

This report is embargoed until
12:01 A.M. on Friday 31 October 2003.

61 PERCENT OF MEDICARE'S NEW PRESCRIPTION DRUG SUBSIDY IS WINDFALL PROFIT TO DRUG MAKERS

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31 October 2003

Windfall – noun 1. Something blown down by the wind, as fruit from a tree
2. Any unexpected acquisition, gain, or stroke of good luck.¹

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Summary

Congress has declared its commitment to keeping prescription drug prices high under any Medicare drug benefit. This report shows that these unrestrained prices—given the remarkably low real cost of producing the added volumes of pills that Medicare patients need—will bestow enormous windfall profits on prescription drug makers.

An estimated 61.1 percent of the Medicare dollars that will be spent to buy more prescriptions will remain in the hands of drug makers as added profits.

- ***This windfall means an estimated \$139 billion dollars in increased profits over eight years for the world's most profitable industry.***
- ***At \$17 billion annually, this means about a 38 percent rise in drug maker profit.***

This is the main reason why the proposed legislation gives patients only a scanty drug benefit, with high continued cost-sharing. The gift to drug makers is also why the plan requires a high taxpayer subsidy—money borrowed from our children and grandchildren.

The legislation would explicitly prohibit Medicare itself from acting to negotiate or contain the drug prices paid under the new program. This ominously parallels the 1965 Medicare law's granting of open-ended payments to hospitals and doctors. Those payment methods proved extraordinarily costly. Congress should not be so naïve today.

The drug industry's current business plan rests on high prices and rapid revenue growth. In giving the drug makers the Medicare bill they demand, Congress offers temporary support to this plan. But the plan itself is not durable because it is simply too costly. Congress is simply deferring serious work to shape a sustainable drug industry.

Cost analysis

Where will the new federal money go if Congress does create a Medicare prescription drug benefit without cutting drug prices?

- We project that \$228 billion of \$400 billion in new federal spending over eight years would be used to buy drugs that patients previously did not get. This is new revenue to the drug industry as a whole—that is, to drug makers, retailers, and wholesalers.
- Together, the retailers' and wholesalers' share is about 24.4 percent. Therefore, the drug manufacturers get the remaining 75.6 percent as gross income.
- Drug makers' costs don't rise much when they produce and sell more pills. Marketing, administration, and research expenses would change little.
- ***Drug makers' only added costs associated with a new Medicare prescription drug benefit are expected to be in manufacturing and in distribution—and these added costs are remarkably low.***

Drug makers' factories are already built, and the ingredients in most medications are inexpensive. This means a very small incremental cost to make the added volume of

drugs that newly covered Medicare patients will need. Estimated added cost of making additional pills is only about five percent of full retail price.

Subtracting the rise in manufacturing and distribution cost yields an estimated rise in net revenue for drug makers. Against that gain, this report offsets drug makers' lower profit on newly discounted drugs formerly sold at full retail price. Conservatively, this report does not estimate several factors that might raise drug makers' profit share—for example, a possible shift of many prescriptions to Medicare from Medicaid.

- ***Drug makers' net increase in profit is estimated at \$139.2 billion over the eight-year early life of the program. This rise in drug makers' profit constitutes fully 61.1 percent of the \$228 billion in Medicare dollars used to buy additional prescription drugs for patients previously unable to afford them.***

The report focuses on drug makers' profits from new business. It does not examine the parallel use of federal funds to sustain profits on old business—drugs that would also be bought by Medicare at high prices.

The report offers a sensitivity analysis of the effects of different assumptions about the split of the additional \$400 billion between dollars used to buy new drugs and dollars used to replace present purchases of drugs, and about the actual cost of manufacturing.

Given current federal deficits, the analysis suggests that Congress is choosing to borrow from our children and grandchildren to bestow large new profits on the drug industry—already the nation's most profitable.

Alternatives

- One option for recouping such unwarranted profits would be a windfall profits tax. Such taxes have a long history in the United States.
- Paying drug makers for the added volume of medications at their low actual cost of production is vital to providing a Medicare prescription drug benefit without yielding windfall profits—to meet patients' needs while remaining affordable for taxpayers.
- Prescription drugs can be made affordable for *all Americans*, though, using similar methods. What's essential, to meet the needs of patients, payers, and drug makers, is a prescription drug peace treaty. This would permit drug makers to switch from today's strategy of high prices and restricted use to a strategy of low prices and high volume. Profits and research can be protected at today's levels at the same time that all Americans obtain all the prescription drugs that work at a price we can afford.

Today's high drug prices are the main source of pressure to enact a Medicare drug benefit—and also the main reason why the bill Congress is likely to pass will be so skimpy for patients and so profitable for drug makers.

The main choice is among suffering and dying for lack of needed drugs, paying much more, and reform. Congress and the drug industry can shape a bill that addresses the core needs of patients, payers, and the industry. They have not yet done so.

A. Introduction

Leaders of the U.S. House of Representatives and Senate hope to enact a Medicare prescription bill in 2003. The president has urged action, saying the “Congress needs to finalize legislation. . . .”² The pharmaceutical industry association shares this urgency, referring, when the House and Senate bills passed in June 2003, to “the critical goal of getting a bill signed into law this year.”³

Unhappily, any bill that is passed is likely to offer older and disabled people on Medicare only a scanty benefit. The main reason is that Congress has declared its commitment that Medicare would pay high prices for drugs.

The legislation would explicitly prohibit Medicare itself from acting to negotiate or contain the drug prices paid under the new program. Relying for cost control entirely on the multitude of new private insurance companies and plans that might offer Medicare prescription drug benefits, the House bill states that the federal government may not “interfere” with them:

- (D) NONINTERFERENCE- In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the **[Medicare Benefits] Administrator may not--**
- (i) require a particular formulary or institute a price structure for the reimbursement of covered outpatient drugs;**
 - (ii) interfere in any way with negotiations** between [the various types of private plans] and drug manufacturers, wholesalers, or other suppliers of covered outpatient drugs; and
 - (iii) otherwise interfere with the competitive nature of providing such coverage through such sponsors and organizations.**⁴

Precisely what will emerge from the conference committee is unknown; the Senate bill has a slightly softer prohibition. But both versions are intent on blocking Medicare from protecting its millions of patients from high drug prices.

A Medicare law could be written to build on the success of current drug price negotiations for the Veterans Administration and for other public agencies (such as community health centers and public hospitals), which have for years won large reductions in drug prices for their much smaller patient populations. Instead, Congress turns to competing private health insurance plans. Yet private health insurance plans are widely-recognized to have failed to contain drug prices for either Medicare HMO enrollees or for the wider array of American workers, families, and employers.

