

Getting a Handle on Prescription Drug Cost Stories

A seminar for journalists presented by the
Foundation for American Communications for
the Midwest Journalism Conference

Minneapolis
Friday 1 April 2005

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Main topics

- A. Where did today's prescription drug controversies originate?
- B. Three views of the world of drugs
- C. Grounding: high U.S. health costs
- D. Data on Rx cost, coverage, and quality
- E. The easiest problem to fix in the USA—the shape of a drug peace treaty
- F. What are the stories?

A. Origins of 3 Rx controversies

1. Cost

- Rising health costs generally
- Rising drug costs particularly
- Incremental drug cost control attempts—generics, importing, formularies, others—haven't worked very well
- High drug profits, power

2. Coverage

- 75 million lack drug coverage
- Hard to craft Medicare benefit with good + affordable coverage

3. Quality

- Perceived efforts by drug makers to manipulate demand (direct-to-patient advertising)
- Manipulate supply (flawed research presented to doctors)
- Costly new drugs marketed aggressively but often no better

B. Three views of world of drugs

1. PhRMA

- Drugs save lives and money on hospitals, doctors
- U.S. drug makers are more innovative
- High U.S. prices finance greater U.S. innovation
- Restraints on U.S. drug prices will cut drug makers' revenues and profits, leading to cuts in research funding
- If high costs or lack of coverage are problems, solutions are drug maker charity + improved insurance coverage and higher spending

B. Three views of world of drugs

2. Incremental cost controls

- Cut prices by importing (politically attractive because looks like market or free trade solution)
- Boost generics, spar with drug makers over patent duration → drug makers respond with “evergreening” and DTCA
- Medicaid or managed care formularies
- Higher co-pays, deductibles— “patient choice”
- Pharmacy benefits managers (PBMs)— allegations of conflict of interest, violation of fiduciary duties

B. Three views of world of drugs

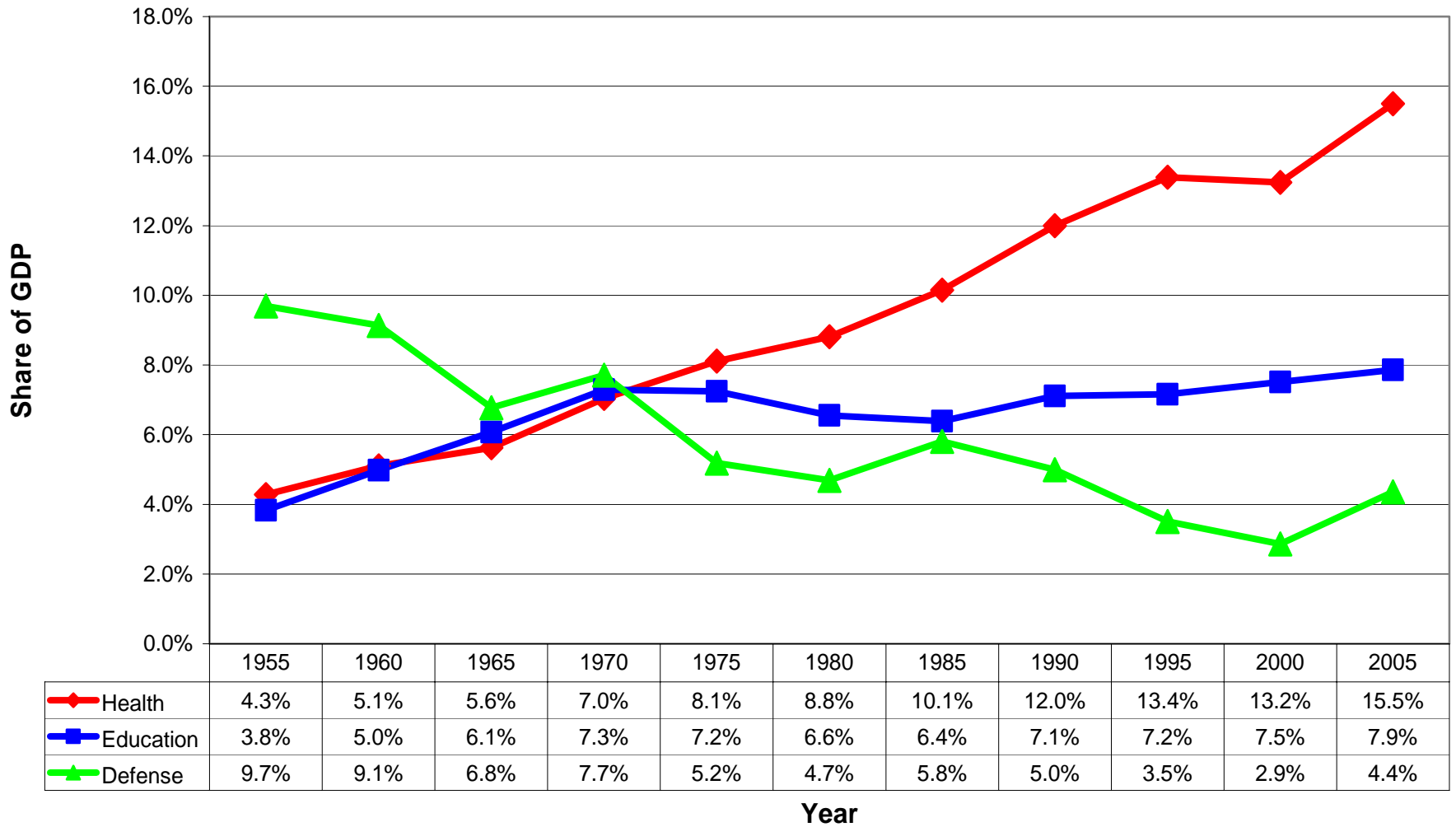
3. Other

- Current choice: suffer for lack of needed meds, spend more, or reform
- Address cost, coverage, and quality problems in integrated way
- Make today's drugs affordable for all while protecting drug makers' profits
- Reward breakthrough research
- Offer MDs trustworthy evidence on need

