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Testimony on H.B. 4084

Pharmaceutical Availability and Affordability Act of 2004

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Disclaimer: As always, I write and speak only for myself,
not on behalf of Boston University or any of its components.

Acknowledgment: This testimony rests heavily on analyses
conducted with my colleague, Deborah Socolar.

Summary

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I. INTRODUCTION

Americans face three alternatives in health care: more suffering (unacceptable), higher spending (unaffordable), or reform. Reform is inevitable, particularly in the field of prescription drugs. H.B. 4084 takes on the unavoidable and vital job of winning lower drug prices for West Virginians. This bill is essential for eight main reasons.

1. Spending on prescription drugs in the United States has doubled every five years since 1994, rising over 4.5 times as fast as the U.S. economy as a whole.
2. If our nation does not get health care costs under control—and especially prescription drug costs—they will crowd out everything else we care about.
3. The world's drug makers are increasingly chemically dependent the U.S., drawing almost one-half their revenue here in 2002, up from one-third in 1996.
4. Soaring drug costs are not sustainable. Drug makers themselves say, "we know we are defying gravity." State governments face only three questions: **When** will drug prices be cut? **Where** will they be cut—in which state? And **how much** will drug prices be cut?
5. **When:** The quicker drug prices are cut, the better for drug makers, payers, and patients.
6. **Where:** Age, illness and disability, poverty, and high prescription drug use combine to make the drug cost problem particularly severe in West Virginia:
 - West Virginians averaged 15.0 prescriptions per person in 2002, two-fifths above the U.S. average of 10.6 per person.
 - The 4th-oldest population of any state, much chronic illness, and high use rates helped make West Virginia **2nd-highest in the nation in prescription drug spending per person** in 1998 (the last year with full data available).
 - West Virginia's prescription drug spending in 1998 was 11.1% of personal health care spending in the state—the highest of any state.
 - High spending plus the 2nd lowest personal income per person of any state mean that West Virginia's **prescription drug spending per person in 1998 was 2.12 percent of personal income, more than two-thirds above the U.S. average. No other state exceeded 1.8 percent of personal income.**

These problems help to explain the human, political, and financial pressure for lower prescription drug prices for West Virginians. Cost containment remedies touted in the past have been shown to be inadequate. Prescription drug costs plague Medicaid and state budgets. West Virginia in fiscal 2002 tied for 2nd highest of the states in the share of Medicaid dollars going to prescription drugs.

7. State governments have been spurred to act to win lower drug prices because Congress has been unwilling and unable to do so.

8. States are exploring diverse prescription drug reforms but, unfortunately, no state has yet made substantial progress toward winning affordable drugs for state government programs, for private employers, or for all citizens of the state. None have yet enacted legislation to win Federal Supply Schedule prices for prescription drugs. This approach is therefore worth attempting.

II. STRENGTHS OF THE BILL

H.B. 4084 is a straightforward piece of legislation. The testimony summarizes seven central provisions. It then offers several comments:

- It is good to allow the possibility of waivers from the FSS price ceiling. But the waiver process is likely to be dynamic, since volume changes affect the price required to cover all legitimate costs and profits. If volume rises in response to lower price, a waiver price (above FSS) would probably not have to be as great as it would have been had volume not increased.
- The legislation is helpful in the way it would directly benefit state programs and also allow others to shelter under the FSS umbrella.
- For now, FSS prices are a useful and practical standard. In time, might West Virginia's use of the FSS lead to a rise in the FSS price itself? That is difficult to ascertain, but possible. Were that to happen, the state could peg prices to an international standard, as many nations have done. But for now, the FSS appears at least as good as alternative standards.
- Cutting prices to FSS levels is far from the sharpest possible price reduction. FSS prices are about a 35 percent discount from average manufacturer's price. By contrast, the Veterans Administration's contract prices are about a 57 percent discount from average manufacturer's price.
- Since most medications for veterans are priced under V.A. contracts or the federal ceiling price, West Virginia's success in gaining FSS prices could not raise prices for drugs sold to the U.S. government for veterans. And ***the price actually paid by an individual veteran is a co-payment set by Congress— now \$7.00.*** President Bush has twice asked Congress to raise

that to \$15.00 for many veterans. His first request was about one year before the West Virginia House of Delegates' January 2004 passage of H.B. 4084.

- Lower prices will to enable more West Virginians to buy needed drugs that they cannot afford today. So volume increases will restore much revenue that drug makers would otherwise have lost to price cuts.

If West Virginia had won FSS prices *for all citizens* in 2000, you would have saved \$308 million, 35.9 percent of spending on brand name drugs. This year, since spending on drugs has risen considerably, ***your savings would reach \$534 million***—if you paid FSS prices *for all West Virginians*.

This bill, if passed and implemented, will help everyone who lives, works, or does business in the state. Can passing this bill hurt West Virginia? No, it can't. The only real risk or cost associated with the bill is that of defending it in court.

Why should West Virginia have to lead the way in winning lower prescription drug prices? Because you have the brains, the guts, and the need to get out in front.

III. CRITICISMS OF THE BILL, AND RESPONSES TO THEM

Some people have criticized this bill, saying that veterans, pharmacists, and drug research will be hurt by it. Some say so with good intentions. Others seem desperate to discredit any effort to win lower drug prices for West Virginia.

Q. Will veterans be forced to pay higher prices if this law passes? The V.A. competitive bidding process for drugs has won prices substantially lower than FSS levels. If West Virginia institutes FSS pricing, its action would have no effect on the price the V.A. pays for most drugs. The federal government has always done better at protecting itself from high drug costs than at protecting American patients as a whole. We can expect this to continue, so veterans will benefit accordingly. Also, what veterans pay is a \$7 co-payment for each drug they buy at V.A. clinics. President Bush twice asked Congress to raise the co-payment to \$15.00 for certain veterans. This had nothing to do with proposed West Virginia legislation. ***The serious threat to veterans' ability to afford prescription drugs is not in the West Virginia Legislature, but rather in the soaring and crushing burden of the cost of pharmaceuticals on the people of the U.S.A.***

Q. Would pharmacists suffer financially? It is hard to anticipate that pharmacists would suffer financially owing to this bill. Since 75.6 percent of the prescription drug dollar goes to manufacturers, efforts to lower drug costs will have to focus sharply on them. Reducing manufacturers' prices will enable more patients to afford their prescriptions, generating more dispensing fees for pharmacists, and bringing in more patients. Further, if West Virginia obtains FSS pricing from manufacturers, it will feel less pressure to squeeze pharmacists.

Q. Will research to develop new drugs decline? Other responses are more likely, for several reasons. Drug makers are anxious to make more money so they will be spurred to invest more in research after this bill makes it harder for them to charge high prices for existing drugs. They could finance vital breakthrough research by spending less on developing copy-cat drugs, and by lowering spending on marketing and advertising. H.B. 4084 rewards the drug industry when it cuts advertising and marketing spending and diverts the savings to breakthrough research. Further, even if drug makers' profits fell after the implementation of FSS pricing levels in the United States, and even if the industry ceased to be the very most profitable, investment can be expected to remain strong.

Q. Will lower prices cause earlier deaths, or other damage to human health and well-being? Will lower prices cause health care standards to decline? PhRMA has said that “price controls have led to declining health care standards in every country where they’ve been instituted.” A look at the evidence shows that this claim is untrue. For example, Germans live longer than Americans—even though they spend 40 percent less per person on prescription drugs.

Q. Why should government intervene to cut drug prices? PhRMA complains about price controls, calling them “socialized medicine.” The reality is that price controls are very widely used throughout health care in every western nation, including the United States. That’s because free market principles rarely work well in practice in health care, no matter how well they sound in theory. That’s why the Reagan Administration introduced price controls on Medicare’s payments to hospitals. The market is almost everyone’s first choice, and it should be. Unfortunately, we don’t have a free market for prescription drugs, and we probably can’t achieve one. (This is because of patents, oligopoly, lack of good scientific information or consumer information, and other factors.) Without a free market, and without government action to protect citizens, we would have anarchy, with drug spending continuing to double every five years.

