

Controlling the Cost Of Prescription Drugs

BY JANE H. WHITE

Pharmaceutical prices have risen dramatically in the past 10 years and will continue to escalate for the next two or three years, Michael Pollard told participants at *Managing the Rising Cost of Drugs: A Multidisciplinary Approach to Improving Hospital Services*, a November 1991 meeting held in Westborough, MA. Pollard, long-time pharmaceutical analyst and partner at the Washington, DC, law firm of Michaels & Wishner, warned the audience of hospital administrators, financial officers, and pharmacists that the rising prices could have a negative impact on hospitals in the future.

Hospitals' pharmaceutical budgets have increased 5 percent to 30 percent during 1991, hospital leaders said at the meeting, which was sponsored by the Healthcare Financial Management Association, Massachusetts Society of Hospital Pharmacists, and Massachusetts Health Data Consortium. The New England Medical Center is predicting a potential increase of 50 percent over the next year, according to William Gouvela, its director of pharmacy. Part of these increases are the unexpected side effect of legislation to lower Medicaid drug prices under the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). The law requires drug companies to offer either their "best price" or a rebate of 12 percent off the average wholesale price of drugs to state Medicaid programs. To recoup lost revenue, many drug companies have raised prices or reduced previous discounts to other purchasers—namely, hospitals, health maintenance organizations (HMOs), the Department of Veterans Affairs (VA), and other federal agencies. Once the data are in, the VA estimates it will have paid \$150 million more for its drugs in 1991 because of lost discounts following OBRA '90's enactment.¹

Complaints from the VA, private purchasers, and elderly constituents regarding the rising costs of drugs have led to a flurry of new bills in Congress to refine the OBRA '90 law or to impose new restraints on the pharmaceutical



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industry. Controlling the cost of prescription drugs is also a politically expedient way to attack the high cost of healthcare. Sen. David Pryor, D-AK, chairperson of the Senate Special Committee on Aging and a key player in the drug pricing debate, highlighted the issue's political nature on the Senate floor, November 21, 1991:

We must have the resolve to stand up to an industry who places profits before patients and greed before the common good. The American public is looking to this Congress to take bold steps and meet the challenge of containing health care costs. If we do not meet the challenge, the American public—as they recently reminded us [with the election of Sen. Harris Wofford, D-PA]—may not be shy about turning to others to get the job done.

This column examines the Medicaid drug pricing legislation, its effect after one year, and the new proposals it has spawned in Congress.

LOWERING DRUG PRICES FOR MEDICAID

During the 1980s Medicaid drug spending rose to a point where states could no longer tolerate the costs. In essence, Medicaid was paying retail price for the same drugs for which other purchasers, such as the VA, HMOs, and some hospitals, had negotiated deep discounts. Because most manufacturers declined to offer the same discounts to Medicaid (about 10 percent to 13 percent of the market), states began to institute a variety of measures to lower their drug bill: caps, increased beneficiary cost sharing, and reduced reimbursements to pharmacies.

Anecdotal evidence that Medicaid policies to limit drug usage had a negative impact on beneficiaries, especially the poor, was recently supported by solid data from Harvard researcher Stephen Soumerai.² Soumerai and colleagues examined 36 months of Medicaid claims data for elderly patients in New Hampshire and New Jersey. New

Hampshire had instituted a three-drug limit for its Medicaid beneficiaries for 11 of the months studied; New Jersey had no such limit. The researchers found that drug usage dropped by 35 percent in New Hampshire after the cap was in place. At the same time, nursing home admissions for chronically ill elderly patients in the state doubled. "The increase in nursing home admissions among the patients at highest risk suggests that loss of medications could have exacerbated preexisting medical problems. . . . The economic impact of preventable institutionalization and its effects on quality of life are severe," noted the authors.

In an effort to lower drug prices rather than limit access—Congress enacted a Medicaid drug rebate—best-price plan in the closing hours of the 101st Congress as part of OBRA '90. As Pollard and Senate staffer John Coster explained, "The enactment of these provisions was the culmination of an intense, sometimes bitter struggle between pharmaceutical manufacturers and selected minority groups on one side, and retail pharmacy groups, state Medicaid directors, the Bush administration, advocates for the poor and elderly, and congressional sponsors of the legislation on the other."³

The new legislation aims to save \$3.4 billion in Medicaid spending over five years. As of April 1, 1991, drug companies were required to sign agreements with the Health Care Financing Administration (HCFA) to provide rebates to the Medicaid drug programs according to a complex formula or to offer states the "best price" that they offer other drug purchasers. The federal government would not provide states matching Medicaid funds for the drugs of manufacturers not entering into such agreements.

In addition to requiring drug manufacturers to give rebates or discounts to the Medicaid program, the law provides for drug utilization review, physician and pharmacist education programs, and point-of-sale electronic claims submission systems that have "the potential to profoundly change the way drugs are prescribed, dispensed, and taken," predicted Pollard and Coster.⁴ The law encourages the use of generic drugs that have received an A rating from the Food and Drug Administration as an additional cost-saving measure.