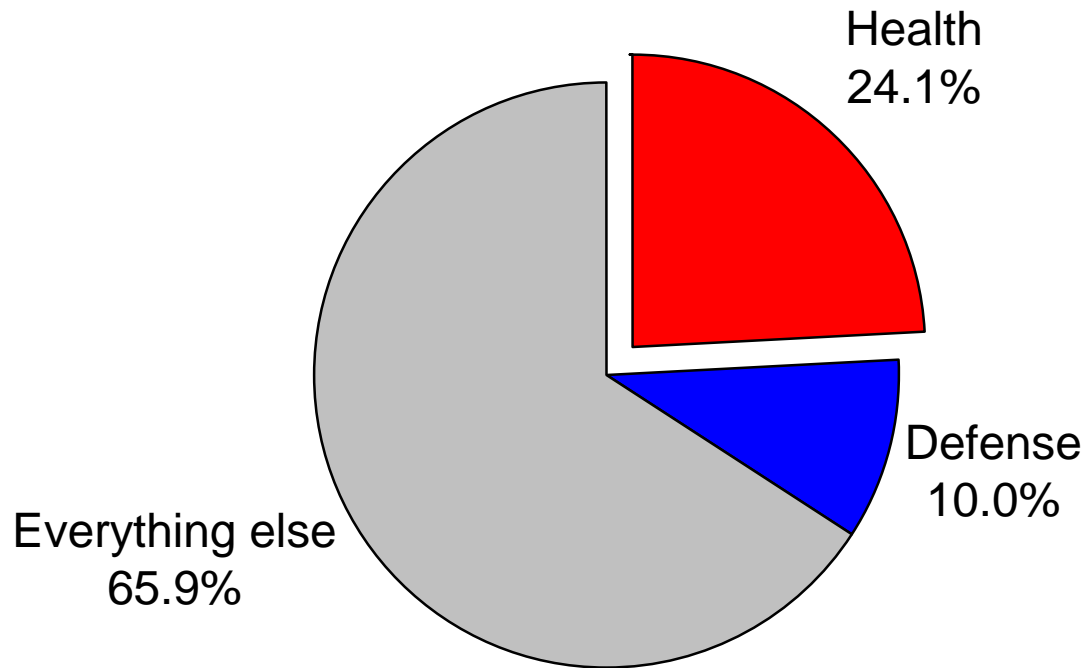
C. Grounding: high U.S. health costs

- Health, education, and defense
- Health absorbed 1/4 GDP growth, 2000-05
- Savings if stabilize health % of GDP
- Health crisis index rises 37%, 1987-2003
- No contingency planning against recession
- Easiest problem to fix

