Coloradans Can't Afford The 'Prescription Drug Fair Pricing Act'

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Issue Backgrounder

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House Bill 01-1108. Prescription Drug Fair Pricing Act. Creates a new state health insurance program that is not means tested. Makes the state a prescription drug wholesaler, politicizes prescription drug pricing, creates a new bureaucracy to act as a commercial middleman, gives the state full access to retail pharmacy business records, puts small bio-tech firms at risk by creating a new category of business crimes.

Synopsis: This bill creates a state health insurance program that is not means tested. It also creates a new set of business crimes. Any Colorado resident without prescription drug coverage would be eligible to participate. The bill does not specify whether the drugs covered under the major medical or stop loss provisions of many private health care plans would count as prescription drug coverage. It requires the state to maximize enrollment by eligible residents.

Any pharmaceutical manufacturer selling prescription drugs in Colorado through any state program would be required to agree to sell its prescription drugs to the state at prices negotiated by the Colorado Department of Health Care Policy and Financing. The difference between the list price and the negotiated price would be given to the state in the form of a cash rebate. The rebates would be put in the prescription program cash fund. The legislation lets the Department of Health Care Policy and Financing claim an annual management fee of one percent of the funds assets for expenses in 2001-02. After that, the monies in the fund would be removed from the control of the state treasurer and would be continuously appropriated to the executive director of the Colorado Department of Health Care Policy and Financing. Though this program represents a potentially huge new entitlement, there is no language stipulating that the programs costs cannot exceed the amount of rebates collected.

All retail pharmacies licensed by the state must sell prescription drugs to program participants at prices determined by the Colorado Department of Health Care Policy and Financing. The state will give the pharmacies a $3.00 professional fee for each prescription handled. The pharmacies will recoup the difference between the list price they pay and the mandated state price by filing claims. The bill requires the state to reimburse them on a weekly or biweekly basis. There is no provision for reimbursing pharmacies for the

interest lost on their funds while waiting for rebate payments. The bill would make it legal for the Department to collect from the retail pharmacies any utilization data necessary to calculate rebates and require it to keep only trade secrets, work product, or proprietary information confidential.

If after all of the paperwork has been processed discrepancies between the rebate paid and the rebate claimed still exist, the state or the manufacturer must hire a mutually agreed upon independent auditor. If the auditor cannot resolve the discrepancy the side owing the money has to justify why the discrepancy exists within sixty days. If agreement still cannot be reached, a lawsuit may be filed before the district court of the City and County of Denver. No provision is made for reimbursing either side for the cost of funds tied up for the 60-day period.

In addition to the reporting required by retail pharmacies, the bill requires an annual program report by the Department of Health Care Policy and Financing. The Department must also report whether the program that it supervises really does deliver lower drug costs by April 1, 2004.

The bill allows the state to sue any manufacturer, labeler, or retail pharmacy that 1) charges a price above the average wholesale price of any prescription drug, 2) makes an unjust or unreasonable profit, 3) charges different people different prices, or 4) refuses to sell drugs in Colorado because Colorado has enacted this legislation. Treble damages, costs, and punitive damages may be collected. After costs, damages would be equally distributed to all plaintiffs.

Discussion: The logic behind this bill rests on a number of assumptions: 1) that price controls work, 2) that instituting price controls will not affect the quality, variety, and cost of pharmaceuticals available to Colorado residents, 3) that state bureaucrats or anyone else can determine what drugs ought to sell for, 4) that the state, which is currently being sued by health care providers for its inability to manage Medicaid programs, can also effectively manage another new health insurance program without harming programs aimed at the states neediest, and 5) that the costs of state administration and the consequent increase in the tax burden along with the losses from market distortions will be less than the price discounts that the state will be able to negotiate.

This legislation will likely increase state health care costs

by increasing Medicaid drug prices.
It may also divert scarce state funds from the truly needy.

Under this legislation, any manufacturer who demands more than the average

wholesale price for any prescription drug is guilty of the crime of Profiteering. Judging from the effects of such reference pricing systems in Germany, New Zealand, and the Netherlands, in practice, this means that the price negotiated by the Department of Health Care Policy and Financing will likely become the highest price that can be charged for pharmaceuticals in Colorado.[1] This legislation is part of a coordinated national campaign led by the Clinton administration to use Medicaid to impose national drug price regulation.[2] Where policies like this have been tried in the United States and other countries they have, without exception, ended up either raising the cost of health care, degrading the quality of health care, or both.

