Escalating Prescription Drug Costs - The Reality and Options for Reform

Testimony Presented
by the
Fiscal Policy Institute
to the
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Task Force on Prescription Drugs

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In October of 2000, The Fiscal Policy Institute prepared a report, "Impossible Choices: Food and Housing or Prescription Drugs," for USAction, an advocacy group for affordable health care. The report details the increase in prescription drug prices during the 1990's, how these increases have compared to increases in the overall cost of living and finally, the report studies the impact of prescription drug price increases on elderly household incomes using data from the Social Security Administration and the Census Bureau. The testimony that we are presenting today summarizes and updates the trends described in that report and presents recent state efforts aimed at controlling escalating drug prices.

The rising cost of prescription drugs presents an enormous challenge to individual consumers and state governments alike. In New York State, 17.2% of the non-elderly population was uninsured in 2000.[1] Nationwide, 14% of the population lacked any type of health insurance coverage in 2000,[2] and almost twice that number - 25% - did not have insurance covering prescription drugs. Over the past decade, prescription drug prices have skyrocketed, leaving many older Americans on fixed incomes (who represent only 12% of the population, but consume one-third of all prescription drugs[3]) to wonder how they will pay for the medication that they need, and leaving state governments with the difficult task of balancing consumer needs with budget realities.

Recent studies have found that three factors are contributing to the rapid increase in prescription drug expenditures:

- growing numbers of prescriptions per person;
- the entry of newer, more expensive drugs into the market that replace older, less expensive drugs; and
- price increases of existing drugs.[4]

In response to escalating prices, states have tried to control costs by:

- limiting the utilization of prescription drugs;
- pressuring manufacturers for price concessions; and
- changing the Medicaid payment formula for prescribed drugs.

While New York State has attempted to control costs through changes in the Medicaid system, the state can do more by using its buying power to get discounts from drug manufacturers. Florida, Michigan and Maine, for example, are implementing innovative new approaches to contain drug costs. These approaches are worthy of examination and will be discussed below.

The growth in the cost of pharmaceuticals is startling when compared to the growth in

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[1]Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2001Current Population Survey," December 2001.

[2]Source: U.S. Census Bureau.

[3]Center for Policy Alternatives, "Prescription Drugs - Overview," www.stateaction.org/issues/healthcare/prescription/index.cfm.

[4]Families USA, "Enough to Make You Sick," June 2001.

prices for other goods. The average retail prescription price increased more than 3 times the rate of general inflation (CPI-all items) and more than twice the CPI for medical care from 1998 to 2000 (9.2% compared to 2.8% and 3.8%, respectively).[5]

While the cost of all drugs is increasing, the cost of brand names drugs is increasing even more rapidly. Brand name drugs became 10.5 times more expensive between 1998 and 2000, while the CPI for all items only rose by 2.8% during this time period.

Prices continue to rise and drug companies reap the benefits. While the Fortune 500 Firms enjoyed a median profitability of 4.5% in 2000, pharmaceutical manufacturers experienced the highest profitability of all industries - 18.6%. Clearly, drug manufacturers are becoming rich at the literal expense of consumers.

These increases in pharmaceutical costs have translated into growing costs in the Medicaid program. Medicaid expenditures for outpatient prescribed drugs grew more than twice as fast as total Medicaid spending from federal fiscal year (FFY) 1997 to FFY 2000, accounting for 16% of the total growth in expenditures over that period.[6] Spending for prescription drugs by the Medicaid program has been growing faster than Medicaid spending for other services (14.8% average annual growth during the 1990-98 period, compared to 11.1% for other acute care, and 9.1% for long-term care). During the most recent period for which data are available (1995-1998) the average annual growth for prescription drugs (14.8%) was 6 times that for other acute care (2.4%) and more than twice that for long term care (6.5%).[7] This means that drug costs continued to grow at 14.8% every year in the second half of the decade, while expenditures on other components of health care declined substantially during this same period. It is estimated that overall spending by and for Medicaid beneficiaries will more than triple over the next decade, rising from $71 billion in 2001 to $228 billion in 2011.

