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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Ann O'Leary's Files

Office of Policy Development, Domestic Policy Council, First Lady's issues

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Teen conference
Teen conference- Carnegie
Teen conference values
Teen conference Clinton Legacy
Teen conference risk behaviors
Afterschool community

Prescription Drug Pricing on Long Island: Drug Companies Profit at the Expense of Older Americans

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Prepared for Rep. Carolyn McCarthy

Minority Staff Report
Committee on Government Reform
U.S. House of Representatives

July 21, 1999

Table of Contents

EXECUTIVE SUMMARY

This staff report was prepared at the request of Rep. Carolyn McCarthy of New York. In Mrs. McCarthy's district on Long Island, as in many other congressional districts around the country, older Americans are increasingly concerned about the high prices that they pay for prescription drugs. Mrs. McCarthy requested that the minority staff of the Committee on Government Reform investigate this issue. This report is the first report to quantify the extent of prescription drug price discrimination in Long Island and its impacts on seniors.

Numerous studies have concluded that many older Americans pay high prices for prescription drugs and have a difficult time paying for the drugs they need. This study presents disturbing evidence about the cause of these high prices. The findings indicate that older Americans and others who pay for their own drugs are charged far more for their prescription drugs than are the drug companies' most favored customers, such as large insurance companies, health maintenance organizations, and the federal government. The findings show that a senior citizen on Long Island paying for his or her own prescription drugs must pay, on average, more than twice as much for the drugs as the drug companies' favored customers. The study found that this is an unusually large price differential -- more than five times greater than the average price differential for other consumer goods.

It appears that drug companies are engaged in a form of "discriminatory" pricing that victimizes those who are least able to afford it. Large corporate, governmental, and institutional customers with market power are able to buy their drugs at discounted prices. Drug companies then raise prices for sales to seniors and others who pay for drugs themselves to compensate for these discounts to the favored customers.

Older Americans are having an increasingly difficult time affording prescription drugs. By one estimate, more than one in eight older Americans has been forced to choose between buying food and buying medicine. Preventing the pharmaceutical industry's discriminatory pricing -- and thereby reducing the cost of prescription drugs for seniors and other individuals -- will improve the health and financial well-being of millions of older Americans.

A. Methodology

This study investigates the pricing of the five brand name prescription drugs with the highest sales to the elderly. It estimates the differential between the price charged to the drug companies' most favored customers, such as large insurance companies, HMOs, and certain federal government purchasers, and the price charged to seniors. The results are based on a survey of retail prescription drug prices in chain and independently owned drug stores in Mrs. McCarthy's congressional district on Long Island. These prices are compared to the prices paid by the drug companies' most favored customers. For comparison purposes, the study also estimates the differential between prices for favored customers and retail prices for other consumer items.

B. Findings

The study finds that:

- **Older Americans pay inflated prices for commonly used drugs.** For the five drugs investigated in this study, the average price differential was 129% (Table 1). This means that senior citizens and other individuals who pay for their own drugs pay more than twice as much for these drugs than do the drug companies' most favored customers. In dollar terms, senior citizens must pay $53.80 to $98.77 more per prescription for these five drugs than favored customers.

Table 1: Average Retail Prices on Long Island for the Five Best-Selling Drugs for Older Americans Are More Than Twice as High as the Prices That Drug Companies Charge Their Most Favored Customers.

Prescriptio Drug	Manufacturer	Use	Prices For Favored Customers	Retail Prices For Long Island Seniors	Differential For Long Island Senior Citizens	
					Percent	Dollar
Zocor	Merck	Cholesterol	$27.00	$102.03	278%	$75.03
Prilosec	Astra/Merck	Ulcers	$59.10	$116.28	97%	$57.18
Procardia XL	Pfizer Inc.	Heart Problems	$68.35	$131.80	93%	$63.45
Norvasc	Pfizer Inc.	High Blood Pressure	$59.71	$113.51	90%	$53.80
Zoloft	Pfizer, Inc.	Depression	$115.70	$214.47	85%	$98.77
Average Price Differential					**129%**	

- **For other popular drugs, the price differential is even higher.** This study also analyzed a number of other popular drugs used by older Americans, and in some cases found even higher price differentials (Table 2). The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the price differential for senior citizens on Long Island was 1,494%. An equivalent quantity of this drug would cost the manufacturers' favored customers only $1.75, but would cost the average senior citizen on Long Island nearly $28.00. For Micronase, a diabetes treatment manufactured by Upjohn, an equivalent dose would cost the favored customers $10.05, while seniors on Long Island are charged an average of $48.96. The price differential was 387%.

- **Price differentials are far higher for drugs than they are for other goods.** This study compared drug prices at the retail level to the prices that the pharmaceutical industry gives its most favored customers, such as large insurance companies, government buyers with negotiating power, and HMOs. Because these customers typically buy in bulk, some difference between retail prices and "favored customer" prices would be expected.

Table 2: Price Differentials for Some Drugs Are Nearly 1,500%.

Prescription Drug	Manufacturer	Use	Prices for Favored Customers	Retail Prices for Long Island Seniors	Price Differential for Long Island Seniors
Synthroid	Knoll Pharmaceuticals	Hormone Treatment	$1.75	$27.90	1494%
Micronase	Upjohn	Diabetes	$10.05	$48.96	387%

The study found, however, that the differential was much higher for prescription drugs than it was for other consumer items. The study compared the price differential for prescription drugs to the price differentials on a selection of other consumer items. The average price differential for the five prescription drugs was 129%, while the price differential for other items was only 22%. Compared to manufacturers of other retail items, pharmaceutical manufacturers appear to be engaging in significant price discrimination against older Americans and other individual consumers.

- **Pharmaceutical manufacturers, not drug stores, appear to be responsible for the discriminatory prices that older Americans pay for prescription drugs.** In order to determine whether drug companies or retail pharmacies were responsible for the high prescription drug prices paid by seniors on Long Island, the study compared average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that the pharmacies on Long Island appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. The retail prices on Long Island are actually below the published national Average Wholesale Price, which represents the manufacturers' suggested price to pharmacies. The differential between retail prices and a second indicator of pharmacy costs, the Wholesale Acquisition Cost, which represents the average price pharmacies actually pay for drugs, is only 18%. This indicates that it is drug company pricing policies that appear to account for the inflated prices charged to older Americans and other customers.

I. THE VULNERABILITY OF OLDER AMERICANS TO HIGH DRUG PRICES

This report focuses on a continuing, critical issue facing older Americans -- the cost of their prescription drugs. Numerous surveys and studies have concluded that many older Americans pay high costs for prescription drugs and are having a difficult time paying for the drugs they need. The cost of prescription drugs is particularly important for older Americans because they have more medical problems, and take more prescription drugs, than the average American. This situation is exacerbated by the fact that the Medicare program, the main source of health care coverage for the elderly, fails to cover the cost of most prescription drugs.

According to the National Institute on Aging, "as a group, older people tend to have more long-term illnesses -- such as arthritis, diabetes, high blood pressure, and heart disease -- than do younger people."[1] Other chronic diseases which disproportionately affect older Americans include depression and neurodegenerative diseases such as Alzheimer's disease, Lou Gehrig's disease, and Parkinson's disease.

The latest survey data indicate that 86% of Medicare beneficiaries are taking prescription drugs.[2] Moreover, older Americans spend almost three times as much of their income (21%) on health care than those under the age of 65 (8%).[3]

The average older American uses 18.5 prescriptions annually,[4] significantly more than the average under-65 population.[5] It is estimated that the elderly in the United States, who make up 12% of the population, use one-third of all prescription drugs.[6]

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[1] National Institute on Aging (NIA), *NIA Age Page* (1997) (online at www.nih.gov/nia/health/pub/medicine.htm).

[2] Health Affairs, *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, 237 (Jan./Feb. 1999).

[3] AARP Public Policy Institute and the Lewin Group, *Out of Pocket Health Spending By Medicare Beneficiaries Age 65 and Older: 1997 Projections* (Feb. 1997).

[4] *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, *supra* note 2, at 237.

[5] Senate Special Committee on Aging, *Developments In Aging: 1996*, 105th Cong., 1st Sess. 121 (1997) (S. Rpt. 36).

[6] Senate Special Committee On Aging, *Developments in Aging: 1993*, 103d Cong., 2d Sess. 35 (1994) (S. Rpt. 403).

Although the elderly have the greatest need for prescription drugs, they often have the most inadequate insurance coverage for the cost of these drugs. With the exception of drugs administered during inpatient hospital stays, Medicare generally does not cover prescription drugs. A recent study by federal researchers found that 35% of Medicare recipients do not have any insurance coverage for prescription drugs.[7]

Although Medicare beneficiaries can purchase supplemental "Medigap" insurance privately, these policies are often prohibitively expensive or inadequate. Only three of the ten available plans offer any prescription drug coverage, and even the best available Medigap policy provides only a $3,000 drug benefit, while still leaving beneficiaries vulnerable to a high deductible and to paying at least half of their total drug costs.[8] Less than 10% of the Medicare population obtains prescription drug coverage from Medigap providers.[9] Moreover, while some Medicare managed care plans may offer optional prescription drug coverage, these plans serve only a small portion of the Medicare population, and have recently withdrawn coverage for over 400,000 seniors.[10]

In total, Medicare beneficiaries pay more than 50% of their drug costs out of their own pockets.[11]

The high costs of prescription drugs, and the lack of insurance coverage, directly affect the health and welfare of older Americans. In 1993, 13% of older Americans surveyed reported that they were forced to choose between buying food and buying medicine.[12] By another estimate, five million older Americans are forced to make this difficult choice.[13]

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[7] *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, *supra* note 2.

[8] *Id.* at 232.

[9] *Id.* at 235.

[10] *Clinton Plans to Intervene as HMOs Exit Medicare*, New York Times, A1 (Oct. 8, 1998).

[11] Health Care Financing Administration, *The Characteristics and Perceptions of the Medicare Population*, 107 (1996).

[12] Families USA Foundation, *Worthless Promises: Drug Companies Keep Boosting Prices*, 6 (Mar. 1995).

[13] Senate Special Committee on Aging, *A Status Report -- Accessibility and Affordability of Prescription Drugs For Older Americans*, 102d Cong., 2d Sess. 2 (1992) (S. Rpt. 100).

II. ARE DRUG COMPANIES EXPLOITING THE VULNERABILITY OF OLDER AMERICANS?

Rep. Carolyn McCarthy of New York asked the minority staff of the Committee on Government Reform to investigate whether pharmaceutical manufacturers are taking advantage of older Americans through price discrimination, and, if so, whether this is part of the explanation for the high drug prices being paid by older Americans in her congressional district. This report presents the results of this investigation.

Industry analysts have recognized that price discrimination occurs in the prescription drug market. According to a recent Standard & Poor's report on the pharmaceutical industry, "[d]rugmakers have historically raised prices to private customers to compensate for the discounts they grant to managed care customers. This practice is known as 'cost shifting.'"[14] Under this practice, "drugs sold to wholesale distributors and pharmacy chains for the individual physician/patient are marked at the higher end of the scale."[15]

Although industry analyses acknowledge that price discrimination occurs, they have not estimated its degree or impact. This report, prepared at Mrs. McCarthy's request, is the first attempt to quantify the extent of price discrimination and its impact on senior citizens on Long Island, New York.

The study design and methodology used to test whether drug companies are discriminating against older Americans in their pricing are described in part III. The results of the study are described in part IV. These results show that drug manufacturers appear to be engaged in substantial price discrimination against older Americans and other individuals who must pay for their own prescription drugs. The impact of the manufacturers' pricing policies on corporate profits is discussed in part V.

III. METHODOLOGY

A. Selection of Drugs for this Survey

This survey is based primarily on a selection of the five patented, nongeneric drugs with the highest annual sales to older Americans in 1997. The list was obtained from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE). The PACE program is the largest outpatient prescription drug program for older Americans in the United States for which claims data is available, and is used in this study, as well as by several other analysts, as a proxy database for prescription drug usage by all older Americans. In 1997, over 250,000

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[14] Herman Saftlas, Standard & Poor's, *Healthcare: Pharmaceuticals,* Industry Surveys, 19-20 (Dec. 18, 1997).

[15] *Id.* at 19.

persons were enrolled in the program, which provided over $100 million of assistance in filling over 2.8 million prescriptions.[16]

B. Determination of Average Retail Drug Prices for Seniors on Long Island

In order to determine the prices that senior citizens are paying for prescription drugs in Long Island, the minority staff and the staff of Mrs. McCarthy's congressional office conducted a survey of nine drug stores -- including both independent and chain stores. Mrs. McCarthy represents the 4th Congressional District in New York, which is located on Long Island and includes the cities of Freeport, Hempstead, and Mineola. The location of the stores is shown in Appendix D.

C. Determination of Prices for Drug Companies' Most Favored Customers

Drug pricing is complicated and drug companies closely guard their pricing strategies. For example, drug companies require HMOs to sign confidentiality agreements before offering them pricing discounts. The best publicly available indicator of the prices drug companies charge their most favored customers is the prices the companies charge the federal government.

The federal government pays for prescription drugs through several different programs. One important program is the Federal Supply Schedule (FSS), which is a price catalogue containing goods available for purchase by federal agencies. Drug prices on the FSS are negotiated by the Department of Veterans Affairs (VA) and often approximate the prices that the drug companies charge their most favored non-federal customers. According to the U.S. General Accounting Office, "[u]nder GSA procurement regulations, VA contract officers are required to seek an FSS price that represents the same discount off a drug's list price that the manufacturer offers its most-favored nonfederal customer under comparable terms and conditions."[17] To obtain additional price discounts available to the private sector, the VA has established at least two additional negotiated-price programs: (1) a VA formulary that operates similarly to the formularies established by well-managed HMOs,[18] and (2) a Blanket Price Agreement (BPA) program, under which the VA commits to purchasing minimum quantities of particular prescription drugs. Yet another program through which the federal government obtains

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[16] Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly January 1 - December 31, 1997* (Apr. 1998).

[17] U.S. General Accounting Office, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain* 6 (June 1997) (emphasis added).

[18] For a detailed description of the Department of Veterans Affairs Formulary program, see the National Formulary Content Page, online at www.dppm.med.va.gov/newsite/national.htm.

prescription drugs is section 340(b) of the Public Health Service Act, which entitles four agencies (the VA, the Indian Health Service, the Department of Defense, and the Public Health Service) to purchase drugs at a maximum price of 24% below the manufacturer's average nonfederal price.

This analysis uses the lowest price paid by the federal government as a proxy for the prices paid by drug companies most favored customers.[19] All prices were updated in June 1999 to reflect current pricing.

D. Determination of Prices Paid by Pharmacies

The survey also looked at two other pricing indicators: (1) the Average Wholesale Price (AWP) and (2) the Wholesale Acquisition Cost (WAC). These two prices provide an indicator of the extent of markups that are attributable to the pharmacy (in contrast to those that are due to the drug manufacturer). The AWP represents the price that manufacturers suggest that wholesalers charge retail pharmacies; the WAC represents the actual average price that wholesalers charge pharmacies. Both AWP and WAC were obtained from the Medispan database and were updated in June 1999 to reflect current pricing.