HEALTH, EDUCATION, AND DEFENSE SHARES OF U.S. GDP, 1955 - 2005

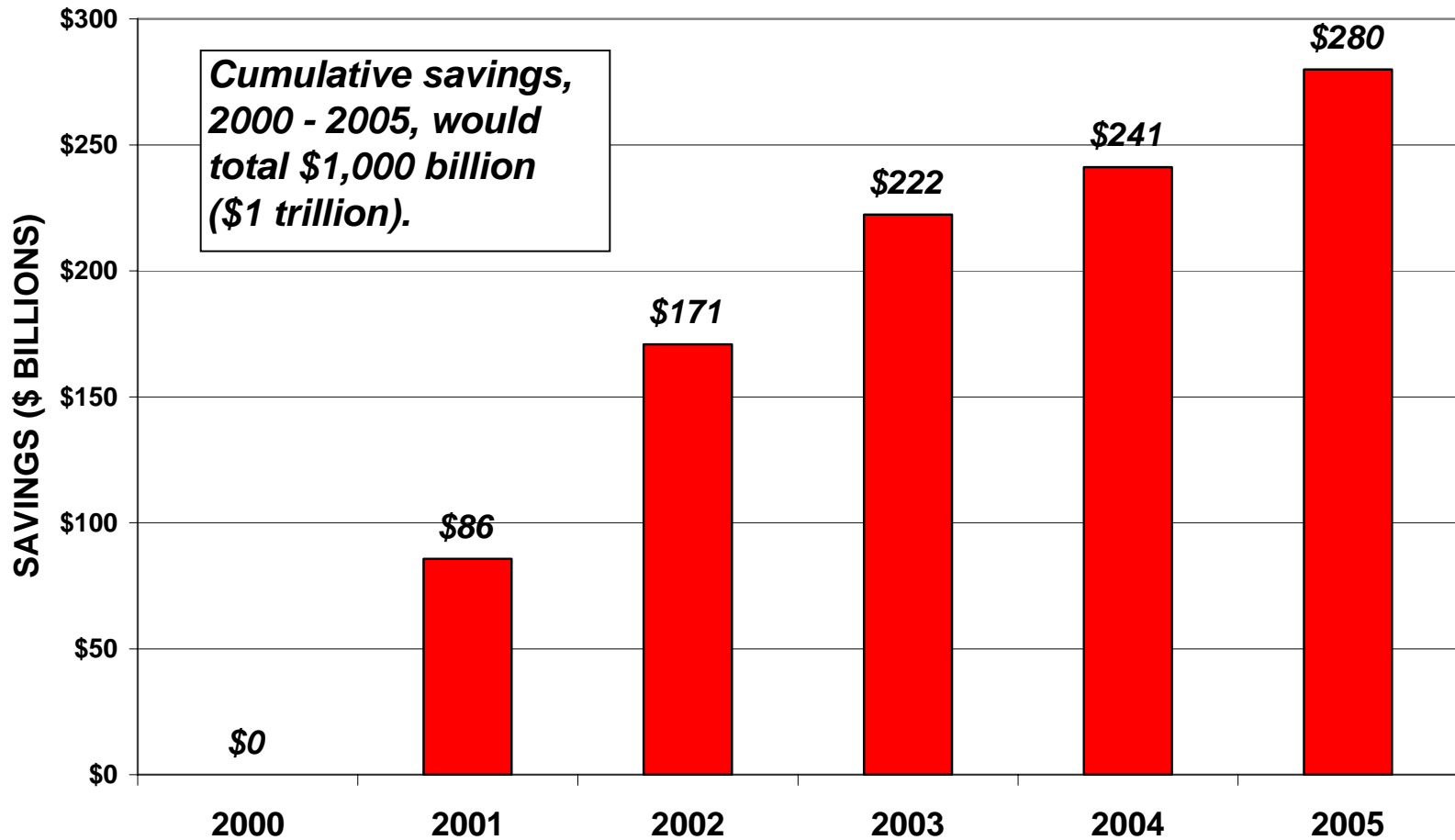


SHARES OF GDP GROWTH, 2000 - 2005

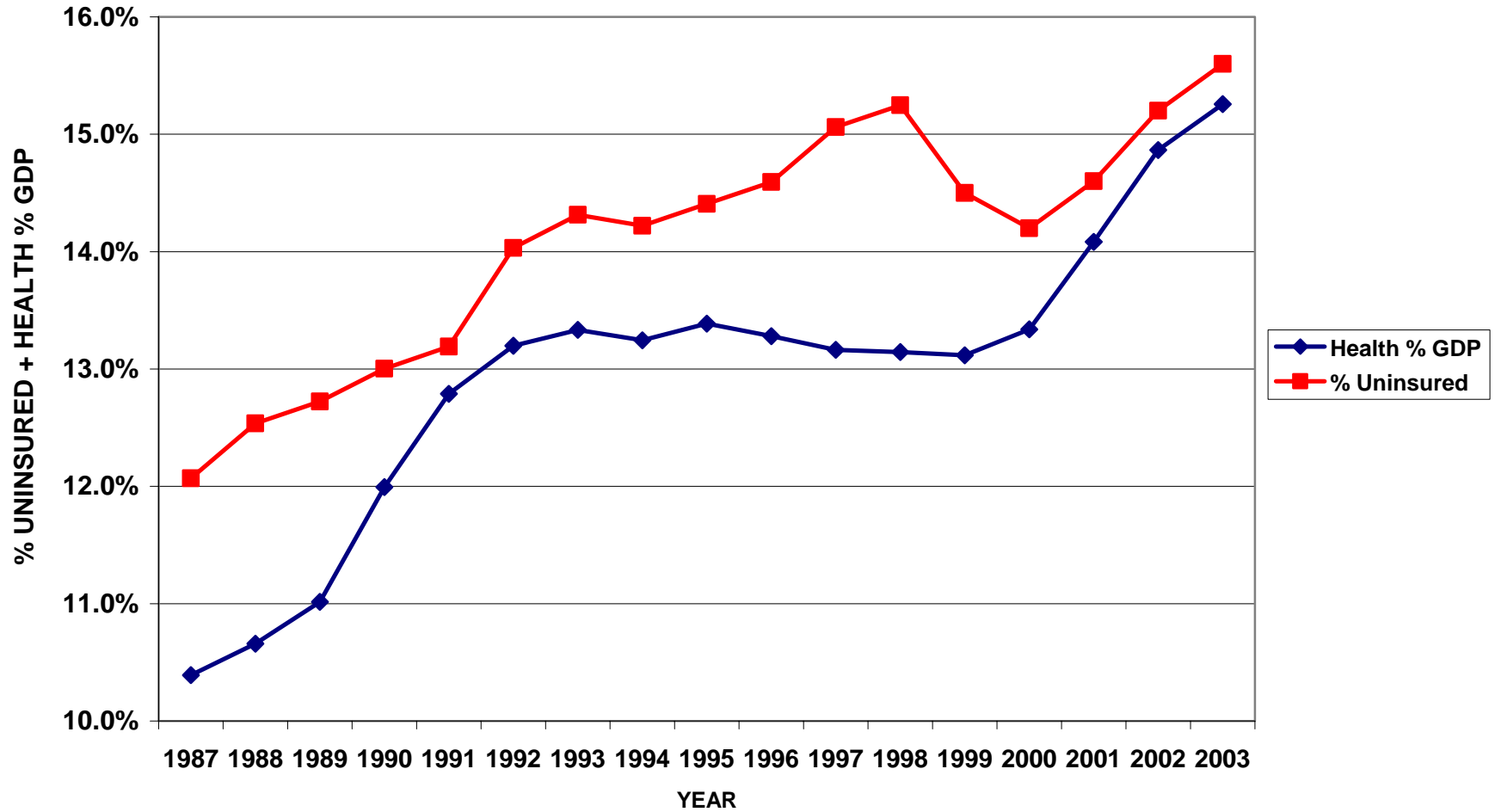


U.S. HEALTH SAVINGS, 2000 - 2005, IN \$ BILLIONS

HAD HEALTH BEEN HELD TO 2000'S 13.2% OF GDP



SHARE UNINSURED AND HEALTH'S SHARE OF GDP, 1987 - 2003



No contingency planning against recession

- Health care addicted to more money for business as usual (rising % of rising GDP)
- 1929-33, nominal GDP fell by 1/2, real 1/4
- Health care isn't prepared for zero-growth in real dollars, let alone a 10% drop
- Living on borrowed money, time, Toyotas
 - 2004 federal budget deficit: 3.5% of GDP
 - 2004 trade deficit: 5.4% of GDP
- Deep recession could see 100 M uninsured, 1,000 hospital closings, 100,000 MDs driving cabs
- Need medical security: affordable care for all, stable revenue for all needed caregivers