The prices of all prescription drugs have been increasing, but most problematic to older Americans is the increase in the prices of the 50 prescription drugs they use most commonly. The prices of these drugs increased by over 30% from January 1994 to January 2000. 39 of these drugs were marketed throughout the six year period studied. Of these 39 drugs: 4 saw their prices more than double, 10 had price increases of 50% or more, 27 had price increases of more than 25%, and all except 2 had increases of more than 15%. The overwhelming majority (83.9%) of the year-to-year price changes exceeded the average annual rate of inflation (2.4%) over this period.

While the overall CPI has increased by 15.5% from January 1994 to January 2000, the costs of the top 50 drugs used by seniors has increased by 30.5% over this same time period. The prices of 37 of the 39 drugs marketed throughout the January 1994 to January 2000 period

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[5]Kaiser Family Foundation, "Prescription Drug Trends - A Chartbook Update," November 2001.

[6]Kaiser Family Foundation, "Medicaid Prescription Drugs," October 2000.

[7]Kaiser Family Foundation, "Prescription Drug Trends - A Chartbook Update," exhibit 8, November 2001.

increased faster than the CPI. 18 of these prescription drugs experienced price increases which were greater than twice the overall increase in the CPI during this period. 11 of these prescription drugs increased in price more than triple the overall change in the CPI. Other basic necessities are increasing at about the same rate as the overall CPI (food and housing costs have risen 15.5% and 16.2%, respectively), but prescription drugs, whose costs are rising faster than inflation, are putting much greater pressure on the budgets of older Americans.

Although Social Security is automatically adjusted for inflation, average prescription drug costs represent an increasing portion of seniors' Social Security benefits. The high cost of prescription drugs puts pressure on the budgets of many elderly couples - many of whom are not classified as 'poor' under the official poverty definition, but have incomes just above the poverty threshold. From 1991 to 1998, average retail prices for prescription drugs have grown more than twice as fast as average monthly Social Security benefits for elderly couples. From 1991 to 1998, the average Social Security benefit of elderly couples increased by 22.9%. Over the same period, the average retail prescription drug price increased by 57.9%. Average prescription drug spending for elderly couples as a percent of average Social Security benefits for elderly couples increased from 8.4% in 1992 to 13.5% in 1999.

Options for Reform

Individual states do have options for containing the rising cost of prescription drugs. New York State, as part of the recently adopted health care plan, amended the Social Services Law to add the following to the list of services and supplies that are not covered by Medicaid:

> A brand name drug for which a multi-source therapeutically and generically equivalent drug, as determined by the federal food and drug administration, is available, unless previously authorized by the department of health. The commissioner of health is authorized to exempt, for good cause shown, any brand name drug from the restrictions imposed by this paragraph;

This legislation also reduces the reimbursement paid to pharmacists under the state's Elderly Pharmaceutical Insurance Coverage (EPIC) program by an estimated $25 million a year and increases the rebates that drug manufacturers must pay to participate in the EPIC program to mirror those currently required under the Medicaid program, saving an estimated $13.2 million per year.

Seeking to reduce state expenditures on prescription drugs is a worthwhile objective given the rate at which these expenditures have increased in recent years. In 2001, Medicaid expenditures on drugs and supplies exceeded $3.1 billion, a 20% increase over expenditures in 2000 and 82% more than expenditures for 1998. While overall Medicaid expenditures grew by an average annual rate of 6.5% between 1998 and 2001, expenditures on drugs and supplies grew by over 27% per year.

In fact, New York could use its purchasing power to get better prices on brand name drugs. Virtually every state in the union has come to recognize that prescription drug costs for state employees and retirees, Medicaid beneficiaries, and the participants in other state funded

programs are increasing much faster than the benefits that these individuals are receiving. But some states are moving much more aggressively to address this problem than are others. Governors Jeb Bush (R-Florida) and John Engler (R-Michigan) have been among the more assertive Governors on this front and their efforts provide some useful models for New York. In the first week in January of this year, a federal district court judge in Tallahassee, Florida, upheld Florida's plan. The following week, however, a county circuit court judge in Michigan issued a preliminary injunction to block the program, ruling that Michigan did not have the "statutory authority" to require pharmaceutical companies to offer discounts on drug prices. On January 11 the state filed an emergency appeal in the Michigan Court of Appeals, asking that the injunction be lifted; the Court sided with the state and the injunction was lifted on January 17, 2002.

