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Driving Down the Cost of Drugs: Battling Big Pharma in the Statehouse

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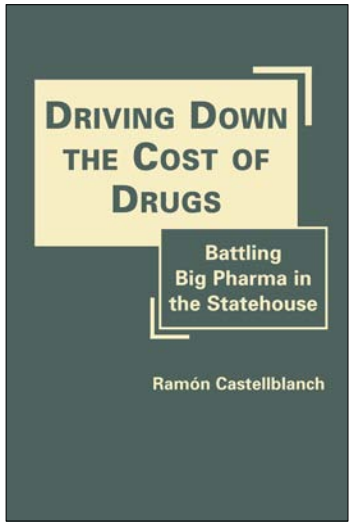

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David, Goliath, and Prescription Drugs

One of the first places where I saw someone outraged by how rising prescription drug prices could mean that she could lose her medicines was at a New England town meeting in the autumn of 2000. At the time, I was a health policy professor at a Connecticut college, Quinnipiac University, and a member of a Connecticut legislative task force looking into the availability of prescription drugs. A public interest group advocating in the legislature to improve access to prescription drugs had gotten me on the task force. To learn how strongly voters felt about the problem and to see if they should do something about it, the task force held a series of hearings around the state and one was in New Britain, Connecticut, an old industrial town. New Britain was still home to Stanley Works, the toolmaker. But once there had been 5,000 jobs in the Stanley Works factory. By the year 2000, most of those jobs were gone.

Our task force was meeting in the old town's senior center, hearing what its retirees had come to say about access to prescription drugs. We sat on a stage at one end of the room; seniors faced us with a standing microphone in the middle aisle. Despite only low tech publicity like flyers and local newspaper articles having announced the event, all the seats were filled and more people were standing around the perimeter of the meeting hall. After we started, many seniors got in line behind the standing microphone waiting to speak. I was surprised to see that the room was packed; I imagine everyone else on the task force was as well.

After waiting her turn, one elderly woman slowly walked from her place at the head of the line to the mike and explained to the panel that she could only walk one day out of three. She told us that she had saved her "walking day" for the day of this hearing so that she could tell us about her problems in getting access to prescription drugs. As did many other witnesses we were to hear, she had brought along all her pill bottles in a paper bag. She took them out of the bag and held each one of them up for us to see. She told us what was in each bottle, what each medicine was for, and what the drugs cost, individually and

cumulatively. She told us what her income was and what portion of it she was already spending on prescription drugs. Next, she explained that, if the price of the medicines in her bag were increased another five or ten percent, then she'd have no choice but to discontinue one of the medicines she had showed us. She finished by asking us on the panel which medicine we thought that she should give up first.

For those of us on the panel, the story she told was not to turn out to be unusual. In hearings around the state, at least one witness would start out by showing us all her pill bottles. At the end of these unrehearsed presentations, each speaker would finish by asking the panel the same question that we heard in New Britain: which medicine should she give up first, if prices went up?

As these witnesses testified at the task force's hearings around Connecticut, they were always observed by drug industry representatives who stood around the edges of the rooms. The representatives' stylish clothes and constant use of cell phones, which were not so common in 2000, made them easy to spot. The industry had a spokesperson on the panel, sometimes a dapper gray-haired woman flown in from Washington, DC, especially for these town meetings. She would make comments that appeared to have been developed using industry focus groups and polls. She used words and catch phrases that sounded as if they were carefully tailored by highly paid wordsmiths. High prices make possible wonderful research, she would argue. She asserted that many diseases could be cured. She warned that, if prices were lowered, cures in the research pipeline would be cut off and many in the room would suffer.

I expected that some in the room would be dazzled by this industry logic; legislators often were. But the seniors defied these expectations: they were unimpressed, and many in the audiences would actually hoot. They didn't seem to care even if the claims were true. Elderly and facing the prospect of losing vital medicines in a few months, many had little interest in possible new cures available in a decade. At each hearing, while the expensively developed messages from the industry representatives bombed, the testimony of plain seniors speaking from the heart about their personal crises carried the day. The industry's message-makers did not expect seniors to dismiss their arguments. Normally, these kinds of persuaders are able to influence US voters with carefully crafted messages that are relentlessly repeated. But, at these meetings, they were met with righteous indignation. People knew high prices were threatening their access to essential medicines, and they were getting a chance to say so.[1]

Fifteen years earlier, I had heard a discussion of the economic logic that led to the high prices that were outraging the seniors around Connecticut and, as is explained in this book's next chapter, around the rest of the United States. In those earlier days, I was getting my start in public policy as a student at the Kennedy School of Government at Harvard. Along with some other students at the Kennedy School, I was able to take a few courses outside of the public policy program. At the time, I was interested in getting involved in what was called "social investing." So, I took the investment course at the Harvard Business School. The course professor presented us with a series of investment experts espousing various strategies. We had a contrarian, we heard about derivatives, and we were given other presentations on picking winners on Wall Street.

