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Dear Mr. Cohen:

On 15 June 2011, Rep. Waxman and others introduced H.R. 2190, the "Medicare Drug Savings Act of 2011." This legislation would require drug makers to pay Medicaid-level rebates on brand name (non-generic) prescription drugs used by patients receiving both Medicare and Medicaid, and also by Medicare patients receiving low-income subsidies.

Such rebates would, on average, be substantially higher than those now typically obtained by the publicly-subsidized private insurance companies marketing Medicare Part D prescription coverage.

On 21 July 2011, Douglas Holtz-Eakin and Michael Ramlet released a report titled C*ost Shifting Debt Reduction to America's Seniors: Medicare Part D Rebates Would Dramatically Increase Drug Premiums* [American Action Forum, http://americanactionforum.org/sites/default/files/AAF_Part%20D%20Financial%20Impact%202_0.pdf.]

This new report claims that "the cost of a new government rebate . . . will not only be borne somewhere else in the economy, this analysis shows that seniors will be forced to pay much higher premiums for their prescription drug plans." This rests on what is claimed to be a conservation assumption that drug makers will absorb one-half of the loss of revenue associated with applying Medicaid rebates to dual-eligibles and LIS patients.

At your request, I have examined this new report's claims and matters bearing on those claims, and now summarize my findings.

First, Holtz-Eakin and Ramlet are questioning whether government action to lower U.S. drug prices is necessary and appropriate.

U.S. prices for brand-name prescription drugs have long been and now remain the highest in the world. As shown in the exhibit on the next page, prices for drugs under patent are much lower in other wealthy democracies than in the U.S.A.

With average U.S. prices at 1.00, Canadian prices were only 52 percent as high in 2010 by exchange rates and only 43 percent as high by purchasing power parities. Prices in France, Italy, Sweden, and the U.K. were even lower than Canadian prices.

These high U.S. prices for brand-name prescription drugs are subsidizing citizens of other wealthy nations and also those holding stock in drug companies that sell to the U.S. market.

Philipson concedes that U.S. prices are high. He also asserts that these high prices allow other nations to act to protect their citizens by regulating drug prices. Writing in today's *Wall Street Journal,* he condemns H.R. 2190 in part because it resembles the practice of many "European governments that act rationally in holding down prices because the global profits that support innovation come from the U.S. market." [Tomas J. Philipson, "A Dangerous Medicare Proposal," *WSJ,* 26 July 2011, http://online.wsj.com/article/SB10001424053111903554904576461752700885960.html?mod=djemITP_h#printMode.]

Philipson is correct about high U.S. drug prices. But that does not make it affordable for all of us who live, work, and do business in the United States to generate a disproportionate share of drug makers' revenues and profits.

That's particularly true because the link between profits and innovation is far from clear.

Exhibit
Average Foreign-to-U.S.A. Price Ratios, 2010

Nation	Market exchange rate	Purchasing Power Parity
Canada	0.52	0.43
France	0.47	0.37
Italy	0.46	0.38
Germany	0.63	0.53
Sweden	0.51	0.39
Switzerland	0.54	0.35
United Kingdom	0.45	0.39
United States	1.00	1.00

Source: Calculated from Patented Medicine Prices Review Board, *Annual Report, 2010*, Ottawa: The Board, 31 May 2011, Table 11, p. 24, http://www.pmprb-cepmb.gc.ca/cmfiles//Publications/Annual%20Reports/AR2010-online-E.pdf.

Note: The original data were expressed as foreign-to-Canadian price ratios with Canadian prices set at 1.00; here, they are expressed as foreign-to-U.S.A. price ratios, with U.S. prices set at 1.00.

Second, for a time, drug makers denied that U.S. prices were high; subsequently, they have argued that high U.S. prices were justified by the high profits that they produced—profits that were allegedly essential to financing research to develop innovative medications. Drug makers asserted that, as a result, U.S. drug companies developed a high share of innovative drugs world-wide.

