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Testimony on S. 375

## **The Safe and Affordable Prescription Drugs Act**

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As always, we testify and write only for ourselves, not on behalf of  
Boston University or any other party.

**Summary** Prescription drug spending in Massachusetts will be about \$5 billion this year. Lower prices are essential to making medications affordable for all Americans. This bill would promote and facilitate purchasing safe and lower-cost drugs from Canada. We therefore urge you to support it.

Drug makers and the FDA claim that buying drugs from Canada is dangerous, would hurt drug makers, and would therefore cripple breakthrough research. They are wrong. Importing would actually boost profits if 45 percent or more of the imported drugs are new prescriptions. Further, we will show that high drug prices have actually become the enemy of breakthrough research.

We will sketch two methods of winning lower drug prices. One would pay marginal cost for additional prescriptions. We will testify that a 20 percent rise in prescription drug use in Massachusetts, from 70 million to 84 million prescriptions yearly, could address unmet needs for medications. This rise can be financed by spending an additional \$101 million yearly. This sum equals less than four months' rise in current spending on prescription drugs in Massachusetts.

A second method would establish a single Massachusetts buyer for all prescription drugs used in the state. It would negotiate lower prices but these would be offset by higher volumes. Drug makers' profits would be intact. And they would no longer need to fear price controls. Most important, all patients would receive needed and effective medications at an affordable cost.

## **1. Problems**

This year, U.S. prescription drug spending of over \$250 billion provides the world's drug makers with about one-half of their world-wide revenue. An impressive accomplishment by only 5 percent of the world's people.

(For charts depicting this and other problems, please refer to the attached Affidavit prepared in support of Illinois Gov. Blagojevich's petition to the FDA.<sup>1</sup>)

Yet some 70 million Americans have no prescription drug insurance. Others have meager coverage.

Drug spending has quadrupled nationally in the past decade. Rising drug prices and spending boost insurance premiums and also the cost of Medicaid and Medicare drug programs.

In Massachusetts, retail prescription drug spending this year will be over \$4.2 billion. When additional spending in hospitals and nursing homes is counted, the total approaches \$5 billion.

In our state, we will spend about as much on medications this year as the \$4.5 billion total to be spent by Denmark plus Sweden—nations with more than double our population, and nations that protect all of their people against the cost of medications.

By contrast, well over one million of us in Massachusetts still have no prescription drug insurance. And no one knows how many will sign up for the new Medicare Part D coverage.

To cover all people in Massachusetts, we could throw more money at the drug makers. But we can't afford it. And they don't really need it.

With such high drug costs and so many people uninsured for prescription drugs, we face three choices. We could spend more—much more. That's unaffordable. We could continue to allow people to suffer avoidable pain and disability, and premature death, for lack of needed meds. That's inhuman. Or we could change—we could reform. That's inevitable, and the sooner the better.

Massachusetts already has the world's costliest health care.<sup>2</sup> Combining improved coverage with cost control is essential if we are going to make Massachusetts health care durably affordable for all of us, and to sustain all needed caregivers.

There are ways to move forward. One is this bill, which seeks to promote and facilitate buying prescription drugs from Canada.

## **2. *Buying drugs at lower prices in Canada is safe and won't hurt research***

Buying drugs from Canada is safe. The attached affidavit documents this assertion.<sup>3</sup>

The FDA and the drug makers say that importing drugs from Canada is not safe. They offer little evidence to support their assertion.

The FDA ignores the simple cause of importing drugs from Canada—high U.S. prices. And it ignores the benefit to Americans of getting low-cost drugs from Canada. Instead, the FDA and its friends in the drug industry focus on the theoretical harm that might be caused by illegal imports.

The FDA ignores the simple fact that if legal imports from Canada resulted in lower U.S. drug prices, there would be no market for illegal imports—whether safe or dangerous. In the U.S. in the 1920s, during Prohibition, some Americans were indeed hurt by drinking poisonous alcohol products. But these illegal products won a market only because alcohol had been made entirely illegal.

The FDA does not blame the world's drug makers for their high U.S. prices. Instead, it blames desperate U.S. citizens for trying to obtain affordable medications. And it tries to stop them from buying safe and vital drugs.

A high FDA official has said that the danger from imports is that it will cut profits, which would harm research, which would—he claimed—harm new drug development.<sup>4</sup> Each piece of argument appears to be untrue. High prices are not the key to high profits. And high profits have not been financing much breakthrough research.

Most people assume that importing more drugs from Canada would cut drug makers' profits.