The bill’s proposed “noninterference” language makes it evident that Congressional leaders do not wish to act in a serious way to win lower drug prices. Most limits on drug costs in the proposed program appear to come at the expense of Medicare patients—in the form of severe limits on coverage—so that most patients must continue paying the great majority of their prescription drug costs, including in the “doughnut hole” where they have no coverage at all.

This proposed language strikingly and ominously parallels the language on paying hospitals and doctors that was inserted in the original Medicare legislation in 1965. Congress then required, essentially, that Medicare pay hospitals by the generous—indeed, open-ended—cost reimbursement methods designed by Blue Cross plans. It required that Medicare pay doctors by Blue Shield plans’ generous usual and customary fee schedules, thus paying doctors prices that they essentially set for themselves.

Those payment methods proved extraordinarily costly. In 1965, Congress’s generosity might have been understandable. The economy was booming and Congress was, perhaps, naïve. In 2003, the economy is not booming and Congress’s eyes should be wide open.

The limits on price controls have apparently been inserted largely at the behest of the prescription drug industry, which generally supports the Medicare bill that Congress is likely to pass. Administration of the benefit through fragmented private insurance plans, with government keeping hands-off, is the approach urged by the pharmaceutical industry association. “[I]t is vital that this be structured properly—that is, through a choice of competing health plans. A government-run program will, inevitably, turn to price controls.”⁵

Awareness seems to be growing that even a meager Medicare prescription drug benefit—and one that includes high premiums and out-of-pocket payments by patients—will still require very large taxpayer subsidies.

The main reason Congress will have to spend so much to win so little benefit for Medicare beneficiaries is that its bill appears likely to pay very high prices for drugs and therefore to bestow very high profits on drug makers.

Possibly, Congress is poised to act in this way because there has been so little discussion of where the new federal money to pay for drugs will actually go if Congress does create a Medicare prescription drug benefit without cutting drug prices.

B. Medicare Drug Benefits: Calculating Drug Makers’ Profits

It is useful to follow the flow of federal dollars through several steps. We consider

1. the share of money lost to administration,
2. the division of the remaining dollars between old business and new business,
3. the share of the gross revenue on new business accruing to manufacturers,
4. the costs of providing the drugs to meet the requirements of the new business,
5. manufacturers’ profits on new business, and
6. offsetting reductions of their profits on old business.

Conservatively, we do not estimate the likely rise in drug makers’ profits on some other old business.

Some analyses require data for which no definite estimates are available. We offer plausible figures, and discuss how the results change with changes in key estimates.

Step 1—the appropriation. At this writing, Congress is widely expected to appropriate some \$400 billion in federal subsidy for the new Medicare prescription drug program to provide eight years of benefits starting in 2006.⁶

Step 2—the administrative share. Suppose that 5 percent (\$20 billion) of this money is absorbed in administering the new benefit. Some of this would be spent in overall program administration, some in traditional Medicare,⁷ some in the pharmacy benefits managers (PBMs) that will manage the benefit, and some in health maintenance organizations (HMOs) or preferred provider organizations (PPOs) that will probably have a role in delivering the benefit. Then, \$380 billion remains.

Step 3—old versus new business. Suppose that 40 percent of this remaining \$380 billion, or \$152 billion from Medicare, is used to buy drugs for patients who had previously used their own money or some other form of coverage. This is replacement spending, or a new way to pay for old business. It is discussed later, in **step 6**.

The 60 percent (\$228 billion in federal dollars) that remains is used to fill prescriptions that patients previously did not get. This is new spending on drugs, or new business—the money we will follow closely in **steps 4 and 5**. This \$228 billion is new revenue to the drug industry as a whole—that is, to drug makers, retailers, and wholesalers.

This report calculates drug makers' profit increase using several different assumptions about the split of added spending between old (replacement) purchases and new (additional) purchases. Please refer to Exhibit 3 for a systematic presentation. In the principal calculation performed in **steps 1-6**, 60 percent of the federal subsidy is expected to be used to purchase additional medications.

For clarity, it is worth noting that these additional federal dollars do not constitute a 60 percent rise in drug spending on Medicare patients. During the eight years from 2006 to 2013, baseline drug spending by or for Medicare beneficiaries is projected to be some \$1.76 trillion.⁸ Thus, the projected \$228 billion in federal dollars to buy new drugs over eight years would signal an increase in drug spending of 13.0 percent.

A substantial share of the federal dollars to subsidized the Medicare drug benefit can be expected to buy new drugs. Many Medicare beneficiaries suffer and die today for lack of needed drugs.

The unmet need for medications is very substantial.

Numerous recent surveys have found evidence of substantial unmet need for medications in the United States. (Although some of these surveyed adults of all ages, the problems found are doubtless greater among seniors, whose health problems are greater and rates of drug coverage are lower than in the under-65 population.)

A study in eight states, for example found that nearly one-fourth of seniors surveyed reported that because of high costs, they skipped doses of medication or failed to obtain prescribed drugs.⁹ In the same survey, chronically ill seniors who were uninsured for drugs skipped medications at rates 2-3 times higher than those who had drug coverage.

A November 2002 Harris poll found that surveyed adults reported these striking problems within the previous year:

- 18 percent—and 33 percent of those in fair or poor health—had failed to ask for prescriptions because of their cost
- 22 percent—and 41 percent of sicker adults—failed to fill a prescription because of the cost
- 15 percent—and 29 percent of sicker adults—took a lower dose to make it last longer
- 18 percent—and 37 percent of sicker adults—took a drug less often than prescribed to make it last longer.¹⁰

Caregivers also see these problems. Caregivers in safety-net hospitals and clinics also report substantial difficulty in helping patients who lack drug coverage obtain the medications they need, with health center pharmacies, in some cases, having to turn away patients when funding runs short.¹¹

We estimate that some 40 percent of some 40 million Medicare beneficiaries lack any prescription drug coverage in 2003, and that millions more are under-insured.¹² We fear, further, that this will worsen substantially by the time a new Medicare benefit takes hold—owing to cuts in retiree health coverage, Medi-Gap coverage, and Medicare+Choice coverage—but our calculations do not take this worsening into account.

Poisaal and Murray have shown that uninsured Medicare beneficiaries (both over-65 and disabled) spend far less on medications than do beneficiaries with any drug insurance.¹³ Relying on those spending differences, by age and disability, we have calculated that a Medicare prescription drug benefit that brought uninsured beneficiaries' spending up to that of insured beneficiaries would require some \$188 billion during the eight years from 2006 to 2013. This would all be new use. It is reasonable to expect that insured beneficiaries would also increase use of medications. This does not reflect the cost of bringing under-insured Medicare beneficiaries up to the spending levels of well-insured beneficiaries. Further, this ignores purchase of additional prescriptions by currently insured beneficiaries.

Step 4—drug makers' share of gross revenue on new business. What share of this additional \$228 billion in drug industry revenue goes to manufacturers? After deducting the shares of this revenue going to retailers and wholesalers, what remains is manufacturers' added gross revenue. It is added *gross* revenue because it does not yet reflect manufacturers' added costs of doing business.