E. Determination of Drug Dosages

When comparing prices, the study used the same criteria (dosage, form, and package size) used by the GAO in its 1992 report, *Prescription Drugs: Companies Typically Charge More in the United States Than In Canada*. For drugs that were not included in the GAO report, the study used the dosage, form, and package size common in the years 1994 through 1997, as indicated in the *Drug Topics Red Book*. The dosages, forms, and package sizes used in the study are shown in Appendix B.

F. Comparison of Price Differentials for Other Retail Items

In order to determine whether the differential between the most favored customer prices and retail prices for drugs commonly used by older Americans is unusually large, the study compared the prescription drug price differentials to price differentials on other consumer products. To make this comparison, a list of consumer items other than drugs available through the FSS was assembled. FSS prices were then compared with the retail prices at which the items could be bought at a large national chain.[20]

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[19] For Norvasc, Prilosec, Procardia XL, Micronase, and Synthroid, the Federal Supply Schedule price was used as the indicator of best price. For Zocor the VA's formulary price was used as the indicator of best price. For Zoloft, the VA's Blanket Pricing Agreement price was used as the indicator of best price.

[20] The items used were paper towels, envelopes, rubber bands, toilet paper, pencils, Rolodexes, tape dispensers, waste baskets, correction fluid, post-it notes, paper clips, and scissors.

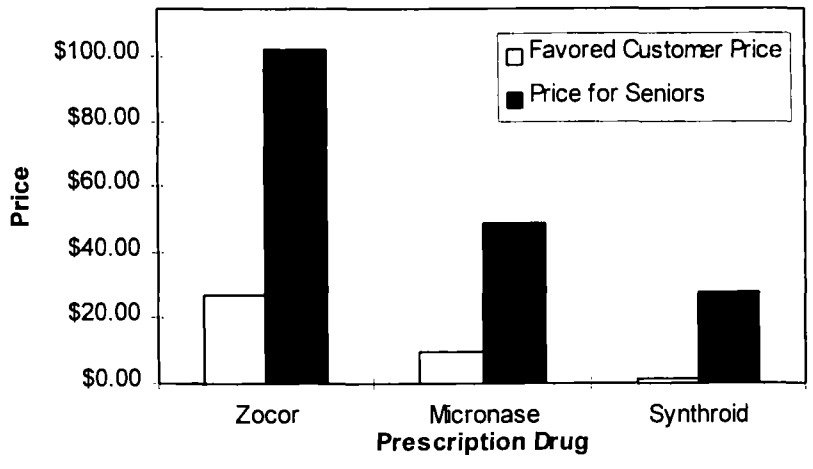
IV. DRUG COMPANIES CHARGE OLDER AMERICANS DISCRIMINATORY PRICES

A. Discrimination in Drug Pricing

In the case of the five drugs with the highest sales to seniors, the average price differential between the price that would be paid by a senior citizen on Long Island and the price that would be paid by the drug companies' most favored customers was 129% (Table 1). The study thus showed that the average price that older Americans and other individual consumers on Long Island pay for these drugs is more than double the price paid by the drug companies' favored customers, such as large insurance companies and HMOs.

For individual drugs, the price differential was even higher. Among the five best selling drugs, the highest price differential was 278% for Zocor, a cholesterol treatment manufactured by Merck. For other popular drugs, the study found even greater price differentials. The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the price differential for senior citizens on Long Island was nearly 1,500%. An equivalent quantity of this drug would cost the most favored customers only $1.75, but would cost the average senior citizen on Long Island $27.90. For Micronase, a diabetes treatment manufactured by Upjohn, the price differential was 387% (Figure 1). Every drug looked at in this study had a large price differential. Among the five highest selling drugs, four (Zocor, Prilosec, Procardia XL, and Norvasc) had price differentials that equaled or exceeded 90%. The lowest price difference was still high -- 85%, for Zoloft.

Figure 1: Older Americans on Long Island Pay Inflated Prices for Prescription Drugs.

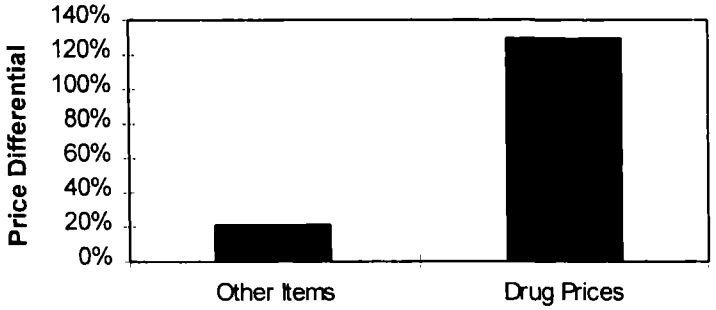


In dollar terms, Zoloft, an antidepressant, had the highest price differential. Senior citizens on Long Island must pay over $95.00 more for 100 tablets of Zoloft than a favored customer. The difference between seniors' prices and prices for favored customers was more than $75.00 for 60 tablets of Zocor and over $50.00 per prescription for each of the remaining three best selling drugs (Procardia XL, Prilosec, and Norvasc).

B. Comparison with Other Consumer Goods

The study also analyzed whether the large differentials in prescription drug pricing could be attributed to a volume effect. The drug companies' most favored customers, such as large insurance companies and HMOs, typically buy large volumes of drugs. Thus, it could be expected that there would be differences between the prices charged the most favored customers and retail prices. The study found, however, that the differentials in prescription drug prices were much greater than the differentials in prices for other consumer goods. The study found that, in the case of other consumer goods, the average difference between retail prices and the prices charged most favored customers, such as large corporations and institutions, was only 22%. The average price differential in the case of prescription drugs was more than five times larger than the average price differential for other consumer goods (Figure 2). This indicates that a volume effect is unlikely to explain the large differential in prescription drug pricing.

Figure 2: Price Differentials on Drugs Commonly Used by Older Americans Are Far Higher Than Differentials for Other Consumer Goods.



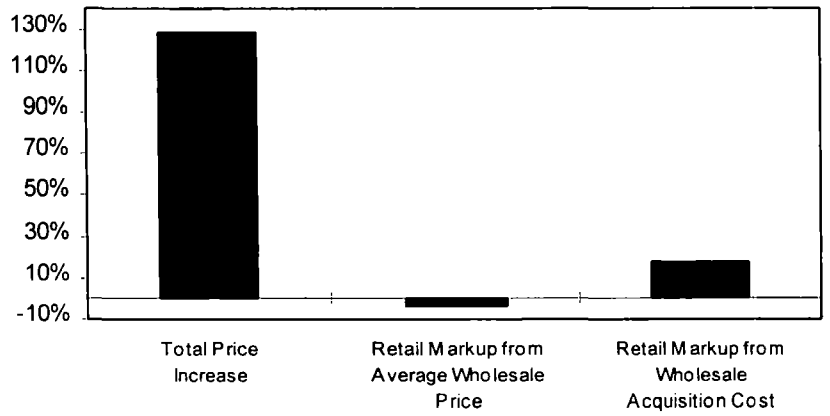
C. Drug Company Versus Pharmacy Responsibility

The study also sought to determine whether drug companies or retail pharmacies are responsible for the high prices being paid by older Americans. To do this, the study compared the average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that pharmacies appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they

sell them. The study found that the average retail price for the five best-selling prescription drugs was actually lower than the published Average Wholesale Price, and only 18% above the pharmacies' Wholesale Acquisition Cost (Figure 3). This finding indicates that it is drug company pricing policies, not retail markups, that account for the inflated prices charged to older Americans and other individual customers. These findings are consistent with other experts who have concluded that because of the competitive nature of the pharmacy business at the retail level, there is a relatively small profit margin for retail pharmacists.[21]

The study found few significant differences in retail prices between pharmacies in different parts of Mrs. McCarthy's district. Moreover, although there were variations in prices between chain and independent pharmacies, these differences were in general not systematic.

Figure 3: Drug Companies, Not Retail Pharmacies, Are Responsible for High Prescription Drug Costs



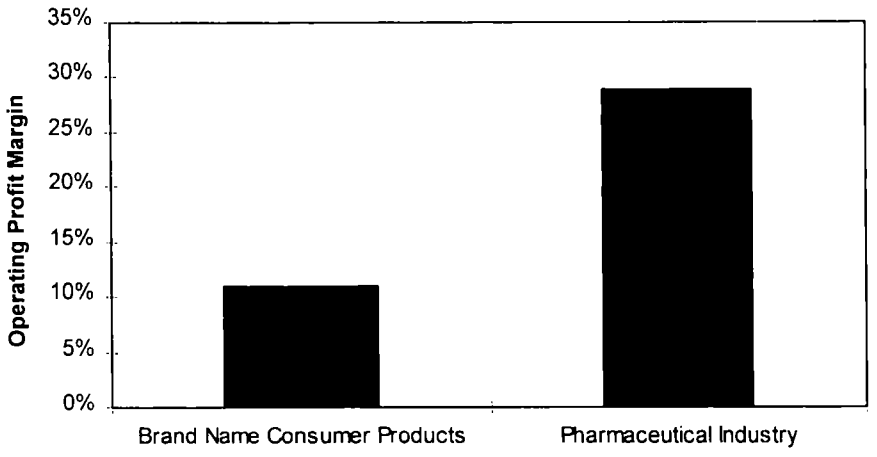
[21] National Association of Chain Drug Stores, *Did You Know . . .* (pamphlet) (citing financial data assembled by Keller Bruner & Company, P.C., Certified Public Accountants 1995).

V. DRUG MANUFACTURER PROFITABILITY

Drug industry pricing strategies have boosted the industry's profitability to extraordinary levels. The annual profits of the top ten drug companies are over $25 billion.[22] Moreover, the drug companies make unusually high profits compared to other companies. The average manufacturer of branded consumer goods, such as Proctor & Gamble or Colgate-Palmolive, has an operating profit margin of 10.5%. Drug manufacturers, however, have an operating profit margin of 28.7% -- nearly three times greater (Figure 4).[23]

These high profits appear to be directly linked to the pricing strategies observed in this study. For instance, Merck, the country's largest pharmaceutical manufacturer, had a 24% increase in sales and a 12% increase in profits in the first quarter of 1999.[24] According to industry analysts, Merck's increased profits were due in large part to sales of Zocor,[25] which is sold on Long Island at a price differential of 278%. Zocor itself accounts for 13% of Merck's revenues.[26]

Figure 4: The Pharmaceutical Industry's Profit Margins Are Larger Than Those for Other Companies.



[22] Fortune, *1999 Fortune 500 Industry List* (1999) (Online at www.pathfinder.com/fortune500/ind21.html).

[23] Paul J. Much, Houlihan Lokey Howard & Zukin, *Expert Analysis of Profitability* (Feb. 1998).

[24] AP, *Merck Sales Jump by 24 Percent* (April 23, 1999).

[25] USA Today, *Drugmakers Have Healthy Outlook* (July 20, 1998).

[26] *Merck Sales Jump by 24 Percent, supra* note 24.

Pharmaceutical companies have been rapidly increasing their prices. These price hikes make it even more difficult for uninsured senior citizens to afford prescription drugs. In 1998, pharmaceutical prices increased by 5.1%, more than three times higher than the overall inflation rate.[27] The price of Synthroid, which is sold on Long Island at a price differential of nearly 1,500%, increased 20.4% in 1998.[28]

Overall, profits for the major drug manufacturers grew by over 21% in 1998, compared to 5% to 10% for other companies on the Standard & Poors Index. The drug manufacturers' profits are expected to grow by up to an additional 25% in 1999.[29] According to one analyst, "the prospects for the pharmaceutical industry are as bright as they've ever been."[30]

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[27] Express Scripts, Inc., *1998 Drug Trend Report* (June 1999).

[28] *Id.*

[29] *Drugmakers Have Healthy Outlook, supra* note 24.

[30] *Id.*

Appendix A

The Five Top Selling Patented, Nongeneric Drugs for Seniors Ranked by 1997 Total Dollar Sales

Rank	Drug	Manufacturer	Indication
1.	Prilosec	Astra/Merck	Ulcer
2.	Norvasc	Pfizer, Inc.	High Blood Pressure
3.	Zocor	Merck	Cholesterol reduction
4.	Zoloft	Pfizer, Inc.	Depression
5.	Procardia XL	Pfizer, Inc.	Heart Problems

Source: Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly: January 1 - December 31, 1997* (Apr. 1998).

Appendix B

Information on Prescription Drugs Analyzed in This Study

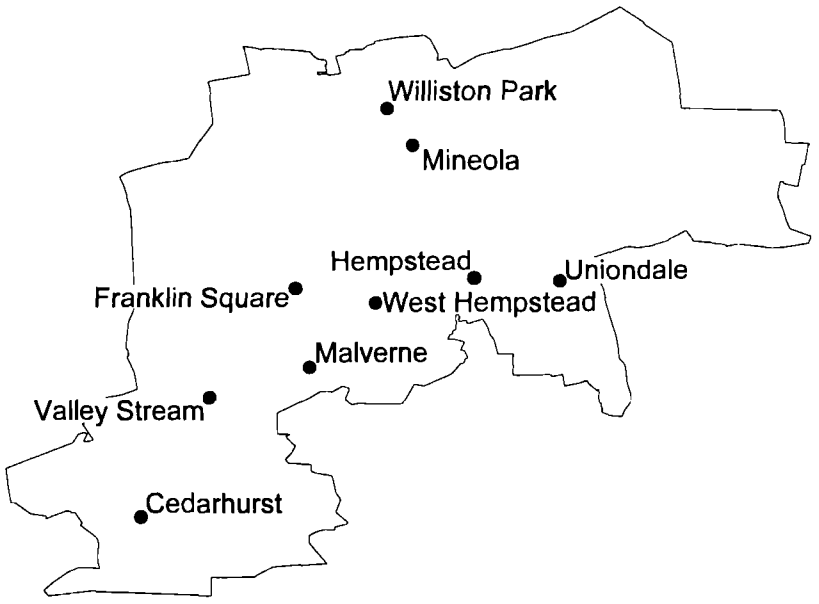
			Prices (Dollars)				
Brand Name Drug	**Dosage and Form**	**Indication**	**Favored Customer Price**	**Wholesale Acquisition Cost**	**Average Wholesale Price**	**Average Retail Price**	**Price Differential (Average Retail Price vs. Favored Customer Price)**
Zocor	5 mg, 60 tablets	Cholesterol reducer	$27.00	$86.07	$106.84	$102.03	278%
Prilosec	20 mg, 30 cap.	Ulcer	$59.10	$100.34	$119.57	$116.28	97%
Procardia XL	30 mg, 100 tab.	Heart Problems	$68.35	$111.46	$138.37	$131.80	93%
Norvasc	5 mg, 90 tablets	High Blood Pressure	$59.71	$96.00	$119.17	$113.51	90%
Zoloft	50 mg, 100 tab.	Depression	$115.70	$182.98	$227.13	$214.47	85%
Average Price Differential							**129%**

Appendix C

Price Comparisons For Non-Prescription Drug Items

Item	FSS Price	Retail Price	Differential
Binder Clip, small, 1 box	$0.49	$0.49	0%
Rubber Bands, 1 lb.	$2.57	$2.67	4%
Toilet Paper, 96 Rolls	$44.74	$47.98	7%
Rolodex, 500 Card	$13.24	$14.29	8%
Tape Dispenser	$1.44	$1.69	17%
Wastebasket, Plastic, 13 qt.	$2.95	$3.49	18%
Scissors	$10.88	$12.99	19%
Pencils, #2, 20-pack	$1.03	$1.26	22%
Paper Towels, 30 Rolls	$22.94	$29.98	31%
Post-It Notes	$2.08	$2.89	39%
Envelopes, 500, White, 20 lb. weight	$6.45	$9.49	47%
Correction Fluid, 18 ml., dozen.	$6.66	$9.99	50%
Average Price Differential			**22%**

Appendix D:
Prescription Drug Pricing Survey Locations in New York's 4th Congressional District



Geography and Map Division, Library of Congress, July 1999 G-1999-76-LMC

Prescription Drug Pricing in Suffolk County: Drug Companies Profit at the Expense of Older Americans

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Prepared for Rep. Michael P. Forbes

Minority Staff
Special Investigations Division
Committee on Government Reform
U.S. House of Representatives

November 18, 1999

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EXECUTIVE SUMMARY

This report, which was prepared at the request of Rep. Michael P. Forbes, investigates why prescription drugs are so expensive for senior citizens in Suffolk County, New York. It finds that price discrimination by drug manufacturers is one of the principal causes of the high drug prices that confront seniors. This report is the first report to quantify the extent of prescription drug price discrimination in Suffolk County and its impacts on seniors.