Actually, we have found, importing drugs from Canada is unlikely to harm drug makers' profits. As the attached report shows, if more than about 45 percent of drugs bought from Canada are new prescriptions, which Americans previously could not afford to fill at high U.S. prices, drug makers' profits actually rise owing to importation from Canada. That's because the rise in volume of drugs sold—in response to lower-priced imports—offsets the lower price of the imported drugs. The attached report documents this analysis.<sup>5 6 7</sup>

PhRMA, its lobbyists, its FDA friends, and its political friends insist that high U.S. drug prices are essential to finance research. They say that if Americans can win lower drug prices—by importing drugs from Canada, for example—research will suffer. They are wrong.

### **3. *The sooner drug prices are cut, the better for patients, for payers—and even for drug makers***

Most Americans know that lower drug prices would be better for us, other things equal. Businesses, families, insurers, HMOs, Medicaid, and Medicare would enjoy immediate relief if they did not have to scramble to find the dollars to pay ever-higher drug bills. Most important, lower prices will allow more people to afford their medications, permitting greater numbers of patients to take the drugs they need and that their doctors prescribe.

PhRMA's fog of fear. Drug makers insist publicly that high prices are essential to finance research. Drug makers and their advocates assert that high drug prices are good for us, and that any effort to make medications affordable for all Americans will harm research and even endanger lives.

In 2000, for example, Tracy Baroni, senior director of policy for the Pharmaceutical Research and Manufacturers of America (PhRMA) said that price controls for prescription drugs “deter investors and that wipes out funds for drug research and development. ‘The lights go out in the labs and there is no R&D,’” she testified to a New Mexico legislative committee.<sup>8</sup>

James P. Pinkerton, a fellow at the New America Foundation, was even more overt—and inflammatory—when he wrote in a March 2004 *Los Angeles Times* op-ed, that drug price controls could harm research, and that this could be “a matter of life and death for millions.”<sup>9</sup>

Baroni, Pinkerton, and their fellow-frighteners are wrong.

***The line they are selling should be called “PhRMA’s Fog of Fear.”***

Disturbingly, when drug makers insist that high U.S. drug prices are essential to finance research, FDA officials agree. Indeed, Peter Pitts, FDA Associate Commissioner, said “We must keep the pump primed for research and development. . . . We depend on the cutting edge medicines produced by the companies that make the investment in science.” Pitts also said that importing drugs from Canada would “undermine the innovation” that U.S. drug makers conduct.<sup>10</sup>

Peter Pitts is wrong. High drug prices are politically impossible to sustain. And high prices have become the enemy of breakthrough research, not its financier.

#### **4. High drug prices are politically impossible to sustain**

PhRMA's fog of fear is designed to allow drug makers to harvest a few more years of high profits before an infuriated public demands affordable medications. If that fury elects a very angry Congress, PhRMA will have helped to engineer the draconian price cuts it wishes to avoid. The alternative, compromise today, would help to avert harsh cuts tomorrow.<sup>11</sup>

Although drug makers insist publicly that high drug prices are essential to financing research, they are wrong. And they almost certainly know it. They cling desperately to high prices because they don't see a practical alternative—one that is, on balance, no more risky and at least as financially adequate. One problem with the drug makers' calculations is that they probably compare magical continuation of today's pricing with the alternatives they dislike. They should be comparing the imminent wreckage of today's pricing with the alternatives.

The sooner drug prices are cut, the less the risk to drug makers and to research itself.

One reason is that the longer U.S. drug prices and spending are allowed to grow to increasingly unsustainable levels, the greater will be the price cut and the risk of dislocation when governments finally act to make medications affordable for their citizens. That drug prices will be cut from a greater height is only part of the problem drug makers will face. The other part concerns the manner in which prices are cut.

The sooner U.S. drug prices are cut, the less angry we will be at the drug makers, and the more moderate and the more reasonable we will be when we cut prices. The sooner prices are cut, the easier it will therefore be to work with drug makers to assure them a gradual transition. And the easier it will be to design and implement an arrangement, such as the guaranteed increase in volume, described shortly, that will protect revenue to finance research.

## **5. High drug prices have become the enemy of breakthrough research**

Drug makers are understandably nervous, the most nervous very-well-dressed people in the United States. Said one big-PhRMA CEO, “We know we are defying gravity.” After all, nothing can keep doubling forever. And blockbuster drugs are going off patent. Relatively few new drugs are in pipeline. Why is that, if drug makers have such high prices and huge profits—so much money to invest in research?

It’s helpful to look at how the drug makers have worked to sustain rapid revenue growth. The drug makers have come to rely excessively on a very conservative strategy that we call the 3Ms—Me-too’s, Mergers to cut competition, and Marketing and advertising. Almost one-half of PhRMA members’ research goes to me-too or copy-cat drugs.<sup>12</sup> Also important to bolstering revenue growth have been increases in price on existing drugs.