Consider first the retail share. According to figures from the National Association of Chain Drug Stores (NACDS), retailers get 21.1 percent of payments made at retail,¹⁴ for pharmacies' costs of dispensing, inventory, and overhead, plus their net income. This figure allows for the various discounts that reduce drug prices for many Americans today, though it does not reflect manufacturers' rebates—such as those required by law to state Medicaid program or those paid through PBMs.¹⁵ The retail share covers pharmacists' dispensing, information systems, cost of carrying inventory, store overhead, profit, and the like.

Suppose that those discounts and rebates today average 15 percent of posted retail charges,¹⁶ and suppose further that the new Medicare drug benefit wins equivalent discounts through its PBMs, HMOs, and PPOs. The amount of the discount does not substantially affect these calculations, as long as we assume it is fairly similar to current discounts.¹⁷ It does not affect the calculations in this report because Medicare program funds saved through discounting is used to buy still more medications, and that saved money therefore flows according to the calculations set out here.

Also according to the NACDS, wholesalers take about 3.3 percent of the payments made at retail.

Together, the retailers' and wholesalers' share is about 24.4 percent.

Therefore, the drug manufacturers get the remaining 75.6 percent as gross income.

Step 5—drug makers' cost associated with new business. What share of the 75.6 percent is cost to drug makers?

Drug makers' costs don't change very much if they produce and sell more pills. To begin, marketing, administration, and research should not be expected to change very much when sales to Medicare patients grow.

There is no reason why drug makers should need to spend more on marketing when Medicare patients obtain drug coverage. Many Americans—and even some in the industry—may agree that the industry already spends more than enough on marketing.¹⁸

Research costs should not increase either. Today, drug makers say they need high prices to sustain research. They may respond to this report by claiming that they would use their vast new profits to conduct more research. But they have never hinted at any plan to vastly expand research when Medicare sends their revenues soaring. And there is no reason to assume that the drug makers should—or could effectively—expand their research budgets tremendously.

Few Medicare beneficiaries who seek a prescription drug benefit now expect that one of the benefit's main aims or consequences is to give drug makers more money that they would promise to use to finance research. Even if those promises were ultimately kept, such a use of scarce public funds should certainly be debated. Any additional substantial growth in drug research might better be used to expand research budgets at the National Institutes of Health. (Already, for example, developing “me-too” drugs consumes a large share—perhaps 40 percent—of industry-financed research.¹⁹)

Drug makers also say that they need high *profits* to sustain today's levels of research. But recall that profits are the sums left after all their costs—including research—are incurred. So profits do not finance research.

The only added costs for drug makers associated with a new Medicare prescription drug benefit are expected to be in manufacturing and in distribution—and these added costs are remarkably low.

Drug makers' manufacturing costs will rise only slightly to produce more medications. Drug makers' factories are already built, and the ingredients in most prescription drugs are inexpensive. So there will be a very small incremental cost to make the added volume of medications that newly covered Medicare patients will use. Estimates from industry sources are that the actual added cost of making additional pills is only about five percent of the undiscounted full retail price.²⁰ Since this full retail price paid under the new Medicare drug benefit is expected to be discounted by 15 percent, the manufacturing share is 5 divided by 85, or 5.9 percentage points.

In addition, drug makers might have to devote 2 percent of their actual revenues to cover the added cost of distribution.

Manufacturers' costs of the additional volume of drugs therefore sum to 7.9 percentage points. Manufacturers' gross revenues were 75.6 percentage points. Subtracting 7.9 from 75.6 leaves 67.7 percent in the hands of manufacturers as net revenue or profit.

This means that fully 67.7 percent of the \$228 billion Medicare dollars that will be spent to buy more prescriptions remains in the hands of drug makers, as profits. This is an increase in profits of \$154.4 billion over eight years.

But that is not the entire story. Drug makers can, at the same time, be expected to suffer a moderate reduction in profit on old business.

Step 6—offsetting profit reduction on old business. Against this rise in drug makers' profits on new business, it is necessary to offset reduced profit on the medications they had formerly sold at full retail price. This calculation begins with the estimated 40 percent of the Medicare prescription drug benefit, or \$152 billion, as calculated in **step 3**, that goes to old drugs.

Suppose that one-third of this money replaces drugs previously bought through Medicare + Choice HMOs, retiree health plans, or other vehicles, and suppose that those drugs were bought at the average 15 percent discount used throughout this report. And suppose further that the remaining two-thirds of this money replaces drugs previously bought by patients out-of-pocket at no discount. The drug makers' loss of profit, *initially*, would be 15 percent of two-thirds of \$152 billion, or \$15.2 billion.

Of course, the savings would be used under the new Medicare drug benefit to buy still more needed drugs, so the actual loss in drug maker profit is substantially less than the \$15.2 billion estimated here. Thus, this report likely underestimates drug makers' profit

gains from Medicare because those recouped profits are not estimated in steps 1-6 though they are briefly considered later, as one of the sensitivity analyses.

If we subtract the offsetting decline of \$15.2 billion from the \$154.4 billion increase in profit calculated in **step 5**, drug makers' net increase in profit is \$139.2 billion over the eight-year early life of the program.

This rise in drug makers' profit of \$139.2 billion constitutes fully 61.1 percent of the Medicare dollars used to buy additional prescription drugs for patients previously unable to afford them.

The calculations made in the above six steps are summarized in Exhibit 1, which follows.

Exhibit 1

Calculating Net Profits to Drug Makers from a \$400 Billion Federal Expenditure to Support a Medicare Prescription Drug Benefit

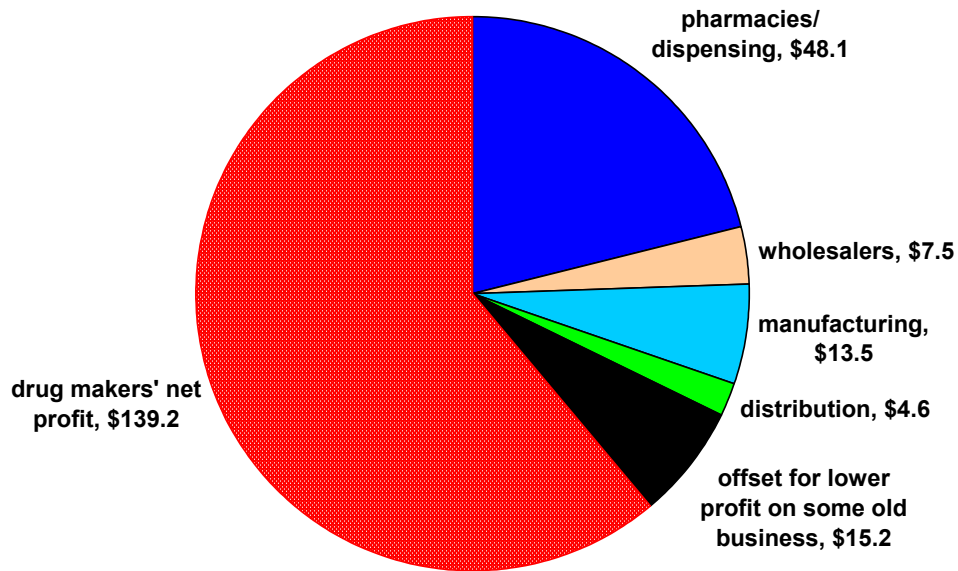
60 Percent of Dollars Buy New Drugs and 5.9 Percent Incremental Manufacturing Cost