This testimony addresses other possible questions and objections to H.B. 4084:

Q. Will drug detailers (salespeople) suffer?

Q. Will patients and hospitals suffer cuts in free samples or charity programs?

Q. Will drug makers’ profits drop if H.B. 4084 is passed?

Q. Will drug makers sue to stop implementation of H. 4084 if it were to pass?

Q. Why should West Virginia have to act and take on the drug makers?

Q. Is the state likely to suffer for taking on the nation’s most profitable industry?

Q. Doesn’t West Virginia have better options, like importing drugs from Canada, keying prices under this bill to Canadian levels, or waiting for Congress to act?

High drug prices now cause unnecessary suffering. The pressure to pass this bill soon is great because it is the best hope for lower prices. ***When your house is on fire, you don’t quibble about the color of the fire truck.***

IDENTIFICATION

My name is Alan Sager. I am a professor of health services at the Boston University School of Public Health, where I have taught health finance, administration, and policy to public health students since 1983, and where I also teach first-year medical students how to avoid getting blindsided by financial and policy problems. I direct our department's master of public health program and serve as one of the two directors of our Health Reform Program. My B.A. degree in economics is from Brandeis and my Ph.D. in city and regional planning, specializing in health care, is from MIT.

I have served on the Massachusetts Health Finance Working Group, on the Massachusetts Attorney-General's Advisory Group on Health Care Reform, and as a hospital trustee. I've testified six times before U.S. House and Senate committees (four times on prescription drug issues and twice on hospital survival problems), and to seven states' legislative committees.

Today's testimony is divided into three parts: an introduction that describes reasons for acting to win lower prescription drug prices in West Virginia; a summary of the bill's main provisions, how they would work, and resulting savings to the state; and a list of questions/objections concerning the bill, along with responses to them.

It is an honor to appear before you this afternoon.

I. INTRODUCTION

As health costs rapidly rise and health coverage steadily declines, Americans face three alternatives:

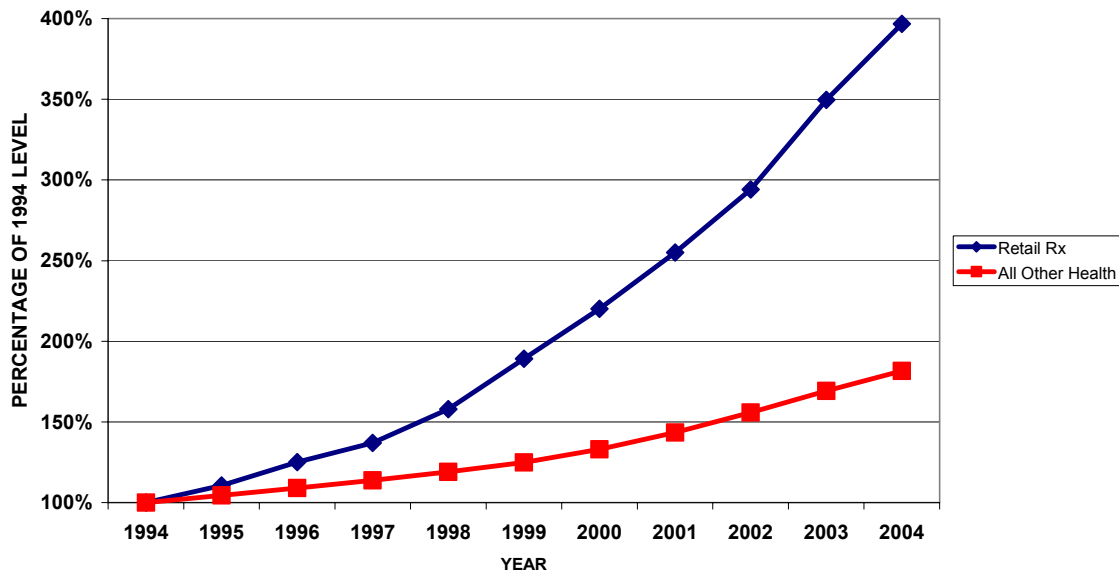
1. More people will suffer and even die for lack of needed care, but that is unacceptable.
2. We will spend much more money on health care each year, but that is unaffordable and unnecessary.
3. We will undertake reforms to do things differently, and that is inevitable. Nowhere is this more so than in the field of prescription drugs.

H.B. 4084 takes on the unavoidable and vital job of reforming prescription drug prices in order to make medications more affordable to the citizens of West Virginia. I suggest that the bill is essential for eight main reasons.

1. **Spending on prescription drugs in the United States has doubled every five years since 1994**, rising more than twice as fast as the rest of health spending. Please refer to Exhibit 1. Spending on prescription drugs has grown more than 4.5 times as fast as the U.S. economy as a whole.¹

Exhibit 1

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

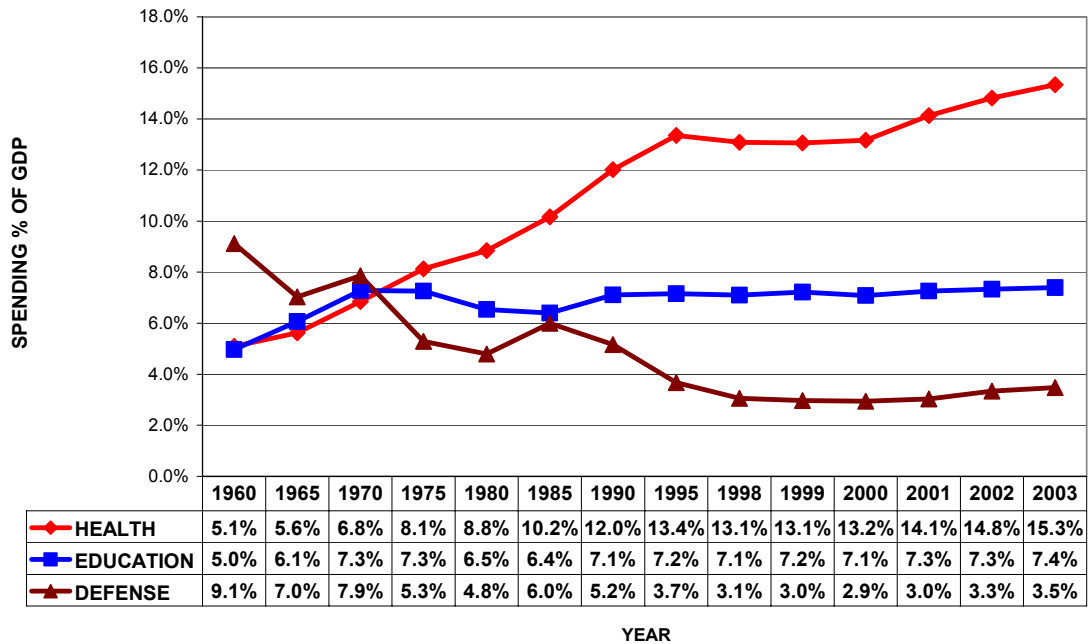


2. And let's not forget that **health care spending itself is not some measly sum. It has been four times reported defense spending** during the past decade. And it is **double education spending**. (Please refer to Exhibit 2.) In 1970, by contrast, health, education, and defense spending were all about the same share of the economy—about seven to eight percent.

If our nation does not get health care costs under control—and especially prescription drug costs—they will crowd out everything else you or I or other Americans care about.

