Rx: Price Controls

Price regulation of prescription drugs is here. That’s not necessarily a bad thing.

JASON PONTIN

Maurice Drouin, who died five years ago, worked at the Baits Mill in Lewiston, Maine, for more than 40 years. His wife, Lauren, who is now 74, worked for a credit union in the same town. While Mr. Drouin was employed, the Baits Mill paid for all his medical expenses. But in 1997, Mr. Drouin was diagnosed with diabetes, suffered a massive heart attack and stroke, and retired.

The pension Mr. Drouin received from the Baits Mill did not provide medical benefits that paid for prescription drugs, nor, given Mr. Drouin’s health, could be afforded a supplementary private insurance plan that did. Medicare, the government program that funds health care for the elderly, does not currently pay for outpatient prescription medicines—and Mr. Drouin was a very sick man who needed a lot of medications.

“We saved for our retirement,” Mrs. Drouin told Senator Olympia Snowe (R-Maine) in a town hall meeting in Lewiston this summer. “But it all went for medication.”

For 11 years, the Drouins, who were never very rich, spent between $3,500 and $6,000 a year on drugs. They spent so much that Mrs. Drouin now lives in subsidized housing. As she has aged, she has taken more and more prescribed drugs herself, and now she has run out of money. In the jargon of American health care policy, she is all “spent out.”

Mrs. Drouin is not alone. This summer, when Congress debated adding prescription drug benefits to Medicare, committee members listened to alarming figures recited by grave experts. Legislators heard that almost one-quarter of Americans under the age of 65, and more than one-third of Medicare patients, have no prescription drug benefits. One-fifth of Americans cannot afford to take at least some of the medications their doctors have prescribed. Among the poor and the elderly, that figure is 40%.

When Medicare was created in 1965, legislators expected that it would pay for hospital treatment for acute conditions. No one anticipated a geriatric population living for years in chronic ill health, treated for two or more conditions with a bewildering range of prescription medications (see “Aging Gracelessly,” August/September).

Hence proposed legislation, supported by both political parties in the House and the Senate, and mandated by President George W. Bush, that would extend prescription drug benefits to the elderly. But as the Drouin’s story suggests, the problem with prescription drugs in the United States is not only that Medicare will not pay for them, it’s that drugs cost so much.

Indeed, if a prescription drug provision were to be added to Medicare without a systematic reform of how the government pays for pharmaceutical drugs, the economic costs would be intolerable. While the Senate’s prescription drug bill budgets $400 billion over the next decade, the Congressional Budget Office puts the real figure for such a public entitlement at a much higher price. According to the CBO, if drug prices continue to increase at their current rate, it would cost the government $7.5 trillion to maintain the prescription drug component of

1 Testimony to the Committee on Government Reform, June 2003, U.S. House of Representatives, June 2003

The United States Foos the Bill

The discrepancy between U.S. prices for brand-name drugs and the costs in other industrialized nations are not just wide—the gap is actually continuing to increase.
Medicare in perpetuity. To provide some context, that number is almost twice the total current U.S. consumer debt.2

Something has to give. What is shifting is political opposition to price controls on pharmaceutical drugs. In fact, through subterfuge mechanisms, the government is already conniving at drug price regulation. To understand why such regulation might be necessary and inevitable—even benign—one must answer these questions: How crazy are the prices of drugs? How did it get so bad? How would price regulations work?

Mind the gap

Americans have always spent a lot on drugs, and they have always paid more for them than people in other countries. During the last 15 years, the nation’s expenditure on drugs has increased by between 10% and 17% a year.3 By contrast, European drug spending has grown only 7% on average during the same period.4 In 2003, U.S. residents spent $213.4 billion on prescription drugs.5 At current rates of expansion, Americans will spend $445.9 billion on prescription drugs in 2012, or 17% of personal health spending.6 No one, not even executives at the pharmaceutical companies, pretends this situation is sustainable.