Easiest problem to fix

- \$1.9 T is enough
- Double Canada, W. Europe—they cover all, live longer, happier with care (though smoke and drink more than we do)
- 1/2 U.S. health spending wasted
 - Clinical, administrative, excess price, theft
 - MDs can find waste, cut it, marshal savings to cover all while improving quality—in context of overall financing and delivery reforms and supporting political deal (ending malpractice and paperwork in exchange for carefully stretching existing dollars to cover all Americans)

D. Data on Rx cost, coverage, quality

1. Cost

- Rising U.S. Rx spending
- Rising Rx spending as % health costs
- U.S. share worldwide spending

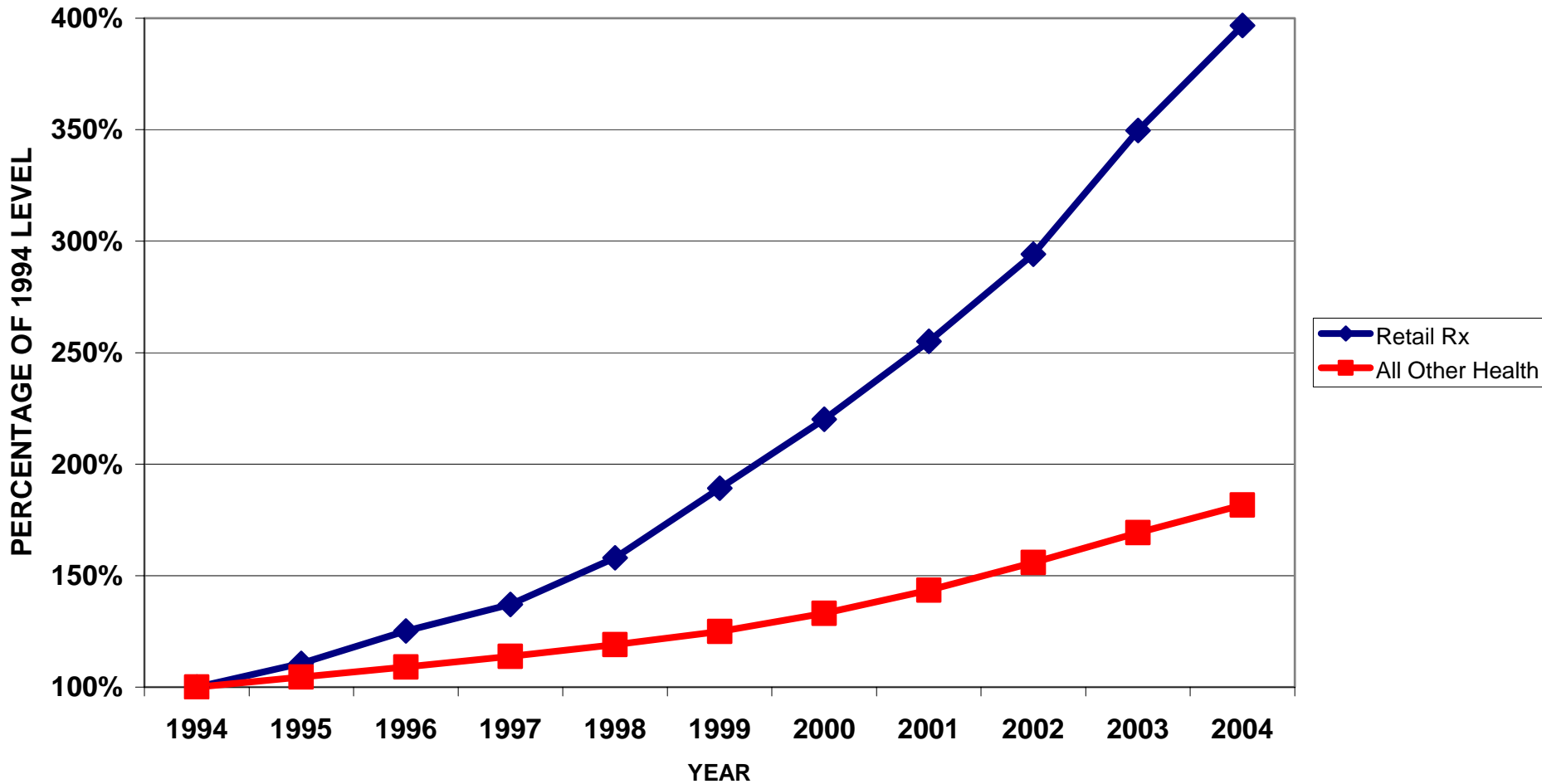
2. Coverage

- Who's uninsured
- New Medicare Part D

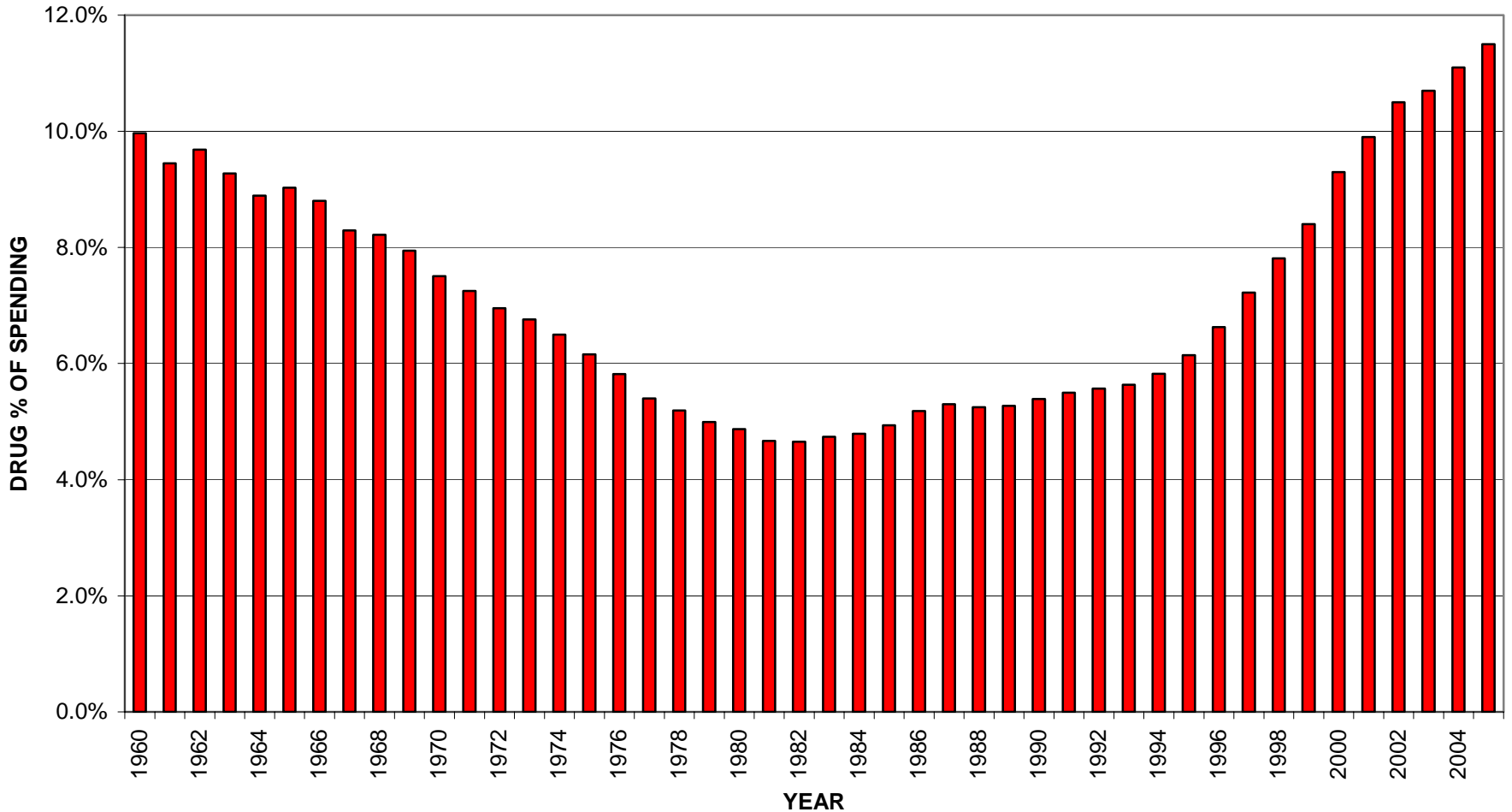
3. Quality

- Doubts about evidence on safety, efficacy, need
- The right meds for the right patients