Element of the calculation	share	\$ billion
<u>1. New federal dollars</u>		\$400.0
<u>2. Share to administration</u>	5.0%	\$20.0
Net federal dollars to buy drugs		\$380.0
<u>3. Old business (replacement) share of federal dollars</u>	40.0%	\$152.0
Net federal dollars to buy new drugs		\$228.0
<u>4. Drug makers' share of gross revenue on new drug business</u>		
Subtract retailers' share	21.1%	\$48.1
Subtract wholesalers' share	3.3%	\$7.5
Equals drug makers' share of gross revenue	75.6%	\$172.4
<u>5. Drug makers' cost associated with new business</u>		
Subtract manufacturing costs - % of new drug gross revenue	5.9%	\$13.5
Subtract distribution cost - % of new drug gross revenue	2.0%	\$4.6
Equals drug makers net revenue on new drug business	67.7%	\$154.4
<u>6. Offsetting reduction in profits on old drug business</u>		
Share of old drugs previously bought at no discount	66.7%	\$101.3
New discount on old drugs previously bought at no discount	15.0%	
Reduction in profit previously garnered on old drugs		\$15.2
Added profit on new business less lower profit on old business		\$139.2
Net added profit as % of federal spending to buy new drugs	61.1%	

A second exhibit displays the shares of the projected \$228 billion in new drug spending from Medicare that are expected to go to various objects, leaving over three-fifths of the money as drug makers' net profit.

Exhibit 2

**WHERE THE MEDICARE DOLLARS GO:
PROFITS AS A SHARE OF SPENDING ON NEW DRUG PURCHASES
\$ Billion**



C. Sensitivity Analysis

1. Projected new/old split and incremental manufacturing cost

New/old split. The calculated rise in drug makers' profits is fairly sensitive to the split of the additional \$400 billion between dollars used to buy new drugs and dollars used to replace (or substitute for) present purchases of drugs.

At the same time, it is worth noting that this report's focus on incremental drug maker profits associated with new business is not intended to downplay or justify drug makers' existing profits on old business. Therefore, if a large share of the \$400 billion in federal dollars to support the new Medicare drug benefit goes to replacing today's out-of-pocket or private insurance spending, the new federal dollars have the effect of sustaining drug makers' prices on that old business—and therefore also their profits—albeit perhaps at slightly reduced rates (depending on the level of discounts obtained by plans offering the new benefit).

That is, the report’s focus on drug makers’ profits garnered on new business should not be taken as an endorsement of the use of federal funds to sustain drug makers’ profits on old business.

Incremental manufacturing cost. The calculated rise in profits is somewhat less sensitive to projected cost of manufacturing additional drugs than it is to the share of federal dollars used to fill new prescriptions.

Exhibit 3 shows how projected profits vary with the projected new/old split and with incremental manufacturing costs.

Exhibit 3

Drug Makers’ Rise in Net Profits Varies with Share of Dollars Buying New Drugs and with Incremental Manufacturing Cost

Profits in \$ Billion

Incremental Manufacturing Cost	Share of Dollars Spent to Buy New Drugs				
	40%	50%	60%	70%	80%
5.9%	\$80.1	\$109.6	\$139.2	\$168.7	\$198.2
7.5%	\$77.7	\$106.6	\$135.5	\$164.4	\$193.3
10.0%	\$73.9	\$101.8	\$129.8	\$157.8	\$185.7
12.5%	\$70.1	\$97.1	\$124.1	\$151.1	\$178.1
15.0%	\$66.3	\$92.3	\$118.4	\$144.5	\$170.5

Note: The \$139.2 billion in profit that is **boldfaced** in Exhibit 1 is the figure that was calculated earlier in steps 1-6. It rests on projections that 60 percent of the \$380 billion in new federal dollars used to buy drugs will be employed to buy new drugs and that incremental manufacturing costs are 5.9 percent of payments made at retail.

2. Factors not considered in this analysis

Use of Medicare funds to sustain profits on old business. As noted earlier, this report focuses on profits that drug makers can be expected to receive on new business—higher volumes of drugs—in response to the new Medicare drug coverage. The report does not track the path of the federal dollars that replace private spending on old drugs, dollars that would have the effect of sustaining drug makers’ prices and profits at fairly high levels.

Shift of Medicaid patients to Medicare. This could well raise the drug makers' profit share somewhat higher. The conference committee has tentatively agreed that poor people who are protected by both Medicare and Medicaid ("dual eligibles") would receive drug coverage through Medicare rather than continuing to receive it through Medicaid.²¹ Even though this is an important change—some 60 percent of Medicaid's total drug spending (60 percent of some \$23 billion in 2003, for example) finances medications for dual eligibles—we do not attempt to estimate here the effect of a possible resulting shift of many prescriptions to Medicare from Medicaid.²²

There has been little public discussion of the prices that would be paid for medications for people who are dually eligible. But industry analysts suggest that this shift would "significantly reduce the impact of Medicaid rebates and preferred drug lists...."²³ Neither bill has any provisions for comparable price cuts to be achieved by the fragmented purchasing of the many new drug insurance plans under Medicare. So there may be a substantial *rise* in the prices paid on behalf of patients dually eligible for Medicare and Medicaid—and that would boost drug makers' profits still further.

Shift of other patients' drug financing to Medicare. Similarly, we do not attempt to estimate here the effects on manufacturers' profit of shifts of patients from programs and agencies that receive steep federal government price discounts (such as the Veterans Administration and community health center pharmacies) to Medicare. Were such shifts to take place, drug makers' profits would rise substantially.

Medicare patients' use of drug makers' own pharmaceutical assistance programs would also probably decline when the patients can receive drug coverage through Medicare. This means the drug makers will start receiving Medicare plan payments for medications that today they are giving away. Some drug maker discount card programs also now offer to fill prescriptions for low-income patients at very low (and in some cases, flat) prices. Many or all of these payments, too, would likely be replaced by higher payments from Medicare, further boosting industry profits.²⁴

Recovering diminished profits on old business. In the calculations presented in this report, the \$15.2 billion in diminished profits on old business (calculated in **step 6**) were assumed, for conservatism and simplicity, to be lost to drug makers entirely.