- ✓ At the outset, it is important to note that drug makers' profits do not finance research. Rather, profits are what remain after various costs—such as administration and marketing, manufacturing, taxes, and research—are paid out.
- ✓ The U.S. drug industry was for several decades consistently the most profitable in the United States. But the connection between high domestic drug prices and profits, on one hand, and innovation, on the other, has been hard to make.
- ✓ Many—perhaps most—of the drug makers in wealthy nations have garnered disproportionate shares of their profits in the U.S. Does that make them equally innovative?
- ✓ Some researchers have questioned the link between high U.S. domestic drug prices and high U.S. shares of new drug development. See, for example, Donald W. Light, "Global Drug Discovery: Europe Is Ahead," *Health Affairs*, Vol. 28, No.5 (2009), pp. w969-w977 (published online August 25, 2009; 10.1377/hlthaff.28.5.w969).
- ✓ In practice, it is hard to attribute innovation to a particular nation. Many individual drug makers have laboratories scattered among many nations. And is a particular drug-making corporation itself native to a particular nation? How can that even be measured?
- ✓ It is far from clear that high prices and profits make for innovation. Indeed, some drug makers that long enjoyed high profits failed to develop enough new and patentable medications to sustain those profits. Some large drug makers have reduced their own investments in research and have turned to buying innovations from smaller companies.

Third, in 2003, when the Medicare Modernization Act was under debate, some said that private insurers would do a better job than public regulators at extracting lower prices from drug makers. If insurers have done so, passage of H.R. 2190 would not result in an increase in rebates paid by manufacturers.

Since private insurers have not done a good job of holding down prices, wouldn't it be wise to move toward public regulation of drug prices—as have almost all other wealthy democracies?

Arguably, the Medicare Modernization Act, which called for many competing insurers, which would negotiate drug prices with manufacturers, was designed not to hold down prices, but rather to fragment buyers' purchasing power and thereby boost drug makers' own prices and revenue.

Fourth, it does not hurt to recall that imposing Medicaid-mandated rebates on dually-eligible patients is simply a return to the state of affairs existing before implementation of MMA on 1 January 2006. Drug makers paid those rebates until then, and H.R. 2190 would therefore simply require a return to the status quo for those six million or so patients.

Fifth, why does the report assume that drug makers will be willing and able to demand and obtain lower negotiated rebates on Part D Medicare patients?

A. Ability. The report seems to assume that drug makers have some optimal or targeted revenue—a figure below the maximum revenue they could obtain—one that they seek to obtain from all payers taken together. Under this assumption, drug makers would offset a higher rebate won by passing H.R. 2190 by cutting their rebate to private Part D insurers. But does that make sense?

Haven't drug manufacturers already negotiated the smallest rebates they can settle for, commensurate with revenue- and profit-maximization? Stockholders habitually demand the highest returns possible. So, to suppose that a return to Medicaid rebates would lead drug makers to seek more money from other Medicare patients is to assume that drug makers have been intentionally and voluntarily leaving huge sums on the table since 1 January 2006. Is that credible?

B. Willingness. Politically, would drug makers choose to slash rebates on other Medicare patients to generate revenue to offset lost revenue owing to imposition of Medicaid-level rebates on dually-eligible and LIS patients?

Further, supposing that drug makers have been leaving money on the table, why does the report assume that, if drug makers sought to offset one-half of their lower profits stemming from H.R. 2190's passage, they would seek to do so entirely by demanding and obtaining lower negotiated rebates on Part D Medicare patients? Why wouldn't they strive to obtain some of their increased, offsetting revenues elsewhere—particularly out of the public eye?

In this connection, it is worth noting that post-rebate drug prices paid by Medicaid are still much more than the marginal cost of manufacturing and distributing those medications. They may well be above the average cost. Either way, they are profitable to the drug makers.

This is apparently different from the case of Medicaid payments to acute hospitals, which are probably below average cost in most states and may even be below marginal cost in some states.