The Florida plan, for example, requires drug manufacturers to give additional percentage discounts to the state's Medicaid program in order to have their drugs included on a list of drugs that are generally available for Medicaid recipients. Drugs not included on this list can still be provided through the Medicaid program, but additional review would be required. Michigan's plan is similar - restricting coverage of popular drugs unless the manufacturers offer steeper discounts.

New York State has now enacted legislation limiting Medicaid recipients' access to brand name drugs when a therapeutically equivalent generic drug is available. But, unlike Florida and Michigan, it is not using its purchasing power to get better prices from brand-name drug manufacturers. The savings of aggressive action on this front are substantial. For example, the Health Reform Program at Boston University School of Public Health has estimated (using data for 2000) that New York could reduce its Medicaid expenditures by over $400 million per year if it were able to purchase brand name prescription drugs at federal supply schedule prices.

New York State could also lower the price of prescription drugs by participating in a regional drug purchasing pool. Such a pool would combine the purchasing power of several states to get a better deal from the drug companies. The first pool of this type was the Northern New England Tri-State Coalition, which was organized in the fall of 2000. These states began by pooling their drug purchases for their Medicaid programs, in an effort to give their 330,000 Medicaid beneficiaries better prescription drugs, while saving state taxpayer dollars.[8] The coalition hopes to trim the states' cumulative $387 million Medicaid prescription drug spending tab by 10 to 15 percent a year. In 2002, New Hampshire projected savings of $7 million for the year through this pool. Eventually, these states plan to expand the pool to cover state and local employees, small businesses, and most of all, people with little or no insurance coverage for prescription drugs, including seniors.

In Illinois, a new approach to protecting poor elderly persons was put in place on January 28, 2002, when the Department of Health and Human Services granted the state a waiver that allows it to extend comprehensive prescription drug coverage to seniors with income up to 200%

[8] "Idea of the Week: A Regional Purchasing Pool for Prescription Drugs," October 27, 2000. www.ndol.org.

of the poverty line using federal Medicaid matching funds[9]. The new coverage replaces a significant portion of a state-funded pharmacy program that helped some 50,000 seniors pay for prescription drugs needed to treat selected conditions in fiscal year 2001.

One of the defining features of the Medicaid program is that it provides states with an entitlement to federal Medicaid matching funds. To pay for its new prescription drug program, however, Illinois has foregone the federal government's guarantee that it will match as needed the amount the state spends on its elderly Medicaid population. Instead, the demonstration project establishes an upper limit or "cap" on the amount the federal government will match of Illinois' spending on its elderly Medicaid population over the next five years. The cap is based on the amount the state anticipated it would need to cover its elderly Medicaid population in the absence of its new demonstration project. Of course, this is a huge gamble for the state to make, as it will be responsible for covering the cost of the Medicaid population's prescription drug needs, should the cost exceed the cap. The state's theory is that its demonstration project will prevent a significant number of seniors from becoming sick and/or poor enough to qualify for full Medicaid coverage, and that the savings it generates by "diverting" seniors from Medicaid eligibility will be sufficient to pay for its new prescription drug program.

Dr. Alan Sager, of the Boston University School of Public Health, insists that continued tinkering with the Medicaid program (discussed above) and attempts at price controls (as Maine has done[10]) are not enough affect the long-run problem of escalating drug prices. He argues that the lack of coordination between these controls and patients' and drug makers' needs will limit the success of these initiatives. Instead of either allocating more funds to prescription drugs or instituting price controls, states should do both in order to win affordable prescription drugs for all residents.[11]

Sager proposes a 'package deal' wherein lower prices are aligned with higher volume in order to protect drug manufacturers' total revenue, profits and research while providing affordable prescription drugs to all people. In this proposal, states would establish themselves as unique wholesalers to buy drugs on behalf of all citizens, carving out prescription coverage from all existing health plans. Sager suggests that the state pay on a prescription-by-prescription basis, or through a contract whereby the state receives an unlimited volume of pharmaceuticals using a flexible budget (paying for higher volume at marginal or incremental cost). To implement this plan, individual states could lower prices through legislating Canadian-level factory prices for brand name drugs. Drug manufacturers would see lower revenue per unit sold, but could make up lost revenue through increased volume (depending on the price elasticity of demand). For

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[9]Kaiser Commission on Medicaid and the Uninsured, "The Financing of Illinois' Prescription Drug Demonstration Project," April 2002.