The report finds that older Americans and others who pay for their own drugs are charged far more for their prescription drugs than are the drug companies' most favored customers, such as health maintenance organizations and the federal government. The report finds that a senior citizen in Suffolk County paying for his or her own prescription drugs must pay, on average, more than twice as much for the drugs as the drug companies' favored customers. And the report finds that this is an unusually large price differential -- more than six times greater than the average price differential for other consumer goods.

In effect, the report finds that the pricing strategies of drug manufacturers victimize those who are least able to afford it. As a result of price discrimination, large corporate and governmental customers with market power are able to buy their drugs at low prices, while senior citizens, who often have the greatest need and the least ability to pay, are forced to pay the highest prices for prescription drugs.

A. Methodology

This report investigates the pricing of the five brand name prescription drugs with the highest sales to the elderly. It estimates the differential between the prices charged to the drug companies' most favored customers, such as HMOs and the federal government, and the prices charged to seniors who lack prescription drug coverage. The results are based on a survey of retail prescription drug prices in chain and independently owned drug stores in Mr. Forbes's congressional district in Suffolk County, New York. These prices are compared to the prices paid by the drug companies' most favored customers. For comparison purposes, the study also estimates the differential between prices for favored customers and retail prices for other consumer goods.

B. Findings

Older Americans in Suffolk County pay inflated prices for commonly used drugs. For the five drugs investigated in this study, the average price differential was 146% (Table 1). This means that senior citizens and other individuals in Suffolk County who pay for their own drugs pay more than twice as much for these drugs than do the drug companies' most favored customers. In dollar terms, senior citizens must pay on average $64.23 to $104.52 more per prescription for these five drugs than favored customers.

Table 1: Average Prices in Suffolk County for the Five Best-Selling Drugs for Older Americans Are More Than Twice as High as the Prices That Drug Companies Charge Their Most Favored Customers.

Prescription Drug	Manufacturer	Use	Prices For Favored Customers	Prices For Seniors	Differential For Senior Citizens	
					Percent	Dollar
Zocor	Merck	Cholesterol	$27.00	$113.29	320%	$86.29
Norvasc	Pfizer, Inc.	High Blood Pressure	$59.71	$124.79	109%	$65.08
Prilosec	Astra/Merck	Ulcers	$59.10	$123.33	109%	$64.23
Procardia XL	Pfizer, Inc.	Heart Problems	$68.35	$142.11	108%	$73.76
Zoloft	Pfizer, Inc.	Depression	$125.73	$230.25	83%	$104.52
Average Price Differential					**146%**	

For other popular drugs, the price differential is even higher. This study also analyzed a number of other popular drugs used by older Americans, and in some cases found even higher price differentials. The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the average price differential for senior citizens in Suffolk County was 1,687%. A typical prescription for this drug would cost the manufacturer's favored customers only $1.75, but would cost the average senior citizen in Suffolk County more than $31.00.

Price differentials are far higher for drugs than they are for other goods. The report compared drug prices at the retail level to the prices that the pharmaceutical industry gives its most favored customers, such HMOs and the federal government. Because these customers typically buy in bulk, some difference between retail prices and "favored customer" prices would be expected. The study found, however, that the differential was much higher for prescription drugs than it was for other consumer goods. The average price differential for the five prescription drugs was 146%, while the price differential for other goods was only 22%.

Pharmaceutical manufacturers, not drug stores, are primarily responsible for the discriminatory prices that older Americans pay for prescription drugs. In order to determine whether drug companies or retail pharmacies cause the high prescription drug prices paid by seniors in Suffolk County, the study compared average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that the pharmacies in Suffolk County have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. This indicates that it is drug manufacturer pricing policies, not pharmacy markups, that account for the inflated prices charged to older Americans and other customers.

I. THE VULNERABILITY OF OLDER AMERICANS TO HIGH DRUG PRICES

Numerous surveys and studies have concluded that many older Americans pay high costs for prescription drugs and are having a difficult time paying for the drugs they need. The cost of prescription drugs is particularly important for older Americans because they have more medical problems, and take more prescription drugs, than the average American. This situation is exacerbated by the fact that the Medicare program, the main source of health care coverage for the elderly, fails to cover the cost of most prescription drugs.

According to the National Institute on Aging, "as a group, older people tend to have more long-term illnesses -- such as arthritis, diabetes, high blood pressure, and heart disease -- than do younger people."[1] Other chronic diseases which disproportionately affect older Americans include depression and neurodegenerative diseases such as Alzheimer's disease, Lou Gehrig's disease, and Parkinson's disease. Older Americans spend almost three times as much of their income (21%) on health care than those under the age of 65 (8%).[2]

The latest survey data indicate that 86% of Medicare beneficiaries are taking prescription drugs.[3] Almost 14 million senior citizens, 38% of all Medicare beneficiaries, use more than $1,000 of prescription drugs annually.[4] The average older American uses 18.5 prescriptions annually.[5] It is estimated that the elderly in the United States, who make up 12% of the population, use one-third of all prescription drugs.[6]

Although senior citizens have the greatest need for prescription drugs, they often have the most inadequate insurance coverage for the cost of these drugs. With the exception of drugs

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[1] National Institute on Aging (NIA), *NIA Age Page* (1997) (online at www.nih.gov/nia/health/pub/medicine.htm).

[2] AARP Public Policy Institute and the Lewin Group, *Out of Pocket Health Spending By Medicare Beneficiaries Age 65 and Older: 1997 Projections* (Feb. 1997).

[3] Health Affairs, *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, 237 (Jan./Feb. 1999).

[4] National Economic Council, Domestic Policy Council, *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage* (July 22, 1999).

[5] *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, *supra* note 3, at 237.

[6] Senate Special Committee On Aging, *Developments in Aging: 1993*, 103d Cong., 2d Sess. 35 (1994) (S. Rpt. 403).

III. METHODOLOGY

A. Selection of Drugs

The principal drugs investigated in this report are the five patented, nongeneric drugs with the highest annual sales to older Americans in 1997. The list was obtained from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE). The PACE program is the largest outpatient prescription drug program for older Americans in the United States for which claims data is available, and is used in this study, as well as by several other analysts, as a proxy database for prescription drug usage by all older Americans. In 1997, over 250,000 persons were enrolled in the program, which provided over $100 million of assistance in filling over 2.8 million prescriptions.[18]

B. Determination of Drug Prices for Seniors

In order to determine the prices that senior citizens are paying for prescription drugs in Suffolk County, the minority staff and the staff of Mr. Forbes's congressional office conducted a survey of ten drug stores -- including both independent and chain stores -- in his district. Mr. Forbes represents the 1st Congressional District in New York, which includes Brookhaven, Smithtown, and the five East End towns. The location of the stores is shown in Appendix D.

C. Determination of Drug Prices for Favored Customers

Drug pricing is complicated and drug companies closely guard their pricing strategies. For example, drug companies require HMOs to sign confidentiality agreements before offering them pricing discounts. The best publicly available indicator of the prices drug companies charge their most favored customers is the prices the companies charge the federal government.

The federal government pays for prescription drugs through several different programs. One important program is the Federal Supply Schedule (FSS), which is a price catalogue containing goods available for purchase by federal agencies. Drug prices on the FSS are negotiated by the Department of Veterans Affairs (VA) and approximate the prices that the drug companies charge their most favored non-federal customers. According to the U.S. General Accounting Office, "[u]nder GSA procurement regulations, VA contract officers are required to seek an FSS price that represents the same discount off a drug's list price that the manufacturer offers its most-favored nonfederal customer under comparable terms and conditions."[19] To obtain

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[18] Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly January 1 - December 31, 1997* (Apr. 1998).

[19] U.S. General Accounting Office, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain* 6 (June 1997) (emphasis added). In an April 21, 1999, letter to Rep. Henry A. Waxman, GAO confirmed that "federal supply schedule prices

E. Determination of Drug Dosages

When comparing prices, the study used the same criteria (dosage, form, and package size) used by the GAO in its 1992 report, *Prescription Drugs: Companies Typically Charge More in the United States Than In Canada*. For drugs that were not included in the GAO report, the study used the dosage, form, and package size common in the years 1994 through 1997, as indicated in the *Drug Topics Red Book*. The dosages, forms, and package sizes used in the study are shown in Appendix B.

F. Price Differentials for Other Consumer Goods

In order to determine whether the differential between the most favored customer prices and retail prices for drugs commonly used by older Americans is unusually large, the study compared the prescription drug price differentials to price differentials on other consumer products. To make this comparison, a list of consumer goods other than drugs available through the FSS was assembled. FSS prices were then compared with the retail prices at which the items could be bought at a large national chain.[23]

IV. DRUG COMPANIES CHARGE OLDER AMERICANS DISCRIMINATORY PRICES

A. Discrimination in Drug Pricing

In the case of the five drugs with the highest sales to seniors, the average price differential between the price that would be paid by a senior citizen in Suffolk County and the price that would be paid by the drug companies' most favored customers was 146% (Table 1). This means that the average price that older Americans and other individual consumers in Suffolk County pay for these drugs is more than double the price paid by the drug companies' favored customers, such as HMOs and the federal government.

For individual drugs, the price differential was even higher. Among the five best selling drugs, the highest price differential was 320% for Zocor, a cholesterol treatment manufactured by Merck. The average senior without drug coverage must pay $113.29 for 60 tablets of Zocor, compared to a favored customer price of just $27.00.

For other popular drugs, the study found even greater price differentials. The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the average price differential for senior citizens in

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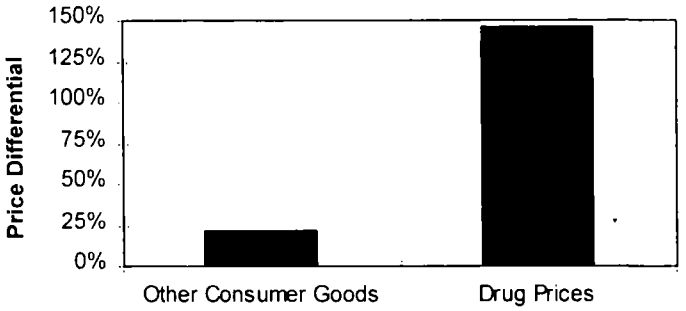
[23] The items used were paper towels, envelopes, rubber bands, toilet paper, pencils, Rolodexes, tape dispensers, waste baskets, correction fluid, post-it notes, paper clips, and scissors.

larger than the average price differential for other consumer goods (Figure 2). This indicates that a volume effect is unlikely to explain the large differential in prescription drug pricing.

Figure 2: Price Differentials on Drugs Commonly Used by Older Americans Are Far Higher Than Differentials for Other Consumer Goods.



C. Drug Company Versus Pharmacy Responsibility

The report also sought to determine whether drug companies or retail pharmacies are responsible for the high prices being paid by older Americans. To do this, the report compared the average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that pharmacies appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. The report found that the average retail price for the five best-selling prescription drugs was just 4% higher than the published Average Wholesale Price, and only 28% above the Wholesale Acquisition Cost (Figure 3). This finding indicates that it is drug company pricing policies, not retail markups, that account for the inflated prices charged to older Americans and other individual customers. These findings are consistent with other experts who have concluded that because of the competitive nature of the pharmacy business at the retail level, there is a relatively small profit margin for retail pharmacists.[24]

The study found few significant differences in retail prices between pharmacies in different parts of Mr. Forbes's district. Moreover, although there were variations in prices between chain and independent pharmacies, these differences were in general not systematic.

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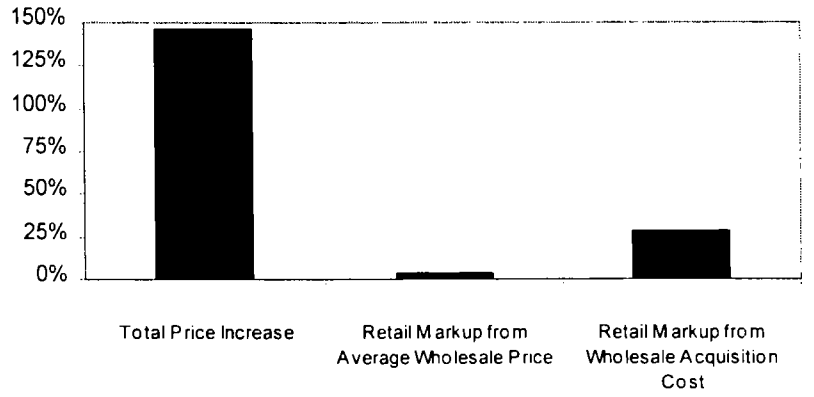
[24] National Association of Chain Drug Stores, *Did You Know . . .* (pamphlet) (citing financial data assembled by Keller Bruner & Company, P.C., Certified Public Accountants 1995).

Figure 3: Drug Companies, Not Retail Pharmacies, Are Responsible for High Prescription Drug Costs



V. DRUG MANUFACTURER PROFITABILITY

Drug industry pricing strategies have boosted the industry's profitability to extraordinary levels. The annual profits of the top ten drug companies are over $25 billion.[25] Moreover, the drug companies make unusually high profits compared to other companies. The average manufacturer of branded consumer goods, such as Proctor & Gamble or Colgate-Palmolive, has an operating profit margin of 10.5%. Drug manufacturers, however, have an operating profit margin of 28.7% -- nearly three times greater (Figure 4).[26]

These high profits appear to be directly linked to the pricing strategies observed in this report. For instance, Merck, the country's largest pharmaceutical manufacturer, had a 24% increase in sales and a 12% increase in profits in the first quarter of 1999.[27] According to industry analysts, Merck's increased profits have been due in large part to sales of Zocor,[28] which is sold in

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[25] Fortune, *1999 Fortune 500 Industry List* (1999) (Online at www.pathfinder.com/fortune500/ind21.html).