IMPACT ON HOSPITALS AND OTHER PURCHASERS

Although members of Congress intended to send a message to drug companies to lower their prices, an opposite trend is in fact emerging. Pryor, who was the chief sponsor of the legislation that evolved into the OBRA '90 law, chastised the pharmaceutical industry in a March 6,

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1991, statement on the Senate floor: "The ink was not dry on the Medicaid legislation before drug companies decided the best response to this legislation was to begin a massive cost shift to other vulnerable populations, rather than slightly trim excessive profits or cut back on huge marketing budgets."⁵ Pryor and other members of Congress were especially incensed that deep discounts to VA drug programs were eliminated in the wake of the Persian Gulf War.

Pollard told participants at the November meeting, "I think the impact of the 1990 legislation is deleterious to large purchasers—hospitals and HMOs that were successful in negotiating favorable pricing." He warned that these drug price changes would not be short term, but rather would represent a "major transition in pricing drugs." He added that it is "important for Congress to hear from hospitals on this." Hospitals are faced with increased drug costs not only because of price shifting, but also because of new and expensive biotechnical drugs coming on the market and more intensive use of drugs for severely ill patients.

At the same meeting, Jerry Cromwell, an economist and president of the Waltham, MA-based Health Economics Research, Inc., asked: "Are prescription drugs really the culprit or the cure for hospital cost inflation? It depends on your perspective." As cure, drugs can help hospital budgets by eliminating the need for expensive surgery, shortening lengths of stay, decreasing admissions by increasing outpatient use, and substituting for other forms of intensive inpatient care. As culprit, however, drugs represent a direct cost to the hospital budget; can add to costs because of adverse reactions or interactions; are sometimes used unnecessarily or suboptimally; and can permit complex, expensive surgery such as transplantation.

NEW LEGISLATION

As OBRA '90's negative effect on other drug purchasers became apparent, members of Congress began introducing new legislation to combat the trend. A number of bills focused on preserving the drug price discounts formerly enjoyed by the VA. The Senate passed a bill sponsored by Sen. Barbara Mikulski, D-MD, on July 18, 1991, to exempt the VA from the best-price calculations for Medicaid. Since previous prices offered to the VA by many drug companies were so low, these companies feared locking in the exceptionally low prices for the Medicaid market as well. Rep. G. V. "Sonny" Montgomery, D-MS, introduced legislation July 15 to roll back VA prices to their 1990 level in addition to exempting them from the best-price calculations.

In November Rep. Ron Wyden, D-OR, introduced a bill that would essentially extend the price provisions of Montgomery's bill to Medicaid and other federal grant programs. An option introduced by Rep. Mike Synar, D-OK, in December 1991 would replace the OBRA '90 best-price requirements for Medicaid with a flat discount. Sen. John Chafee, R-RI, has introduced similar fixed-percentage rebate legislation for Medicaid in the Senate.

Perhaps the toughest legislative proposal comes from Pryor, incensed that drug companies were apparently circumventing the intent of OBRA '90. In introducing the Prescription Drug Cost Containment Act of 1991 in late November, he said: "We thought Congress had sent a message that said to the pharmaceutical manufacturers of this country that no longer are you going to continue increasing your prices over the cost of inflation without some action by Congress." Pryor noted that between October 1990 and October 1991 drug prices had increased 10.1 percent, more than triple the 2.9 percent rate of general inflation. This rate is consistent with the trend of the past decade: Drug prices increased 158 percent between July 1980 and July 1990, compared with a 58 percent increase in inflation, according to Pryor.

Sen. William S. Cohen, R-ME, who is the ranking minority member on Pryor's Special Committee on Aging, cosponsored the November legislation, noting that "while the [drug] prices are being controlled in other countries, the prices are allowed to go without any restraint in our country." The legislation would link drug-pricing policy to an obscure tax subsidy that many pharmaceutical manufacturers are enjoying at a rate of \$2 billion a year industry-wide, in addition to tax credits for pharmaceutical research and development. Section 936 of the tax law allows credits for income earned by high-technology companies in Puerto Rico and other U.S. territories. Pryor's legislation would reduce the Section 936 tax credit for those drug manufacturers which raised prices beyond the inflation rate. The proposal would also set up demonstration projects regarding outpatient prescription drugs for Medicare beneficiaries and establish a Prescription Drug Policy Review Commission to analyze drug price trends here and abroad and make recommendations to Congress.

On November 21 Cohen told the Senate, "While companies may attack this approach as unfair price controls, it is only fair that the federal government reassess the subsidies it provides an industry through the Tax Code when that industry is making windfall profits at the expense of the American consumer."