[10] Maine began the 'Healthy Maine Prescription Program' in June, 2001. Average savings to consumers were estimated at 25% of retail prices; earnings test applies. The drug industry sued the federal government to stop the Maine program, but in late February a federal judge ruled that the state could continue the Health Maine program.

[11]Sager, Alan, "State Prescription Drug Policy: Separating Fact from Fear." Available at: www.healthreformprogram.org.

consumers, this plan would amount to universal prescription coverage, but would mean higher taxes to facilitate state involvement on behalf of all citizens. This plan has yet to be attempted in any state, but serves as an example of a comprehensive method of state involvement.

APPENDIX A

The following is a summary of 2002 New York State bills that deal with prescription drugs.[12] An (*) indicates bills subject to 2001-02 carry-over rules or procedures.

A.1705
A.3119
S.1104
Senator Marchi

Would mandate that the cost of pharmaceutical drugs in NY state be no more expensive than any other location where such drugs could be purchased, except in any country whose gross national product per capita is less than fifty percent of the gross national product of the United States. Provides criminal and civil penalties. (Filed 1/01; re-sent to Codes Committee 1/9/02)

A.2098
S.1690
Senator Marchi

Would enact an interstate compact on equitable pricing of pharmaceutical patented and generic drugs; makes it a felony to sell pharmaceutical patented or generic drugs in any signatory state at a price which is greater than any price charged for such drug to any other person, firm, corporation, state, government, department, agency, etc. in this country or any other place in the world.
(Filed 1/25/01; re-sent to Codes Committee, 1/9/02 *)

A.3182
Assemblyman Stringer

Would require pharmacies participating in the Medicaid program to sell prescription drugs to Medicare recipients at Medicaid prices, plus an electronic transmission fee. (Filed 1/31/01; re-sent to Social Services Comm, 1/9/02 *)

A.4176
Assemblyman Lafayette
S 3384

Would prohibit price discrimination by manufacturers of prescription drugs in the price they offer drugs for sale to various purchasers or wholesalers; would require manufacturers offer such drugs "on the same terms they offer to their most favored purchasers".
(Filed 2/6/01; re-sent to Health Comm., 1/9/02 *)

A.5967
Assemblyman Lafayette

Would create the "Fair Pricing for Prescription Drugs Act" providing for the establishment and operation of the prescription drug fair pricing program. Would

[12] Source: www.ncsl.org

require retail and wholesale sales at prices no higher than federal or foreign prices. (Filed 3/1/01; re-sent to Health Comm., 1/9/02 *)

A.6841
Assemblyman Gottfried

Would require the state to apply for a Medicaid waiver to provide discounted drugs for uninsured persons up to 300% of the federal poverty level. It would help many seniors 55-65 who are not eligible for EPIC. The bill is similar to program in Maine and Vermont that received approval from HCFA.
(Filed 3/6/01; sent to Ways and Means 3/20/01; enacting clause deleted/died, 1/9/02 *)

A.7557
Assemblyman Gottfried

Would create a prescription drug discount program for uninsured residents. NY Health Dept. would negotiate discounts with manufacturers; any health plan or health provider (hospitals, nursing home, clinic or practitioner could join.). Participating pharmacies would sell at a discounted price based on the program discount and a dispensing fee (AWP-6%)- rebate + dispensing fee).
(Passed Assembly, 6/26/01; died in Senate; returned to Assembly, 1/9/02; rules committee discharged and returned to ways and means, 2/5/02 *)

A.7832
Assemblyman Burling
S.4191
Senator Maziarz

Would require pharmaceutical drug manufacturers and wholesalers to annually disclosure to the general public, all of its gifts to health care practitioners that prescribe drugs when such gifts have a value of $75 or more.
(Filed 3/27/01; re-sent to Finance Committee, 1/9/02 *)

S.4509
Sen. Hannon

Would establish the program for state cost reduction in pharmaceuticals within the department of health; provides for the bulk purchase by the state of all pharmaceuticals used by the state or paid for by the state; provides for mandatory participation; requires the commissioner of health to establish an information network on the best therapeutic and cost-effective utilization of pharmaceuticals.
(Filed 4/17/01; re-sent to Health Committee, 1/9/02 *)