Exhibit 2

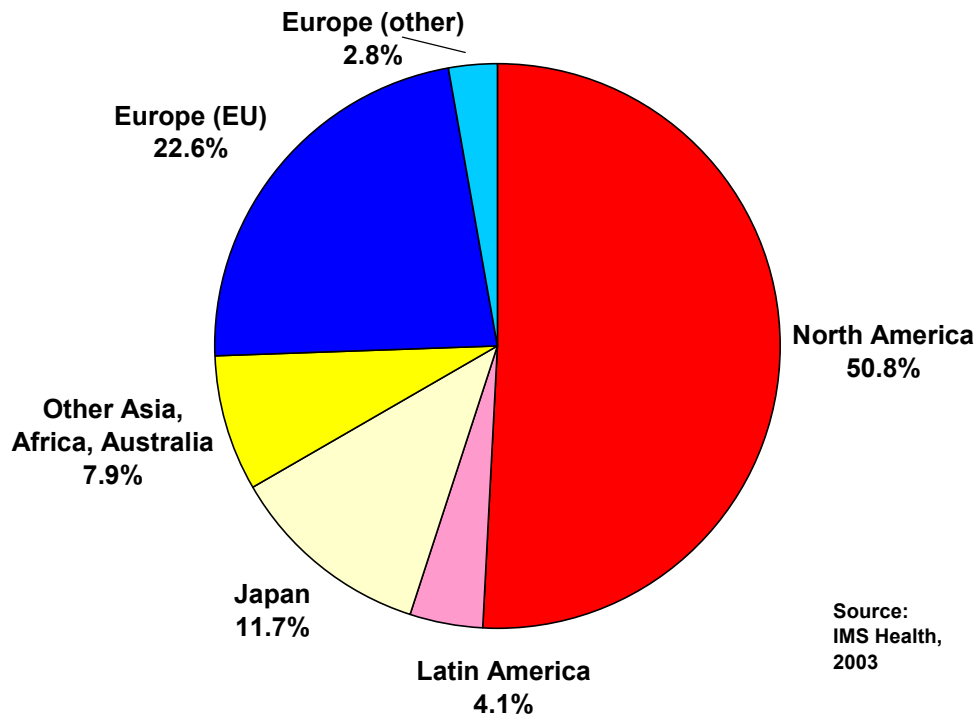
**HEALTH, EDUCATION, AND DEFENSE SPENDING,
U.S., 1960 - 2003, AS PERCENT OF GDP**



3. As shown in Exhibit 3, the *world's drug makers drew almost one-half their revenue from U.S. citizens in 2002, up from one-third in 1996.*² What this means is that drug makers are more and more chemically dependent on American citizens each year. And we're only five percent of the world's people.

Exhibit 3

SHARES OF WORLD'S Rx SPENDING, 2002



4. The question is **not whether** the rapid rise in spending on prescription drugs will be slowed or reversed, but rather when and how it will be slowed or reversed. These staggering increases in prescription drug spending are not sustainable. Nothing can double every five years. The drug makers themselves know that this is true. The CEO of one of the world's great drug manufacturing corporations said, "We know we are defying gravity."

The business plan that the world's drug makers have relied on in recent decades to keep profits and revenues high is gradually coming apart. Few new blockbuster drugs are coming on the market to replace those whose patents are expiring. Manufacturers' growing dependence on the U.S. market has sparked dozens of public and private efforts to contain spending. Financial and political pressures are growing.³

The three questions before each state government concern:

- **When** will prescription drug spending increases be cut or reversed?
- **Where** will these spending increases be cut or reversed—which state will take on the job?
- **How much** will spending increases be cut or reversed?

5. **Regarding timing, the sooner drug prices are cut, the better for drug makers, payers, and patients.** The world's drug makers will not fall from an even more artificially inflated high price level. The sooner we cut drug prices, 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. Payers would enjoy immediate relief if they did not have to scramble to find the dollars to pay ever-higher drug bills. Perhaps most important, lower prices will allow greater numbers of patients to take the drugs they need and that their doctors prescribe.

6. **Regarding place, the problem of high drug costs is particularly severe in West Virginia. Age, illness and disability, poverty, and high prescription use combine to make for these higher costs.**

West Virginia ranks fourth among the states (virtually tied with Florida, Maine, and Rhode Island), in the share of its people aged 65 and above.⁴ That share is 16 percent of the population, versus a U.S. average of 12 percent.

In 2000, West Virginia ranked

- fourth-highest among the states in diagnosed diabetes cases per 100 adults (two-thirds higher than the U.S. average)
- third-highest in cancer deaths per 100,000 citizens (12.2 percent above the U.S. average)
- third-highest in heart disease deaths per 100,000 citizens (18.1 percent higher).⁵

At the same time, 43 percent of West Virginians had incomes under 200 percent of poverty in 2000, compared with 35 percent of all Americans. The state ranked fifth-highest in the nation in the share of its residents with incomes below 200 percent of poverty.⁶

West Virginians averaged 15.0 prescriptions per capita in 2002, two-fifths above the national average of 10.6 prescriptions per capita.⁷

Four important problems emerge from these realities. These four problems help to explain the human and political pressure that has led to the serious consideration of seeking FSS prices for West Virginia.

1. With an older population, a greater burden of chronic illness, and higher prescription use rates, it is not surprising that West Virginia was ***second-highest in the nation in total prescription drug spending per person*** in 1998, the last year for which complete data are available. Spending per person then was \$428, 28 percent higher than the national average of \$335 per person.⁸
2. West Virginia's prescription drug spending in 1998 was 11.1 percent of personal health care spending in the state (one-quarter above the US 8.9 percent share)—and the highest of any state.
3. At the same time, 1998 per capita personal income in West Virginia was second-lowest among the states, 24.8 percent below the U.S. average (\$20,234, vs. \$26,893 for the United States).⁹
4. The combination of high prescription drug spending and low incomes means that ***West Virginia's prescription drug spending per person in 1998 was 2.12 percent of personal income, 69.6 percent above the national share of 1.25 percent of personal income. No other state exceeded 1.8 percent of personal income.***

Sparked by these grave human and financial problems, West Virginia has tried to use some of the cost containment methods touted in the past, such as boosting the generic share of prescriptions filled by public employees to above 50 percent of the total, I am told. But these remedies are not adequate.

Throughout the nation, rising Medicaid costs plague state legislatures that are obliged to balance their budgets. This is now dramatically visible in West Virginia.¹⁰ In West Virginia, even more than in most other states, the rising cost of prescription drugs is one of the biggest causes of crisis in Medicaid. In fiscal year 2002, West Virginia tied for second with Florida in the share of its Medicaid dollars (17.3 percent) going to pay for prescription drugs.¹¹

Exhibit 4 displays percent changes in various components of the West Virginia Medicaid program between 1995 and 2003. Although prescription drugs grew second-fastest in percentage terms, their actual dollar growth was the greatest, with a \$160 million rise in spending levels over eight years.¹²

Exhibit 4

Changes in the Components of the West Virginia Medicaid Program, 1995 to 2003

Physicians	- 3%
Hospitals (excluding DSH dollars)	+6%
All other services (incl. managed care)	+18%
Nursing home care	+51%
Drugs (net of rebates)	+162%
Home/community-based waiver services	+214%

7. State governments have been spurred to act to win lower drug prices because Congress has been unwilling and unable to do so. This fall, Congress voted to refuse to act to win lower drug prices for all Americans. The new Medicare drug bill fails to import drugs from Canada. It prohibits Medicare from pooling its buying power to bargain for lower prices effectively. Instead, it deliberately fragments Medicare’s buying power among lots of PBMs, HMOs, PPOs, and new drug-only insurance plans. Those mechanisms have done little to contain drug costs in the past.

Americans cannot afford more years of soaring drug spending. This explains the proliferation of state attempts to try to limit prescription drug spending in the United States. Unfortunately, these early efforts have not been remotely commensurate with the problem of soaring prescription drug spending.

8. The National Conference of State Legislatures staff recently summarized recent experience with state-level prescription drug reform.¹³ In the 2003 legislative session, 49 states considered more than 325 bills to lower drug costs, improve coverage, and achieve related aims. Methods concerned multi-state or agency bulk purchase, clearinghouse information, discount programs, drug importation, marketing and advertising, Medicaid drug costs, regulation of pharmacy benefit managers, preferred drug lists, re-use or recycling of drugs, drug subsidies, and several others. Some 82 laws passed in 39 states.