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Gerald Mossinghoff, president of the Pharmaceutical Manufacturers Association (PMA), called the proposed legislation "unwise and discriminatory" in a press statement on November 21. "Senator Pryor here is flirting with price controls, which have never worked and would cause more harm than good," he said. The PMA has pushed Congress to acknowledge the cost-saving potential of drug therapy compared with more expensive surgery and other forms of disease management. A study conducted by the Battelle Medical Technology Assessment and Policy Research Center in Seattle backs up the pharmaceutical industry's claims of cost savings. The study quantified the contribution of pharmaceuticals between 1940 and 1990 at 1.6 million lives saved, or \$141 billion in direct and indirect costs.⁶

The pharmaceutical industry also defends its robust profit margins of 15.5 percent and price increases of triple the inflation rate, saying they are necessary to ensure continued commitment to research and development (R&D). The cost of bringing a new drug to market is now pegged at \$231 million, according to industry estimates.⁷ Pharmaceutical industry R&D costs totaled \$9.6 billion in 1991 and are estimated at \$10.9 billion for 1992, according to PMA spokesperson Mark Grayson. Rough estimates of industry spending on promotion and marketing of drugs range from \$10 billion (according to Pryor) to \$5 billion (according to Sen. Ted Kennedy, D-MA). The PMA disputed the \$10 billion figure and said it has not collected data on pharmaceutical marketing, according to Grayson.⁸ The congressional Office of Technology Assessment is now undertaking a study of these R&D costs.

DRUG COSTS IN OTHER COUNTRIES

Some members of Congress are defending measures to control drug prices on the grounds that most other developed countries have instituted price controls and are paying less than U.S. citizens for the same drugs. This leads to market distortions for U.S. purchasers and consumers. British analyst Michael Burstall explained that most European Economic Community nations control prices of individual medicines. "The main exceptions to this are the United Kingdom, which controls profits; Germany and the Netherlands, which limit reimbursement for many drugs to a flat rate; and Denmark, which, uniquely, permits a free market."⁹

Data from the Organization for Economic Cooperation and Development (OECD), however, show that U.S. per capita spending for drugs in 1988 was \$182, well below the OECD average of \$218. France reached a high of \$492 per per-

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son. Nevertheless, the article's authors add that "studies suggest that the U.S. situation is characterized by relatively low utilization per person, and high prices per unit of service."¹⁰

While Congress and the pharmaceutical industry joust to control drug costs in an "equitable" and politically expedient manner, hospitals are faced with imminently rising costs. Pollard suggested several strategies hospitals can employ to put pressure on drug companies. First, "it's not enough just to get a good contract price, you have to channel demand." This means showing manufacturers that hospitals can transfer demand for drugs to different products or classes of drugs. If hospitals exert their market power in this way, they can achieve some leverage over price. Second, Pollard urged hospitals to voice their concerns over price shifting to members of Congress: "People in Congress are listening now." □

NOTES

1. Michael R. Pollard and John M. Coster, "UpDate: Savings for Medicaid Drug Spending," *Health Affairs*, Summer 1991, pp. 196-206.
2. Stephen B. Soumerai et al., "Effects of Medicaid Drug-Payment Limits on Admission to Hospitals and Nursing Homes," *New England Journal of Medicine*, October 10, 1991, pp. 1,072-1,077.
3. Pollard and Coster.
4. Pollard and Coster.
5. David Pryor, "Johnny Comes Marching Home to Increased Prescription Drug Prices," *Congressional Record*, March 6, 1991, pp. S2,711-S2,712.
6. Richard J. Kogan, "Future Value of Pharmaceuticals," *Health Affairs*, Fall 1991, pp. 277-279.
7. Pharmaceutical Manufacturers Association, "Industry Perspective: Drug Prices," Washington, DC, July 1991.
8. Pharmaceutical Manufacturers Association, "Fact Sheet: Pharmaceutical Prices and Profits," Washington, DC, November 6, 1991.
9. M. L. Burstall, "Europe after 1992: Implications for Pharmaceuticals," *Health Affairs*, Fall 1991, pp. 157-171.
10. George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, "Health Care Systems in 24 Countries," *Health Affairs*, Fall 1991, pp. 22-38.

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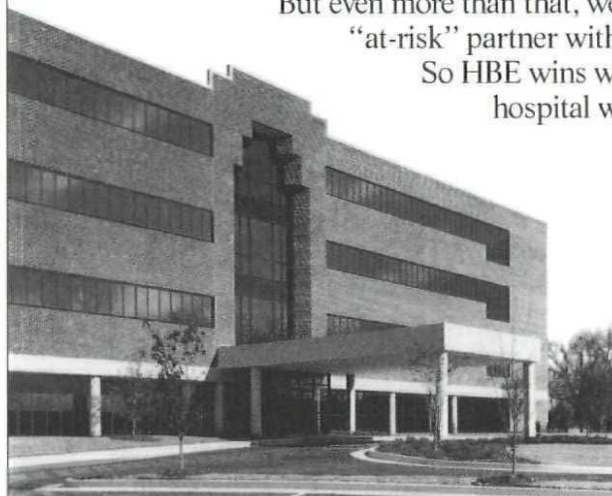
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