Underpinning much of this conservative strategy has been the undermining of objective science—from the conduct of research to the reporting of research (and the non-reporting of some research findings) to the subsidization of journal publication and all the rest. Evidence-based prescribing must rest on objective evidence—evidence that’s too often lacking today.

Rationalizing much of this conservative, cautious strategy has been the public talk of the drug makers themselves, often supported by hijacked free market enthusiasts. To the degree that our analysis is correct, the drug makers are not vigorous and unrestrained free market competitors but rather high-price, low-volume members of restrictive medieval guilds.

Drug makers and their friends like to assert that the political threat of price controls undermines breakthrough research. They shout publicly that they won’t conduct risky breakthrough research without the reward of enormous profits, so the threat of price controls should be withdrawn.

We suggest that drug makers have it only half right. Yes, rewards do induce risk-taking. But no, the threat of price controls is not political whimsy or opportunism. Rather price controls are an inevitable result of drug makers’ own financial success in the U.S. market. Did they really expect that they could quadruple their U.S. revenues from 1994 to 2004 without facing serious consequences? We believe that drug makers have already privately recognized that price controls are inevitable so, therefore, they have already begun to rely heavily on the conservative strategies for boosting revenue that were just described.

High drug prices are not necessary to generate drug makers’ profits or finance research. Prices could be cut without harm to drug makers’ profits. If profits are sustained, so is capacity to finance research.

## 6. A prescription drug peace treaty

Because prescription drug spending in the United States and in Massachusetts is so high, and because the added cost of making more pills is so low, it should be possible to cover everyone without spending much more money.

Once the research is done and the factory is built, the added cost of making more pills is very small. This is sometimes called the incremental cost or the marginal cost. If the face of low incremental cost is ignored, then programs to improve access to medications—like Medicare’s new Part D—are likely to bestow undeserved windfall profits on drug makers.<sup>13</sup>

Today, many patients are unable to afford the medications they need and therefore don’t get them. In this testimony, we suggest that the net shortfall in use equals 20 percent of current use.

Drug makers’ inefficient private welfare programs don’t begin to fill the gap. There is a better way.

State government could fight for lower prices for drugs. That would cut drug makers’ revenues. But drug makers would recoup some of the lost revenue through greater private purchase of prescription drugs, as lower prices enable more people to afford to buy their drugs.

Drug makers could recoup the rest of their lost volume through greater public insurance of prescription drug costs. For example, Massachusetts could raise the income eligibility for Prescription Advantage. The improved eligibility would be financed from the savings won by extracting lower prices from the drug makers.

As a result of all this, everyone in Massachusetts could be protected against the cost of medications, and drug makers’ revenues would not have fallen.

But the drug makers’ costs would have increased by the amount required to make more pills. To keep them financially whole (with their return on equity intact), they could be paid for this small added cost.

We calculate the added cost at almost \$60 million this year—or about 1.5 percent of current spending.<sup>14</sup>

Additionally, pharmacies should be paid for their added dispensing costs. We estimate these at some \$40 million this year.<sup>15</sup>

Together, added manufacturing and dispensing costs would total just over \$100 million. This one-time rise in spending would equal less than four months of current increases in today’s prescription drug spending in Massachusetts.

## **7. A single buyer for prescription drugs**

An alternative would be to empower state government to act as a wholesaler. It would never take physical possession of medications. These would continue to flow through today's distribution channels.

Rather, the Commonwealth would negotiate a simple package deal with each drug maker. If you, Drug Maker X, sold \$400 million of your products in Massachusetts last year, for example, we'll give you \$416 million this year, allowing 4 percent inflation. And we'll pay you the added manufacturing and distribution cost of all increases in volume. But you have to fill all prescriptions written for Massachusetts patients.

In this way, the drug maker is financially whole. Its profits and its sums available for research don't fall. Everyone in Massachusetts gets the medications he or she needs. Total spending rises by the small actual cost of manufacturing, distribution, and dispensing.

All this concerns drugs that were marketed last year. If a drug maker proposes to market a new drug this year, its added benefits and costs would have to be evaluated. If the added benefits were proven to be worth the added money, it would be bought and the wholesaler would pay the drug maker additional sums. If the added benefits were proven to be small and the added cost were proven to be high, the wholesaler would not purchase the drug, but doctors would be free to prescribe it. The cost would not be covered by insurance, though. Individuals would have to pay privately.

This is easiest to do if all drug purchases are channeled through a single buyer. Indeed, all financing could be carved out of existing private and public insurance plans and directed to the single buyer.

