

AARP™ RX WATCHDOG REPORT

JUNE 2007

A CONSUMER NEWSLETTER ON PRESCRIPTION DRUG PRICE TRENDS

D.C. Legislator Combats High Drug Costs

“Americans help finance miracles yet we pay the most for them.”

David Catania was first elected to the Council of the District of Columbia in 1997. As chair of the Committee on Health, he champions a variety of initiatives that focus on improving healthcare for uninsured and low-income residents of the District, including expanding access to affordable prescription drugs. Catania also chairs the National Legislative Committee on Rx Pricing (NLARx), a nonprofit consisting of representatives from 20 state legislatures working to make prescription drugs more affordable.



being. But high costs often put those benefits out of reach.

I see what happens when people cannot get the medicine they need to treat chronic disease. In D.C., where we have a substantial low-income population, levels of hypertension and diabetes are high. Lack of access to appropriate medication fills our emergency rooms and drives up our care costs. D.C. has the lowest life expectancy in the country and the second

highest drug costs. Is there a connection? Not necessarily. But the high costs don't help. [See chart page 3.]

How much do prescription drugs cost the District government?

Looking into the cost to our publicly financed systems such as Medicaid, mental health programs, HIV programs, and employee and retiree benefits, I found estimates that the District government spends between \$300 and \$400 million dollars a year on drugs. That's hard to quantify because so much of the expense is capitated. However, simple fee-for-service expenses for prescription drugs have gone from \$80 million to \$130 million in just the last four years.

What is the human cost of expensive medicines?

I am struck by the abundance of riches that science permits in increased longevity, productivity and well-

Does the public sector contribute to the research and development costs of new drugs?

Yes. American taxpayers contribute heavily to the R&D that brings new drugs to the consumer. It's not only the amount of spending that makes a huge difference but the point at which that spending enters the system. Publicly funded research often initiates the process that results in the discovery of a new drug by uncovering areas of promise. Pharmaceutical companies then invest the dollars that allows them to bring the product to the market.

This is unfair. We are helping finance these miracles yet all the privileges go to the manufacturer at the expense of the consumer.

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How do you respond to the industry’s argument that high profits fund the development of life-saving drugs?

I understand the economics of prescription drugs, the need to invest heavily in developing drugs not all of which earn back the investment. But the profits these companies make on successful drugs is enormous.

What measures have you introduced to increase access to affordable prescription drugs?

In 2004 the District Council passed Access Rx, a bill I wrote. It has three principal titles:

Title one mandates the District government to employ a variety of cost-cutting strategies like multi-state pooling and use of a preferred drug list (PDL). These two will save the District between \$5 and \$10 million on just our fee-for-service expense.

The second title concerns pharmacy benefit managers (PBMs). These are companies like Medco and ExpressScripts hired by employers or insurance companies to administer prescription drug benefit plans. PBMs report profits in the high 20-percent range.

Title three requires drug manufacturers to disclose their marketing costs. The pharmaceutical industry fought the release of these regulations from the summer of 2004 until the first week of May when the regulations finally became official.

Title two makes the District one of only two jurisdictions in the country that requires PBMs to serve as a fiduciary for the insurance company. That means savings achieved through rebate arrangements with the manufacturer must be passed along to the consumer. This replaces the relationship that now exists in which PBMs often play the insurer against the drug manufacturer while keeping the amount of their rebates secret from the insurer and the employer.

The PBMs took us to court to block implementation of this title but we prevailed.

You had another bill regarding excessive pricing that is still tied up in legal challenges. What’s the status?

Mindful that so many prescription drugs sold around the world are actually manufactured in Ireland under U.S. patent, we took a look at drug pricing in four wealthy nations — Australia, Canada, United Kingdom and Germany. Each has a different mechanism for pricing but each pays much less for brand-name prescription drugs than we do. [Ed: for a discussion of Canada’s system, see *AARP Rx Watchdog*, 1/2/2007; of the U.K.’s system, see *AARP Rx Watchdog*, 3/2007.]

The Australians base their price on efficacy, so the more value a drug offers a patient the higher the price of that drug. If a drug offers no improvement over products already on the market, the drug maker cannot charge more.

Germany negotiates prices for the entire country, essentially bulk buying. The U.K. and Canada each have different mechanisms. Our legislative proposal said when a manufacturer charges District consumers more than 35 percent of the average charged in those four high-income countries, there is a presumption of excessive pricing. The manufacturer then had the right to explain in court why the high price was necessary.