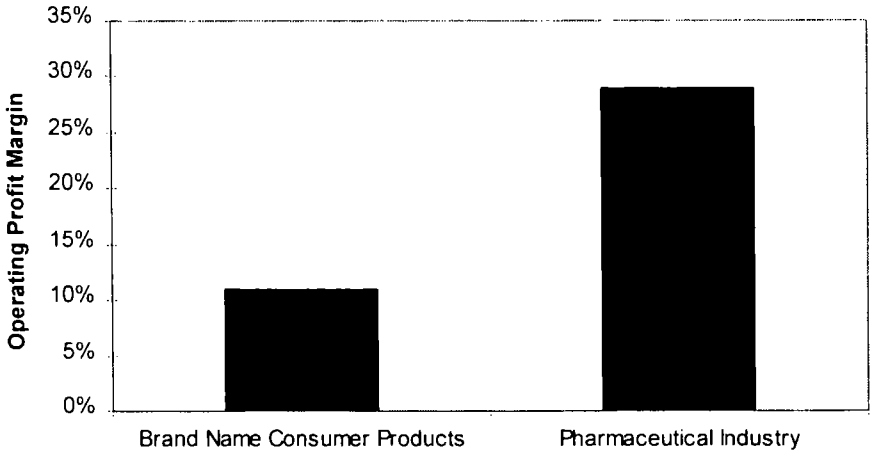
[26] Paul J. Much, Houlihan Lokey Howard & Zukin, *Expert Analysis of Profitability* (Feb. 1998).

[27] AP, *Merck Sales Jump by 24 Percent* (April 23, 1999).

[28] USA Today, *Drugmakers Have Healthy Outlook* (July 20, 1998).

Suffolk County at a price differential of 320%. Zocor itself accounts for 13% of Merck's revenues.[29]

Figure 4: The Pharmaceutical Industry's Profit Margins Are Larger Than Those for Other Companies.



Pharmaceutical companies have been rapidly increasing their prices for drugs used by senior citizens. These price hikes make it even more difficult for uninsured senior citizens to afford prescription drugs. In 1998, the prices for the 50 prescription drugs most frequently used by senior citizens increased by 6.6%, more than four times the inflation rate.[30] The price of Synthroid, which is sold in Suffolk County at a price differential of more than 1,650%, increased by more than six times the inflation rate.[31]

Overall, profits for the major drug manufacturers grew by over 21% in 1998, compared to 5% to 10% for other companies on the Standard & Poors Index. The drug manufacturers' profits are expected to grow by up to an additional 25% in 1999.[32] According to one analyst, "the prospects for the pharmaceutical industry are as bright as they've ever been."[33]

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[29] *Merck Sales Jump by 24 Percent, supra* note 27.

[30] Families USA, *Hard to Swallow: Rising Drug Prices for America's Seniors* (Nov. 1999).

[31] *Id.*

[32] *Drugmakers Have Healthy Outlook, supra* note 28.

[33] *Id.*

Appendix A

The Five Top Selling Patented, Nongeneric Drugs for Seniors Ranked by 1997 Total Dollar Sales

Rank	Drug	Manufacturer	Indication
1.	Prilosec	Astra/Merck	Ulcer
2.	Norvasc	Pfizer, Inc.	High Blood Pressure
3.	Zocor	Merck	Cholesterol reduction
4.	Zoloft	Pfizer, Inc.	Depression
5.	Procardia XL	Pfizer, Inc.	Heart Problems

Source: Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly: January 1 - December 31, 1997* (Apr. 1998).

Appendix B

Information on Prescription Drugs Analyzed in This Study

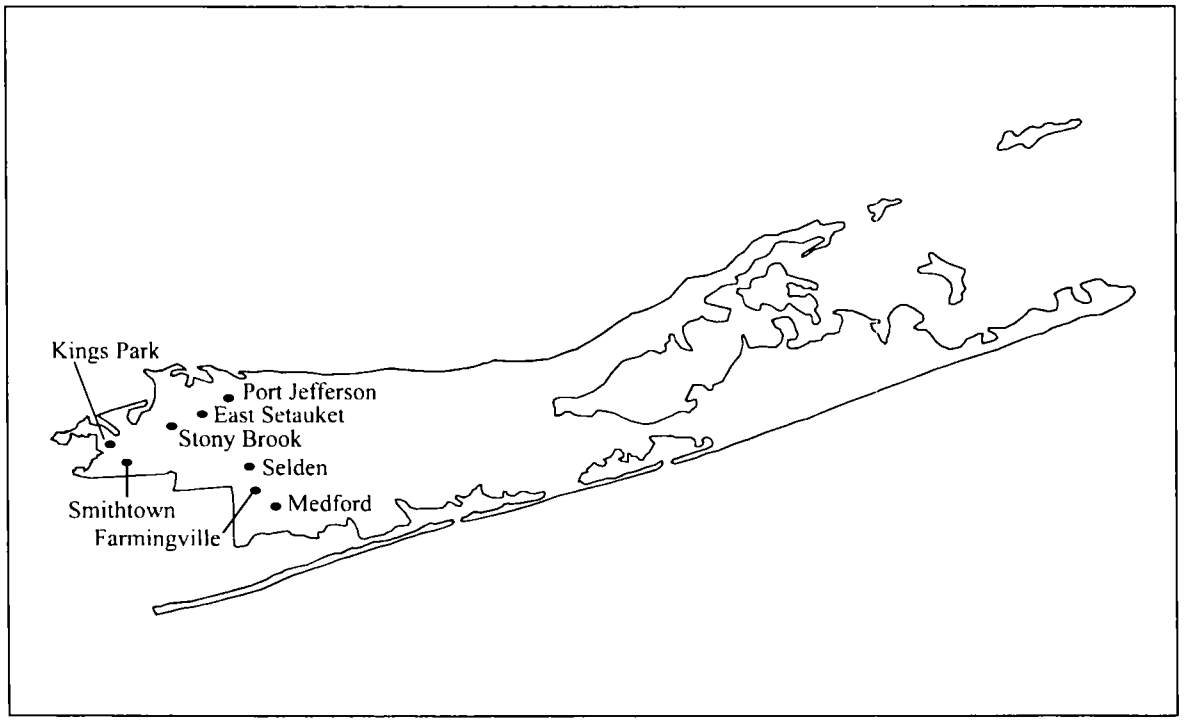
			Prices (Dollars)				
Brand Name Drug	**Dosage and Form**	**Indication**	**Favored Customer Price**	**Wholesale Acquisition Cost**	**Average Wholesale Price**	**Average Retail Price**	**Price Differential (Average Retail Price vs. Favored Customer Price)**
Zocor	5 mg. 60 tablets	Cholesterol reducer	$27.00	$86.07	$106.84	$113.29	320%
Norvasc	5 mg. 90 tablets	High Blood Pressure	$59.71	$96.00	$119.17	$124.79	109%
Prilosec	20 mg. 30 cap.	Ulcer	$59.10	$100.34	$119.57	$123.33	109%
Procardia XL	30 mg. 100 tab.	Heart Problems	$68.35	$111.46	$138.37	$142.11	108%
Zoloft	50 mg. 100 tab.	Depression	$125.73	$182.98	$227.13	$230.25	83%
Synthroid	.05 mg. 100 tab.	Hormone Treatment	$1.75	N/A	N/A	$31.28	1687%
Micronase	2.5 mg. 100 tab.	Diabetes	$10.05	N/A	N/A	$53.33	431%

Appendix C

Price Comparisons For Non-Prescription Drug Items

Item	FSS Price	Retail Price	Differential
Binder Clip, small, 1 box	$0.49	$0.49	0%
Rubber Bands, 1 lb.	$2.57	$2.67	4%
Toilet Paper, 96 Rolls	$44.74	$47.98	7%
Rolodex, 500 Card	$13.24	$14.29	8%
Tape Dispenser	$1.44	$1.69	17%
Wastebasket, Plastic, 13 qt.	$2.95	$3.49	18%
Scissors	$10.88	$12.99	19%
Pencils, #2, 20-pack	$1.03	$1.26	22%
Paper Towels, 30 Rolls	$22.94	$29.98	31%
Post-It Notes	$2.08	$2.89	39%
Envelopes, 500, White, 20 lb. weight	$6.45	$9.49	47%
Correction Fluid, 18 ml., dozen.	$6.66	$9.99	50%
Average Price Differential			**22%**

Appendix D:
Prescription Drug Pricing Locations in New York's 1st Congressional District



Map created by the Geography and Map Division,
Library of Congress, November 1999

Prescription Drug Pricing in the 7th Congressional District in New York: Drug Companies Profit at the Expense of Older Americans

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Prepared for Rep. Joseph Crowley

Minority Staff
Special Investigations Division
Committee on Government Reform
U.S. House of Representatives

October 28, 1999

Table of Contents

EXECUTIVE SUMMARY

This staff report was prepared at the request of Rep. Joseph Crowley of New York. In Mr. Crowley's district, as in many other congressional districts around the country, older Americans are increasingly concerned about the high prices that they pay for prescription drugs. Mr. Crowley requested that the minority staff of the Committee on Government Reform investigate this issue. This report is the first report to quantify the extent of prescription drug price discrimination in Mr. Crowley's district and its impacts on seniors.

Numerous studies have concluded that many older Americans pay high prices for prescription drugs and have a difficult time paying for the drugs they need. This study presents disturbing evidence about the cause of these high prices. The findings indicate that older Americans and others who pay for their own drugs are charged far more for their prescription drugs than are the drug companies' most favored customers, such as large insurance companies, health maintenance organizations, and the federal government. The findings show that a senior citizen in Mr. Crowley's district paying for his or her own prescription drugs must pay, on average, more than twice as much for the drugs as the drug companies' favored customers. The study found that this is an unusually large price differential -- more than six times greater than the average price differential for other consumer goods.

It appears that drug companies are engaged in a form of "discriminatory" pricing that victimizes those who are least able to afford it. Large corporate, governmental, and institutional customers with market power are able to buy their drugs at discounted prices. Drug companies then raise prices for sales to seniors and others who pay for drugs themselves to compensate for these discounts to the favored customers.

Older Americans are having an increasingly difficult time affording prescription drugs. By one estimate, more than one in eight older Americans has been forced to choose between buying food and buying medicine. Preventing the pharmaceutical industry's discriminatory pricing -- and thereby reducing the cost of prescription drugs for seniors and other individuals -- will improve the health and financial well-being of millions of older Americans.

A. Methodology

This study investigates the pricing of the five brand name prescription drugs with the highest sales to the elderly. It estimates the differential between the price charged to the drug companies' most favored customers, such as large insurance companies, HMOs, and certain federal government purchasers, and the price charged to seniors. The results are based on a survey of retail prescription drug prices in chain and independently owned drug stores in Mr. Crowley's congressional district in New York. These prices are compared to the prices paid by the drug companies' most favored customers. For comparison purposes, the study also estimates the differential between prices for favored customers and retail prices for other consumer items.

B. Findings

The study finds that:

- **Older Americans pay inflated prices for commonly used drugs.** For the five drugs investigated in this study, the average price differential was 140% (Table 1). This means that senior citizens and other individuals who pay for their own drugs pay more than twice as much for these drugs than do the drug companies' most favored customers. In dollar terms, senior citizens must pay $62.10 to $103.30 more per prescription for these five drugs than favored customers.

Table 1: Average Prices in Mr. Crowley's District for the Five Best-Selling Drugs for Older Americans Are More Than Twice as High as the Prices That Drug Companies Charge Their Most Favored Customers.

Prescription Drug	Manufacturer	Use	Prices For Favored Customers	Prices For Seniors	Differential For Senior Citizens	
					Percent	Dollar
Zocor	Merck	Cholesterol	$27.00	$107.74	299%	$80.74
Norvasc	Pfizer, Inc.	High Blood Pressure	$59.71	$126.26	111%	$66.55
Prilosec	Astra/Merck	Ulcers	$59.10	$121.20	105%	$62.10
Procardia XL	Pfizer, Inc.	Heart Problems	$68.35	$136.68	100%	$68.33
Zoloft	Pfizer, Inc.	Depression	$125.73	$229.03	82%	$103.30
Average Price Differential					**140%**	

- **For other popular drugs, the price differential is even higher.** This study also analyzed a number of other popular drugs used by older Americans, and in some cases found even higher price differentials (Table 2). The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the price differential for senior citizens in Mr. Crowley's congressional district was 1,723%. An equivalent quantity of this drug would cost the manufacturers' favored customers only $1.75, but would cost the average senior citizen in Mr. Crowley's district over $31.00. For Micronase, a diabetes treatment manufactured by Upjohn, an equivalent dose would cost the favored customers $10.05, while seniors in Mr. Crowley's district are charged an average of $53.85. The price differential was 436%.

Table 2: Price Differentials for Some Drugs Are More Than 1,700%.

Prescription Drug	Manufacturer	Use	Prices for Favored Customers	Prices for Seniors	Price Differential for Seniors
Synthroid	Knoll Pharmaceuticals	Hormone Treatment	$1.75	$31.90	1723%
Micronase	Upjohn	Diabetes	$10.05	$53.85	436%

- **Price differentials are far higher for drugs than they are for other goods.** This study compared drug prices at the retail level to the prices that the pharmaceutical industry gives its most favored customers, such as large insurance companies, government buyers with negotiating power, and HMOs. Because these customers typically buy in bulk, some difference between retail prices and "favored customer" prices would be expected. The study found, however, that the differential was much higher for prescription drugs than it was for other consumer items. The study compared the price differential for prescription drugs to the price differentials on a selection of other consumer items. The average price differential for the five prescription drugs was 140%, while the price differential for other items was only 22%. Compared to manufacturers of other retail items, pharmaceutical manufacturers appear to be engaging in significant price discrimination against older Americans and other individual consumers.

- **Pharmaceutical manufacturers, not drug stores, appear to be responsible for the discriminatory prices that older Americans pay for prescription drugs.** In order to determine whether drug companies or retail pharmacies were responsible for the high prescription drug prices paid by seniors in Mr. Crowley's congressional district, the study compared average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that the pharmacies in Mr. Crowley's district appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. The retail prices in Mr. Crowley's district are just 2% above the published national Average Wholesale Price, which represents the manufacturers' suggested price to pharmacies. The differential between retail prices and a second indicator of pharmacy costs, the Wholesale Acquisition Cost, which represents the average price wholesalers actually pay for drugs, is only 25%. This indicates that it is drug company pricing policies that appear to account for the inflated prices charged to older Americans and other customers.

I. THE VULNERABILITY OF OLDER AMERICANS TO HIGH DRUG PRICES

This report focuses on a continuing, critical issue facing older Americans -- the cost of their prescription drugs. Numerous surveys and studies have concluded that many older Americans pay high costs for prescription drugs and are having a difficult time paying for the drugs they need. The cost of prescription drugs is particularly important for older Americans because they have more medical problems, and take more prescription drugs, than the average American. This situation is exacerbated by the fact that the Medicare program, the main source of health care coverage for the elderly, fails to cover the cost of most prescription drugs.

According to the National Institute on Aging, "as a group, older people tend to have more long-term illnesses -- such as arthritis, diabetes, high blood pressure, and heart disease -- than do younger people."[1] Other chronic diseases which disproportionately affect older Americans include depression and neurodegenerative diseases such as Alzheimer's disease, Lou Gehrig's disease, and Parkinson's disease. Older Americans spend almost three times as much of their income (21%) on health care than those under the age of 65 (8%).[2]

The latest survey data indicate that 86% of Medicare beneficiaries are taking prescription drugs.[3] Almost 14 million senior citizens, 38% of all Medicare beneficiaries, use more than $1,000 of prescription drugs annually.[4] The average older American uses 18.5 prescriptions annually,[5] significantly more than the average under-65 population.[6] It is estimated that the

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[1] National Institute on Aging (NIA), *NIA Age Page* (1997) (online at www.nih.gov/nia/health/pub/medicine.htm).