But this is not really true. In a Medicare drug benefit, it can be expected that reduced prices will spur purchase of a higher volume of prescription drugs. Thus, even if the new benefit means that the industry sells fewer drugs at full retail price, the resulting savings to buyers—diminished profits to the industry—would be recycled to buy more medications, used just like the original \$400 billion in federal subsidy. On the first round of recycling, \$5.3 billion of this sum accrues to drug maker profit. Successive rounds would add sharply diminishing sums. It therefore appears that the drug makers would recoup as profit at least one-third of the \$15.2 billion in profits that they would initially lose on old business.

Profits on premiums. Medicare beneficiaries who elect to sign up for the new drug program are expected to pay some \$420 annually in premiums. Suppose that only one-half of beneficiaries sign up for the new benefit, or roughly 20 million Americans. That

would generate some \$8.4 billion in premiums annually. Even supposing that premiums are frozen, total premiums over eight years would total \$67.2 billion. (Eight years is the period covered by the \$400 billion in federal subsidy.)

Carrying this \$67.2 billion through steps 1 through 6, as done earlier with the federal share, yields an additional \$23.4 billion in profit to drug makers.

Expected net additions to profits. The sum of profits on premium dollars and recovered diminished profits on old business is \$28.7 billion, equal to an additional 20.6 percent of the \$139.2 billion. This makes a total increase in drug maker profits of \$167.2 billion over eight years.

D. Comments

Since the drug makers will be paid prices that are similar to those they charge today, huge windfall profits would accrue to the drug industry—already the nation’s most profitable.²⁵

1. Meager benefits

This rise in profits contrasts substantially with the fairly scanty benefits that Medicare patients are likely to gain under the new program.

Using the Kaiser Family Foundation’s cost calculator,²⁶ we have compared an individual’s out-of-pocket drug spending with and without a new benefit. Viewed from the standpoint of improving beneficiary well-being, the results are not impressive until spending rises fairly high.

According to the Kaiser Family Foundation, “The typical senior will have an estimated \$3,160 in total drug expenses in 2006.”²⁷ Patients in this range would still pay over \$2,000 out-of-pocket, according to this calculator, under both S.1 and H.1. Please refer to Exhibit 4, on the next page, for additional income groups.

The House bill would leave higher-income Medicare beneficiaries with substantially higher out-of-pocket costs than those shown here.

Exhibit 4

**Out-of-pocket Spending on Prescription Drugs
with and without a New Medicare Drug Benefit**

Current out-of-pocket spending	S.1 Out-of-pocket spending	H.1 (income under \$60,000) Out-of-pocket spending
\$1,000	\$1,057.50	\$ 820
\$2,000	\$1,557.50	\$1,020
\$3,000	\$2,057.50	\$2,020
\$4,000	\$2,557.50	\$3,020
\$6,000	\$4,138.75	\$3,920
\$8,000	\$4,338.75	\$3,920
\$10,000	\$4,538.75	\$3,920

2. The percentage rise in drug makers' profits

If we consider only the \$139.2 billion rise in projected drug maker profits calculated in steps 1-6 (and ignore the recouped profits on old business and profits on premium dollars), how much do drug makers' projected profits rise as a percentage of baseline profits?

It is difficult to project baseline drug industry profits for the eight years beginning in 2006. They might rise or fall. It is even somewhat difficult to specify drug makers' current profits *on drug-making*, industry-wide.

We begin with *Fortune's* reported 2002 profits of the ten largest drug makers, \$35.9 billion.²⁸ This figure includes all profits of these ten prescription drug makers, including money they earned in other—often lower-margin—lines of business. For example, Merck's profits include those of its PBM, Merck-Medco. (Thus, the often-cited company-wide return on revenue figures are, for some drug makers, noticeably lower than returns on prescription drug sales alone.²⁹) But this *Fortune* figure excludes profits of all other drug makers. For convenience, let us assume that this inclusion and exclusion cancel out one another. If this is correct, all drug makers' 2002 profits on drug-making alone totaled \$35.9 billion.

We then assume that profits rise by 6 percent annually from 2002 to 2006. Profits on drug-making in 2006 would then be \$45.3 billion.

If we take projected profits on new Medicare prescriptions of \$139.2 billion over eight years, as calculated here, then annual new profits equal \$17.4 billion. We then divide this yearly \$17.4 billion in projected additional profit by the projected baseline yearly profit of \$45.3 billion. We find that the ***new prescriptions filled under the Medicare drug benefit as now proposed, with unrestrained prices, could increase drug makers' annual profits by 38.4 percent.***

3. *Living on borrowed money and borrowed time*

Creating so scanty a public benefit for patients while allowing so large a rise in private profit is surprising—particularly at a time of massive budget deficits and massive trade deficits. It appears that Congress intends to borrow from our children and grandchildren—dollars they will have to repay tomorrow—to bestow large new profits on drug makers today.

In 2003, the United States' estimated net deficit in exports of goods and services was \$495.9 billion.³⁰ In fiscal year 2003, the United States' federal deficit was an estimated \$374.2 billion.³¹ Adding these two deficits together yields \$868.3 billion. Estimating 2003 gross domestic product at \$10.85 trillion, these two deficits together amount to 8.0 percent of the economy—nearly one-twelfth of the economy—an alarming figure.

Amidst this economic crisis, a gift to the drug makers of \$139.2 billion in higher profits cannot be what the taxpayers wish—or what a careful Congress would intend to do. The nation would be squandering our money on enriching the world's most profitable industry, amidst continued squalor and suffering for the sick people counting on Medicare to protect them.

Some point to a recent dip in drug maker profits and express the hope that Medicare will buttress or restore those profits.³² This is not the best possible use of increasingly scarce public funds. But if an objective of the Medicare prescription drug benefit is to protect or enhance drug makers' profits, the desirability of this objective and the cost of reaching it should be debated publicly.

4. *Stop-Gap Solution: A Windfall Profits Tax*

One option for preventing unwarranted profits would be a windfall profits tax.

This tax could be applied, for example, to all profits exceeding a firm's previous level, or to all profits exceeding an established uniform standard for reasonable profit.

Such taxes have a long history in the United States. The U.S. had excess profit taxes to prevent profiteering on stepped up government spending and wartime production during and after World War I, World War II, and the Korean War. These were steep taxes that at times reached 95 percent of profits above defined levels. A crude oil windfall profits tax was adopted in 1980, and not phased out completely until 1993.³³ And in the past few years there has been visible discussion of reviving a tax on windfall energy profits.