One day, we had a guest lecturer who explained the logic by which Wall Street analysts' profit expectations affected a business's stock price. Our guest told us that the movement of a stock price for a business reflected the difference between what Wall Street analysts expected that business's profits to be and what they actually turned out to be. If a business's profits met or exceeded expectations, then its stock price should hold steady or go up. If it failed to live up to expectations, then its stock price should go down. So, a good business in which to own stock would be one with profits that consistently met or exceeded expectations. Its price should only move upward. One problem with prices based on expectations, our expert warned, is that analysts tend to raise expectations for a business each time it meets its previously set expectations. If a business's profits meet expectations once, then it seems more likely that the business will meet expectations again, driving the stock price higher. But, as expectations get higher, they become harder to meet. Eventually, the expectations are not met causing the stock price to fall and hurting the efforts of those who held it to increase the size of their portfolios.

Then, our guest told us of one set of businesses that did not have this problem—the pharmaceutical industry. These businesses kept meeting expectations and their stock prices just kept going up. To explain how they could, he told us how profit expectations are built in the pharmaceutical industry. To begin with, the industry's big profits are based on "blockbusters." In this industry, a blockbuster is basically a drug for which its owner has a patent and can charge high prices and that many patients would take for a long time. For example, in 2010, cholesterol-lowering drugs like Crestor were blockbusters. Tens of millions took them daily, many in the United States paid a high price for them (Hirschler 2010), and they would take them daily for years.

Expectations for the prescription drug industry are based on what our expert called "blockbusters in the pipeline," drugs under development that are designed to become the next blockbusters. So, to meet expectations and keep their stock prices rising, the hoped-for blockbusters must pan out to become actual blockbusters. Here, our guest told us, we could trust the top businesses in the pharmaceutical industry. As evidence of their reliability he pointed out to us one drugmaker who had had a string of so-called blockbusters in the pipeline that had met expectations: Merck. It consistently met expectations and so its stock price kept going up. To sum up his talk, our expert folded his hands as though he were praying, raised his eyes to the ceiling of the Harvard Business School lecture hall, and, in a hushed voice, invoked the name of his miracle-working stock: "St. Merck."

Unfortunately, the prices of blockbusters that led the lecturer to view his stock with such reverence also meant that some needed drugs would be too expensive for many Americans. Without high-priced drugs on which millions of paying customers were dependent, there could be few, if any, blockbusters. Without blockbusters, big drugmakers' profits would disappoint Wall Street and their prices would fall. But the requirement that made pharmaceutical investors richer also made some medicines too expensive for some who needed them, threatening their access to them. Efforts to restrain prescription drug price inflation and improve access for those unable to afford high prices would run counter to the way that the industry makes its big profits and that its investors get their big returns.

In the United States, high prices, such as those charged by the pharmaceutical industry in selling blockbusters, can be effectively challenged in the political arena. But, contrary to what many expect, relying on an argument that high drug prices would endanger the health of many would do little, if anything, to move decisionmakers in the political arena to improve access to medicines. In our country, policymaking has little to do with the quality of arguments for justice. On a day-to-day basis, policymaking is mainly driven by the pressure of competing interest groups on politicians

If policymakers were going to do something about access to medicines, then some interest group or groups would have to stand up for those in need and pressure them. But most of the competing interest groups in our political system are private interest groups like the pharmaceutical industry and have relatively simple missions: make sure that relevant policies support the highest profits possible for themselves.

To fulfill their political missions, private interests rely most heavily on campaign contributions and money generally to influence politicians.

That's where public interest groups come in. Public interest groups are different; they have much less money than private interest groups and need alternative ways to sway policymakers. With little money, they need to convince politicians that they have enough popular support that it would be politically risky for the officeholders to ignore them. They use grassroots tactics like trying to generate large numbers of letters, calls, or visits to officeholders. They include staging demonstrations. A large turnout of seniors as at the New Britain town meeting could be evidence of the kind of popular support of public interest group needs. Without such evidence, public interest groups are relatively powerless.