[2] AARP Public Policy Institute and the Lewin Group, *Out of Pocket Health Spending By Medicare Beneficiaries Age 65 and Older: 1997 Projections* (Feb. 1997).

[3] Health Affairs, *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, 237 (Jan./Feb. 1999).

[4] National Economic Council, Domestic Policy Council, *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage* (July 22, 1999).

[5] *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, *supra* note 3, at 237.

[6] Senate Special Committee on Aging, *Developments In Aging: 1996*, 105th Cong., 1st Sess. 121 (1997) (S. Rpt. 36).

elderly in the United States, who make up 12% of the population, use one-third of all prescription drugs.[7]

Although the elderly have the greatest need for prescription drugs, they often have the most inadequate insurance coverage for the cost of these drugs. With the exception of drugs administered during inpatient hospital stays, Medicare generally does not cover prescription drugs. According to a recent analysis by the National Economic Council, approximately 75% of Medicare beneficiaries lack dependable, private-sector prescription drug coverage.[8]

Thirty-five percent of Medicare recipients, over 13 million senior citizens, do not have any insurance coverage for prescription drugs.[9] In rural areas, the problem is even worse, with 48% of Medicare recipients lacking any prescription drug coverage.[10] In total, Medicare beneficiaries pay more than half of their drug costs out of their own pockets.[11]

Even when seniors have prescription drug coverage, the coverage is often inadequate. The number of firms offering retirees prescription drug coverage is declining, from 40% in 1994 to 30% in 1998.[12] Medigap policies are often prohibitively expensive, while offering inadequate coverage.[13] Medicare managed care plans are also sharply reducing benefits and coverage.[14]

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[7] Senate Special Committee On Aging, *Developments in Aging: 1993*, 103d Cong., 2d Sess. 35 (1994) (S. Rpt. 403).

[8] *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage*, *supra* note 4.

[9] *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, *supra* note 3.

[10] *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage, supra* note 4 (supplemental materials).

[11] Health Care Financing Administration, *The Characteristics and Perceptions of the Medicare Population*, 107 (1996).

[12] *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage, supra* note 4.

[13] Only three of the ten available plans offer any prescription drug coverage, and even the best available Medigap policy provides only a $3,000 drug benefit, while still leaving beneficiaries vulnerable to a high deductible and to paying at least half of their total drug costs. Moreover, the cost of these policies increases with age, making them even less affordable for those who need them the most. Less than 10% of the Medicare population obtains prescription drug coverage from Medigap providers. *Prescription Drug Coverage, Utilization, and Spending*

The high costs of prescription drugs and the lack of insurance coverage cause enormous hardships for older Americans. In 1993, 13% of older Americans surveyed reported that they were forced to choose between buying food and buying medicine.[15] By another estimate, five million older Americans are forced to make this difficult choice.[16]

II. ARE DRUG COMPANIES EXPLOITING THE VULNERABILITY OF OLDER AMERICANS?

Rep. Joseph Crowley of New York asked the minority staff of the Committee on Government Reform to investigate whether pharmaceutical manufacturers are taking advantage of older Americans through price discrimination, and, if so, whether this is part of the explanation for the high drug prices being paid by older Americans in his congressional district. This report presents the results of this investigation.

Industry analysts have recognized that price discrimination occurs in the prescription drug market. According to a recent Standard & Poor's report on the pharmaceutical industry, "[d]rugmakers have historically raised prices to private customers to compensate for the discounts they grant to managed care customers. This practice is known as 'cost shifting.'"[17]

Among Medicare Beneficiaries, supra note 3.

[14] While some Medicare managed care plans may offer optional prescription drug coverage, these plans are dramatically reducing coverage, with nearly 60% reporting that they will cap prescription drug benefits below $1,000, and 28% reporting that they will cap benefits below $500 in the year 2000. These managed care plans are also withdrawing coverage for over 400,000 seniors this year, and are expected to drop coverage for an additional 50,000 next year. Overall, only 6% of Medicare recipients obtain prescription drug coverage through managed care plans. *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage, supra* note 4; *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries, supra* note 3.

[15] Families USA Foundation, *Worthless Promises: Drug Companies Keep Boosting Prices,* 6 (Mar. 1995).

[16] Senate Special Committee on Aging, *A Status Report -- Accessibility and Affordability of Prescription Drugs For Older Americans*, 102d Cong., 2d Sess. 2 (1992) (S. Rpt. 100).

[17] Herman Saftlas, Standard & Poor's, *Healthcare: Pharmaceuticals,* Industry Surveys, 19-20 (Dec. 18, 1997).

Under this practice, "drugs sold to wholesale distributors and pharmacy chains for the individual physician/patient are marked at the higher end of the scale."[18]

Although industry analyses acknowledge that price discrimination occurs, they have not estimated its degree or impact. This report, prepared at Mr. Crowley's request, is the first attempt to quantify the extent of price discrimination and its impact on senior citizens in the 7th Congressional District in New York.

The study design and methodology used to test whether drug companies are discriminating against older Americans in their pricing are described in part III. The results of the study are described in part IV. These results show that drug manufacturers appear to be engaged in substantial price discrimination against older Americans and other individuals who must pay for their own prescription drugs. The impact of the manufacturers' pricing policies on corporate profits is discussed in part V.

III. METHODOLOGY

A. Selection of Drugs for this Survey

This survey is based primarily on a selection of the five patented, nongeneric drugs with the highest annual sales to older Americans in 1997. The list was obtained from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE). The PACE program is the largest outpatient prescription drug program for older Americans in the United States for which claims data is available, and is used in this study, as well as by several other analysts, as a proxy database for prescription drug usage by all older Americans. In 1997, over 250,000 persons were enrolled in the program, which provided over $100 million of assistance in filling over 2.8 million prescriptions.[19]

B. Determination of Average Drug Prices for Seniors

In order to determine the prices that senior citizens are paying for prescription drugs in Mr. Crowley's congressional district, the minority staff and the staff of Mr. Crowley's congressional office conducted a survey of eight drug stores -- including both independent and chain stores. Mr. Crowley represents the 7th Congressional District in New York, which includes the communities of Flushing and Jackson Heights in northern and northwestern Queens, and Throgs Neck and Pelham Bay in the Bronx. The location of the stores is shown in Appendix D.

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[18] *Id.* at 19.

[19] Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly January 1 - December 31, 1997* (Apr. 1998).

C. Determination of Prices for Drug Companies' Most Favored Customers

Drug pricing is complicated and drug companies closely guard their pricing strategies. For example, drug companies require HMOs to sign confidentiality agreements before offering them pricing discounts. The best publicly available indicator of the prices drug companies charge their most favored customers is the prices the companies charge the federal government.

The federal government pays for prescription drugs through several different programs. One important program is the Federal Supply Schedule (FSS), which is a price catalogue containing goods available for purchase by federal agencies. Drug prices on the FSS are negotiated by the Department of Veterans Affairs (VA) and often approximate the prices that the drug companies charge their most favored non-federal customers. According to the U.S. General Accounting Office, "[u]nder GSA procurement regulations, VA contract officers are required to seek an FSS price that represents the same discount off a drug's list price that the manufacturer offers its most-favored nonfederal customer under comparable terms and conditions."[20] To obtain additional price discounts available to the private sector, the VA has established at least two additional negotiated-price programs: (1) a VA formulary that operates similarly to the formularies established by well-managed HMOs,[21] and (2) a Blanket Price Agreement (BPA) program, under which the VA commits to purchasing minimum quantities of particular prescription drugs. Yet another program through which the federal government obtains prescription drugs is section 340(b) of the Public Health Service Act, which entitles four agencies (the VA, the Indian Health Service, the Department of Defense, and the Public Health Service) to purchase drugs at a maximum price of 24% below the manufacturer's average nonfederal price.

This analysis uses the lowest price paid by the federal government as a proxy for the prices paid by drug companies most favored customers.[22] All prices were updated in September 1999 to reflect current pricing.

D. Determination of Prices Paid by Pharmacies

The survey also looked at two other pricing indicators: (1) the Average Wholesale Price (AWP) and (2) the Wholesale Acquisition Cost (WAC). These two prices provide an indicator

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[20] U.S. General Accounting Office, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain* 6 (June 1997) (emphasis added).

[21] For a detailed description of the Department of Veterans Affairs Formulary program, see the National Formulary Content Page, online at www.dppm.med.va.gov/newsite/national.htm.

[22] For Norvasc, Prilosec, Procardia XL, Zoloft, Micronase, and Synthroid, the Federal Supply Schedule price was used as the indicator of best price. For Zocor the VA's formulary price was used as the indicator of best price.

of the extent of markups that are attributable to the pharmacy (in contrast to those that are due to the drug manufacturer). The AWP represents the price that manufacturers suggest that wholesalers charge retail pharmacies; the WAC represents the actual average price that wholesalers pay to acquire drugs. The typical wholesaler markup on drugs for sale to pharmacies is an additional 2% - 4%.[23] Both AWP and WAC were obtained from the Medispan database and were updated in June 1999 to reflect current pricing.

E. Determination of Drug Dosages

When comparing prices, the study used the same criteria (dosage, form, and package size) used by the GAO in its 1992 report, *Prescription Drugs: Companies Typically Charge More in the United States Than In Canada.* For drugs that were not included in the GAO report, the study used the dosage, form, and package size common in the years 1994 through 1997, as indicated in the *Drug Topics Red Book.* The dosages, forms, and package sizes used in the study are shown in Appendix B.

F. Comparison of Price Differentials for Other Retail Items

In order to determine whether the differential between the most favored customer prices and retail prices for drugs commonly used by older Americans is unusually large, the study compared the prescription drug price differentials to price differentials on other consumer products. To make this comparison, a list of consumer items other than drugs available through the FSS was assembled. FSS prices were then compared with the retail prices at which the items could be bought at a large national chain.[24]

IV. DRUG COMPANIES CHARGE OLDER AMERICANS DISCRIMINATORY PRICES

A. Discrimination in Drug Pricing

In the case of the five drugs with the highest sales to seniors, the average price differential between the price that would be paid by a senior citizen in Mr. Crowley's congressional district and the price that would be paid by the drug companies' most favored customers was 140% (Table 1). The study thus showed that the average price that older Americans and other individual consumers in Mr. Crowley's district pay for these drugs is more than double the price paid by the drug companies' favored customers, such as large insurance companies and HMOs.

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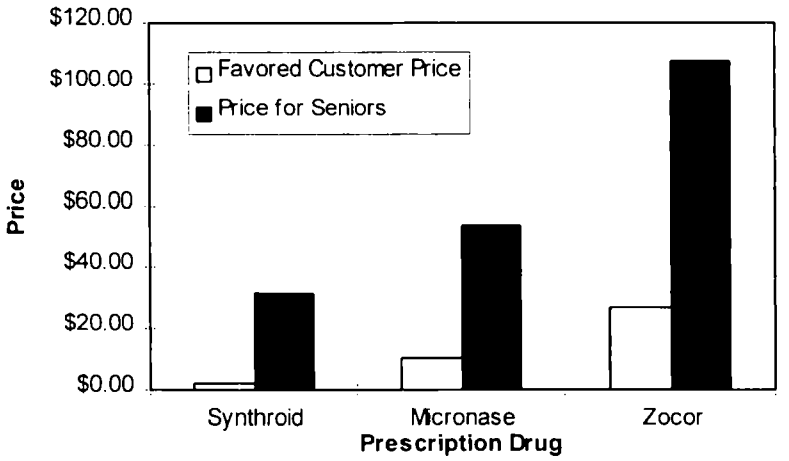
[23] Patricia M. Danzon, *Price Comparisons for Pharmaceuticals: A Review of U.S. and Cross-National Studies* (April 1999).

[24] The items used were paper towels, envelopes, rubber bands, toilet paper, pencils, Rolodexes, tape dispensers, waste baskets, correction fluid, post-it notes, paper clips, and scissors.

For individual drugs, the price differential was even higher. Among the five best selling drugs, the highest price differential was 299% for Zocor, a cholesterol treatment manufactured by Merck. For other popular drugs, the study found even greater price differentials. The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the price differential for senior citizens in Mr. Crowley's district was more than 1,700%. An equivalent quantity of this drug would cost the most favored customers only $1.75, but would cost the average senior citizen in Mr. Crowley's congressional district $31.90. For Micronase, a diabetes treatment manufactured by Upjohn, the price differential was 436% (Figure 1). Every drug looked at in this study had a large price differential. Among the five highest selling drugs, four (Zocor, Norvasc, Prilosec, and Procardia XL) had price differentials that equaled or exceeded 100%. The lowest price difference was still high -- 82%, for Zoloft.

Figure 1: Older Americans in Mr. Crowley's District Pay Inflated Prices for Prescription Drugs.



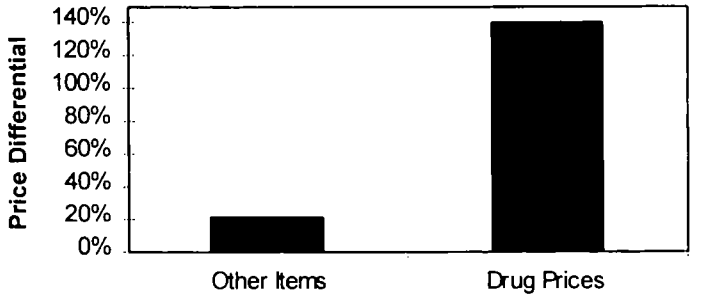
In dollar terms, Zoloft, an antidepressant, had the highest price differential. Senior citizens in Mr. Crowley's district must pay over $100 more for 100 tablets of Zoloft than a favored customer. The difference between seniors' prices and prices for favored customers was more than $80.00 for 60 tablets of Zocor and over $60.00 per prescription for each of the remaining three best selling drugs (Procardia XL, Norvasc, and Prilosec).

B. Comparison with Other Consumer Goods

The study also analyzed whether the large differentials in prescription drug pricing could be attributed to a volume effect. The drug companies' most favored customers, such as large insurance companies and HMOs, typically buy large volumes of drugs. Thus, it could be expected that there would be differences between the prices charged the most favored customers and retail prices. The study found, however, that the differentials in prescription drug prices were much greater than the differentials in prices for other consumer goods. The study found

that, in the case of other consumer goods, the average difference between retail prices and the prices charged most favored customers, such as large corporations and institutions, was only 22%. The average price differential in the case of prescription drugs was more than six times larger than the average price differential for other consumer goods (Figure 2). This indicates that a volume effect is unlikely to explain the large differential in prescription drug pricing.

Figure 2: Price Differentials on Drugs Commonly Used by Older Americans Are Far Higher Than Differentials for Other Consumer Goods.