The mere fact that an average exists implies that there are normal market prices above and below it. People untutored in economic theory are fond of asserting that selling a product at anything other than a single price is some form of unjust discrimination. In fact, the opposite is true; in general, charging different consumers different prices based on their willingness to pay is an efficient way to cover high fixed costs, including research and development. The pharmaceutical industry has exceptionally high R&D costs, some estimates put them at 25 to 50 percent of total drug costs.[3] Discriminatory pricing also makes everyone better off in conventional markets by maximizing the amount of the product that is produced.

To appreciate the full effect of this legislation one must understand that pharmaceutical companies wishing to stay in business must earn enough to fund current operations, pay capital costs, and fund the research and development that creates new products. They do this by selling their products. At present they charge different people different prices based on ones willingness to pay. If some customers are willing to pay high prices, the companies can afford to charge others less. As is the case with airline seats, consumers who pay full price get the product they want immediately. Those who pay discount rates that only cover the costs of production and a portion of the joint R&D costs may have to wait for what they want. Prices are lowest for those who cannot afford their drugs at all and receive them through the physician sample programs or drug charity programs run by the large pharmaceutical firms.

Because this legislation effectively makes differential pricing illegal, it virtually ensures that the state will pay higher prices for drugs. Pharmaceutical companies must somehow cover their costs. If the state arbitrarily reduces the spectrum of prices that they can charge, drug companies are left with three options for covering their costs. They can reduce the discounts they offer lower cost purchasers like state Medicaid programs, cut back on sample and charity programs, and cut back on research and development. Each of these alternatives harms consumers.

When the federal government used similar tactics to force pharmaceutical

companies to give best-price discounts to Medicaid as part of the Omnibus Budget Reconciliation Act of 1990, the General Accounting Office found that the median best price discount declined from 24% to 14% for HMOs, and from 28% to 15 % for group purchasing organizations between 1991 and 1993. The Congressional Budget Office found that the weighted average best-price discount in a sample of about 800 brand-name products declined from 37% in 1991 to 19% in 1994.[4]For those in government programs this was terrible news, because price-sensitive bureaucrats typically respond to price increases by rationing life-saving medicines.

In 1994, for example, Medicare bureaucrats decided that they were paying too much for erythropoietin (EPO), a biotechnology product used to control anemia in kidney dialysis patients. People who take it while on dialysis are healthier and longer-lived. Medicaid announced that it was lowering the price it would pay for the drug. To handle the inevitable shortage it rationed the amount patients could get and refused to cover patients who were not about to expire without it. As a result, more people died, and those who would have been helped before they got sick spent more time on dialysis and in hospitals. [5]

Because this legislation extends Medicaid discounts to virtually the entire state population, it virtually ensures that state drug costs will explode. Bureaucrats faced with exploding costs invariably resort to rationing necessary drugs. Medicaid was originally designed to provide health care for the truly needy. Programs like this, which provide aid to everyone regardless of their means, divert scarce funds from the truly poor, ensuring that they will be denied necessary medical care.

This legislation institutes drug price controls. Price controls always do more harm than good.

The blackouts in California are just the latest example of what happens when legislators try to help consumers by passing price controls to make the things that they buy more affordable.Though this legislation tries to disguise its pharmaceutical price controls as manufacturers rebates, the fact remains that it forces all drug manufacturers doing business in the state to offer their products at a price determined by the Colorado Department of Health Care Policy and Financing and then requires the Department to set the price at which retail pharmacies can sell them. There is no evidence that the Department has any particular expertise in drug pricing. At a time when ballooning health care programs are creating real strains in the state budget, its officials would be under terrific pressure to set artificially low drug prices in order to keep state expenditures under control.

The claim that Colorado citizens pay too much for drugs and that the state can lower the prices they pay is unsubstantiated. Claims like this can usually be traced back to two 1998 minority staff reports from the House Committee on

Government Reform and Oversight, two General Accounting Office Studies, and the fact that one can obtain certain kinds of brand name drugs more cheaply in Canada and Mexico. Well-known flaws in these studies render their conclusions worthless. Just 10 drugs were studied, generic prices were not included, and only list prices for the smallest package sizes were considered. Frequency of use was ignored. When Wharton Professor Patricia M. Danzon examined all drugs sold at retail pharmacies in various nations she found that the average U.S. consumer would have paid 3 percent more in Canada, 27 percent more in Germany, 44 percent more in Switzerland, and 9 percent more in Sweden.[6]Her results understate the U.S. price advantage because she did not include any discounts resulting from contracts between manufacturers and large insurers.