Recent support for a windfall profits tax on pharmaceutical makers has come from health professionals,³⁴ state legislators,³⁵ and some members of Congress.³⁶

A related approach is used in the United Kingdom, which has set a cap on allowable pharmaceutical profits. Unlike most other developed nations, where government and national health plans negotiate or set drug prices, the U.K. has allowed drug makers substantial freedom to set their own prices, within the constraints of the profit cap.

A windfall profits tax would only be a stop-gap. The funds raised could be used to help finance the Medicare drug benefit. The tax therefore would recoup for the public good most or all of the sums paid to drug makers far beyond their actual costs—un-earned sums that they will garner if prices are unrestrained. And by taxing away income above certain levels, it would deter drug makers from setting such high prices.

Drug makers may protest that they are facing increasing price pressure and that their recent profit reports are not as positive as in past years. But their profits are still among the highest of any industry, and a Medicare windfall would carry them much higher still.

5. Affordable Drugs for Medicare and for All Americans

Further effort is needed to build a durable foundation for affordable medications for Medicare patients and all Americans. High drug prices are the major source of soaring U.S. drug spending and therefore the major reason why patients are paying so much to fill prescriptions (if they can pay) or suffering for lack of needed drugs (if they can't pay). By high prices, we include both price increases on existing drugs and marketing of new drugs with little or no added clinical benefits—drugs that replace older, equivalent, and much cheaper drugs.

High drug prices are therefore both the main source of pressure to enact a Medicare drug benefit and the main reason why any bill that Congress is likely to pass will be at once so skimpy to patients and so profitable to drug makers.

Deep price cuts are therefore essential to ensuring access to needed medications. Deep price cuts—and the volume increases that will result—are also vital to ensuring durable profits and research financing. But a more comprehensive approach is required.

Paying drug makers for the added volume of medications at their low actual cost of production would be one vital element of any plan to provide a Medicare prescription drug benefit without yielding windfall profits—and also without harming drug makers' profits, or their capacity to finance research. It is vital to any Medicare drug benefit program that meets patients' needs while remaining affordable for taxpayers.³⁷

6. Prescription Drug Peace Treaty

Prescription drugs can and must be made affordable for all Americans, though, using similar methods. (Much of this could also be achieved through strategic reforms in individual states.) What's essential, to meet the needs of patients, of taxpayers and others who pay for prescription drugs, *and of drug makers*, is a prescription drug peace treaty.³⁸ Drug prices would be sharply cut for all Americans, under federal law. If nothing else changed, drug makers' revenues and profits would fall substantially. But two things do change.

First, lower prices will raise private sales volume substantially as prices fall, offsetting much or most of the price cut's effects on industry revenues and profits.

Second, the peace treaty would guarantee that expanded public programs replace any remaining revenue and profit loss by subsidizing drug purchases for patients who can't afford even the newly discounted prices.

Public funds would also pay manufacturers' actual added cost of making more pills, and pharmacies' added dispensing cost—an estimated total of around \$10 billion yearly. This could finance a one-third rise in prescriptions to address today's unmet need.

Under this treaty, drug makers fill all doctors' prescriptions for all Americans, and drug makers' own profits and ability to finance research are preserved.

This treaty requires trust among drug makers, public and private payers, patients, and voters. It requires public leadership and also abandonment of fantasies that the market can somehow win affordable drugs for all, adequate research funding, and sustainable profits. Drugs' patent monopolies and other obstacles hinder creation of a free market.

A central element of the peace treaty is that lower prices would benefit drug makers as well as patients and payers. Drug makers would shift to a business plan based on lower prices and higher volume from their current business plan of high prices combined with limits on use.³⁹ This will benefit drug makers in the long run—and even in the mid-run—as their current business plan—resting on both high prices and very rapid revenue growth—is absolutely not sustainable.

Over the longer term, as we have described elsewhere, other reforms are also needed to foster innovation (rather than copycat research), to provide caregivers and patients with reliable information on drugs' relative effectiveness and cost, and to fairly allocate drug costs internationally, by nations' abilities to pay.⁴⁰

These steps are not only essential to win adequate and affordable coverage today, they are our obligation to future generations. If Medicare continues to pay high prices, the enormous sums that we would be choosing to throw away in windfall profits for drug makers would not even be our money. Given the size of the federal deficit, the federal government's share of the cost will all be borrowed—borrowed from our grandchildren.

The proposals now before Congress would increase the deficit to enrich drug manufacturers while leaving seniors struggling. Both the House and Senate bills intentionally diffuse Medicare's buying power in order to preclude substantial discounts.

Instead, let us allow government to act, to hold back the windfall. If we do, we can affordably provide comprehensive drug coverage for sick and vulnerable Medicare patients—and indeed all Americans—while protecting drug makers' current profits and their ability to finance research.

The drug industry is committed to a regime of high prices and sustained rapid revenue growth as a vehicle for financing profits and research, and appears likely to obtain a Medicare drug bill that fosters those aims. Were this bill to pass, it would offer substantial short-term benefits to the industry, as discussed in this report, but these short-term benefits would sustain the industry's business model of high prices and rapid revenue growth in the United States for only a few more years. Indeed, this business model is not sustainable. Depending on revenue growth that doubles every five – six years is not a durable method of protecting research, profits, or stock prices. The drug

industry should re-think every aspect of its present business model—pricing, research financing, marketing, and the rest.

For the nation, the main choice is among suffering and dying for lack of needed drugs, paying much more, and reform. Congress and the drug industry can shape a bill that addresses the core needs of patients, payers, and the industry. They have not yet done so.

NOTES

¹ *Webster's New World Dictionary*.

² "President Calls on Congress to Complete Work on Medicare Bill," Remarks by the President, 29 October 2003, www.whitehouse.gov/news/releases/2003/10/20031029-1.html.

³ Pharmaceutical Research and Manufacturers Association, "PhRMA Praises Senate and House for Crucial Step," press release, 27 June 2003, www.phrma.org.

⁴ In H.R.1, Title VIII - MEDICARE BENEFITS ADMINISTRATION, Sec.801, creating new section 1809 of Social Security Act, see 1809 (c)(1) (D).

⁵ Alan F. Holmer, "How Can We Not Afford Prescription Drugs in America?" 24 January 2003, www.phrma.org

⁶ Although widely-cited estimates of the legislation's cost cover 10 years (2004-2013), the drug benefit would not start until two years later. Only about \$1 billion is anticipated to subsidize a "transitional" drug discount card program before then. Congressional Budget Office Cost Estimate, H.R.1 and S.1, 22 July 2003, p. 4, Table 1, and p. 22, [ftp://ftp.cbo.gov/44xx/doc4438/hr1s1.pdf](http://ftp.cbo.gov/44xx/doc4438/hr1s1.pdf).