C. Drug Company Versus Pharmacy Responsibility

The study also sought to determine whether drug companies or retail pharmacies are responsible for the high prices being paid by older Americans. To do this, the study compared the average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that pharmacies appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. The study found that the average retail price for the five best-selling prescription drugs was just 2% higher than the published Average Wholesale Price, and only 25% above the Wholesale Acquisition Cost (Figure 3). This finding indicates that it is drug company pricing policies, not retail markups, that account for the inflated prices charged to older Americans and other individual customers. These findings are consistent with other experts who have concluded that because of the competitive nature of the pharmacy business at the retail level, there is a relatively small profit margin for retail pharmacists.[25]

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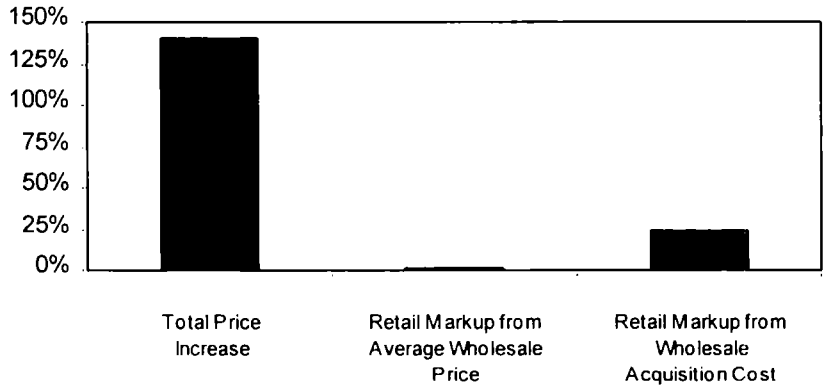
[25] National Association of Chain Drug Stores, *Did You Know . . .* (pamphlet) (citing financial data assembled by Keller Bruner & Company, P.C., Certified Public Accountants 1995).

The study found few significant differences in retail prices between pharmacies in different parts of Mr. Crowley's district. Moreover, although there were variations in prices between chain and independent pharmacies, these differences were in general not systematic.

Figure 3: Drug Companies, Not Retail Pharmacies, Are Responsible for High Prescription Drug Costs



V. DRUG MANUFACTURER PROFITABILITY

Drug industry pricing strategies have boosted the industry's profitability to extraordinary levels. The annual profits of the top ten drug companies are over $25 billion.[26] Moreover, the drug companies make unusually high profits compared to other companies. The average manufacturer of branded consumer goods, such as Proctor & Gamble or Colgate-Palmolive, has an operating profit margin of 10.5%. Drug manufacturers, however, have an operating profit margin of 28.7% -- nearly three times greater (Figure 4).[27]

These high profits appear to be directly linked to the pricing strategies observed in this study. For instance, Merck, the country's largest pharmaceutical manufacturer, had a 24% increase in sales and a 12% increase in profits in the first quarter of 1999.[28] According to

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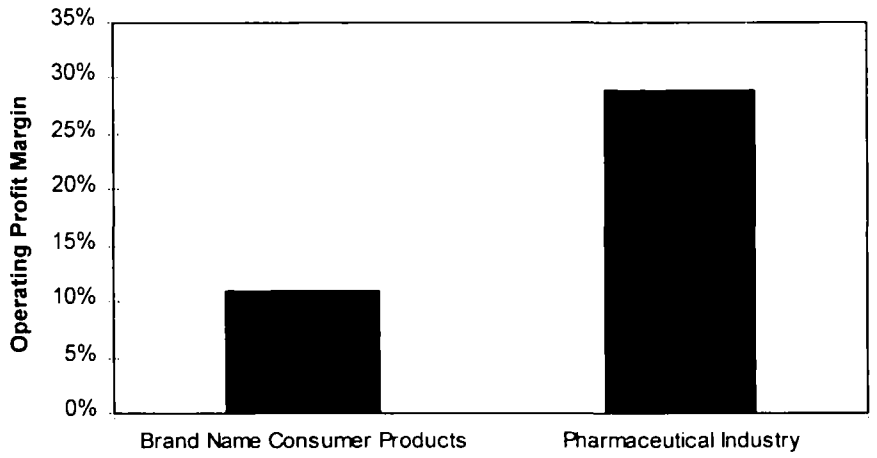
[26] Fortune, *1999 Fortune 500 Industry List* (1999) (Online at www.pathfinder.com/fortune500/ind21.html).

[27] Paul J. Much, Houlihan Lokey Howard & Zukin, *Expert Analysis of Profitability* (Feb. 1998).

[28] AP, *Merck Sales Jump by 24 Percent* (April 23, 1999).

industry analysts, Merck's increased profits were due in large part to sales of Zocor,[29] which is sold in Mr. Crowley's district at a price differential of 299%. Zocor itself accounts for 13% of Merck's revenues.[30]

Figure 4: The Pharmaceutical Industry's Profit Margins Are Larger Than Those for Other Companies.



Pharmaceutical companies have been rapidly increasing their prices. These price hikes make it even more difficult for uninsured senior citizens to afford prescription drugs. In 1998, pharmaceutical prices increased by 5.1%, more than three times higher than the overall inflation rate.[31] The price of Synthroid, which is sold in Mr. Crowley's district at a price differential of more than 1,700%, increased 20.4% in 1998.[32]

Overall, profits for the major drug manufacturers grew by over 21% in 1998, compared to 5% to 10% for other companies on the Standard & Poors Index. The drug manufacturers' profits are expected to grow by up to an additional 25% in 1999.[33] According to one analyst, "the prospects for the pharmaceutical industry are as bright as they've ever been."[34]

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[29] USA Today, *Drugmakers Have Healthy Outlook* (July 20, 1998).

[30] *Merck Sales Jump by 24 Percent*, *supra* note 27.

[31] Express Scripts, Inc., *1998 Drug Trend Report* (June 1999).

[32] *Id.*

[33] *Drugmakers Have Healthy Outlook*, *supra* note 28.

[34] *Id.*

Appendix A

The Five Top Selling Patented, Nongeneric Drugs for Seniors Ranked by 1997 Total Dollar Sales

Rank	Drug	Manufacturer	Indication
1.	Prilosec	Astra/Merck	Ulcer
2.	Norvasc	Pfizer, Inc.	High Blood Pressure
3.	Zocor	Merck	Cholesterol reduction
4.	Zoloft	Pfizer, Inc.	Depression
5.	Procardia XL	Pfizer, Inc.	Heart Problems

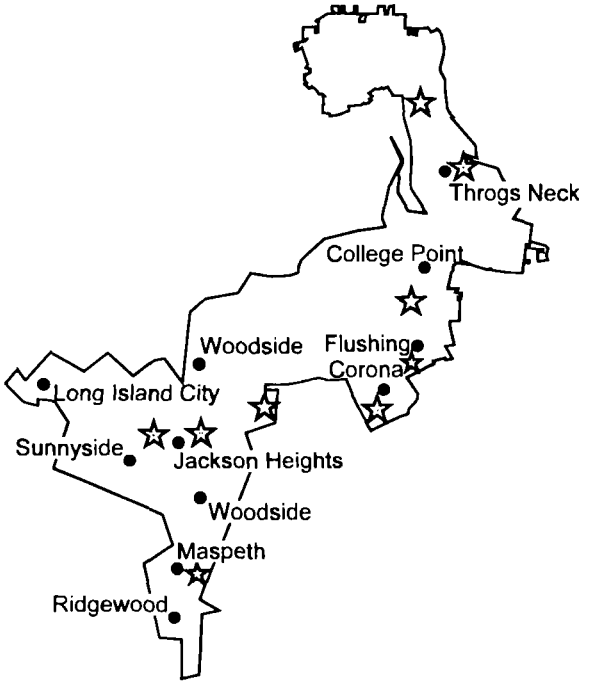
Source: Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly: January 1 - December 31, 1997* (Apr. 1998).

Appendix B

Information on Prescription Drugs Analyzed in This Study

			Prices (Dollars)				
Brand Name Drug	**Dosage and Form**	**Indication**	**Favored Customer Price**	**Wholesale Acquisition Cost**	**Average Wholesale Price**	**Average Retail Price**	**Price Differential (Average Retail Price vs. Favored Customer Price)**
Zocor	5 mg, 60 tablets	Cholesterol reducer	$27.00	$86.07	$106.84	$107.74	299%
Norvasc	5 mg, 90 tablets	High Blood Pressure	$59.71	$96.00	$119.17	$126.26	111%
Prilosec	20 mg, 30 cap.	Ulcer	$59.10	$100.34	$119.57	$121.20	105%
Procardia XL	30 mg, 100 tab.	Heart Problems	$68.35	$111.46	$138.37	$136.68	100%
Zoloft	50 mg, 100 tab.	Depression	$125.73	$182.98	$227.13	$229.03	82%
Average Price Differential							**140%**

Appendix D:
Prescription Drug Pricing Survey Locations in New York's 7th Congressional District



☆ Prescription Drug Pricing Survey Locations

Geography and Map Division, Library of Congress, October 1999, LMC

Prescription Drug Pricing in the 26th Congressional District In New York: Drug Companies Profit at the Expense of Older Americans

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Prepared for Rep. Maurice D. Hinchey

Minority Staff Report
Committee on Government Reform and Oversight
U.S. House of Representatives

Updated
October 9, 1998

Table of Contents

EXECUTIVE SUMMARY

This staff report was prepared at the request of Rep. Maurice D. Hinchey of New York. In Mr. Hinchey's district, as in many other congressional districts around the country, older Americans are increasingly concerned about the high prices that they pay for prescription drugs. Mr. Hinchey requested that the minority staff of the Committee on Government Reform and Oversight investigate this issue.

Numerous studies have concluded that many older Americans pay high prices for prescription drugs and have a difficult time paying for the drugs they need. This study presents new and disturbing evidence about the cause of these high prices. The findings indicate that older Americans and others who pay for their own drugs are charged far more for their prescription drugs than are the drug companies' most favored customers, such as large insurance companies and health maintenance organizations. The findings show that a senior citizen in Mr. Hinchey's district paying for his or her own prescription drugs must pay, on average, nearly twice as much for the drugs as the drug companies' favored customers. The study found that this is an unusually large price differential -- approximately four times greater than the average price differential for other consumer goods.

It appears that drug companies are engaged in a form of "discriminatory" pricing that victimizes those who are least able to afford it. Large corporate and institutional customers with market power are able to buy their drugs at discounted prices. Drug companies then raise prices for sales to seniors and others who pay for drugs themselves to compensate for these discounts to their favored customers.

Older Americans are having an increasingly difficult time affording prescription drugs. By one estimate, more than one in eight older Americans has been forced to choose between buying food and buying medicine. Preventing the pharmaceutical industry's discriminatory pricing -- and thereby reducing the cost of prescription drugs for seniors and other individuals -- will improve the health and financial well-being of millions of Americans.

A. Methodology

This study investigates the pricing of the ten brand name prescription drugs with the highest sales to the elderly. It estimates the differential between the price charged to the drug companies' most favored customers, such as large insurance companies and HMOs, and the price charged to seniors. The results are based on a survey of retail prescription drug prices in chain and independently owned drug stores in Mr. Hinchey's congressional district in New York. These prices are compared to the prices paid by the drug companies' most favored customers. For comparison purposes, the study also estimates the differential between prices for favored customers and retail prices for other consumer items.

B. Findings

The study finds that:

- **Older Americans in New York pay inflated prices for commonly used drugs.** For the ten drugs investigated in this study, the average price differential in Mr. Hinchey's district was 86%. When just the five most popular drugs for seniors are considered, the price differential increases to 95% (Table 1). This means that senior citizens and other individuals who pay for their own drugs pay nearly twice as much for these drugs than the drug companies' most favored customers.

Table 1: Average Retail Prices for the Best-Selling Drugs for Older Americans in New York Are Nearly Twice as High as the Prices That Drug Companies Charge Their Most Favored Customers.

Prescription Drug	Manufacturer	Use	Prices for Favored Customers	Retail Prices for New York Senior Citizens	Price Differential for New York Senior Citizens
Zocor	Merck	Cholesterol	$42.95	$102.09	138%
Prilosec	Astra/Merck	Ulcers	$56.38	$112.41	99%
Relafen	Smithkline Beecham	Arthritis	$62.58	$120.31	92%
Procardia XL	Pfizer Inc.	Heart Problems	$67.35	$125.72	87%
Fosamax	Merck	Osteoporosis	$31.86	$57.93	82%
Vasotec	Merck	High Blood Pressure	$56.08	$101.00	80%
Zoloft	Pfizer, Inc.	Depression	$123.88	$217.32	75%
Norvasc	Pfizer Inc.	High Blood Pressure	$58.83	$102.17	74%
Cardizem CD	Hoechst Marrion Roussel	Angina/Hypertension	$99.36	$172.02	73%
Ticlid	Hoffman-LaRoche	Stroke	$75.28	$124.07	65%
Average Price Differential		**Top Five Drugs** **Top Ten Drugs**			**95%** **86%**

- **For other popular drugs, the price differential is even higher.** This study also analyzed a number of other popular drugs used by older Americans, and in some cases found even higher price differentials (Table 2). The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the price differential for senior citizens in New York was 1,450%. An equivalent dose of this drug would cost the manufacturer's favored customers only $1.75, but would cost the average senior citizen in New York $27.13. For Micronase, a diabetes treatment manufactured by Upjohn, an equivalent dose would cost the favored customers $10.05, while seniors in New York are charged $41.27. The price differential was 311%.

Table 2: Price Differentials for Some Drugs Are More Than 1,400%.

Prescription Drug	Manufacturer	Use	Prices for Favored Customers	Retail Prices for New York Senior Citizens	Price Differential for New York Senior Citizens
Synthorid	Knoll Pharmaceuticals	Hormone Treatment	$1.75	$27.13	1450%
Micronase	Upjohn	Diabetes	$10.05	$41.27	311%

- **Price differentials are far higher for drugs than they are for other goods.** This study compared drug prices at the retail level to the prices that the pharmaceutical industry gives its most favored customers, such as large insurance companies and HMOs. Because these customers typically buy in bulk, some difference between retail prices and "favored customer" prices would be expected. The study found, however, that the differential was much higher for prescription drugs than it was for other consumer items. The study compared the price differential for prescription drugs to the price differentials on a selection of other consumer items. The average price differential for the ten prescription drugs was 86%, while the price differential for other items was only 22%. Compared to manufacturers of other retail items, pharmaceutical manufacturers appear to be engaging in significant price discrimination against older Americans and other individual consumers.

- **Pharmaceutical manufacturers, not drug stores, appear to be responsible for the discriminatory prices that older Americans pay for prescription drugs.** In order to determine whether drug companies or retail pharmacies were responsible for the high prices being paid by seniors in Mr. Hinchey's congressional district, the study compared average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that New York pharmacies appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. The retail prices in New York are only 3% above the published national Average Wholesale Price. The differential between retail prices and a second indicator of pharmacy costs, the prices from one wholesaler, is only 21%. This indicates that it is drug company pricing policies that appear to account for the inflated prices charged to older Americans and other customers.

I. THE VULNERABILITY OF OLDER AMERICANS TO HIGH DRUG PRICES

This report focuses on a continuing, critical issue facing older Americans -- the cost of their prescription drugs. Numerous surveys and studies have concluded that many older Americans pay high costs for prescription drugs and are having a difficult time paying for the drugs they need. The cost of prescription drugs is particularly important for older Americans because they have more medical problems, and take more prescription drugs, than the average American. This situation is exacerbated by the fact that the Medicare program, the main source of health care coverage for the elderly, fails to cover the cost of most prescription drugs.

According to the National Institute on Aging, "as a group, older people tend to have more long-term illnesses -- such as arthritis, diabetes, high blood pressure, and heart disease -- than do younger people."[1] Other chronic diseases which disproportionately affect older Americans include depression and neurodegenerative diseases such as Alzheimer's disease, Lou Gehrig's disease, and Parkinson's disease.

