

America's Real Drug Problem

Pharmaceuticals have replaced hospitals as Americans' prime health worry

BY ROBERT WORTH

FRANK AND LOIS DEZELICH NEVER CONSIDERED themselves poor. Frank worked in construction and building insulation all his life, and when they retired they built their own home in Bedford, Va. Then Frank had a stroke, and lost his speech and became paralyzed on one side. Medicare, the federal program to insure the elderly against the high cost of medical care, paid for most of his hospital expenses. But after he came home he had to start taking six different medications, to control his seizures and ulcers, keep his muscles from knotting up, and to manage other side effects of the stroke. Neither Medicare nor the "Medigap" supplements Frank and his wife pay for covers the cost of prescription drugs. And that cost is astronomically high. Soon after Frank returned from the hospital, Lois was paying over \$400 a month for drugs alone, plus a variety of other medical supplies that weren't covered. All together, she was putting over half of their monthly income into health care—and she had a daughter and granddaughter to support too.

In theory, people like Lois and Frank can switch to one of the three Medigap plans that does cover drugs. But when Lois tried, she was denied because of Frank's "pre-existing condition." Meanwhile, the price of Frank's drugs is going up, and Lois is worried that soon she won't be able to afford them. "The hardest part is not knowing whether he's going to get his medication," she says. "I'm on the phone with the pharmacy almost every day to try to get free samples. I don't know where to turn to. And others have even less money than I do. How are they surviving?"

It's a good question. When Medicare was enacted in 1965, the elderly were worried about hospital costs, not drugs. Few Americans had retiree health benefits, and a serious illness could destroy their savings and leave them destitute. Medicare helped to solve that problem by paying for the bulk of hospital costs. But

since then "there's been a dramatic shift in the locus of care," says Dr. Philip Lee, who was assistant secretary of health under Lyndon Johnson, and who headed Johnson's Task Force on Prescription Drugs. "Back then, when you were really sick you went to the hospital. Now much more care of chronically ill people happens at home, with drugs. It's in a site where the patient pays for it, as opposed to being covered by insurance in a hospital." There's also a great deal more drug-based preventive care, designed to treat risky conditions like high cholesterol and hypertension before they land people in the hospital.

These new drugs have improved the lives of the elderly immeasurably. But many cost thousands of dollars a year, and the prices are rising. Drug costs rose at four times the rate of inflation last year, and they have grown almost as fast for most of the past two decades. Partly for that reason, drugs are the fastest-growing share of health costs, rising at almost four times the rate of hospital spending. In one Boston-based private health care plan, outpatient expenditures rose from 7 percent of all expenditures in 1994 to 13 percent in 1997, and are projected to overtake hospital costs (about 20 percent) by 2002. Seniors represent a vastly disproportionate share of that cost. People over 65 represent 12.4 percent of the US population, but they account for over a third of drug expenditures.

Despite these rocketing expenses, insurance coverage for drugs is getting worse, not better. A third of seniors pay for their medications entirely out of pocket. But that figure is misleading, because coverage for the other two-thirds is very patchy. Unlike the fairly comprehensive coverage most working people enjoy, retiree plans tend to have large deductibles and copayments, and there's a cap on the annual payout. If their drug costs are high, they end up paying for most of it themselves. And even this minimal coverage is eroding. The number of private health plans offering insurance to Medicare-eligible retirees has dropped steadily.

ly in recent years. Many seniors have some drug coverage through Medicare HMOs, but a number of these HMOs have withdrawn from Medicare in the past year. Others are placing caps on drug coverage. By next year, an estimated one third of HMOs will cap drug coverage at \$500 annually or less.

In theory, seniors can purchase drug coverage through Medigap policies. But only three of the ten available Medigap plans offer drug coverage, and they tend to be more expensive than the other options. Worse, many seniors who apply for these plans, like Frank Dezelich, are turned down because of their "pre-existing conditions." One senior told me he was required to fill in a five-year pharmaceutical history as part of his application. He had taken only one drug in that period—Zantac. He was denied. He wrote the company and asked if Zantac could be excluded from his coverage, so that he would go on paying for it out of pocket and be insured for everything else. They said no.