RETAIL PRESCRIPTION DRUG AND ALL OTHER HEALTH SPENDING, 1994 - 2004, AS PERCENTAGE OF 1994 SPENDING



RETAIL PRESCRIPTION DRUGS AS PERCENT OF U.S. HEALTH SPENDING, 1960 - 2005



HOW SIX DRUG MAKERS SPENT THEIR MONEY, 1999

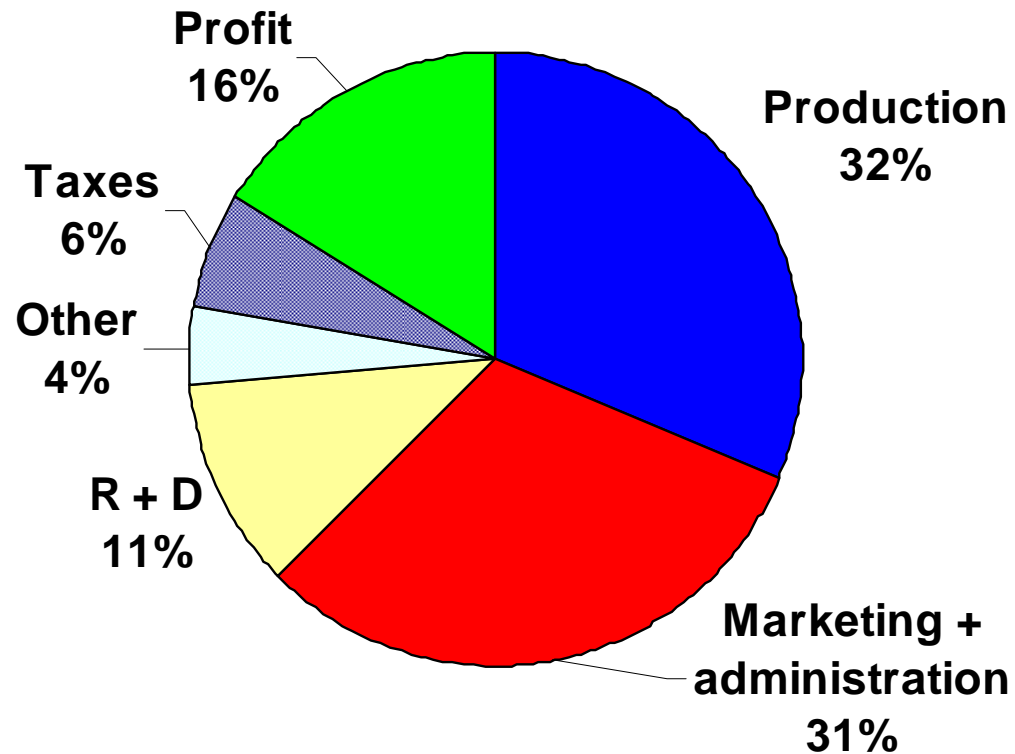
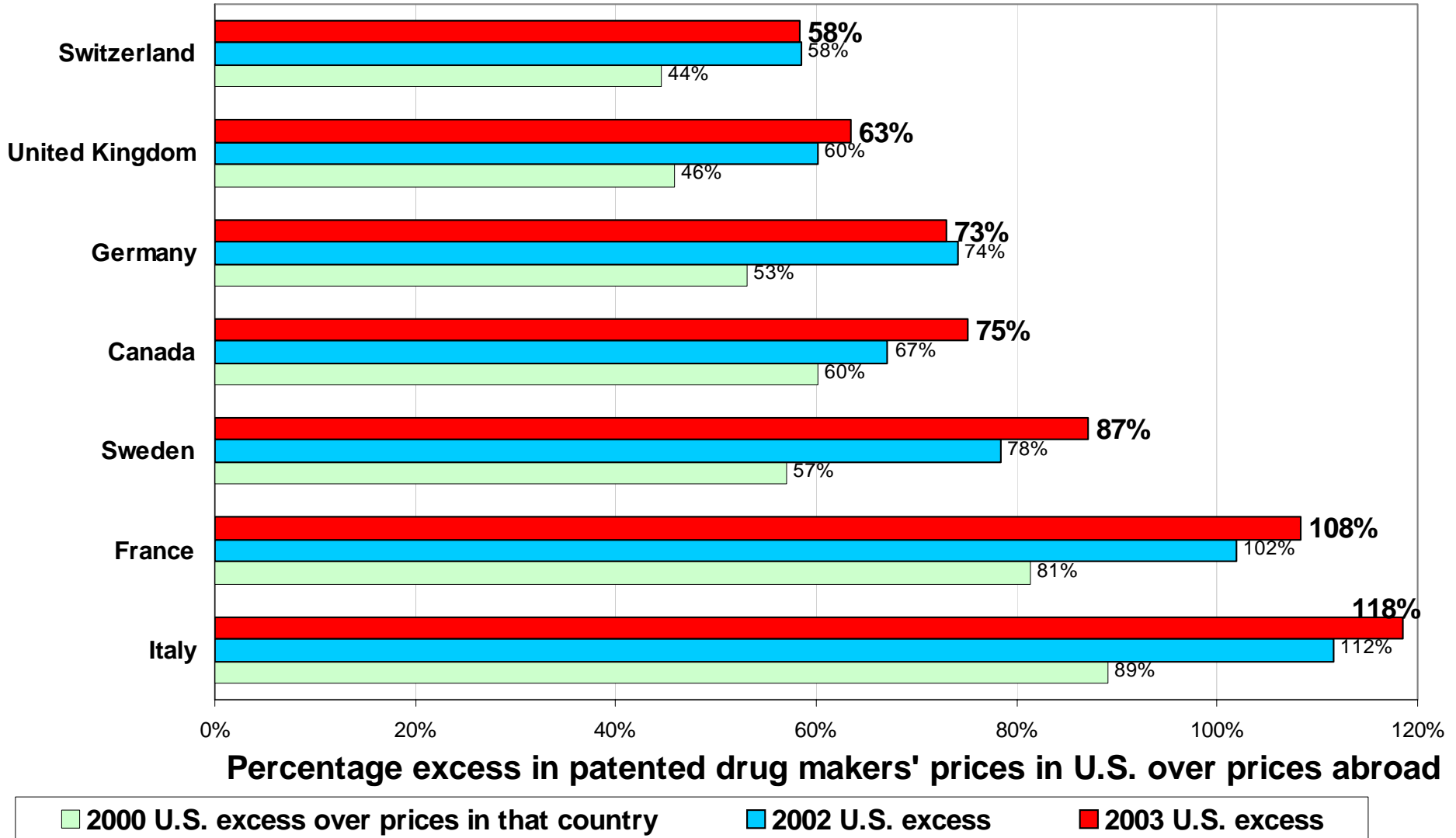
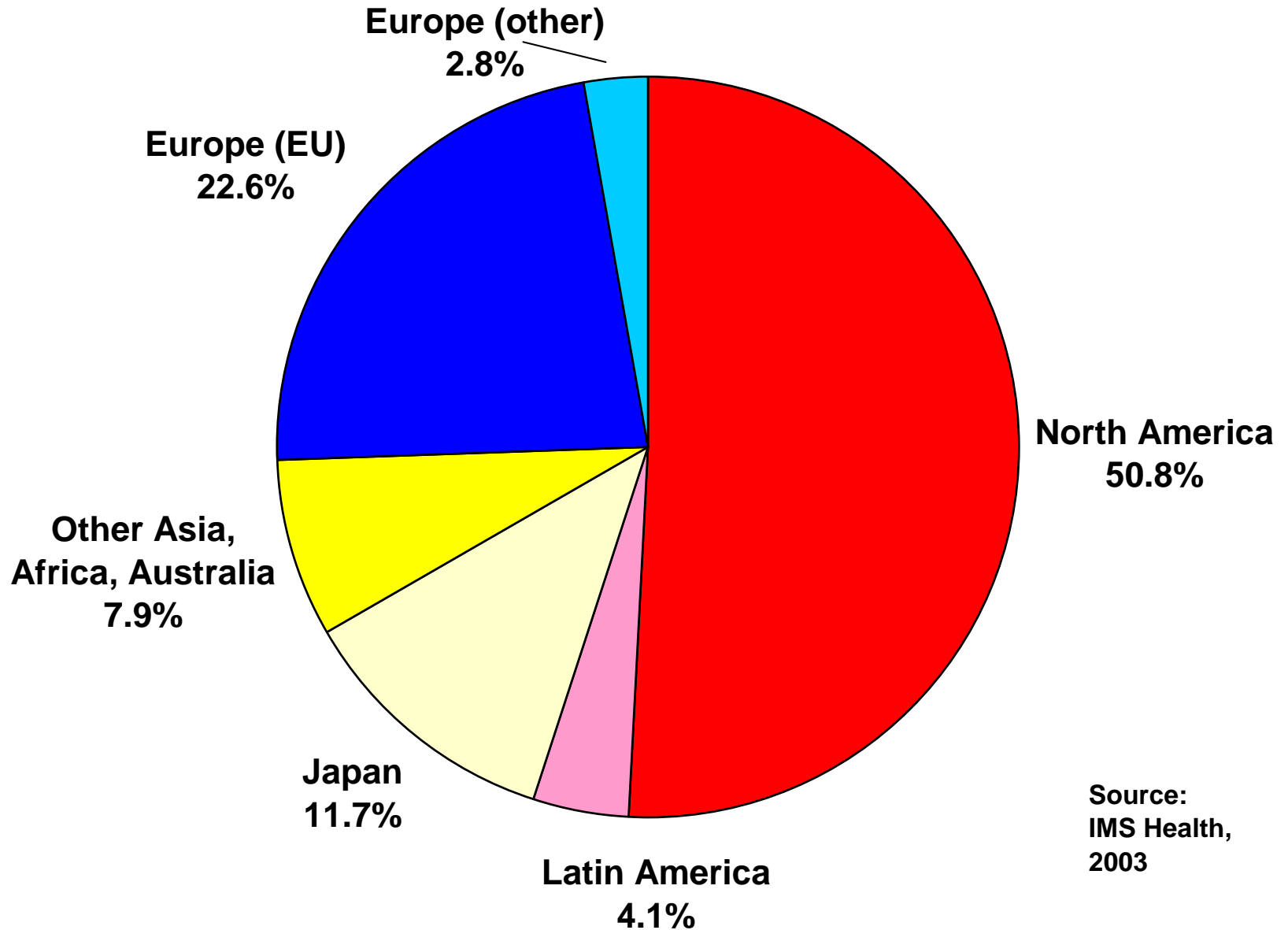