⁷ Medicare's own added administrative costs are estimated at \$10 billion. Congressional Budget Office Cost Estimate, H.R.1 and S.1, 22 July 2003, p. 6-7, and Table 2, [ftp://ftp.cbo.gov/44xx/doc4438/hr1s1.pdf](http://ftp.cbo.gov/44xx/doc4438/hr1s1.pdf)

⁸ Dan L. Crippen, Director, Congressional Budget Office, "CBO Testimony before the Committee on Finance, U.S. Senate, 7 March 2002, table 3. The CBO estimates go through 2012. We project 2013 baseline spending at \$312 billion.

⁹ Dana Gelb Safran and others, "Prescription Drug Coverage and Seniors: How Well Are States Closing the Gap?" *Health Affairs*, 31 July 2002, posted at www.healthaffairs.org

¹⁰ Harris Interactive, "Higher Out-of-Pocket Costs Cause Massive Non-Compliance in the Use of Prescription Drugs," 9 December 2002, www.harrisinteractive.com

¹¹ Suzanne Felt-Lisk et al., "Monitoring Local Safety-Net Providers: Do They Have Adequate Capacity?" *Health Affairs*, September/October 2002, p. 277, 280.

¹² Mary A. Laschober, Michelle Kitchman, Patricia Neuman, and Allison A. Strabic, "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999," *Health Affairs*, web exclusive, 27 February 2002.

¹³ John A. Poisal and Lauren Murray, "Growing Differences between Medicare Beneficiaries with and without Drug Coverage," *Health Affairs*, Vol. 20, No. 2 (March/April 2001), pp. 74-85.

¹⁴ The National Association of Chain Drug Stores estimated that in 2002, manufacturers received 75.6 percent of the retail cost of prescription drugs, the wholesalers 3.3 percent, and retailers 21.1 percent. "Industry Facts-at-a Glance," <http://www.nacds.org/wmspage.cfm?parm1=507>, accessed 23 October 2003.

¹⁵ Laura Miller, Senior Economist, National Association of Chain Drug Stores, personal communication, 28 October 2003.

¹⁶ For a discussion of rates of discounts and rebates, please refer to Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable for All and to Protect Research, with State-by-State Savings*, Boston: Health Reform Program, Boston University School of Public Health, 5 October 2000, pp. 43-45, www.healthreformprogram.org.

¹⁷ And that is reasonable, given the handcuffs that the bill is expected to place on public efforts to regulate drug prices.

¹⁸ Remarkably, even some drug industry officials have begun questioning the value of the nearly 90,000-strong drug sales force in the U.S. For example, the *Wall Street Journal* recently quoted the CEO of Glaxo saying, "Is it necessary? No, but if my competitor can [reach physicians more quickly] ... I'm at a disadvantage. This has been an arms race in the worst possible manner." Similarly, Merck's CEO said, "Having more sales reps ... is not a source of competitive advantage." (Scott Hensley, "As Drug-Sales Teams Multiply, Doctors Start to Tune Them Out," *The Wall Street Journal*, 13 June 2003.)

Many in the general public view marketing as a major driver of prescription drug costs. For example, 30 percent of adults in an April 2003 *Wall Street Journal*/Harris poll thought that marketing and advertising cost contributes the *most* to drug prices; 42 percent blamed profit margins, while just 23 percent pointed to the cost of medical research. ("Prescription Drug Price Controls Seen as Healthy Solution," *WSJ Online/Harris Interactive Health-Care Poll*, *Wall Street Journal Online Edition*, 13 May 2003, <http://online.wsj.com/article/0,,SB105242316813321800,00.html>)

¹⁹ Industry analyst DiMasi has estimated that some 40 percent of pharmaceutical industry-financed research aims to develop me-too drugs. As cited by Merrill Goozner, "The Price Isn't Right," *The American Prospect*, Vol. 11, No. 20, 11 September 2000, <http://www.americanprospect.com/archives/V11-20/gozner-m.html>. Goozner also reports that "FDA statistics for the 1990s suggest that about half of the industry research is aimed at developing me-too drugs."

²⁰ How can this be so low? First, because producing the medications consumes a relatively small share of the average manufacturer's total revenues. In 1999, for example, only 32 percent of six large drug makers' revenues, on average, was devoted to acquiring raw materials and to manufacturing drugs. (See Alan Sager and Deborah Socolar, *Affordable Medications for Americans*, Report for the Prescription Drug Task Force, United States House of Representatives, 27 July 1999, Exhibit 11, <http://www.house.gov/berry/prescriptiondrugs/Resources/sager.pdf>.) As this is the

average cost, which includes substantial fixed costs for engineering, equipment, and workers, then the marginal cost of producing additional volumes will be substantially lower.

The low apparent marginal cost of the antibiotic Cipro was revealed in the widespread discussion of the federal government's purchase of a large supply after the anthrax scare. See, for example, comments of Agnes Varis, president of Agvar Chemicals, cited in Keith Bradsher, "Bayer Halves Price for Cipro, but Rivals Offer Drugs Free," *The New York Times*, 26 October 2001, <http://www.nytimes.com/2001/10/26/business/26CIPR.html>; and William Haddad, CEO of United States Research and Development Corp., cited in Gardiner Harris, "Bayer's Cipro Will Be Profitable, Even on Discount Deal With U.S.," *Wall Street Journal*, 26 October 2001. See also Deborah Socolar and Alan Sager, "Windfall Profits Despite Discounted Price," 28 June 2002, Boston: Health Reform Program, Boston University School of Public Health, www.healthreformprogram.org

The president of Merck has dismissed attention to "the marginal cost – the cost of making the pill at the end of the process – which is a tiny percent of the total cost" – but when drug makers' volume is rising, that is the relevant cost figure. (Edward Scolnick, as quoted in Jeff Evans, "Merck research chief tells why drug costs are so high in U.S.," http://www.news.cornell.edu/Chronicle/01/2.15.01/Scolnick_cover.html)

Costs of raw materials are typically very low. One report noted that the vital ingredient for Xalatan, a successful medication to prevent glaucoma, costs only about one percent of annual sales. (Jeff Gerth and Sheryl Gay Stolberg, "Medicine Merchants: Birth of a Blockbuster; Drug Makers Reap Profits on Tax-backed Research," *New York Times*, 23 April 2000.) See also, for example, Elyse Tanouye, "U.S. Develops Expensive Habit With Drug Sector Growth Spurt," *Wall Street Journal*, 16 November 1998, stating, "the cost of raw materials runs only a few cents in pills that often sell for up to \$15 apiece."

Second, private conversations with managers of drug factories have supported the 5 percent figure.

Third, prices set by manufacturers of generic drugs are very much lower than those set by manufacturers of brand name drugs. A Mylan executive, for example, asserted that her company sold two-fifths of its 104 products at prices equal to 10 percent or less of the prices charged by brand name manufacturers. (Patricia Sunseri, "FTC Antitrust Complaint vs. Mylan," 23 December 1998, www.genericaccess.com/info.html.) This, too, suggests that drug makers' marginal costs are very low.