With such poor coverage and such high prices, middle-class seniors have a hard enough time paying for their drugs. It's even worse for the poor. Seniors who are below the poverty line but don't qualify for Medicaid spend roughly 50 percent of their income on prescription drugs and other health care costs. It's hardly surprising that many of these people skimp on their medications. Some elderly men and women are literally forced to choose between drugs and food. And we're not talking about Viagra. One New Hampshire study of Medicaid recipients found that when drug use was limited, recipients cut back on such vital medicines as insulin, lithium, cardiovascular drugs, and bronchiodilators. Denying such life-saving drugs to people in need isn't just inhumane. It's also a waste of money in the end, because the people who fail to take them are likely to become critically ill and to require more costly medical care. A follow-up study in New Hampshire found that chronically ill seniors affected by limits on Medicaid drug payments were twice as likely as members of a control group to enter nursing homes and hospitals—where they rack up larger bills that are footed by the government (and therefore by the taxpayer).

It shouldn't have to be that way. Life-saving drugs are a necessity, not a luxury for the rich. Just as Medicare took care of the desperate need for hospital insurance for the elderly back in 1965, so now we need to ensure that no one suffers or dies for lack of prescription drugs. Clinton's proposal for a Medicare drug benefit would help. But it would still leave seniors putting a hefty portion of their income into drugs, because it only covers 50 percent of each prescription,

and it would be capped at \$1,000 a year (at least at first). And it's likely to push up drug prices for people under 65 who lack insurance, as the drug companies try to make up for their lost revenue.

That's why the government should step in and use its buying power on behalf of those who need it the most. This is what Canada and most European nations do for all their citizens, and they pay much less than we do for the same drugs. In fact, our federal government already negotiates a hefty discount when it buys drugs for the Veterans Administration and the military, and the states do something similar for Medicaid recipients. (The government's "best price" for Zocor, a cholesterol drug, is about \$27 for 60 five-miligram tablets; uninsured people pay \$108 for the same amount.) There's no reason not to let the uninsured into one of these large buying pools and give them the same discounts. Drug companies dislike these practices, because they cut into their profits. But those complaints ring a little hollow when elderly people are skipping meals so they can pay for their medications.

Medicareless

With this kind of suffering going on, you have to wonder: Why has it taken so long to get a proposal for a Medicare drug benefit? After all, Phil Lee's Task Force on Prescription Drugs recommended creating such a benefit in 1969. Thirty years later, the price of drugs has gone through the roof, and we still don't have one, despite the fact that 70 percent of respondents in a recent *Newsweek* poll said the lack of drug coverage is the "most important problem in health care," and 84 percent listed drug coverage as "absolutely essential" for health care coverage.

The answer, naturally, is money. Congress did pass a Medicare drug benefit back in 1988, as part of the Medicare Catastrophic Coverage Act, but it fell victim to those who successfully tarred it as an unfair tax. Originally proposed by President Reagan and congressional Republicans in 1987, the bill started out as a fairly modest effort to help seniors pay for the costs of catastrophic illnesses like cancer, which could bankrupt a low-income family when their Medicare insurance ran out after 90 days in the hospital. The final product included 80 percent of prescription drug costs after a \$600 deductible, along with full coverage for hospital stays of any length after a \$560 deductible, and other benefits.

