would reduce drug makers' revenues by $801 million, as shown—*if nothing else changed*. But the volume of drugs sold would rise as prices fell, as more people would be able to afford to fill prescriptions.
- **Higher volume would replace much or most of the revenue** that drug makers would otherwise lose to lower prices. And price cuts would permit expanding government programs for people who can't afford even the lower prices. Public funds to buy more drugs would offset the remaining loss of revenue from price cuts—and even could be guaranteed to fill any revenue gap.
- **The real cost of making more pills averages just 5 cents on the retail dollar**, and also will be paid.

A drug price peace treaty could guarantee all the state's people all needed drugs, without much higher spending, while protecting drug makers' revenues, profits, and research. Such a peace treaty can buy time to develop better evidence on which patients need which drug. Over time, it could boost research with high returns for breakthrough drugs. The peace treaty is an essential first step toward making medications durably affordable.

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Disclaimer: As always, we write and speak only for ourselves, not on behalf of Boston University or any of its components.

For full report, including methods and data sources, see *A Prescription Drug Peace Treaty* (Oct. 2000), on the internet at **http://dcc2.bumc.bu.edu/hs/ushealthreform.htm**