Even with it, they are hard pressed when confronted by powerful private interests. While a public interest lobbyist must usually wait outside politicians' offices for chances to talk to them, private interest representatives can use their contributions to gain access through closed political events and by enticing legislative and executive branch leaders into their own offices. Big businesses playing this "inside game" can also muster high-paid experts, attorneys, and media professionals to bolster their efforts. Public interest groups playing the "outside game" only have their usually modestly or unpaid supporters using grassroots tactics to press their cases. Given this disparity, public interest groups engaging in politics in the United States often find the odds heavily stacked against them. In the case of people in this country needing medicines and trying to gain greater access to them, public interest groups would have to do political battle with the pharmaceutical industry. The chances of their success would seem somewhere between slim and none, given the extraordinary political clout of drugmakers. In taking on the pharmaceutical industry, a public interest group is playing David to their Goliath. But, in spite of such a daunting situation, advocates for those needing medicines—such as some of us at the Connecticut hearings—would find in time that it was worth the effort to challenge the pharmaceutical industry over access to medicines.

This book is about the political contest between people advocating for those like the elderly woman in New Britain and those running businesses like Merck. It looks at it in three different states, one large and two small. It seeks to draw lessons from these cases as to how grassroots advocates could prevail over wealthy interest groups. In three stages, this book looks into how public interest lobbyists could beat a powerful force like the pharmaceutical industry in a legislative battle. The first part of this book outlines in greater detail the basis of how the industry generates profits and the impact of this strategy on public

health. With this background, it becomes easier to understand the events described herein, in particular what prompted seniors to react the way they did to the industry's policies and what policy options were available to those who were working to increase their access to needed medicines. The second section of the book presents the stories of the three different state cases in which public interest groups challenged the pharmaceutical industry through their legislatures. The section goes on to discuss how the industry altered its profitmaking tactics in the face of these challenges. The first two cases are political battles in New England: Vermont and Maine. Vermont in 1999 and 2000 was the first state where an effort was made to do something about the rapid prescription drug price inflation of the late 1990s.

While price legislation failed in Vermont, the second case, Maine in 2000, was the archetype of success for challenging the powerful pharmaceutical industry. It is the classic David-and-Goliath story: a legislative victory inspired by local grassroots activists against the then most profitable industry in the world. The third case took place in California in 2006 where, again, prescription drug access advocates won a major legislative victory over the daunting power of the industry's political arm, the Pharmaceutical Research and Manufacturers of America (PhRMA), and enacted a bill modeled after the legislation with which grassroots leaders had defeated PhRMA in Maine.

In the years that have followed these legislative victories over drug prices, the pharmaceutical industry has been able to prevent implementation of the state laws. Nevertheless, these wins did help generate and maintain political pressure felt at the national level that is leading to increased access to medicines and that is posing a growing threat to high drug prices. As described in Chapter 5, the Maine legislation and subsequent copycat bills around the country pushed PhRMA, in 2003, to lobby President Bush and the Republican Congress to enact the Medicare Modernization Act, (MMA) a law that deeply involves the federal Medicare program in the financing of medicines for seniors. The industry hoped that the MMA would satisfy popular demands for access to medicines while leaving prices high. But, the law was so poorly designed that it initially did little to improve access to medicines. Further, federal payment for health care through such laws puts the industry in a position where more of its sales can be subjected to the purchasing power of the US government. In this time of crushing US budget deficits, it is probably only a matter of time until the federal government acts to lower its drug costs. So, the law cannot be relied upon to protect high prices and the state victories could well bear fruit in lower drug prices.

The book's third section uses its cases to address the question on which this book focuses: how grassroots advocates sometimes defeat the rich and powerful in the political arena. From this discussion, it suggests larger lessons about factors that may explain how public interest lobbyists can push the rich and powerful to better act in the interests of the communities in which they operate.

This book is written from the point of view of a health policy academic who has sided with advocates for increased access to needed medicine and who has had a ringside seat from which to view the cases under study. In New England in 2000, I was part of a multistate group demanding broader access to essential medicines for residents. Our coalition included the Vermont legislators whose work showed our multistate group that a state could take on high prescription drug prices. It also included the Maine legislators who were to beat PhRMA in 2000 and who, later, successfully defended their legislation against the industry's lawsuits. After returning to my home state of California in 2002, I ended up working with the OURx Coalition, the group that spearheaded access advocates' win in 2006. I write in the hope that this work will contribute to the efforts of activists to politically challenge the rich and powerful.

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[1] The Connecticut legislature did later act to substantially expand its state's program aimed at helping residents afford medicines, ConnPACE (Connecticut Citizen Action Group 2010). As a result of the work of ConnPACE starting in 2000 and running over the next few years, approximately 50,000 Connecticut seniors and people with disabilities pay no more than $16.25 per prescription (Wilson-Coker 2006).