Unfortunately, no state has yet been able to make substantial progress toward winning durably affordable medications—not for state government programs, not for private employers, and not for all citizens of the state.

None have yet enacted legislation to win Federal Supply Schedule prices. This approach is therefore worth attempting.

II. STRENGTHS OF THE BILL

A. Summary of the bill's mechanisms

H.B. 4084 is a straightforward piece of legislation. Some seven central provisions are highlighted here.

1. The bill would have the legislature find that national and state markets for prescription drugs have failed, and that this failure “prevents all citizens of West Virginia from having affordable access to prescription drugs.”¹⁴
2. A pharmaceutical commission would be created. It would be composed of four high-level state administrators and three citizens with experience in insuring pharmaceutical coverage.
3. Prices to be paid for pharmaceuticals could not exceed those listed on the Federal Supply Schedule (FSS), plus a dispensing fee, except in specific instances. The commission could negotiate lower prices.
4. These prices would apply to patients covered under public employee insurance, Medicaid, West Virginia's children's health insurance program, and workers' compensation. The bill carefully specifies that the application to Medicaid and children's health insurance would be conditional on receiving a federal waiver should that be judged necessary. Additionally, private insurers, self-insured employers, free clinics, and other entities may apply to obtain these prices.

5. Three grounds for requesting waivers from FSS prices are specified in the bill.
 - a. Drug makers may seek waivers from the FSS price limit for individual drugs whose development, production, and distribution costs, plus other reasonable costs and profits, exceed the FSS levels.
 - b. Manufacturers of sole source drugs are also entitled to request waivers.
 - c. And generic manufacturers may seek waivers if their legitimate costs exceed FSS levels or if the waiver can be expected to lower the overall cost of drugs.

6. Advertising and marketing costs are explicitly excluded from the list of reasonable costs that could justify a waive from the FSS price limit. Additionally, drug makers must annually report to the pharmaceutical commission on a wide range of marketing, advertising, and related costs.

7. The commission is authorized to pursue alternative methods of winning lower drug prices. These include exploring purchasing drugs from Canada. That may involve the state in seeking federal waivers or serving as a drug wholesaler. Additionally, the commission is permitted to develop other methods to lower cost and improve access to medications. These could include working in concert with other states to advance the legal and political struggle to win FSS prices.

Several comments about these seven sets of provisions may be useful. First, it is a good idea to permit the granting of waivers from the FSS price ceiling. The process of granting waivers is likely to be a dynamic one, since the price required to cover all legitimate costs and profits is itself affected by volume changes. For example, if a drug's volume rises in response to lower price, it can actually be as profitable or even more profitable than it had been before the price was cut. At the least, the waiver price (above FSS) would probably not have to be as great as it would have been had volume not been considered.

Second, the legislation is helpful in the way it would directly benefit state programs and also allow for others to shelter under the FSS umbrella.

Third, for now, the FSS is a useful standard. It is a practical one. FSS prices are publicly available; they can even be obtained on-line.¹⁵ In time, might West Virginia's use of FSS lead to a rise in the FSS price itself, offsetting some of the state's gains? That is difficult to ascertain, but it is possible.¹⁶ Were that to happen, prices could then be pegged against a more robust international standard, such as the lowest (or median) of certain nations' prices—as Canada has done, as many other nations have done, and have some propose the U.S.

should do.¹⁷ Again, for now, Baitty concludes that the FSS standard is a useful one, at least as good as the alternatives.¹⁸

Fourth, cutting West Virginians' prescription drug prices to FSS levels is far from the sharpest price reduction that might have been sought through this bill. Schondelmeyer has examined various prices as a percentage of the published average wholesale price (AWP). Exhibit 5 presents Schondelmeyer's findings.

Fifth, FSS prices average 51.7 percent of AWP. They amount, I calculate, to a 35.4 percent discount from average manufacturer's price.

By contrast, the Veterans Administration contract price is 34.6 percent of the AWP. This amounts to a 56.8 percent discount from average manufacturer's price.

Sixth, since most medications purchased by veterans are governed by prices set under VA contracts or under the federal ceiling price, West Virginia's success in gaining FSS prices could not raise prices for these drugs sold to the United States government for use by veterans.¹⁹ Further, as noted later, the price actually paid by an individual veteran is a co-payment amount that is set by Congress—currently at \$7.00, although President Bush has twice asked Congress to raise the co-payment to \$15.00 for many veterans. The president's first request to raise the co-payment came about one year before the West Virginia House of Delegates passed H.B. 4084 on the 23rd of January of 2004.

Exhibit 5

Estimated Prices for Selected Public Purchasers, as Percent of AWP

<u>Payment standard</u>	<u>percentage of AWP</u>
Average wholesale price	100.0
Average manufacturer's price	80.0
Medicaid, minimum	67.9
Medicaid, net of rebates	60.5
Federal Supply Schedule (FSS)	51.7
Section 340B health centers	49.0
Federal ceiling price (FCP)	47.9
VA contract	34.6

Source: Stephen Schondelmeyer, Prime Institute, School of Pharmacy, University of Minnesota, 2001.²⁰

Of course, the FSS works only on price, not on volume. Total spending is a product of price and volume. Cutting price can be expected to increase the quantity of prescription drugs demanded by West Virginians. That is not, in itself a bad thing. It means that more citizens of the state are able to afford needed medications prescribed by their physicians—drugs they are not able to afford today. At the same time, volume increases in response to the lower prices will restore much of the revenue that would otherwise have been lost by drug makers as a result of the imposition of the original cuts in prices to FSS levels.

B. Savings to West Virginians from paying FSS prices

If this bill succeeds in winning lower prescription drug prices for West Virginians, more citizens of this state will be able to afford the medications their doctors prescribe. Their health will improve. People will live longer. They will suffer less pain and disability.

As shown in Exhibit 6, if West Virginia could have won FSS prices for all citizens in 2000, you would have saved \$308 million, a sum equal to 35.9 percent of spending on brand name drugs.²¹ This year, owing to the considerable rise in spending on brand name prescription drugs in West Virginia, your savings would increase to \$534 million if you paid FSS prices, a jump in savings of 73 percent in four years. This estimate assumes that all West Virginians benefit from FSS pricing.

Exhibit 6

West Virginians’ Savings on Brand Name Prescription Drugs, 2000 and 2004, If All Payers Paid FSS Prices

(\$ million)

	Estimated Spending	Spending at FSS Prices	Savings at FSS Prices
2000	\$857	\$549	\$308
2004	\$1,486	\$951	\$534
Increase in savings, 2000 to 2004, from paying FSS prices			73.3 percent

Source: Calculations, methods, and data sources are described in Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty-- Cutting Prices to Make Prescriptions Affordable for All and to Protect Research, 4 October 2000--with State-by-State Savings Estimates*, Boston: Boston University School of Public Health, 5 October 2000, www.healthreformprogram.org. Estimates for 2004 are increased in proportion to national estimates of spending on retail prescription drugs, 2000 to 2004.

This bill, if passed and implemented, will help everyone who lives, works, and does business in West Virginia. It will help them by making prescription drugs more affordable.

What is the downside? Can passing this bill hurt West Virginia? No, it can't. The only real risk or cost associated with the bill is that of defending it in court.

Even so, you might ask, why should West Virginia have to lead the way in winning lower prescription drug prices? Because you have the brains and the guts—and the need—to get out in front. I hope you will also find the votes.

III. CRITICISMS OF THE BILL, AND RESPONSES TO THEM

Some people have criticized this bill, saying that veterans, pharmacists, and pharmaceutical research will be hurt by it.

Some have said these things honestly and with good intentions. Others seem to have been motivated by a desperate need to discredit any efforts to win lower drug prices for the citizens of West Virginia.

People who have a lot to lose often don't play fair. And they sometimes don't tell the truth.

