N.E. states may join to lower drug costs

By Richard A. Knox

The number one health policy problem of the day — the soaring cost of prescription
drugs — is leading state officials and consumer advocates to propose solutions once dis-
missed as radical.

Legislators and public officials are exploring the idea of combining entire state
populations, perhaps even all of New Eng-
land, into giant drug purchasing groups to
wrest the deep discounts and rebates that
drug companies now grant only to favored
customers such as large HMOs and Medi-
ad programs.

Another alternative under active dis-
sussion is whether states can find ways to legis-
late pharmaceutical price discounts of 20 to
40 percent — in effect, price controls at the
state level.

Such proposals are considered quixotic in
Washington, but many state legislators say
drug manufacturers have less clout at their
level.

Moreover, constituents upset about high
pharmacy prices — such as politically potent
elders — have more direct access to local legis-
lators, which make the lawmakers more
vulnerable to grass-roots pressure.

Senator Peter Shumlin, a Democrat who
is Vermont’s Senate president, said he and
his colleagues can’t go to the barber shop or
grocery store without hearing “a lot of sad
stories about people who can’t afford to buy
their drugs.”

Unlike members of Congress, he added,
state legislators don’t have to raise multimil-

lion-dollar campaign chests to get elected
and therefore don’t depend on contributions
from the drug industry.

“It only makes sense, if Congress isn’t
going to do anything, to explore how states
can work together,” Shumlin said.

The notion of concerted state action is
catching fire in New England as the best
strategy to rein in prescription drug expen-
ditures rising by 15 percent a year. Pharma-

cueutical cost increases are outstripping all
other health sectors and threaten to surpass
total hospital expenditures in the next year
or two.

The signs of state activism are suddenly
everywhere, driven by pressure on elders
with no drug coverage, on families that face
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escalating HMO premiums, and on state spending for Medicaid and drug-subsidy programs.

Shumlin plans to host a Thursday meeting in Montpelier with legislative leaders and policy advisors from Massachusetts, Vermont, Maine, and New Hampshire to discuss how they might work together to control the cost of prescription drugs.

"There's strength in numbers," Shumlin said.

The Massachusetts budget, passed last month, contains a little-noticed mandate to create a drug-purchasing pool that could encompass 25 percent of the Bay State's population. This fall, California enacted a law that requires pharmacies to give discounts of up to 40 percent to Medicare beneficiaries. Vermont is even considering state-subsidized bus passes so residents could travel to Montreal to buy drugs at about half of what it would cost in the United States.

Some legislators, health officials, and advocates have concluded that state action to create large purchasing groups offers the best, and simplest, approach. Prescription drug spending in the six New England states totals an estimated $5.4 billion a year.

"I think it could be done," said Judith Kurland, regional director of the US Department of Health and Human Services for New England. "The health care purchasing power of the six New England states, with our 13 million people, is comparable to all of Canada's, with its 29 million population."

The region's proximity to Canada, where drug prices are set by individual provinces, also makes for telling contrasts.

Lucille Danyow, a 78-year-old breast cancer patient from St. Albans, Vt., made the trip to Quebec last July with four other women from her "healing group" to buy tamoxifen, a cancer drug that costs about seven times more south of the border, according to a recent study by Vermont officials.

"I got a three-month supply for less than $50," Danyow said. The average Vermont retail price for the same quantity of tamoxifen is $386.74, according to the state study.

Kurland has no power to implement a regional drug-purchasing "buyer's club," as she calls it. But the state governments might, even in the face of expected opposition from the pharmaceutical industry.

Not surprisingly, industry representatives vow to fight state legislation on prices. They say that all such proposals are based on wrong-headed notions of why US drug prices are so much higher than in Canada or any other nation.

Maryjean Powell, who handles government price control issues for the Pharmaceutical Research and Manufacturers Association, cited one study that found half of the price difference between the United States and Canada is because the two nations have disparate laws on product liability.

"All the provisions that make our system so much of a lottery don't exist in Canada," Powell said. She notes that Canada does not have strict product liability laws, allow class-action law suits, patent pograms, or allow lawyers to launch suits on the prospect of large fees from eventual awards.

Jeff Tewhitt, a spokesman for the pharmaceutical association, added that government price controls in the United States would slow manufacturers' ability to develop new lifesaving drugs. Opponents criticize that claim, noting that drug companies spend more on marketing and administration than they do on research and development, reap the benefits of government-sponsored research, and have plenty of room in their profit margins to fund new product development.

The industry's approach is more coverage for drugs "rather than government-imposed price constraints," Powell said.

In fact, many states have focused recently on expanding coverage to targeted populations, such as low-income seniors and uninsured families. But many view this initiative as an important step in reducing drug prices.

"The state simply cannot afford to subsidize the drug companies without limits," said Geoffrey Wilkinson, executive director of Massachusetts Senior Action Council.

Pharmacy price trends, for instance, will critically affect the feasibility of a Massachusetts plan to design an insurance program to cover catastrophically high pharmacy costs for all elders an effort mandated by the recent budget legislation. Untrimmed price inflation, analysts say, would drive premiums so high that elders could be discouraged from buying coverage when they are healthier, offsetting the costs of heavier users.

Massachusetts' current budget includes a mechanism to negotiate pharmaceutical prices on behalf of a group that will include Medicare recipients; low-income elders in the state's Senior Pharmacy program; state, county, and municipal employees; and those who are uninsured or underinsured.

These groups may add up to 1.6 million people, or 1 in 4 Bay State residents. The door may be opening, however, for a broader group-purchasing approach that would encompass the entire state population. A proposal to accomplish this, filed annually since 1996 by Representative Pat Jehle, a Somerville Democrat, is attracting mainstream support.

While New England state legislators strategize and debate options, consumers are left to stopgap measures, such as periodic drug-buying trips to Canada. That's what Lucille Danyow expects to do next month, when her latest cache of cancer medicine runs out.

Last time, her husband drove her to Quebec. "But he's 85," she worried last week, "and I don't know what the weather will be next month."