According to the American Association of Retired Persons, older Americans spend almost three times as much of their income (21%) on health care than do those under the age of 65 (8%), and more than three-quarters of Americans aged 65 and over are taking prescription drugs.[2]

The average older American takes 2.4 prescription drugs.[3] More importantly, older Americans take significantly more drugs on average than the under-65 population.[4] It is estimated that the elderly in the United States, who make up 12% of the population, use one-third of all prescription drugs.[5]

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[1] National Institute on Aging (NIA), NIA Age Page (www.nih.gov/nia/health/pub/medicine.htm).

[2] AARP Public Policy Institute and the Lewin Group, *Out of Pocket Health Spending By Medicare Beneficiaries Age 65 and Older: 1997 Projections* (February 1997).

[3] AUS/ICR for the American Association of Retired Persons, National Pharmaceutical Council, and Pharmaceutical Executive Magazine, *Survey on Prescription Drug Issues and Usage Among Americans Aged 50 and Older,* 1 (May 1996).

[4] Senate Special Committee on Aging, *Developments In Aging: 1996*, 1 S. Rep. 36, 105th Cong., 1st Sess. 121 (1997).

[5] Senate Special Committee On Aging, *Developments in Aging: 1993*, 1 S. Rep. 403, 103d Cong., 2d Sess. 35 (1994).

Although the elderly have the greatest need for prescription drugs, they often have the most inadequate insurance coverage for the cost of these drugs. A 1996 AARP survey indicated that 37% of older Americans do not have insurance coverage for prescription drugs.[6] As a result, many older Americans -- a large percentage of whom live on a limited, fixed income -- are forced to pay the full, out-of-pocket expense of prescription drugs.

The primary reason for this burden is that, with the exception of drugs administered during in-patient hospital stays, Medicare generally does not cover prescription drugs. While Medicare managed care plans may offer optional prescription drug coverage, they are available only as an option subject to the discretion and fiscal priorities of the health plans. Moreover, these Medicare managed plans currently serve only a small portion of the Medicare population.

Although Medicare beneficiaries can purchase supplemental "Medigap" insurance privately, these policies are often prohibitively expensive or inadequate. For example, one of the standardized Medigap policies available provides only a $3,000 drug benefit, while still leaving beneficiaries vulnerable to a high deductible and to paying at least half of their total drug costs.[7]

Medicare beneficiaries without public or private prescription drug coverage are the group most at risk of high out-of-pocket prescription drug costs. According to the Senate Special Committee on Aging, this group includes those "who are not poor enough to receive Medicaid, do not have employer-based retiree prescription drug coverage, and cannot afford any other private prescription drug insurance plans."[8]

The high costs of prescription drugs, and the lack of insurance coverage, directly affect the health and welfare of older Americans. In 1993, 13% of older Americans surveyed reported that they were forced to choose between buying food and buying medicine.[9] By another estimate, five million older Americans are forced to make this difficult choice.[10]

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[6] AARP Public Policy Institute and the Lewin Group, *supra* note 1.

[7] Families USA Foundation, *Worthless Promises: Drug Companies Keep Boosting Prices*, 6 (March 1995).

[8] Senate Report 36, *supra* note 4, at 122.

[9] Families USA Foundation, *supra* note 7, at 6.

[10] Senate Special Committee on Aging, *A Status Report -- Accessibility and Affordability of Prescription Drugs For Older Americans*, S. Rep. 100, 102d Cong., 2d Sess. 2 (1992).

II. ARE DRUG COMPANIES EXPLOITING THE VULNERABILITY OF OLDER AMERICANS?

Rep. Maurice D. Hinchey of New York asked the minority staff of the Committee on Government Reform and Oversight to investigate whether pharmaceutical manufacturers are taking advantage of older Americans through price discrimination, and if so, whether this is part of the explanation for the high drug prices being paid by older Americans in his congressional district. This report presents the results of this investigation.

Industry analysts have recognized that price discrimination occurs in the prescription drug market. According to a recent *Standard & Poor's* report on the pharmaceutical industry, "[d]rugmakers have historically raised prices to private customers to compensate for the discounts they grant to managed care customers. This practice is known as 'cost shifting.'"[11] Under this practice, "drugs sold to wholesale distributors and pharmacy chains for the individual physician/patient are marked at the higher end of the scale."[12]

Although industry analyses acknowledge that price discrimination occurs, they have not estimated its degree or impact. This report, prepared at Mr. Hinchey's request, is the first attempt to quantify the extent of price discrimination and its impact on senior citizens in New York.

The study design and methodology used to test whether drug companies are discriminating against older Americans in their pricing are described in part III. The results of the study are described in part IV. These results show that drug manufacturers appear to be engaged in substantial price discrimination against older Americans and other individuals who must pay for their own prescription drugs. Drug manufacturers' profitability is discussed in part V.

III. METHODOLOGY

A. Selection of Drugs for this Survey

This survey is based primarily on a selection of the ten patented, nongeneric drugs with the highest annual sales to older Americans in 1997. The list was obtained from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE). The PACE program is the largest out-patient prescription drug program for older Americans in the United States for which claims data is available and is used in this study, as well as by several other analysts, as a

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[11] Herman Saftlas, Standard & Poor's, *Healthcare: Pharmaceuticals,* Industry Surveys, 19-20 (December 18, 1997).

[12] *Id.* at 19.

proxy database for prescription drug usage by all older Americans. In 1997, over 250,000 persons were enrolled in the program, which provided over $100 million of assistance in filling over 2.8 million prescriptions.[13]

B. Determination of Average Retail Drug Prices for Seniors in New York

In order to determine the prices that the elderly are paying for prescription drugs in New York, the minority staff and the staff of Mr. Hinchey's congressional office conducted a survey of eleven pharmacies -- including four chain and seven independent stores -- in Mr. Hinchey's congressional district. Mr. Hinchey represents New York's 26th Congressional District, which includes the Binghamton-Johnson City-Endicott region. The locations of the pharmacies surveyed in this study are shown in Appendix D.

C. Determination of Prices for Drug Companies' Most Favored Customers

Drug pricing is complicated and drug companies closely guard their pricing strategies. The best publicly available indicator of the prices companies charge their most favored customers, such as large insurance companies and HMOs, is the Federal Supply Schedule (FSS).

The FSS is a price catalog containing goods available for purchase by federal agencies. Drug prices on the FSS are negotiated by the Department of Veterans Affairs. The prices on the FSS closely approximate the prices that the drug companies charge their most favored nonfederal customers. According to the U.S. General Accounting Office (GAO), "[u]nder [General Services Administration] procurement regulations, VA contract officers are required to seek an FSS price that represents the same discount off a drug's list price that the manufacturer offers its most-favored nonfederal customer under comparable terms and conditions."[14] Thus, in this study, FSS prices are used to represent the prices drug companies charge their most favored customers.

This update includes FSS prices as of October 8, 1998. These prices represent changes in the FSS prices from the initial staff report. This update also corrects a technical error in the initial report.

D. Determination of Prices Paid by Pharmacies

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[13] Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly* (January 1 - December 31, 1997).

[14] U.S. General Accounting Office, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain* (June 1997) (emphasis added).

The survey also looked at two other pricing indicators: (1) the Average Wholesale Price (AWP) and (2) the prices charged pharmacies by a large drug wholesaler. These two prices provide an indicator of the extent of markups that are attributable to the pharmacy (in contrast to those that are due to the drug manufacturer). The AWP is an average of prices charged by the drug wholesalers to retail pharmacies. The AWP prices were obtained from the *1997 Drug Topics Red Book.*[15] As another measure of wholesale prices, the study used the wholesale prices charged pharmacies by McKesson, the world's largest wholesaler.

E. Determination of Drug Dosages

When comparing prices, the study used the same criteria (dosage, form, and package size) used by the GAO in its 1994 report, *Prescription Drugs: Companies Typically Charge More in the United States Than in Canada.* For drugs that were not included in the GAO report, the study used the dosage, form, and package size common in the years 1994 through 1997, as indicated in the *Drug Topics Red Book.*

F. Comparison of Price Differentials for Other Retail Items

In order to determine whether the differential between FSS prices and retail prices for drugs commonly used by older Americans is unusually large, the study compared the prescription drug price differentials to price differentials for other consumer products. To make this comparison, a list of consumer items other than drugs available through the FSS was assembled. FSS prices were then compared with the retail prices at which the items could be bought at a large national chain.[16]

IV. DRUG COMPANIES CHARGE OLDER AMERICANS DISCRIMINATORY PRICES

A. Discrimination in Drug Pricing

For the ten patented, nongeneric drugs most commonly used by seniors, the average differential between the price that would be paid by a senior citizen in Mr. Hinchey's congressional district and the price that would be paid by the drug companies' most favored customers was 86% (Table 1). The five most popular drugs for seniors are Prilosec, Norvasc, Zocor, Zoloft, and Procardia XL. The average price differential for these top five drugs is even

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[15] Medical Economics Company, Inc., *1997 Drug Topics Red Book.*

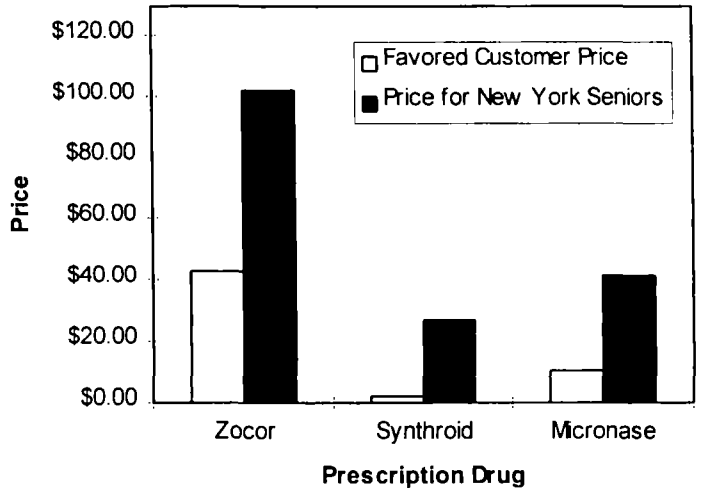
[16] The items used were binder clips, rubber bands, toilet paper, Rolodexes, tape dispensers, wastebaskets, scissors, pencils, paper towels, post-it notes, envelopes, and correction fluid.

higher: 95%. The study thus showed that the average price that older Americans and other individual consumers in Mr. Hinchey's district pay for these drugs is nearly double the price paid by the drug companies' favored customers, such as large insurance companies and HMOs.

For individual drugs, the price differential was even higher. Among the ten best selling drugs, the highest price differential 138% for Zocor, a cholesterol-reducing drug manufactured by Merck.

For other popular drugs, the study found even greater price differentials. The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the price differential for senior citizens in New York was 1,450%. An equivalent dose of this drug would cost the most favored customers only $1.75 but would cost the average senior citizen in New York $27.13. For Micronase, a diabetes treatment manufactured by Upjohn, the price differential was 311% (Figure 1).

Figure 1: Older Americans In New York Pay Inflated Prices for Prescription Drugs.



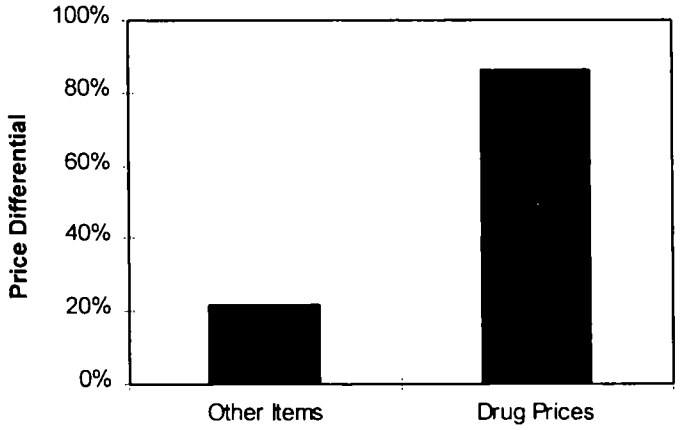
Every drug looked at in this study had a large price differential. Three drugs had price differentials of over 90%, and six of the ten best-selling drugs had price differentials equal to or higher than 80%.

B. Comparison With Other Consumer Goods

The study also analyzed whether the large differentials in prescription drug pricing could be attributed to a volume effect. The drug companies' most favored customers, such as large

insurance companies and HMOs, typically buy large volumes of drugs. Thus, it could be expected that there would be differences between the prices charged the most favored customers and retail prices. The study found, however, that the differentials in prescription drug prices were much greater than the differentials in prices for other consumer goods. The study found that, in the case of other consumer goods, the average differential between retail prices and the prices charged most favored customers, such as large corporations and institutions, was only 22%. The average price differential in the case of prescription drugs was almost four times larger than the average price differential for other consumer goods (Figure 2). This indicates that a volume effect is unlikely to explain the large differential in prescription drug pricing.

Figure 2: Price Differentials on Drugs Commonly Used by Older Americans Are Far Higher Than Differentials for Other Consumer Goods.



C. Drug Company Versus Pharmacy Responsibility

Finally, the study sought to determine whether drug companies or retail pharmacies were responsible for the high prices being paid by older Americans. To do this, the study compared the average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that pharmacies appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. The study found that the average retail price for the ten most common drugs was only 3% higher than the published national Average Wholesale Price, and only 21% higher than the price available directly from one large wholesaler (Figure 3). This finding indicates that it is drug company pricing policies, not retail markups, that account for the inflated prices charged to

older Americans and other individual customers. These findings are consistent with other experts who have concluded that because of the competitive nature of the pharmacy business at the retail level, there is a relatively small profit margin for retail pharmacists.[17]

Moreover, the study found few differences between retail prices at pharmacies in different parts of Mr. Hinchey's district. Prices at all eleven pharmacies surveyed were within 8% of the average prices.[18]

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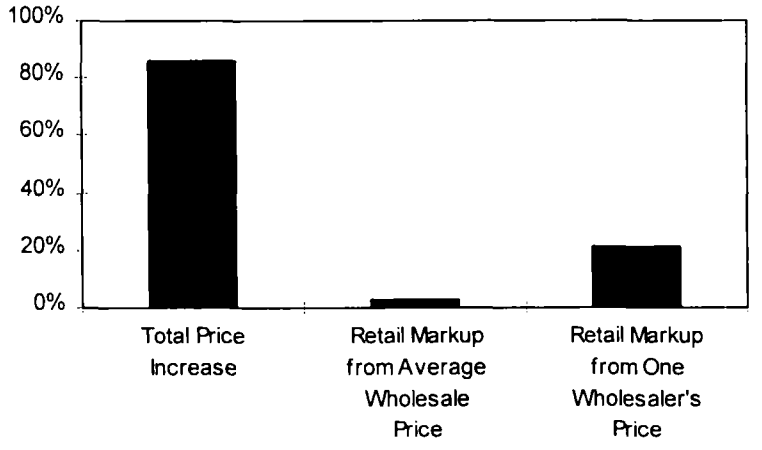
[17] National Association of Chain Drug Stores, *Did You Know . . .* (pamphlet) [citing financial data assembled by Keller Bruner & Company, P.C., Certified Public Accountants (1995)].