Q. Some very bad things have been said about this bill. Can we believe PhRMA's and their friends' allegations?

Sadly, over the dozen years that I have been studying prescription drugs in the United States of America, I have been forced to conclude PhRMA, its members, its front organizations (sometimes called Astroturf grass roots organizations), and the like sometimes tend to be a little economical with the truth. Still, when their words can be carefully, independently, and objectively corroborated, they can be trusted.

PhRMA, its members, its fronts, its lobbyists, and its other good friends are not villains, but they are desperate people fighting a rearguard action for a bad cause—high prices that make medications unaffordable for many West Virginians and other Americans.

Q. Will veterans be forced to pay higher prices if this law passes? At least one veterans group wrote West Virginia legislators to complain that this could be a problem.²² Additionally, a Pfizer representative said that “If West Virginia imposes price controls on us, we have to make up that decrease somewhere else.” “We would have to raise our prices on the veterans who have sacrificed for their country.”²³

It is useful begin by separating two different things. One is the co-payment that a veteran makes to buy an outpatient prescription at a V.A. facility for use at home. This is what a veteran pays. The other is the price that the federal government pays to drug makers to buy a drug in the first place.

Prices to the federal government to buy drugs might change as a result of this law. Or they might not. The V.A. competitive bidding process for drugs has succeeded in winning prices substantially lower than FSS levels.²⁴ But one thing we can count on is that the federal government has always done a much better job of protecting itself against the high cost of drugs than it has done in protecting American patients as a whole. The federal government does pay less than the rest of us do for medications.²⁵ We can expect it will continue to do so, and that veterans, among others, will continue to benefit accordingly.

Regarding what veterans pay, Congress set a co-payment for veterans of \$2.00 per prescription in 1990.²⁶ This is the price that veterans pay for each 30-day supply of a drug that they buy at V.A. clinics. But in 2000, Congress authorized an increase in the monthly co-payment to \$7.00.²⁷

It is President Bush who has twice asked Congress to raise the co-payment to \$15.00 for certain veterans. Congress rejected this request in the 2004 budget but the president renewed this request for the 2005 budget.²⁸ The president’s actions had nothing to do with proposed West Virginia legislation. Instead, they stemmed from a combination of the soaring cost of prescription drugs in the United States as a whole and the Bush Administration’s VA cuts. It is therefore reasonable to conclude that the serious threat to veterans’ ability to afford prescription drugs is not in the possible actions of the Legislature of the State of West Virginia, but rather in the crushing burden of the cost of pharmaceuticals on the people of the United States of America.

It is difficult to understand how Pfizer or other drug makers could threaten veterans with higher co-payments since those are set by Congress, and since Congress cannot be expected always to vote as drug makers wish.

Further, regarding what the VA pays drug makers when it buys for veterans, Baitty finds that “the VA actually pays significantly less than the FSS for most of its drug purchases. For about 77 percent of the drugs, the Federal Ceiling Price

(FCP) established by federal law is equal to or lower than the FSS price; and 23 percent of the VA's drug purchases were pursuant to its national contracts, which average 33 percent lower than the FSS."²⁹ This means that, if West Virginia does institute FSS pricing, its action would have no effect on the price the VA pays for most drugs. PhRMA's threats that West Virginia's actions could harm veterans should be examined in light of this evidence.

- - -

Q. Would pharmacists suffer financially?

H.B. 4084 does indeed give the new Commission the authority "to obtain favorable rates and dispensing fees."³⁰ At the same time, the bill provides that participating pharmacies may be eligible for a rebate to prevent "any loss of income."³¹

While the net result of these provisions is difficult to anticipate precisely, it is hard to expect that pharmacists would suffer financially owing to the passage of this bill. There are three main reasons. First, since 75.6 percent of the prescription drug dollar goes to manufacturers and only 21.1 percent goes to pharmacies,³² it is clear that efforts to lower the cost of medications will have to focus sharply on the manufacturers.

Second, any reductions in the price of prescription drugs sold by manufacturers will make it possible for more patients to afford their prescriptions (as discussed shortly in this testimony). Filling these added prescriptions will generate additional dispensing fees for pharmacists, boosting their profits. Additionally, lower drug prices should bring more patients into the drug store, where they will buy other products as well.

Third, some state Medicaid programs have already been cutting dispensing fees to pharmacists. It appears that, in some states, Medicaid had been paying higher fees than did private pharmacy benefits managers.³³ This means that there is no association between West Virginia's pursuit of FSS pricing and cuts in payments to pharmacies. Indeed, if West Virginia obtains FSS pricing from manufacturers, its motivation to squeeze pharmacists will be diminished.

At the same time, I would like to emphasize the importance of identifying and retaining an adequate and well-distributed network of community pharmacies in each state. Pharmacists are a vital part of the public's health infrastructure. Unless pharmacies' legitimate fixed and variable costs of efficient operation are met, needed pharmacies run the risk of closing, which will make needed medications and professional advice less available to citizens. Fragmenting pharmaceutical dispensing among mail-order and community pharmacies can make it harder for community pharmacists to check for drug interactions and

otherwise advise patients properly. Similarly, mail-order dispensing of drugs for long-term use may look like a less costly alternative in some instances,³⁴ but if it drains too much volume from community pharmacies, the latter could face a choice between raising their prices on antibiotics, pain-killers, and other drugs that the patient needs immediately—in order to cover their costs—and closing.

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Q. Will drug detailers (salespeople) suffer?

Some drug company sales representatives have made this claim recently.³⁵ No risk to a job can be taken lightly, but it is helpful to appreciate that the people of West Virginia, more than the people of almost all other states, have limited financial resources, so dollars spent on drug detailers' salaries are dollars that are not available to buy drugs or other things. And when drug companies pay more money to more detailers, that means less money available to finance breakthrough research into new life-saving medications.

This choice becomes clear when we note that PhRMA members' medical R&D employment fell 2 percent between 1995 and 2000 while their marketing employment rose 59 percent.³⁶ Since this information was publicized, PhRMA apparently ceased providing these employment figures on its web site.

But the *Wall Street Journal* has reported that, "Some drug makers concede that there are too many salespeople -- and that the glut contributes to the growing cost of health care."³⁷

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Q. Will patients and hospitals suffer for lack of free samples or for cuts in drug makers' discount card or private charity programs?

This allegation³⁸ suggests that drug makers might either retaliate against West Virginia for passing this bill, or that drug makers won't be able to afford free samples, discount cards, or private charity in the future.

Just as there is no such thing as a free lunch, there is no such thing as a free prescription drug. Today, drug makers categorize the cost of their free samples under marketing costs. They give away drugs to help induce doctors to prescribe them and patients to buy them. H. 4084 is designed to win lower drug prices, so more patients will be able to afford their medications and will therefore have less need for free samples.

Further, lower prices will make it easier for employers and for the State of West Virginia to retain and even expand financial protection against prescription drug costs.

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Q. Will drug makers' profits drop if H.B. 4084 is passed?

First, a few obvious statements. Profits are the difference between total revenue and cost. Total revenue is the product of price and volume.

The change in drug makers' total revenue after the passage of H.B. 4084 depends greatly on patients' reactions to the lower prices that H.B. 4084 would win for West Virginians. Lower prices almost always mean higher private market demand. But how much would demand rise when price falls?

Merrill Lynch estimated in 1999 that if a Medicare prescription drug benefit were combined with a cut in drug prices of 40 percent, the worst case would be a six percent drop in revenue and the best case would be a slight rise in revenue.³⁹ In other words, drug makers would recoup almost all—perhaps all—of the revenue lost from a price cut—through higher private market demand for medications.

This estimate seems to rest on the understanding that many patients cannot today afford to buy the medications their doctors prescribe, and many doctors do not even write some prescriptions, knowing that their patients would not fill them. In 1998, for example, Medicare beneficiaries with prescription drug coverage filled an average of 24.4 prescriptions while those without coverage filled only 16.7 prescriptions, a difference of 46.2 percent.⁴⁰

When use of prescription drugs rises if H.B. 4084 passes, manufacturers' costs rise also. But fortunately, the marginal or incremental cost of making more pills and capsules is very small, once the research is done and the factories are built. We estimate average marginal cost at 5 percent of retail price.⁴¹

If drug makers' profits drop somewhat owing to a combination of a small drop in total revenue and a small rise in total cost, it can be expected that drug making will still be among the most profitable industries in the United States, though it may not remain the single most profitable industry.