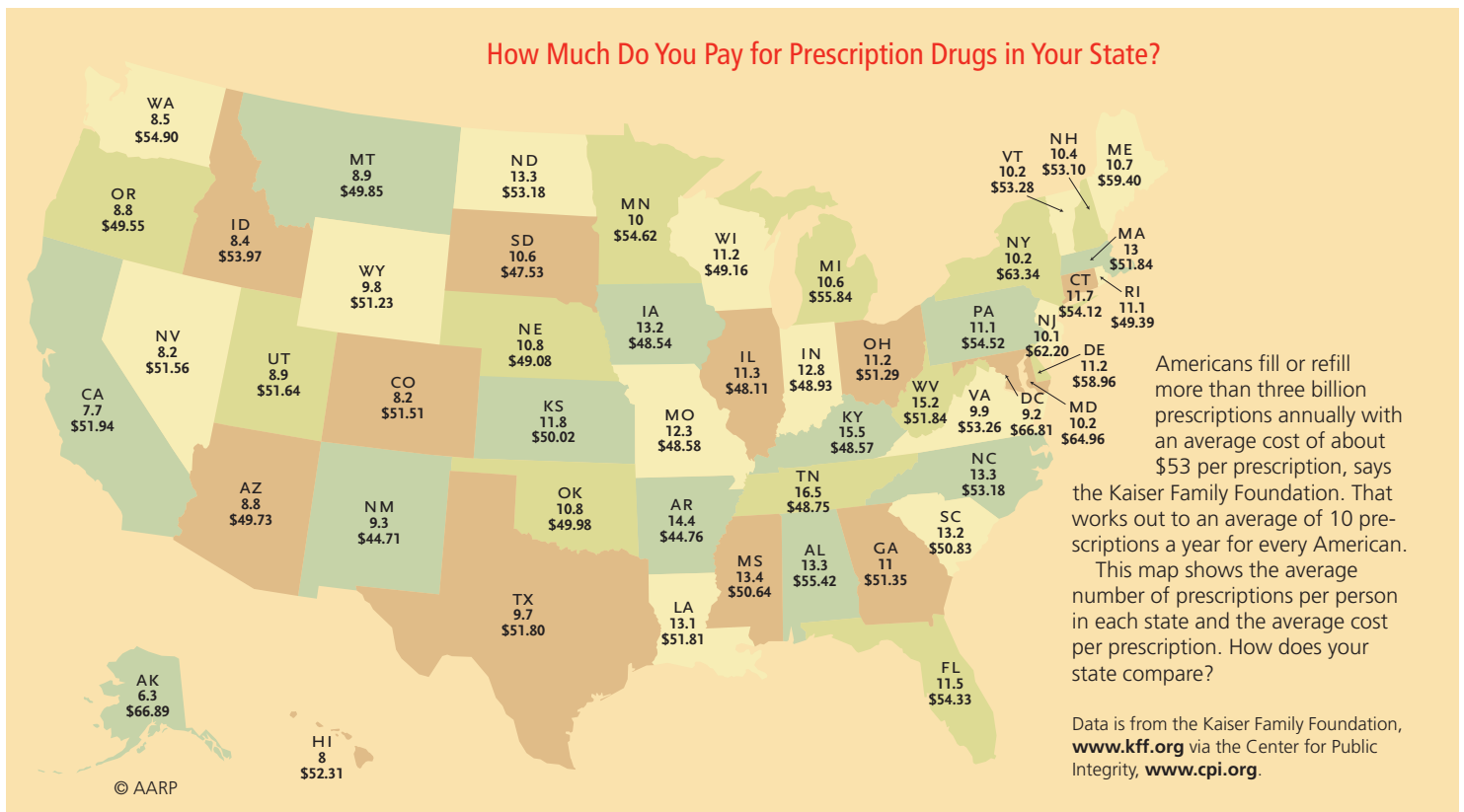
The excessive pricing bill is before the court of appeals because of a patent issue. We look forward to a ruling from the appeals court, and if we don’t win we’ll have guidance on how to fix the bill.

What savings do you anticipate achieving from PBM transparency?

That’s hard to say. The top three PBMs account for more than half of all prescriptions written in the country. If that isn’t an oligopoly I don’t know what is.