In closing: It is very inexpensive to finance needed medications for all who live in Massachusetts. This is the easiest problem to fix in health care.

Massachusetts has the prescription drug buying power of a medium-size European nation, if we pool all of our purchasing together and empower a single statewide buyer. We should then be able to negotiate a peace treaty with drug makers.

Thank you for the opportunity to appear before you today and to submit this written testimony.



## Notes

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<sup>1</sup> Alan Sager, *Affidavit in Support of Governor Blagojevich's Petition to the FDA to authorize the State of Illinois to import prescription drugs from Canada*, 8 April 2004, <http://www.affordabledrugs.il.gov/pdf/SagerAffidavit.pdf> and [www.healthreformprogram.org](http://www.healthreformprogram.org).

<sup>2</sup> Alan Sager and Deborah Socolar, "A Few Realities of Massachusetts Health Care, 2005," Boston: Health Reform Program, [www.healthreformprogram.org](http://www.healthreformprogram.org).

<sup>3</sup> Alan Sager, *Affidavit in Support of Governor Blagojevich's Petition to the FDA to authorize the State of Illinois to import prescription drugs from Canada*, 8 April 2004, <http://www.affordabledrugs.il.gov/pdf/SagerAffidavit.pdf> and [www.healthreformprogram.org](http://www.healthreformprogram.org).

<sup>4</sup> "FDA Warns that Efforts to Import Canadian Drugs Could Hurt Innovation," *Sacramento Bee*. This article was reprinted on PhRMA's own web site, [www.phrma.org](http://www.phrma.org).

<sup>5</sup> Alan Sager and Deborah Socolar, *Do Drug Makers Lose Money on Canadian Imports*, Boston: Health Reform Program, Boston University School of Public Health, 15 April 2004, [www.healthreformprogram.org](http://www.healthreformprogram.org).

<sup>6</sup> Christopher Rowland, "Study Says Importing Drugs May Not Hurt Profits," *Boston Globe*, 15 April 2004.

<sup>7</sup> Jennifer Powell, "Canada Dash May Mean Cash: Rx Imports Could Boost Drug Makers, Study Says," *Boston Herald*, 15 April 2004.

<sup>8</sup> Tracy Baroni, senior director of policy, Pharmaceutical Research and Manufacturers of America (PhRMA), in Deborah Baker, "Many in Southwest Lack Drug Benefits: Study Urges States to Fight High Costs," *Albuquerque Journal*, 7 September 2000.

<sup>9</sup> James P. Pinkerton, "Reining in Prescription Prices Is a Seductive Idea. But It Might Kill You," *Los Angeles Times*, 18 March 2004.

<sup>10</sup> "FDA Warns that Efforts to Import Canadian Drugs Could Hurt Innovation," *Sacramento Bee*. This article was reprinted on PhRMA's own web site, [www.phrma.org](http://www.phrma.org).

<sup>11</sup> Alan Sager, "Winning Durably Affordable Innovative Drugs: A Few Lessons from the Arguments over Importing Drugs from Canada," Symposium on U.S. and Canadian Pharmaceutical Policy, University of Connecticut Law School, 29 October 2004, [www.healthreformprogram.org](http://www.healthreformprogram.org).

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<sup>12</sup> Merrill Goozner made this assertion in “The Price Isn’t Right,” *American Prospect*, 11 September 2000. Joseph DiMasi of the Tufts University Center for the Study of Drug Development concurred in this estimate.

<sup>13</sup> Alan Sager and Deborah Socolar, How Much Would Drug Makers’ Profits Rise under a New Medicare Prescription Drug Benefit? A Response to PRI/PwC’s Undocumented and Disjointed Critique of our 31 October 2003 Report, 2<sup>nd</sup> Edition, Boston: Health Reform Program, Boston University School of Public Health, 12 April 2004, [www.healthreformprogram.org](http://www.healthreformprogram.org); and Alan Sager and Deborah Socolar, 61 Percent of Medicare’s New Prescription Drug Subsidy Is Windfall Profit to Drug Makers, Health Reform Program, Boston University School of Public Health, 31 October 2003, [www.healthreformprogram.org](http://www.healthreformprogram.org).

<sup>14</sup> This calculation assumes that retail prescription drug spending in 2005 in Massachusetts is about \$4.2 billion, that average actual price paid per prescription is about \$60, and that the marginal cost of making more pills equals about 7 percent of price paid, and that a net rise of 20 percent in volume of medications—net of offsetting cuts in today’s use that’s clinically inappropriate.

<sup>15</sup> Pharmacists should be paid for dispensing the higher volume of medications. At \$3.00 per prescription, this would be about \$42 million, making the added payments to manufacturers and pharmacists almost \$101 million annually.