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Q. Will research to develop new drugs decline?

Cutting prices in West Virginia and other states to FSS levels might lead to reductions in research. But, for several reasons, other responses are more likely.

First, drug makers are anxious to make more money. Lower prices could spark them to develop useful new breakthrough drugs. They will be spurred to invest more in research once they see that West Virginia has truncated their opportunities to make more and more money by charging high prices for existing drugs.

Second, drug makers could finance more vital breakthrough research by backing off their investments in developing copy-cat or me-too drugs. Today, these are estimated to absorb fully 40 to 50 percent of drug makers' research budgets.⁴² These drugs are sometimes said to be valuable clinically, to help certain patients, and also financially, to hold down prices. If a breakthrough drug has much value but some undesirable side effects, one or more me-too drugs can be useful on clinical grounds. But once the West Virginia law holds manufacturers to FSS prices, drug makers will no longer be able to claim that copy-cat drugs that compete by price is essential to holding down spending on drugs.

Third, drug makers could finance much more research by lowering spending on marketing and advertising. Indeed, under H.B. 4084, if they can show higher research, manufacturing, and other legitimate costs, they can justify West Virginia prices in excess of FSS levels. In other words, H.B. 4084 helps to reward the drug industry when it cuts advertising and marketing spending and diverts the savings to breakthrough research and other valuable functions.

Fourth, in a world awash in excess manufacturing capacity for automobiles and many other consumer durables, and with large resources of capital seeking profitable investment opportunities, the prescription drug business should still be able to attract ample investment funds.

During the 28 years since 1970 for which data are available, median drug maker return on equity has averaged 22.1 percent. Its return on equity has averaged three-fourths above that of all U.S. industries.⁴³ The trend rose steadily over the three decades. During six of the nine years from 1993 to 2001, drug making has been the most profitable industry among those examined by the *Fortune* magazine tabulators. It never fell below third place out of 35 to 48 different industry groupings. Even if drug makers' profits fell after the implementation of FSS pricing levels in the United States, and even if the industry ceased to be the very most profitable, investment can be expected to remain strong.

These corporation-wide data on return on equity under-state the profitability of drug manufacturing to the extent that they include lines of business that are typically less profitable than drug-making.

Fifth, regulating drug prices would remove much of the uncertainty that today hangs over the industry. Most intelligent observers do understand that untrammelled perpetual doubling of revenues every five years was never in the cards. And the sooner governments in the United States act to make medications more affordable for their citizens, the more moderate will be governments' actions. If pressure and anger become great, governments will be more aggressive and precipitous in their actions when they finally move.

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Q. Will drug makers sue to stop implementation of H. 4084 if it were to pass?

They probably would work to overthrow the bill or, at least, delay its implementation for as long as possible. Among others, their arguments will probably concern:

- state reliance on the *federal* supply schedule
- states may not regulate drug prices
- state regulation of drug prices constitutes a taking of private property without appropriate compensation

This is to be expected.

Something else is possible. That would be for the drug makers to work with the State of West Virginia to implement the new law smoothly—to maximize benefit of the citizens of the state, and to minimize harm to the drug makers themselves.

The latter would constitute a Nixon-like opening to China or a Sadat-like opening to Israel. Drug makers' would thereby aim to adapt to the clearly emerging realities that the prices they desire are not acceptable today to the overwhelming share of the U.S. public—and will not be acceptable tomorrow to the overwhelming share of state and federal elected officials. The drug makers would aim to get ahead of the curve and bend it to their reasonable benefit.

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Q. Will lower prices cause earlier death, greater disability, other damage to human health and well-being? Will lower prices cause health care standards to decline?

Ms. Wanda Moebius of PhRMA said that “price controls have led to declining health care standards in every country where they’ve been instituted.”⁴⁴

A look at the evidence shows that this claim is untrue. It is also a red herring.

A document by Bain & Company, cited approvingly on PhRMA’s web site, claimed that “Delay in patient access to new drugs in Europe is linked to a widening, negative disparity in health outcomes, compared to the U.S.”⁴⁵

The Bain document (four pages of text and graphs) claimed that Germany, for example, suffers \$5 billion in losses annually from work absences, acute care, and mortality owing to slower use of new drugs. The claim is unsubstantiated. Not even hypothetical calculations are provided.

Here are a few of the serious problems with the Bain document, one that PhRMA boosts on its web site.

- The Bain document notes that the Germans spend “nearly 40 % less per capita on drugs than the US does.”⁴⁶
- What it does not note is that Germany was still fifth-highest in the world in drug spending per person in 2001 (the latest year for which I have available data), while the U.S. was first.⁴⁷
- Nor does the Bain document note that Germans live longer than Americans⁴⁸—even though they spend 40 percent less per person on drugs—and even though they spent 43 percent per person less on health care overall in 2001.⁴⁹
- Nor does the Bain document note that Germans suffered far fewer potential years of life lost in 1999 than Americans—2,672 per 100,000 women and 5,119 per 100,000 men, compared with 3,836 for American women and 6,648 for American men.⁵⁰ The U.S. suffered a 43.6 percent excess in potential years of life lost by women and a 29.9 percent excess years of life lost by men.
- The Germans manage to do live longer and suffer far fewer potential years of life lost this even though they are older than we are, and even though they smoke and drink more than we do.
 - The share of the German population aged 65 and above in 2000 was 16.4 percent, compared with only 12.3 percent in the United States.⁵¹

- German alcohol consumption was 27.7 percent greater than in the U.S. in 1998.⁵²
- And 29.3 percent more Germans smoked than did Americans in 1999.⁵³

According to Lexchin, the Bain report seems to simply assume that new drugs, with their higher prices, are typically better than older drugs.⁵⁴ But some newer drugs are merely higher-priced pharmaceuticals that are little different from those they replace, while others are actually less appropriate or effective than older alternatives.

Perhaps most important, this entire claim by PhRMA and Bain has no bearing on the debate on the bill before you today. It is a red herring.

That is because winning FSS prices for West Virginians would simply not affect the pace of new drug approvals in the United States. Those approvals are governed by the Food and Drug Administration. Only the price of those drugs is at stake here.

For these reasons, the Bain report appears to be more of a political document than an analytic one, in that it seems designed to support the argument that higher European prices for prescription drugs would actually benefit Europeans. The reality is somewhat different. High U.S. drug prices do finance a disproportionate share of the world's pharmaceutical research. And a great deal of drug research is conducted in the United States.

But, if so, what is the connection between raising the money in the United States and conducting the research here? These are two separate activities. Please consider that—

- First, all of the world's drug makers have open access to harvesting huge sums in the U.S. market, with its high and largely unregulated prices.
- Second, superior research performance by U.S. drug makers—if it is a reality—therefore has no connection with high U.S. drug prices.
- Third, if more new drugs are indeed being developed in the United States in recent years, a contention which has itself been questioned,⁵⁵ the most logical explanation would be the doubling of the National Institutes of Health research budget in the five years between 1998 and 2003—coupled with the high level of funding prevailing even before 1998. This public support for basic research in the United States has long far exceeded public financing in other nations. It is this publicly financed infrastructure of research grants that does much to explain the level of new drug development in the United States.

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Q. Why should government intervene to fix or regulate prices? Doesn't everyone realize that the free market is always better than government regulation? Didn't you watch the Berlin Wall get knocked down? Don't you know that price controls never work, PhRMA asks?

PhRMA complains about price controls, calling them “socialized medicine,” in a desperate attempt to discredit this bill’s well-designed efforts to win more affordable medications for West Virginians.