So far, so good. The trouble, as always, came with the money. Congress declared that all Medicare recipients who paid more than \$150 a year in federal income tax would be required to pay a special 15 percent sur-

tax, capped at \$800 per person. This meant that people earning under \$25,000 a year would pay \$58 a year for the coverage; those earning about \$40,000 would put in \$400 a year; and those in the highest income brackets would pay the full \$800. To most seniors, that was a truly wonderful bargain. But it didn't take long for the Conservative Caucus, the National Committee to Preserve Social Security and Medicare, and other

Drugs are the fastest-growing share of health costs, rising at almost four times the rate of inflation last year.

seniors' lobbies to begin warning their members about the "Seniors Only Income Tax Increase" to which they'd been subjected. They also asked for money to help fight the bill. Within weeks, Congress was flooded with more than 2 million letters and thousands of phone calls from angry seniors denouncing the bill. The pressure worked, and in 1989 Congress repealed the Act. The lesson for politicians was clear: Don't ask affluent seniors to pay for their poorer cohorts.

More recently, the pharmaceutical industry has targeted Clinton's proposal for a Medicare drug benefit, because they think the cost of insuring seniors will grow so high that the government will impose price controls, cutting into their revenue. In July a pharmaceutical front group started airing a television ad in which an elderly woman named Flo warns against adding a drug benefit to Medicare: "I don't want big government in my medicine cabinet." The ad was immediately compared to the notorious "Harry and Louise" ads run by the insurance industry back in 1993 and 94, which were credited with helping to kill the Clinton health care bill.

It's not clear yet who would end up paying for the Clinton plan, or if it would lead to price controls. But several bills being floated in Congress and in the states do address the fact that U.S. consumers currently pay the highest retail prices for drugs in the world. There are bills to allow drugs to be imported from other countries, giving Americans access to lower foreign prices. There are bills that would alter U.S. patent law, cutting back on the drug companies' ability to charge virtually anything they want for drugs. And there are bills that would empower government—whether state or federal—to create large buying pools, thereby protecting uninsured people from high retail costs.

Your Money Or Your Life

The standard justification for forcing drug companies to help to foot the bill is that there is no free market for drugs. Once makers have a patent on a chemical formula, they have a de facto monopoly and can charge the public as much as they want. And they do: According to *The Wall Street Journal*, the drug industry's profits are "the envy of the corporate world."

In 1998 *Fortune* magazine rated pharmaceuticals as the top industry based on return on revenues, return on assets, and return on equity.

The drug industry has an answer to that. Its lobbying arm, the Pharmaceutical Research and Manufacturers of America, claims that high U.S. prices

are necessary because American pharmaceuticals "bear the world's research burden," developing a disproportionate share of new drugs. If we paid less, profits would go down, and the flow of new life-saving wonder drugs would come to a halt. Or, to put the pharmacologic a little more succinctly: *Your Money or Your Life*.

It's true that many of the best drugs of recent years have been made by American companies. But it's not at all clear that they deserve the credit. The National Institutes of Health does a third of the nation's research, in terms of money, and is responsible for some of the most powerful drugs ever: penicillin, polio vaccine, and AZT. Although the U.S. pharmaceutical industry claims to fund roughly 43 percent of the country's research, that figure is misleading. The Office of Technology Assessment found in 1993 that two-thirds of research goes to "copycat" drugs—drugs designed to replicate the effect of a drug patented by another company. And according to the U.S. Senate Committee on Aging, "many of the dollars drug manufacturers claim are spent on research are actually spent on marketing research."

Furthermore, private companies often make enormous profits from taxpayer-funded research. Taxol, for example, a powerful anti-cancer drug developed almost entirely by the federal government, costing taxpayers about \$35 million, is licensed to Bristol-Myers Squibb. Taxol costs 30-40 cents per milligram to manufacture, according to James Love, director of the Consumer Project on Technology. Pharmacies retail it for \$62 per milligram. Stories like this led the Office of Technology Assessment to conclude in 1993 that federal policies were inadequate to protect the public's interest in affordable drug prices and reasonable compensation for the taxpayers' investment in research. Yet instead of demand-

ing a fairer bargain, the government has gone the other way. In 1995 the NIH gave up its right to require "reasonable pricing" by drug companies for medications developed either through government research or through government-industry collaboration.