How much more Americans pay for drugs than Europeans pay makes for startling statistics—and the gap is growing (see “The United States Pouts the Bill,” page 69 of Acumen, Issue 3). For instance, between 2000 and 2002, the difference between what prescription drug prices in Germany and the United States grew by two-fifths. Specific drug prices are even more startling: a one-month supply of Prevacid, a popular acid reflux treatment manufactured by TAP Pharmaceuticals, costs $177.96 in the United States; the average price in other rich nations is $56.59.7 Last year the best-selling drugs cost 77% more money in the United States than they did in Canada or Europe. So great is the U.S. appetite for drugs, and so much less are the prices that Europeans pay, that by May 2003, the U.S. market represented 51% of the global sales of pharmaceutical drugs.8

This situation is far from new. From 1959 to 1961, the average price of Pentintill V, manufactured by Eli Lilly, was $18.00 a month in the United States but only $6.50 in Great Britain.9

The inflation equation

Drug price increases alone cannot explain the increase in spending. From 1992 to 2002, 47% of the growth in prescription spending was due to what health care economists call “utilization inflation,” or the increase in the number of prescriptions purchased. During that period, this number grew 74%, while the U.S. population swelled only 12%. Astonishingly, the average American purchased 11 prescriptions in 2002, 4 more than were purchased in 1992, and twice the number a European buys: Americans love their drugs.10

But with the exception of utilization inflation, high U.S. prices can be attributed, in one way or another, to the pricing strategies of companies. This is because U.S. pharmaceutical companies practice frank, unembarrassed price inflation. The average annual increase in retail prescription prices (a number that reflects both the price changes of existing drugs and the changes in use of newer, higher-priced drugs) was 7.3% from 1992 to 2002, more than double the average inflation during the same period. In 2002 it was worse: prices for 18 of the most prescribed medicines grew by more than three times the rate of inflation.11

This price inflation has meant wonderful profits for pharmaceutical companies. According to the Fortune 500, pharmaceutical companies were the most profitable businesses in the world last year, whether measured by return on equity, return on assets, or return on revenue. In 1998, a banner year, return on equity reached 39.4%, half again more than the average in any other industry. True, if profits are adjusted for the cost of risk (a calculation economists claim to be able to make), pharmaceutical companies become less profitable—but they become less profitable than software companies, which are very profitable indeed.

An important subsidiary cause of price inflation is the increase in spending on advertising and marketing. Consumer advertising of new, high-priced drugs was 7 times greater in 2001 than in 1995. In 2000, pharmaceutical manufacturers spent $1.6 billion on television advertising—30 times more than they spent in 1996, the year before the U.S. Food and Drug Administration dropped its ban on TV drug ads. In all, drug companies spent $16 billion on advertising and marketing in

7. Testimony to the Committee on Government Reform. Op cit.
2001; $10 billion of that sum was for free drug samples for physicians.12 These costs, while explaining utilization inflation, have nevertheless been passed on to the consumer.

The reason why drug companies are so busy raising prices and hyperactively peddling their wares in the United States is that if they don’t do it here, they can’t do it anywhere. Drug prices are lower in Canada and Europe because they are tightly regulated by the government. Drug ads are still banned in these markets.

According to Alan Sager, Ph.D., a professor of public health at Boston University and a noted proponent of drug price regulation, pharmaceutical companies accept foreign price regulations with suspiciously good grace. Why? “The manufacturers’ willingness to accept restraints on their revenues in other nations by their ability to raise prices on helpless Americans, the world’s shock absorber,” says Dr. Sager.

He estimates that drug companies extract between 50% and 75% of their profits from Americans. This “domestic price shift,” in the jargon of health-care economists, constitutes a kind of unacknowledged subsidy of European drug consumers by the United States. These price controls are an old form of public welfare, dating back 50 years. In other words, because affluent Europeans will not pay for pharmaceuticals, Mrs. Druein cannot pay for them.

Seeds of rebellion
In May, in the case of Pharmaceutical Research and Manufacturers of America v. Walsh, the U.S. Supreme Court ruled that the pharmaceutical industry was unlikely to succeed in its challenge to a Maine law that would reduce the prices of prescription drugs for residents of that state. The law, called Mainsite, would allow the state to pool its resources when purchasing drugs for state programs. Then on July 25th, the House of Representatives approved a measure that would let private Americans and medical providers import cheap medicines from Canada and Europe.

Maine’s law and the House vote are a rebellion against the pharmaceutical industry, which lobbied hard to defeat the measures. Both would allow disguised forms of price regulation. Both suggest there is growing bipartisan demand for price controls, and that the judiciary will not oppose such regulation. But whether price controls would actually work is still debated, and deeply politicized: the subject reflects not only the self-interest of the parties involved, but also their ideological preferences.