We are not privy to all the ways in which PBMs profit from their agreements with drug companies,

How Much Do You Pay for Prescription Drugs in Your State?



insurers and employers. We do know that if a drug company wants its drug on a PBM formulary, it has to pay and that payment usually comes in the form of higher rebates. We know that PBMs often fail to disclose to the insurer the actual price they reimbursed a pharmacy for a specific drug. We also know about the practice of drug switching. A PBM makes a deal with a drug company to switch prescriptions from a competitor to the drug company's own brand.

There are layers upon layers of hidden costs in these transactions so it's hard to say what the savings will be. But the potential is substantial.

What are you working on now?

Academic detailing. Detailers are the people who represent drug companies directly to doctors. We are looking at the practice of pitching a drug for off-label uses. That means using the medicine to treat a condition other than those approved by the Food and Drug Administration (FDA). Using an epilepsy drug to treat mental illness, for example.

We're looking at requiring detailers in D.C. to have a science background. Currently, drug companies focus on hiring upbeat personalities to represent them. I have nothing against cheerful people but doctors

often don't have a substantial pharmacological background. They can be easily influenced by representatives of drug companies who could be making claims that have not been substantiated by the FDA. That's a potential hazard to public safety.

I want to create a reverse academic detailing program in which we recruit detailers to work for the District. Their job will be to remind doctors that drugs have been approved for the treatment of specific conditions. I'm inclined to require informed consent so that when a doctor prescribes a drug for off-label use, the patient has to know that. I'm also thinking about imposing a licensing fee on academic detailers and using those funds to finance the District detailers.

Is this an unique approach to protecting consumers?

Yes. Our effort to regulate detailers will be first of its kind in the country. We regulate beauticians and barbers more heavily than we regulate people distributing pharmaceuticals that can kill you.

But the most states can do is focus on safety and access. We really need the federal government to step up to its responsibility to American consumers and stop their practice of providing privileges to drug companies at the expense of their own people.

Most Doctors Accept Things of Value from Medical Industry

The overwhelming majority of American doctors have relationships with representatives of the medical industry that have some value to those doctors according to the results of a national survey published in the *New England Journal of Medicine* (www.nejm.org).

More than nine in 10 (94 percent) of the 1,662 doctors taking part in the study reported having “some type of relationship” with the industry — drug or device makers and other related companies. About eight in 10 (84 percent) allowed industry representatives to buy them food or drink in the workplace or to give them drug samples (78 percent.) More than one-third (35 percent) accepted reimbursement for attending professional meetings including continuing medical education (CME) sessions. More than a quarter (28 percent) received payment for activities such as consulting, giving lectures, serving on advisory boards or enrolling patients in clinical trials.

“This is a well-researched, scientific article that deserves follow up,” said AARP Board member Byron Thames, who was general manager of a five-person family practice in Florida prior to his retirement. “Clearly these things need to be looked at, starting with physicians. They should look ask if these relationships are worth the sharp increases we’ve been seeing in brand-name drug prices.”

The survey reflects the experiences of physicians in six medical specialties: anesthesiology, cardiology, family practice, general surgery, internal medicine and pediatrics. The type and extent of relationships with industry varied significantly by specialty and by the physician’s practice setting.

Cardiologists were far more likely to receive payments from the industry than doctors in the other specialists. Family practitioners were visited most

often by industry representatives. Doctors who practiced in one-person or small group offices met more often with industry representatives than did those who practiced in hospitals or clinics.

In accounting for the varied patterns of relationships between physicians and the medical industry, authors of the report came up with various hypotheses. One is that the industry targets opinion leaders. Cardiologists, whose choice of prescriptions are thought to influence the decisions of non specialists, are far more likely to “receive direct payment” than other physicians. That is also the case for physicians who develop clinical practice guidelines or who train doctors.

“The industry’s practice of targeting opinion leaders was

news to me,” Thames said. “Maybe it shouldn’t have been, but it was.”

To account for the high number of relationships doctors in smaller practices have with industry representatives, authors of the report suggested that: these doctors might have more flexibility in what they prescribe than do doctors in larger settings; hospitals and clinics may be more likely to restrict these relationships, and hospitals and clinics may be more likely to provide independent medical information that reduces the physicians need to rely on industry representatives.

The study also shows that industry representatives visit physicians far more than previous studies indicated suggesting that there has been an “intensification of industry marketing since the 1990s.”

Looking to counter the increase in high pressure marketing, AARP New York has joined with other state groups to require the drug industry to make its relationships with doctors public. A bill is currently before the legislature requiring drug companies to reveal all gifts to doctors valued at \$75 or more.