It's also clear that drugs are priced according to what the market will bear, not according to the cost of their research. Thanks to patent protections, drugs that cost a dollar or two to manufacture can sell for hundreds. Take Levamisole, for example, a drug known to be effective in preventing colon cancer from recurring after surgery. Patients must take the drug for a year, and for a year's supply Johnson & Johnson charged \$1,500. But if you bought the same amount of Levamisole from another company for treating sheep, you would pay just over \$14, according to a doctor at New York City's Mayo Clinic. Since people are willing to pay more than animal keepers, Johnson & Johnson made a killing. But it's likely that some people who couldn't afford the drug died.

There are a number of areas outside research where drug companies could cut back on expenses. Of the 15 largest drug makers, all had marketing, selling, and administrative expenses that were at least 78 percent higher than their own claimed figures for research and development. Thanks to revisions in Food and Drug Administration policies in 1985 and 1997, drug companies now spend tremendous amounts on direct-to-consumer marketing. Spending in this area went from \$553 million in 1991 to \$1.3 billion in 1998, increasing more than twentyfold. They also spend a lot of money marketing their drugs to doctors, often at lavish vacation "seminars." Spending a long weekend in Honolulu isn't exactly the best way for a doctor to make impartial decisions about what he should prescribe for his patients, particularly when you consider that the companies funding these junkets are paid to sell drugs, not to tell the truth. In addition, drug companies spend vast amounts on lobbying campaigns to have their patents extended. Schering-Plough, for instance, is currently spending millions on a lobbying campaign to have the patent for their popular allergy drug Claritin extended by three years.

Finally, drug companies have used the research excuse to fight legislation in the past—and been proved wrong. In the early 1980s the brand-name pharmaceutical industry lobbied against the Waxman-Hatch Act, which made generic drugs more available, arguing that it would lower profits and cut into research funding. Since then R&D has more than doubled, and the rate of new drug approval has increased dramatically.

Pump Up The Volume

The drug makers' resistance to change becomes less defensible when you consider that they might not lose much profit if prices dropped, because demand would increase correspondingly. According to a Merrill Lynch study, if Medicare recipients were to get a 40 percent discount on drug prices—as Rep. Tom Allen and several others in Congress are now proposing—the volume of sales would offset the loss in revenue almost entirely. Even if that proved optimistic, the losses incurred would be relatively small. The marginal cost of making more pills, once a drug line has been established, has been estimated at 5 percent of retail price. Boston University's Access and Affordability Monitoring Project has estimated that making 25 percent more medications would cost the drug makers about \$1.25 billion. If the 12 largest companies alone had borne that financial burden in 1998, they would still have been the most profitable industry in the country by a healthy margin.

The Allen plan would not be difficult or costly to establish. The federal government already gets a hefty discount on drugs for the V.A. and the military; the Allen plan would simply add Medicare beneficiaries to the mix. Another precedent exists at the state level. Fourteen states currently have pharmacy programs that provide substantial discounts to low-income seniors who don't qualify for Medicaid.

Unfortunately, restricting the plan to senior citizens would probably drive up prices for those who remain uninsured. This is not a small concern. There are now close to 70 million Americans—one in four—without any drug insurance at all, and many if not most of the rest of us have very poor coverage.

That's why some state governments are now considering negotiations with drug companies on behalf of all their citizens, not just the elderly. Massachusetts state legislators have proposed the Act to Reduce Out-patient Prescription Drug Costs and to Expand Coverage, which aims to win discounts of at least 20 percent for drugs under patent, and 14 percent on generic medications. Vermont has held hearings on a similar plan. Canada already runs a very similar drug plan, with several provinces negotiating drug prices for their citizens.

This may sound like a drastic, top-down solution. But it's based on one of the fundamentals of the free market: Pool your buying power and get better prices. Until Congress agrees on a Medicare drug benefit—and that may be a long time—there's no better way to reduce the suffering of people like Frank and Lois Dezelich.