Finally, why is so much of the evidence offered here for drug makers' low marginal costs essentially anecdotal? Because drug makers' vigorous insistence that all such information is proprietary has made available very little systematic evidence on the pharmaceutical industry's internal cost structure. Legislation requiring the industry to open its books, and hearings exploring evidence under subpoena appear essential in the wake of the Supreme Court's *Bowsher vs. Merck* decision in 1983 which said that the federal government could not require drug manufacturers to disclose whether or not they were making a profit on their discounted sales to the Veterans Administration.

²¹ Sarah Lueck, "Panel Agrees on Drug Coverage for Poor in Medicare, Medicaid," *The Wall Street Journal*, 2 October 2003.

²² The CBO estimated that, by 2013, the House bill's approach would save \$99 billion from Medicaid and other federal drug spending, because dually-eligible patients would have their prescriptions covered by Medicare instead. But the CBO does not appear to estimate the higher costs likely to be incurred if these prescriptions can no longer benefit from Medicaid's "best price" provisions. Congressional Budget Office Cost Estimate, H.R. 1 and S. 1, 22 July 2003, p. 7, Table 2, and p. 14, <ftp://ftp.cbo.gov/44xx/doc4438/hr1s1.pdf>.

²³ "Medicare Rx Agreement Nears; Bill Looks Good for Pharmaceutical Firms," *The Pink Sheet*, Vol. 65, No. 043 (27 October 2003), p. 3.

²⁴ See, for example, Julie Appleby, "Lilly offers prescription card to low-income seniors," *USA Today*, 5 March 2002, <http://www.usatoday.com/money/health/2002-03-05-lilly-rx-card.htm>. (In this case, as the article notes, Lilly garnered much publicity for offering \$12 monthly prescriptions to patients who, under another Lilly program, were eligible already to receive their medications for free.)

²⁵ See, for example, analysis of Fortune 500 data in Public Citizen Congress Watch, *Drug Industry Profits: Hefty Pharmaceutical Company Margins Dwarf Other Industries*, Washington: Public Citizen, June 2003, http://www.citizen.org/documents/Pharma_Report.pdf.

²⁶ <http://www.kaisernetwork.org/static/kncalc.cfm>

²⁷ Kaiser Family Foundation, Medicare and Prescription Drug Chartpack, June 2003, <http://www.kff.org/content/2003/6087/6087v4.pdf>.

²⁸ *Fortune*, 17 April 2003.

²⁹ For example, Merck reported a before-tax return on revenue of 26.3 percent for 1999, including revenue and profit on Medco. But on its prescription drug business alone, we calculated, Merck garnered a before-tax return on revenue of 37.4 percent. (Alan Sager and Deborah Socolar, "Prescription Drug Spending is Already Enough to Buy All the Drugs All Americans Need," American Public Health Association Annual Meeting, 13 November 2000.

³⁰ Bureau of Economic Affairs, "Gross Domestic Product: Second Quarter 2003 (Final)," *BEA News*, BEA 03-3 (26 September 2003), Table 3. This is the average of the first two quarters of 2003.

³¹ Sue Kirschoff, "Federal Deficit Hits Record \$374.2 Billion," *USA Today*, 21 October 2003.

³² See, for example, "Medicare Rx Agreement Nears; Bill Looks Good for Pharmaceutical Firms," *The Pink Sheet*, Vol. 65, No. 043 (27 October 2003), p. 3; and Vanessa Fuhrmans, "Change Could Be an Upper for Pharmaceutical Industry," *Wall Street Journal*, 11 July 2003.

³³ Jerry Tempalski, "Revenue Effects of Major Tax Bills," Office of Tax Analysis, U.S. Department of the Treasury, December 1998, appendix, page 11, www.taxfoundation.org/Historical/RevenueEstHistory.pdf

³⁴ A leader in the pharmacy industry proposed the idea to us 7-8 years ago. The American Public Health Association supports use of an excess profits tax as one legitimate strategy for reducing pharmaceutical prices. (APHA Policy Statement 20006: "Making Medicines Affordable: The Price Factor," position paper, adopted 15 November 15 2000, http://www.apha.org/legislative/policy/Pols2000_rev.pdf)

³⁵ For example, bill 5225 proposed in the Connecticut General Assembly in 2003 by State Representative Patricia Dillon would use "a windfall profits tax on pharmaceutical companies" to help finance the state's pharmaceutical assistance program.

³⁶ See, for example, U.S. Representative Pete Stark, "Saving Medicare – Statement before the Subcommittee on Health, Committee on Ways and Means," 28 February 2001.

³⁷ See, for example, Alan Sager, "Crafting an Affordable Medicare Prescription Drug Benefit: Lessons from the Veterans Administration Experience," U.S. House Government Reform Committee, Subcommittee on National Security and Veterans Affairs, 22 July 2002. Such an alternative approach is also sketched in Alan Sager and Deborah Socolar, "New Strategies Can Finance an Affordable and Comprehensive Medicare Drug Benefit," *Pharmacists Planning Service Inc. Newsletter*, Winter 2004, p. 6. Both are posted at www.healthreformprogram.org.

³⁸ See, for example, Alan Sager, "Provisions of a Prescription Drug Peace Treaty," 10th Annual Invitational Conference on Pharmaceutical Costs, Tucson, 30 January, 2002; Alan Sager, *Americans Would Save \$38 Billion In 2001 If We Paid Canadian Prices For Brand Name Prescription Drugs: How to Win those Savings and Use Them to Protect All Americans against High Drug Costs without Hurting Drug Makers or Drug Research*, testimony to U.S. Senate Commerce Committee, Subcommittee on Consumer Affairs, 5 September 2001; Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty--Cutting Prices to Make Prescriptions Affordable for All and to Protect Research—with State-by-State Savings Estimates*, Boston: Health Reform Program, Boston University School of Public Health, 4 October 2000, all posted at www.healthreformprogram.org

³⁹ See Alan Sager and Deborah Socolar, "Lower U.S. Prescription Drug Prices Are Vital to Both Patients and Drug Makers, But Instead, U.S. Prices Have Been Rising Rapidly Relative to Those in Other Wealthy Nations," Boston: Health Reform Program, Boston University School of Public Health, 24 July 2003, www.healthreformprogram.org.

⁴⁰ See, for example, Alan Sager, "Protecting Consumers Completely and Rewarding Drug Makers Fairly: A Prescription Drug Peace Treaty for the U.S.A.," Trans-Atlantic Consumer Dialogue on Intellectual Property, Washington, D.C. 1 November 2002, www.healthreformprogram.org; Alan Sager and Deborah Socolar, "Do Rx drugs cost too much? The market needs a peace treaty," *Business and Health*, October 1997.