When governments set prices, the real question, as California electricity consumers have discovered, is not whether drugs are cheaper but whether they are available at all. Some forms of some drugs may be cheaper in other countries, but many others are simply not available. Price controls also make manufacturers less likely to innovate in the packaging and delivery methods that do so much to ease patient lives in the United States.

In Canada, the Patented Medicines Price Review Board, a group with more purchasing clout than the State of Colorado, negotiates pharmaceutical prices for the whole country. As a result, Canadian generic drugs are uniformly more expensive than those in the U.S. This is no small matter given that 45% of U.S. prescriptions are for generics.[7] In Britain, the British government reduced drug price increases to less than the rate of inflation. Return on capital in the pharmaceutical industry declined to 10%, domestic profits declined to 4.5 percent of sales and the once thriving British pharmaceutical industry shifted research and development to the United States. Britain now has third-world cancer survival rates because its cost control-infatuated bureaucrats say that such drugs are too expensive and refuse to pay for them. Individual patients dying from cancer who may disagree have no say in the matter.France and Italy produce no new drugs and generic drug production is miniscule because government price regulators allow manufacturers little profit. Those countries forgo innovative future therapies and the vigorous price competition among generic manufacturers that, in the U.S., operates over time to push all drug prices down in favor of cost control now. As is inevitably the case, bureaucrats in control of drug prices invariably put their budgets ahead of the general welfare.

This legislation ignores these economic realities and instead sets laughable standards for determining whether its proposed prescription drug program will make Colorado citizens better off. Required program assessment (26-4-1104) consists of a report due by April Fools Day, 2004, that reviews data from the Medicaid prescription drug program for the most recent six months available and lists the most frequently prescribed drugs in the prescription program, the most expensive drugs, the average cost of drugs in the program, and the

average cost of drugs for people not in the program. In short, data from Medicaid are to be used to evaluate the Prescription Drug Program. What the program does to people outside of Medicaid will not be addressed. There is no requirement that any sort of realistic cost-benefit analysis be attempted. Given that the Department of Health Care Policy and Financing has the revenues from the program continuously appropriated, there is little reason to expect that it will find fault.

The paperwork required by this legislation will impose substantial costs on Colorado business, consumers, and government.

Because the rebate program proposed in this legislation imposes additional reporting requirements for every prescription filled, it immediately increases the cost of every prescription by $3.00, the amount it proposes to pay retail pharmacies as a professional fee for handling the mind-boggling amount of paperwork the legislation would impose. Mick Kolassa, a professor in the College of Pharmacy at the University of Mississippi, estimated the real cost of paperwork for a similar federal program, the Drug Fairness Act, at $15.00 per prescription.[8]One way or another, retail drug prices will increase to cover the additional costs.

The costs of maintaining a price control and rebate bureaucracy should not be borne by taxpayers. With the rapid expansion of new health care programs during the Romer administration, Colorado health bureaucracies are experiencing significant managerial stresses and have been sued by several HMOs for their inability to run the programs already in place.[9] This legislation represents a potentially huge new entitlement program that may further degrade the performance of existing programs. There is no convincing evidence to support the assertion that its costs will exceed its benefits or that it will generate sufficient rebates to cover the additional costs it imposes.

To monitor the program created by this legislation will require armies of analysts to study the notion of fair pricing in support of state negotiations, crowds of clerks and accountants to verify rebate amounts, and fraud investigators to check utilization data along with new data systems and the techs to run them. Other likely costs include the inevitable undetected fraud that accompanies programs like this and the welfare losses that will occur when, not if, the state sets the wrong prices. Paying retail pharmacies too little will reduce their numbers, causing losses for consumers. Paying pharmaceutical manufacturers too little will reduce innovation and make some therapies unavailable, possibly with deadly consequences. The requirement that pharmacies make their records available to the state implies that the state will be able to track individual pharmacy records, a fact that raises

significant privacy concerns that are not addressed in this legislation.

Proponents of this legislation should keep in mind the fact that the U.S. Department of Defense has had extensive experience in best price negotiation and maintains an enormous bureaucracy devoted to it. Its best price achievements include $700 toilet seats.

This legislation criminalizes normal business activities. It makes doing business in the state riskier and more expensive.

If enforced it could destroy the states small biotechnology companies.