Exhibit 2:
U.S. Brand Name Prescription Drug Prices
Continue Rising Farther Above Prices in Other Nations

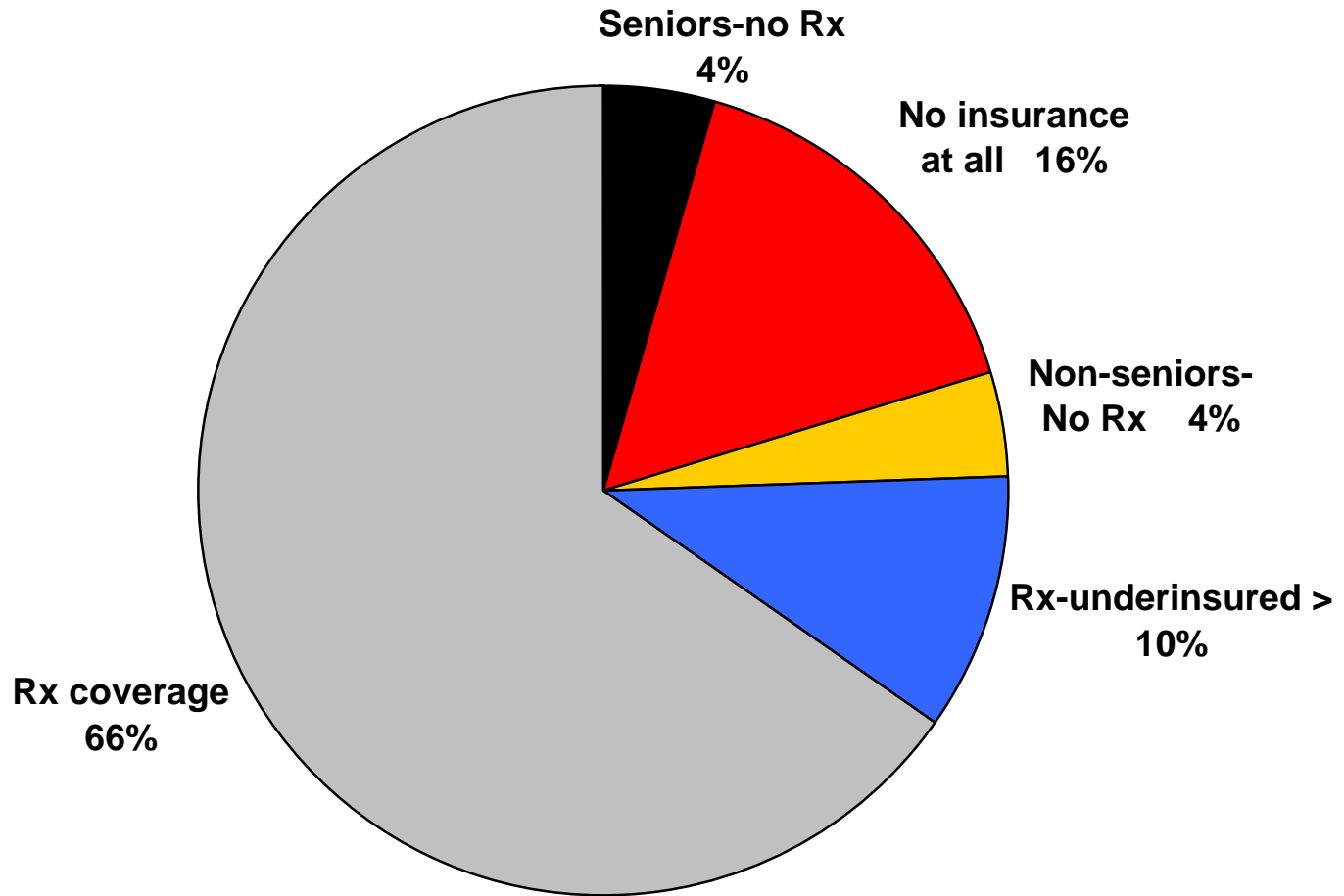


SHARES OF WORLD'S Rx SPENDING, 2002



Source:
IMS Health,
2003

98 MILLION AMERICANS LACKED PRESCRIPTION DRUG FINANCIAL SECURITY IN 2000



New Medicare Part D

- Costly premiums for patients
 - Medicare D = \$420/year * 2 people = \$840
 - Medicare B = \$1,052 * 2 = \$2,105
 - Together = 10.9 percent median income
- Weak coverage
 - Deductible, co-pays, black hole of no-pay
- Huge additional drug maker profits
 - + \$139 billion in first eight years (if all eligible beneficiaries enroll)
 - higher volume, low marginal cost, and little price restraint

New Medicare Part D

- Implementation issues
 - 25 months to implement, versus 11 for Medicare + Medicaid in 1965-1966
 - Complicated choices
 - Especially for Medicare/Medicaid dual eligibles
- High total costs
 - \$400 billion initial estimate may really have been \$534 billion (Scully – Foster)
 - Both included two very-low-cost early years, so underestimated true annual cost

Doubts about evidence on safety, efficacy, need

- Drug makers
 - Finance research, let contracts
 - Have huge financial stakes in outcome
 - Suppress negative findings
 - Provide great share of information on use
 - Sponsor physician education
 - Advertise to physicians, patients

Marketing wrong way to inform MDs

- MDs prescribed right antibiotic for urinary tract infection for
 - One-half of patients in 1990
 - One-quarter of patients in 1999
- Accidental degradation, misleading information, or just forgetting

E. The easiest problem to fix in the USA—the shape of a drug peace treaty

1. Making today's drugs affordable for all
2. Boosting incentives for breakthrough research

1. Making today's drugs affordable for all

Recognizing high unmet need and low marginal cost of making more pills

- Lower price to Canadian levels, which would cut drug makers' revenue by some \$40 billion, BUT →
- Replace all lost revenue through higher private market and publicly-subsidized volumes
- Cover marginal cost of manufacturing and dispensing added pills
- Drug makers are financially whole and all Americans get meds their physicians prescribe, for an added cost of about 6 months increase in spending
- Or simply sign an annual total contract with each drug maker—agree to fill all prescriptions

2. Boosting incentives for breakthrough research

- To bolster profits, drug makers seem to excessively rely on conservative 3M's—
 - Marketing/advertising
 - Mergers
 - Me-too drugs (about 1/2 of research dollar)
- And on price increases on today's drugs
- Why a conservative strategy?
 - Fear of price controls?
 - Flawed discovery process?

2. Boosting incentives for breakthrough research

- Cut prices and raise volume for today's meds, thereby easing fear of price controls
- Phase out “push” financing (drug makers keep prices high to generate lots of money and spend some of it to finance research)
- Move to “pull” financing (award a \$50 billion prize to drug maker for effective new Alzheimer's med, and so on, undercutting case for very high prices for good meds)

F. What are the stories?

- Importing, generics, PBMs—can they best be seen as side-shows, distractions?
- Will it be possible to implement the new Medicare Part D successfully?
- How much more will its cost grow? Will premiums rise?
- How much visible pain, confusion, and disruption of needed medications will be caused by switching dual eligibles from Medicaid to Medicare?
- Will the Part D insurers succeed in obtaining substantial discounts from drug makers? What evidence will they offer?
- How will patients cope when their new Part D insurer does not cover some of the meds they need?
- What ingenious techniques will states discover to regulate drug prices, and which states will do so?
- Research: will pressure for transparency grow? For neutral financing? Will MDs demand trustworthy data?

For more—

- “Isn't it time we stopped paying such high prices for prescription drugs?”

Nieman Watchdog's **ASK THIS** September 20, 2004

How much longer will we let drug makers stymie efforts to win affordable medications for all Americans by falsely insisting that high prices are essential to finance breakthrough research?

http://niemanwatchdog.org/index.cfm?fuseaction=ask_this.view&askthisid=0058

- www.healthreformprogram.org, USHR page