The reality is that price controls are widely used throughout health care in almost every western nation, including the United States. That’s because free market principles rarely work well in practice in health care, no matter how well they may work in theory.

Of course, the market is almost everyone’s first choice, and it should be. It’s certainly my first choice, whenever possible. But, unfortunately, we don’t have a free market for prescription drugs, and we probably can’t achieve one. (This is because of patents, oligopoly, lack of good scientific information or consumer information, and other factors.) So, without a free market, and without government action to protect citizens, we would have anarchy, with drug spending continuing to double every five years.

Please consider that it was the Reagan Administration in 1983 that approved a new law that ended cost reimbursement of hospitals and introduced Medicare’s Prospective Payment System. That has substantially tightened payments to hospitals, which I have seen as a trustee of a hospital that closed, but all of us realize that to continue cost reimbursement would have doomed Medicare to bankruptcy years ago.

Most Americans are naturally conservative, as we should be. And we do not favor reckless government intervention. We favor less government, unless there is no alternative. Our years of forbearance in the face of soaring drug costs testify to our patience. But our patients are suffering and dying for lack of needed medications. Congress is inert. Other state efforts have accomplished little. It is time to move forward.

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Q. Why should West Virginia have to act by taking on the drug makers?

Because you have the brains and the guts to do it, because you are suffering more from high drug costs than is any other state, and because no state has moved seriously to tackle this problem since Maine tried its own approach several years ago.

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Q. Is West Virginia likely to suffer for having taken on the most profitable industry in the U.S.A.?

What else could they do that's worse than enduring the soaring cost of vital medications?

Drug makers can't refuse to sell drugs in West Virginia, because that could expose them to paying treble damages if they are subsequently convicted of organizing an illegal boycott (in violation of anti-trust laws), and because they might even face criminal and civil penalties if any patient suffered avoidable pain, disability, or death owing to denial of needed drugs occasioned by drug maker retaliation against West Virginia.

And we have to remember that the drug companies are not monsters. They are not even villains. They are only incredibly desperate people fighting to make as much additional profit as possible before we Americans and our legislators come to our senses and finally rein in their prices.

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Q. Doesn't West Virginia have options that are superior to this bill, like importing drugs from Canada, keying prices under this bill to Canadian levels, or waiting for Congress to act?

When your house is on fire, you fight it with the fire truck, fire hoses, and fire fighters that you've got. H. 4084 is the bill before you.

Importing drugs from Canada is a good individual, retail-level idea that saves money and can even save lives. But it isn't a statewide or wholesale solution. A nation of 30 million can't supply a nation of 300 million. And we don't have to wash our pills at a Canadian laundromat to get them clean.

In conclusion, thank you very much for the opportunity to appear before you this afternoon. I will be happy to respond to any questions.

NOTES

¹ We calculate and project a rise of 296.7 percent in retail prescription drug spending between 1994 and 2004. Adding a six percent rise in nominal gross domestic product to the U.S. Bureau of Economic Analysis's 2003 GDP estimate yields a 65 percent rise in nominal GDP between 1994 and 2004. $2.967/0.65 = 4.56$. For BEA GDP data, please refer to <http://www.bea.gov/bea/dn/gdplev.xls>, access confirmed 16 February 2004. Assuming continued low inflation, the six percent nominal rise is roughly in line with the Mortgage Bankers' Association of America projection of a real rise in GDP in 2004 of 4.7 percent. See "Mortgage Bankers: US GDP To Grow Over 4% Next 3 Years," Dow Jones Business News, 22 January 2004, http://biz.yahoo.com/djus/040122/1305001257_2.html, access confirmed 16 February 2004.

² 1997: IMS Health, "World Review, 15 Largest Pharmaceutical Markets in the World, 1997," www.ims-global.com/insight/world_in_brief/new_yearly/largest.htm, accessed 5 May 1999.

2002: IMS Health, "IMS Reports 8 Percent Constant Dollar Growth in 2002 Audited Global Pharmaceutical Sales to \$400.6 Billion," www.imshealth.com, accessed 26 February 2003.

³ See, for example, Scott Hensley, "Ads, Co-pays, and Price Gaps," *Wall Street Journal Online*, 9 February 2004. The Bain & Company health sector home page claims that the traditional business model is endangered. See http://www.bain.com/bainweb/Consulting_Expertise/industries_detail.asp?indID=7. A remarkable document is a 168-page new report prepared for the drug industry and priced at \$1,200.00. It calls on drug makers to prepare to rely less on research and more on what it calls "S&M," sales and marketing. See Advance Tech Monitor, *The Pharmaceutical Market Outlook to 2010: Essential Analysis of Key Drivers of Change #14*, Data Monitor, 31 January 2004.

⁴ Kaiser Family Foundation, State Health Facts Online, www.statehealthfacts.kff.org, access confirmed 17 February 2004.

⁵ Kaiser Family Foundation, *State Health Facts, 50-state comparisons*, www.statehealthfacts.kff.org, access confirmed 17 February 2004.

⁶ Kaiser Family Foundation, *State Health Facts, 50-state comparisons*, www.statehealthfacts.kff.org, access confirmed 17 February 2004.

⁷ Versipan Scott Levin data from Kaiser Family Foundation, *State Health Facts, 50-state comparisons*, www.statehealthfacts.kff.org, access confirmed 13 February 2004.

⁸ Centers for Medicare and Medicaid Services, *1998 State Estimates (State of Provider) – All Payers – per Capita Drugs*, <http://www.cms.hhs.gov/statistics/nhe/state-estimates-provider/>, , access confirmed 18 February 2004. More recent estimates, covering 71 percent of retail dispensing in 2002, show West Virginia retail prescription drug spending at 23 percent above the U.S. average. See Kaiser Family Foundation, *State Health Facts Online*, <http://statehealthfacts.kff.org>, access confirmed 17 February 2004. The data originate from Versipan Scott Levin.

⁹ United States Department of Commerce, Bureau of Economic Affairs, *Personal Income by State*, <http://www.bea.gov/bea/regional/spi/drill.cfm>, access confirmed 18 February 2004.

¹⁰ John Heys and Scott Finn, “Cutting Medicaid,” *Charleston Sunday Gazette-Mail*, 15 February 2004.

¹¹ “The Government Performance Project,” *Governing Magazine*, February 2004, www.governing.com/gpp/2004/dpresc.txt, access confirmed 12 February 2004.

¹² These data are included in a presentation on West Virginia Teaching Hospitals for a Teaching Hospitals Dinner, 17 February 2004, pp. 8 and 9.

¹³ Karmen Hansen and Richard Cauchi, *2003 Prescription Drug Sate Legislation*, National Conference of State Legislatures, updated 12 February 2004, <http://www.ncsl.org/programs/health/drugdisc03.htm>, access confirmed 17 February 2004.

¹⁴ H.B. 4084, Section 2(a)(4).

¹⁵ Pharmacy Benefits Management, Strategic Healthcare Group, Department of Veterans Affairs, *Drug & Pharmaceutical Prices*, <http://www.vapbm.org/PBM/prices.htm>, access confirmed 18 February 2004.

¹⁶ See, for example, Anna Cook, "Pricing Mechanisms Used by the Federal Government to Contain Prescription Drug Costs," U.S. Department of Health and Human Services Conference on Pharmaceutical Pricing Practices, Utilization, and Costs, 8-9 August 2000.

¹⁷ Canada, for example, compares its prices with those in the U.S.A., the U.K., France, Germany, Italy, Sweden, and Switzerland. See, for example, Patented Medicines Prices Review Board, Performance Report for the Year through 31 March 2003, http://www.tbs-sct.gc.ca/rma/dpr/02-03/pmprb-cepmb/pmprb-cepmb03d01_e.asp?printable=True, access confirmed 17 February 2004. Other nations set price ceilings in relation to groups of other countries. See, for example, Konrad Wallerstein, *Price Controls in Europe*, Families USA annual conference, Mayflower Hotel, 23 January 2004, <http://www.familiesusa.org/site/DocServer/3>, access confirmed 17 February 2004. U.S. Rep. Tom Allen and others have introduced H.R. 3662, a bill to let states and municipalities buy prescription drugs for their employee, retiree, and pharmacy assistance programs at prices no more than the manufacturers' average price in Canada, France, Germany, Italy, Japan, and the United Kingdom. (This bill does not seem likely to pass Congress soon.)