This legislation creates a new set of crimes, known as illegal profiteering, formerly found only in Communist countries or lawless third world dictatorships. It defines illegal profiteering as asking more than the average wholesale price for a drug, charging prices that lead to any unjust or unreasonable profit, discriminating unreasonably, or which prevents, limits, lessens, or restricts the sale or distribution of prescription drugs in the state as a result of this program.

If such laws were currently in existence, bio-tech and high-tech companies formed to promote breakthrough inventions would probably exist in much smaller numbers. Innovative small companies typically lose money for years during product development. If things go as planned, they earn huge profits after launch and for as long as they can protect their patent rights or otherwise fend off imitators. Those huge profits are necessary to compensate people for the enormous risk that they take when they commit their savings and their careers to uncertain ventures. In fact, Colorado legislators who really care about the sick should welcome high profits. High profits benefit drug consumers by attracting additional investment in drug research. This promotes the research to create the new products that have done so much to improve peoples chances of leading long, active, and healthy lives.

It does no good to assert that government functionaries in charge of deciding just what constitutes an unjust or unreasonable profit will show good judgment. The evidence from other countries shows that they do not, and economists familiar with bureaucratic evaluation of reasonable profits find that government entities systematically underestimate the amount of spending required for research and development. In reality there is no way that any government agency or court can arrive at any reasonable estimate of a just profit, in part because the required data are simply unavailable. Current drug company profits reflect investments in R&D made 10 to 20 years ago as well

as science, markets, politics, and consumer demand. As Patricia Danzon put it Free entry to pharmaceutical R&Dwhich is evidenced by the large number of startup companieswill reduce expected profits to competitive levels. Efforts to limit profits by dictating current prices will deter entry and reduce R&D. Thus, the best measure of whether current profits are too high is whether current R&D is considered excessive.[10]

Unjust discrimination is also a term without definition. As described above, economic theory demonstrates that price discrimination is a normal practice that generally benefits everyone by making more of a product available than would be the case under a single price.

Finally, the bill makes it a crime not to do business in Colorado if the state passes this bill.How the state will separate dislike of Colorado legislative practices from normal responses to business conditions remains a mystery.

In view of these considerations, it is reasonable to conclude that this bill declares open season on the business practices of pharmaceutical companies. In doing so it invites ceaseless litigation and sets a precedent that puts all businesses in the state at risk from legislative meddling.

[1] Patricia Danzon. 1997. Can Pharmaceutical Price Regulation and Innovation Coexist?Excerpts from a speech given at Patients First, a Fraser Institute conference on health care reform held in Toronto and Vancouver, Canada, on November 3-4, 1997.http://www.fraserinstitute.ca/publications/forum/1998/march/health.html.

[2] Robert Goldberg. 23 January 2001. Wave Goodbye to Medical Progress, National Review Online, http://www.national review.com/comment/comment012301e.shtml.

[3]Patricia Danzon. 1997. Can Pharmaceutical Price Regulation and Innovation Coexist?Excerpts from a speech given at Patients First, a Fraser Institute conference on health care reform held in Toronto and Vancouver, Canada, on November 3-4, 1997.

[4]Cited in Patricia M. Danzon. 2000. Making Sense of Drug Prices, Regulation, 23,1, p. 59.http://www.cato.org//pubs/regulation/regv23n1/danzon.pdf.

[5] Robert Goldberg. October 1999. Ten Myths About the Market for Prescription Drugs, Policy Report No. 230. National Center for Policy Analysis, Dallas, Texas, p. 16.http://www.ncpa.org/studies/s230/s230.html.

[6]Patricia M. Danzon. 2000. Making Sense of Drug Prices, Regulation, 23,1,

pp. 56-63.http://www.cato.org//pubs/regulation/regv23n1/danzon.pdf

[7] David Gratzer. 23 May 2000. Canadas Prescription to Prevent Drug Research, National Post. As posted at http://www.galen.org/news/052300.html on 20 June 2000.

[8]Robert Goldberg. October 1999. Ten Myths About the Market for Prescription Drugs, Policy Report No. 230. National Center for Policy Analysis, Dallas, Texas, p. 15.http://www.ncpa.org/studies/s230/s230.html..

[9] Marsha Austin. 3 October 2000. Kaiser sues state over Medicaid. Suite claims payments knowingly withheld. Denver Post, p. C1.

[10]Patricia M. Danzon. 2000. Making Sense of Drug Prices, Regulation, 23,1, p. 62.http://www.cato.org//pubs/regulation/regv23n1/danzon.pdf.