On the one hand are those who are sincerely alarmed by the prospect of price controls. They believe such regulation would have a deadening effect on research and development of new drugs. Moreover, they are skeptical about whether a government agency could effectively and fairly manage something as politically fraught as drug prices.

On the other hand are those who feel honest distaste for the scale of profits enjoyed by pharmaceutical companies when so many Americans have no prescription drug benefits. They distrust making felicities of free markets, and they believe in the power of an activist government to organize essential services like health care.

John Calfee, Ph.D., a resident scholar at the American Enterprise Institute, a conservative think tank, is a leading opponent of price controls, much called upon by industry organizations like the Pharmaceutical Research and Manufacturers of America. He explains, “Price controls are invariably established with the best of intentions, usually to achieve limited goals for a limited time. Then the controls themselves go to work to create an intractable mix of vested interests.”

Conservatives’ most worrisome criticism of price controls is that they would impede pharmaceutical R&D. “Pharmaceutical research incentives arise primarily from subjective estimates of future prices and profits for new drugs if the research turns out to be successful,” Dr. Calfee has written. “In the absence of objective standards, price regulators would find powerful incentives to reduce drug prices below sufficient levels to reward innovative research. Research firms would anticipate the effects of price controls and would curtail innovative research because potential payoffs were reduced.”13

How fair is this criticism? Not very. Drug companies habitually obscure how much they really spend on R&D. In 2002, Merck assigned only 11% of its after-tax revenue to R&D, while profits accounted for 19%, and marketing, advertising, and administration were 29% (see "A Bitter Pill," 13 Calfee, J.E. (2001)


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Another argument that price controls would not affect research is that pharmaceutical companies are not good at R&D. A Tufts University study that purportedly demonstrates that it costs $837,000,000 to develop a new drug is highly misleading; pharmaceutical companies have been notoriously inefficient in recent years, developing few new drugs, and at very high cost. Increasingly, small biotechnology firms have been more productive using less capital (see "The Failure of Industrialized Research," May/June). Human ingenuity is such that, even with less money, drug companies would probably find a way to do better research.

Road map to price controls
The first thing to note about how price controls might work is that they would not necessarily destroy high profits. A little economic arithmetic suggests that existing profits could be protected through an intelligent application of price regulation (thus protecting research, if it was, in fact, dependent on today's high profits).

Imagine that the prices of most prescription drugs in the United States were cut by 40%, so that Americans paid what Canadians now pay for drugs. Pharmaceutical manufacturers would lose about $50 billion in revenue. But if the "price elasticity" (how much consumer demand responds to the changing price of a product) of prescription drugs was sufficient, lost revenue would be replaced with higher sales volumes.

Though this idea may seem hopelessly optimistic, the price elasticity of drugs may be greater than pharmaceutical companies have supposed. Price elasticity is a function of a product's general utility, and many essential drugs are demonstrably underused because those who want them cannot afford them. Lower drug prices would encourage higher demand from those patients with private or employer-funded insurance plans. Cheaper prescription drugs would mean that Medicare and Medicaid could offer prescription drug benefits. The results of price controls might be beneficial to everyone—patients could afford the drugs their physicians prescribed, and drug manufacturers would still earn huge profits.

U.S. regulators would likely control prices indirectly, by regulating the costs of developing and distributing a drug, or directly, by determining a drug's medical and economic benefits and fixing its price—or by some combination of the two. The mechanisms used would be similar to those now employed in Europe: rebates, purchasing pools, classic price controls, profit caps, and greater use of generics.

One attractive idea, proposed by Dr. Sager and his Boston University colleague Deborah Socolor, is that any domestic price control should be part of a broader, international trade agreement, or a "prescription drug peace treaty." The proposed trade agreement would negotiate fair prices for prescriptions, based on average national incomes. It would continue to subsidize drug sales to developing nations that could not otherwise afford them, but it would use U.S. economic power to wrest a fair sharing of drug costs. Americans would no longer subsidize the health care of other wealthy nations.

All these proposals are necessarily speculative. Any real system of price controls would combine a variety of mechanisms, as well as ideas not envisioned here. But that such concepts were debated by Congress this summer is a startling development. In part, politicians considered controls for pragmatic reasons: they were panicked by how much the government might have to spend on Medicare drug benefits. Perhaps they also noted the anger in the millions of Americans who, like Laurette Dornin, resent spending so much on prescription drugs and want the government to do something about it.

But Congress may further suspect something more dramatic is happening—that Americans now so value their medicines they believe they have a right to them.