¹⁸ Rebecca A. Baitty, Memorandum on H.B. 4088, February 2004.

¹⁹ Rebecca A. Baitty, Memorandum on H.B. 4088, February 2004.

²⁰ Cited in William H. Von Oehsen III, Marice Ashe, and Kathryn Duke, "Executive Summary: Pharmaceutical Discounts under Federal Law: State Program Opportunities, *American Journal of Health-System Pharmacies*, Vol. 60, No. 6 (2003), pp. 551-553, posted on Medscape on 9 May 2003, www.medscape.com/viewarticle/452564_print, access confirmed 18 February 2004.

²¹ For calculations, please refer to Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty-- Cutting Prices to Make Prescriptions Affordable*

for All and to Protect Research, 4 October 2000--with State-by-State Savings Estimates, Boston: Boston University School of Public Health, 5 October 2000, www.healthreformprogram.org.

²² Benjamin H. Butler, Legislative Director, National Association for Uniformed Services, letter to Sen. Roman Prezioso, 5 February 2004.

²³ Quoted in Kate Long, "Drug Bill Attracts National Interest," *Charleston Sunday Gazette-Mail*, 15 February 2004.

²⁴ United States General Accounting Office, *Prescription Drugs: Expanding Access to Federal Prices Could Offset Price Changes*, Washington: The Office, August 2000, GAO/HEHS-00-118, p. 8.

²⁵ See, for example, Kate Long, "50 to 4,000 % Markup: Government Gets Big Drug Discounts You Can't Get," *Charleston Gazette*, 7 September 2004.

²⁶ 38 U.S.C. 1722A.

²⁷ Veterans Millennium Health Care and Benefits Act, P.L. 106-117.

²⁸ See, for example, Rep. Peter DeFazio, Floor Statement, U.S. House of Representatives, 5 November 2003; and Associated Press, "See the Details of President Bush's Budget Plan," 3 February 2004.

²⁹ Rebecca A. Baitty, Memorandum on H.B. 4088, February 2004.

³⁰ H. 4084, section 6.

³¹ H. 4084, section 10.

³² The remaining 3.3 percent goes to wholesalers. These are 2002 data. See National Association of Chain Drug Stores, *Industry Facts at a Glance*,

<http://www.nacds.org/wmspage.cfm?parm1=507>, access confirmed 17 February 2004.

³³ See, generally, Rebecca A. Baitty, Memorandum on H.B. 4088, February 2004.

³⁴ Barbara Martinez, "Forcing Employees to Buy Drugs Through the Mail: New Corporate Policies Curb Ability to Fill Prescriptions At the Local Pharmacy," *Wall Street Journal*, 18 February 2004.

³⁵ Scott Finn, "Drug Salesmen Say Bill Could Kill Their Jobs," *Charleston Gazette*, 17 February 2004.

³⁶ Deborah Socolar and Alan Sager, "Drug Industry Marketing Staff Soars While Research Staffing Stagnates," Boston: Health Reform Program, Boston University School of Public Health, Data Brief No. 1, 6 December 2001, www.healthreformprogram.org.

³⁷ Scott Hensley, "As Drug-Sales Teams Multiply, Doctors Start to Tune Them Out," *Wall St. Journal*, 13 June 2003.

³⁸ Reported in Scott Finn, "Drug Salesmen Say Bill Could Kill Their Jobs," *Charleston Gazette*, 17 February 2004.

³⁹ Merrill Lynch Fundamental Equity Research Department, *A Medicare Drug Benefit: May Not Be So Bad*, In-depth Report on Pharmaceuticals, New York: Merrill Lynch, 23 June 1999.

⁴⁰ John A. Poisal and Lauren Murray, "Growing Differences between Medicare Beneficiaries with and without Drug Coverage," *Health Affairs*, Vol. 20, No 2 (March-April 2001), pp. 74-85.

⁴¹ For calculations, please refer to Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty-- Cutting Prices to Make Prescriptions Affordable for All and to Protect Research, 4 October 2000--with State-by-State Savings Estimates*, Boston: Boston University School of Public Health, 5 October 2000, www.healthreformprogram.org, p. 26.

⁴² Merrill Goozner. "The Price Isn't Right," *The American Prospect*, Vol. 11, Issue 20 (11 September 2000), <http://www.prospect.org/print/V11/20/goozner-m.html>, access confirmed 17 February 2004. According to Goozner, DiMasi of the Tufts Center for the Study of Drug Development agrees that some 40 percent of industry-financed research aims to develop me-too drugs. Goozner also reports that "FDA statistics for the 1990s suggest that about half of the industry research is aimed at developing me-too drugs."

⁴³ *Fortune Magazine*, *Fortune* 500 and 1,000 tabulations, annual data.

⁴⁴ Lawrence Messina (Associated Press), "Drug Bill Includes \$308M in Savings," *Huntington Herald Dispatch*, 26 January 2004.

⁴⁵ PhRMA, "New Bain Study Shows European Price Controls Hurts E.U. Economy, Stifles Innovation, and Keeps New Medicines from Patients," <http://www.phrma.org/whoweare/presscorner/06.02.2004.906.cfm>, accessed 13 February 2004.

⁴⁶ Jim Gilbert and Paul Rosenberg, "Imbalanced Innovation," presented at the Governors of the World Economic Forum for Healthcare, Davos, Switzerland, 22 January 2004, p. 3.

⁴⁷ Manfred Huber and Eva Orosz, "Health Expenditure Trends in OECD Countries, 1990-2001," *Health Care Financing Review*, Vol. 25, No. 1 (Fall 2003), pp. 1-22, Figure 8.

⁴⁸ In 1999, German life expectancy at birth was 80.7 years for women and 74.7 years for men, while the comparable figures for the United States were 79.4 and 73.9 years. See Organization for Economic Cooperation and Development, "Life Expectancy in Years," 1960 to 1999, *OECD Health Data, 2002, 4th edition*, <http://www.oecd.org/dataoecd/12/47/1935443.xls>, access confirmed 16 February 2004.

⁴⁹ Calculated from data presented in Manfred Huber and Eva Orosz, "Health Expenditure Trends in OECD Countries, 1990-2001," *Health Care Financing Review*, Vol. 25, No. 1 (Fall 2003), pp. 1-22, Figure 5.

⁵⁰ OECD, "Potential Years of Life Lost," *Health at a Glance, 2003*, <http://www.oecd.org/dataoecd/19/18/16361640.xls>, access confirmed 16 February 2004.

⁵¹ Population 65 Years Old and over – Percent of Total Population, *OECD Health Data, 2002, 4th Edition*, <http://www.oecd.org/dataoecd/13/29/1935784.xls>, access confirmed 16 February 2004.

⁵² Alcohol Consumption, Liters per Capita, Age 18 and above, *OECD Health Data, 2002, 4th Edition*, <http://www.oecd.org/dataoecd/13/25/1935745.xls>, access confirmed 16 February 2004.

⁵³ Tobacco Consumption – Percent of Population Daily Smokers, *OECD Health Data, 2002, 4th Edition*, <http://www.oecd.org/dataoecd/13/27/1935761.xls>.

⁵⁴ Joel Lexchin, School of Health Policy and Management, York University, Toronto, Personal Communication to Deborah Socolar, 14 February 2004.

⁵⁵ Donald W. Light and Joel Lexchin, "Will Lower Drug Prices Jeopardize Drug Research? A Policy Fact Sheet," *The American Journal of Bioethics* Vol. 4, No. 1, pp. W3-W6, http://bioethics.net/journal/infocus/pdf/4_1_InFocus_Light.pdf,