Sixth, it is wrong-headed to claim either that the present Medicare Part D arrangements are legitimate because they are justified by free market competition or that a move to save money through price regulation is an expensive step backward. [See, Tomas J. Philipson, "A Dangerous Medicare Proposal," *Wall Street Journal,* 26 July 2011, http://online.wsj.com/article/SB10001424053111903554904576461752700885960.html?mod=djemITP_h#printMode. Also see Renee Winsky, "Plan to Save on Medicare Drug Costs Would Hurt Seniors—and Maryland's Economy," *Baltimore Sun,* 25 July 2011, http://www.baltimoresun.com/news/opinion/oped/bs-ed-medicare-prescription-drugs-20110725,0,3981654,print.story.]

Current arrangements don't come close to resembling those that would prevail in a competitive free market. Indeed, there is reason to conclude that they were designed to thwart free market competition, not to advance it. Please consider these three aspects.

A. The Medicare Part D program was deliberately established with multiple small and fragmented insurers to minimize buyers' power to win lower prices from drug makers. Medicare was prohibited from negotiating directly with drug makers to win lower prices.

B. Costs of prescription drugs are among the most predictable costs in health care, particularly durable need for high-cost chronic-use medications. This allows patients to engage in adverse selection when choosing among individual Part D insurance plans.

But the presence of dozens of competing insurance plans in most regions—often with changing benefits—makes it hard for patients to identify a policy that does a good job of covering the cost of their medications. Rational consumers find it difficult to spot a plan that offers a good deal, one that includes meds they are taking, at the lowest premium, deductible, co-payment, co-insurance and other costs.

Too much information makes it hard for consumers to act rationally in their own self-interest. [See, for example, Medicare Rights Center, *Planning Ahead: Recommendations for Plan Finder, Inspired by Beneficiaries,* Summer 2011, http://www.medicarerights.org/pdf/Planning-Ahead-Recommendations-for-Plan-Finder.pdf.]

C. Drug makers have patents for brand name drugs. The resulting exclusivity is designed to allow drug makers to charge higher prices. This is monopoly, not competition.

While the many Part D insurers do compete with one another for patients, their market shares are typically so small that they tend not to have much power to extract lower prices from drug makers who sell competing products.

Seventh, some criticize H.R. 2190's demands for savings through higher rebates as likely to result in under-payment of drug makers, paralleling Medicare's alleged under-payment of hospitals under Medicare's Prospective Payment System.

Two recent papers on hospital cost shifting involving Medicare are relevant in this connection. They suggest that the problem may not be low Medicare payments but rather high hospital costs. Stensland, Gaumer, and Miller offer evidence that:

> Hospitals with strong marker power and higher private-payer and other revenues appear to have less pressure to constrain their costs. Thus, these hospitals have higher costs per unit of service, which can lead to losses on Medicare patients. Hospitals under more financial pressure—with less market share and less ability to charge higher private rates—often constrain costs and can generate profits on Medicare patients. [Jeffrey Stensland, Zachary R. Gaumer, and Mark E. Miller, ""Private-payer Profits Can Induce Negative Medicare Margins," *Health Affairs,* Vol. 29, No. 5 (May 2010), pp. 1045-1051, http://content.healthaffairs.org/content/29/5/1045.full.pdf+html.]

Robinson offers complementary findings, reporting that:

> [F]aced with shortfalls between Medicare payments and projected costs, hospitals in concentrated markets focus on raising prices to private insurers, while hospitals in competitive markets focus on cutting costs. [James Robinson, "Hospitals Respond to

Medicare Payment Shortfalls by Both Shifting Costs and Cutting Them, Based on Market Concentration," *Health Affairs, Vol.* 30, No. 7 (July 2011), pp. 1265-1271, http://content.healthaffairs.org/content/30/7/1265.full.pdf+html.]

The phrase "market power" is probably an oxymoron, in that pricing power doesn't exist in a genuine freely competitive market. In such a market, each buyers and seller has so small a share of the market that the market alone makes the price. That's why one price prevails and all payers pay that price.

If, in the face of the evidence and arguments raised here, drug makers are willing and able to boost prices substantially to offset their losses from the imposition of Medicaid-level rebates on dually-eligible and LIS patients, would they not be inviting the comprehensive price regulation that MMA prohibited? And would they not be inviting stockholder suits for failure to minimize Part D rebates in the past, thereby failing to maximize past profits?

I hope these thoughts are useful.

Cordially,

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