[18] In 1993, independent pharmacies sued 19 drug manufacturers, alleging that the differential between the prices charged most favored customers and the prices charged pharmacies violated antitrust laws. In 1996, 11 of these drug manufacturers agreed to settle with the pharmacies. Under this agreement, these pharmaceutical companies promised to offer pharmacies the same price discounts as favored customers like large HMOs if the pharmacies could show the same ability to move market share as the favored customers. On July 13, 1998, four additional drug manufacturers agreed to a settlement under similar terms.

Unfortunately, the results of this study cast doubt on whether these agreements are likely to end the price discrimination practices of the large pharmaceutical companies. Eight of the ten most popular prescription drugs in this survey -- Zocor, Norvasc, Prilosec, Procardia XL, Relafen, Vasotec, Fosamax, and Zoloft -- are covered by the agreement reached in 1996, and there is still large price discrimination for all of these drugs. Synthroid is also covered under the agreement, and this drug has a price differential of more than 1,400%.

The reason for the continued high price differentials may be that, unlike hospitals or HMOs, pharmacies cannot control decisions made by doctors about what drugs to prescribe, and thus are unable to demonstrate to the drug manufacturers that they can influence market share. The doubts raised by this study are consistent with the observations of other industry analysts, who note that "there is already intense skepticism among retail buying groups for independent drugstores about whether the smaller independents will have the ability to qualify for the potential windfall and pass the savings on to customers." Wall Street Journal, *Drug Makers Agree To Offer Discounts For Pharmacies*, July 15, 1998, p. B4, column 3.

Figure 3: Drug Companies, Not Retail Pharmacists, Are Responsible for High Drug Costs Paid by Older Americans.



V. DRUG MANUFACTURER PROFITABILITY

Drug industry pricing strategies have boosted the industry's profitability to extraordinary levels. The annual profits of the top 10 drug companies is nearly $20 billion.[19] Moreover, the drug companies make unusually high profits compared to other companies. The average manufacturer of branded consumer goods, such as Proctor & Gamble or Colgate-Palmolive, has an operating profit margin of 10.5%. Drug manufacturers, however, have an operating profit margin of 28.7% -- nearly three times greater (Figure 4).[20]

These high profits appear to be directly linked to the pricing strategies observed in this study. For instance, Merck, the country's largest pharmaceutical manufacturer, had an increase

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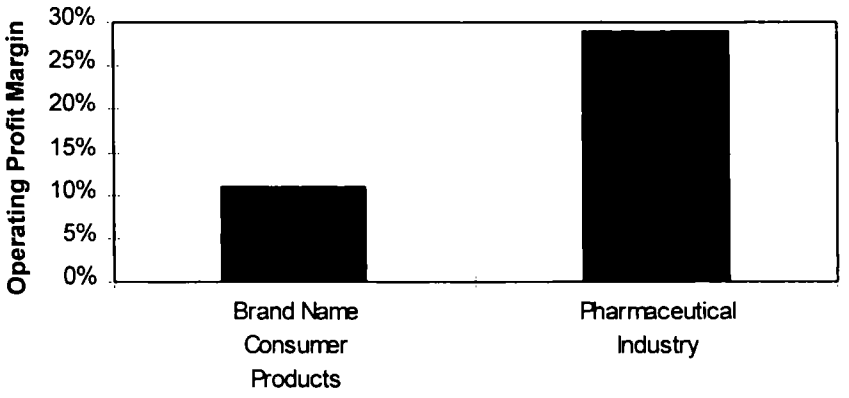
[19] *See* 1998 Fortune 500 Industry List (www.pathfinder.com/fortune500/indlist.html).

[20] Paul J. Much, Houlihan Lokey Howard & Zukin, *Expert Analysis of Profitability* (February 1988).

in profits of 15% to 18% in the second quarter of 1998. According to industry analysts, Merck's increased profits were due in large part to sales of Zocor and Fosamax.[21] Both of these drugs are sold at large price differentials to seniors and other individual consumers in Mr. Hinchey's district. Zocor, which is sold in Mr. Hinchey's district at a price differential of 138%, itself accounts for 6% of Merck's revenues.[22]

Overall, profits for the major drug manufacturers are expected to grow by about 20% in 1998, compared to 5% to 10% for other companies on the Standard & Poors Index. The drug manufacturers' profits are expected to grow by up to an additional 25% in 1999.[23] According to one analyst, "the prospects for the pharmaceutical industry are as bright as they've even been."[24]

Figure 4: The Pharmaceutical Industry's Profit Margins Are Larger Than Those for Other Industries.



[21] USA Today, *Drugmakers Have Healthy Outlook* (July 20, 1998).

[22] IMS America, *Top 200 Drugs of 1997* (1998).

[23] USA Today, *supra* note 22.

[24] *Id.* at D1.

Appendix A

Information on Prescription Drugs Analyzed In This Study

			Prices (Dollars)				
Brand Name Drug	**Dosage and Form**	**Indication**	**FSS**	**Major Whole-saler**	**AWP**	**Average Retail Price**	**Price Differential**
Zocor	5 mg, 60 tablets	Cholesterol reducer	$42.95	$85.47	$106.84	$102.09	138%
Prilosec	20 mg, 30 cap.	Ulcer	$56.38	$99.20	$108.90	$112.41	99%
Relafen	500 mg, 100 tab.	Arthritis	$62.58	$88.88	$111.10	$120.31	92%
Procardia XL	30 mg, 100 tab.	Heart	$67.35	$105.05	$131.31	$125.72	87%
Fosamax	10 mg, 30 tablets	Osteo-porosis	$31.86	$50.91	$51.88	$57.93	82%
Vasotec	10 mg, 100 tab.	Blood Pressure	$56.08	$85.56	$102.94	$101.00	80%
Zoloft	50 mg, 100 tab.	Depression	$123.88	$172.44	$215.55	$217.32	75%
Norvasc	5 mg, 90 tablets	Blood Pressure	$58.83	$97.92	$125.66	$102.17	74%
Cardizem CD	240 mg, 90 tablets	Angina	$99.36	$154.10	$165.42	$172.02	73%
Ticlid	250 mg, 60 tablets	Stroke	$75.28	$99.44	$108.90	$124.07	65%
Average Price Differential -- Top Ten Drugs							**86%**
Average Price Differential -- Top Five Drugs							**95%**

Appendix B

The Ten Top Selling Patented, Nongeneric Drugs for Seniors Ranked by Total Dollar Sales

Rank	Drug	Manufacturer	Indication
1.	Prilosec	Astra/Meck	Ulcer
2.	Norvasc	Pfizer, Inc.	High Blood Pressure
3.	Zocor	Merck	Cholesterol reduction
4.	Zoloft	Pfizer, Inc.	Depression
5.	Procardia XL	Pfizer, Inc.	Heart Problems
6.	Vasotec	Merck	High Blood Pressure
7.	Cardizem CD	Hoechst Marion Roussel	Angina
8.	Ticlid	Hoffman-LaRoche	Stroke
9.	Fosamax	Astra/Merck	Osteoporosis
10.	Relafen	Smithkline Beecham	Arthritis

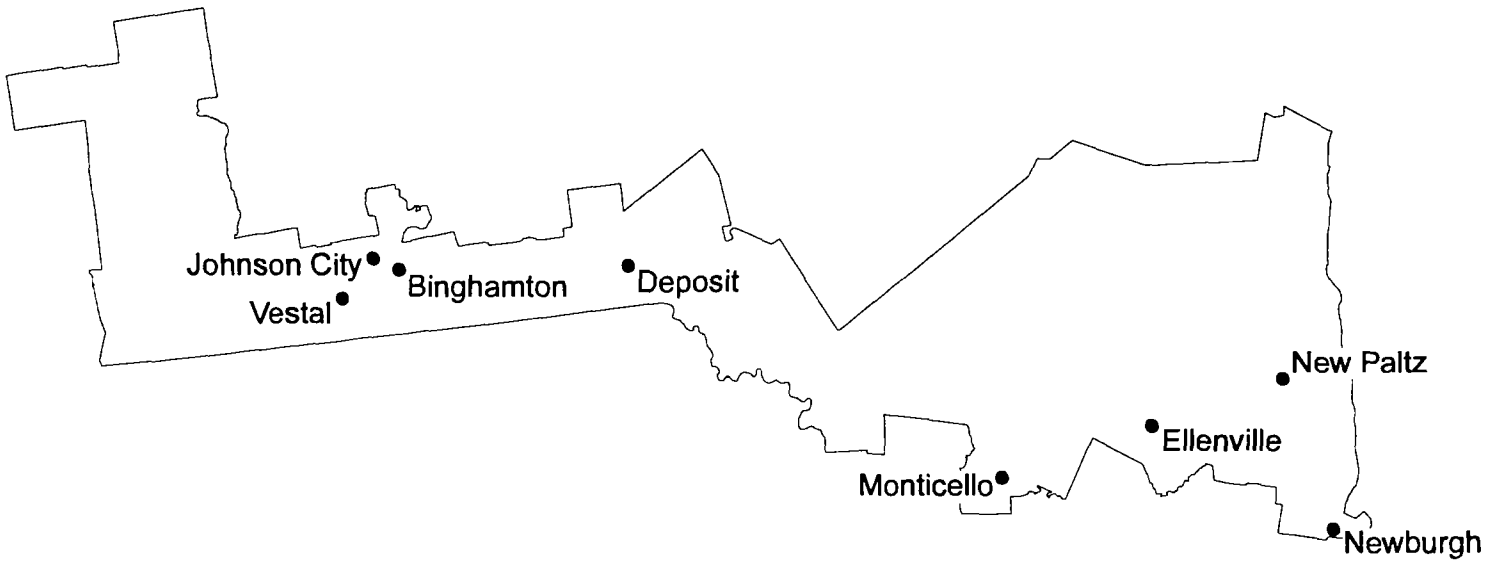
Source: Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly* (January 1 - December 31, 1997).

Appendix C

Price Comparisons for Non-Prescription Drug Items

Item	FSS Price	Retail Price	Differential
Binder Clip, small, 1 box	$0.49	$0.49	0%
Rubber Bands, 1 lb.	$2.57	$2.67	4%
Toilet Paper, 96 Rolls	$44.74	$47.98	7%
Rolodex, 500 cards	$13.24	$14.29	8%
Tape Dispenser	$1.44	$1.69	17%
Wastebasket, Plastic, 13 qt.	$2.95	$3.49	18%
Scissors	$10.88	$12.99	19%
Pencils, #2, 20-pack	$1.03	$1.26	22%
Paper Towels	$22.94	$29.98	31%
Post-It Notes	$2.08	$2.89	39%
Envelopes, 500, White, 20 lb. weight	$6.45	$9.49	47%
Correction Fluid, 18 ml., dozen.	$6.66	$9.99	50%
Average Price Differential			**22%**

Appendix D
Prescription Drug Price Survey Locations in New York



Library of Congress, Geography and Map Division, September 1998. G-1998-38-S.I.

Phones: 301-951-9643 or –9648
Fax: 301-951-0340
Cell: 202-365-0202
WHCA Pager # 4088

Carol M. Beach

Fax

To: Ann O'L	**From:** Carol Beach
Fax: Pam's Fax	**Pages:** Cover + 20
Phone:	**Date:** 2/7
Re: Peters. Drugs	**CC:**

House Democratic Caucus Retreat

February 6, 2000

I appreciate the honor of being on this panel, especially with 2 Members of Congress who have been leaders in advancing the cause of a health system that better serves seniors, people with disabilities, low-income consumers, and all consumers.

I have been asked to focus on the Medicare prescription drug issue from the consumer perspective. Before getting to that; I want to let you know that CU is in strong support of building a PD benefit into Medicare, and we would be very happy if this happened before more comprehensive reforms are considered. We believe that it is very important that Congress preserve the universal benefit package that was the cornerstone of Medicare when it was enacted in 1965. We believe that the introduction of Medicare HMOs and Medicare+Choice undermined the principle of universal benefits and is unfair to many consumers who by virtue of their geographical location or unwillingness to buy into the managed care structure have a different, inferior package of benefits. We believe that HMO's will continue to be a step ahead of the government's ability to measure HMOs' ability to cherry pick the healthy, and adjust their payments. We oppose the failed Breaux-Thomas premium support proposal of 1999 and support the Administration's commitment in its Medicare proposal to a **standard** Medicare benefit. I brought some handouts which go through the Breaux plan and Clinton plan in detail.

Turning to prescription drugs:

I plan to provide some figures to help set the context for the need for a new PD benefit. Highlights:

-- Medicare beneficiaries are burdened by out-of-pocket PD costs.

-- PD costs are rising much faster than inflation.

-- Medigap policies that include drug coverage are a very poor value and should

not be considered an adequate substitute for a universal Medicare drug benefit.

Some background statistics:

- Demand for prescription drugs is growing rapidly, for a number of reasons. In 1998, pharmacists filled 2.8 billion prescriptions. This number is expected to grow to 4 billion by 2005.
- The pharmaceutical industry is extremely profitable. A Families USA study reported that 24 pharmaceutical companies had median net profits of 20%, 4.5 times the 4.4 median profit of all Fortune 500 companies.
- A Boston School of Public Health Study found the pharmaceutical industry to be the most profitable industry, with return on equity 2.3 times the average company's return on equity, in the 1990's.
- Seniors typically pay more than two times the prices that drug companies charge their most favored customers, according to research by the House Committee on Government Reform. A Public Citizen survey recently yielded the same results.

Point 1. **Medicare beneficiaries need protection against high out-of-pocket costs from prescription drug expenses.**

- 57% (more than half) of people 65 and over are more likely than any other age group to have out-of-pocket health care costs that exceed 10% of their income -- and a large part of these expenditures are the result of prescription drug costs. [Hidden from View]
- The average person 65 and over buys just over 20 prescriptions per year, spending on average $720. Average out-of-pocket costs for pd's for this age group are $373. 87% of seniors purchase at least one pd.

[Household component, MEPS, 1996]

- An AARP study shows that seniors with income below poverty are spending 9% of their income ($8760) on drugs.

Point 2. **Prescription drug costs -- especially those paid by seniors -- are high, are increasing quickly, and are expected to continue to increase at rates far higher than the overall inflation rate.**

Chart 1 (Explain)

- There are varying estimates of the rate of growth of prescription drug costs, but all estimates show these costs growing at several times the general rate of inflation. The estimates range from 6.1 percent to 18 %. Just this week the American Journal of Health-System Pharmacy projected that drug costs in 2000 will outpace 1999 drug costs by 12 to 15 percent. [18% cited by Public Citizen, citing NIHCM; Journal: BNA Health Policy Report, January 31, 2000]
- Rapid PD inflation will severely erode the value of any Medicare benefit with a benefit cap -- unless costs are brought under control.

Point 3. **One prevalent argument used against expanding Medicare benefits to include prescription drugs is that people can buy private Medigap coverage for prescription drugs: the problem with this argument is that Medigap prescription drug coverage is both very limited and very LOW VALUE.**

Chart 2

- In 1990, under the leadership of Cong. Waxman and Cong. Stark, Congress reformed the medigap market, with the establishment of 10 standard benefit packages.
- *Consumer Reports* rated medigap policies in 1998. Because of the medigap reforms, it is now possible to make comparisons between premiums of different packages. I compared premiums for policies

with prescription drugs vs. Policies without prescription drugs.

- Seniors who decide to buy prescription drug coverage in medigap policies pay a high price for very little premium. Those who buy Plan C -- which has a $250 deductible and limits benefits to a maximum of $1250, typically pay about $1850 for this prescription drug benefit. In other words, the extra premium they pay is about 48 % HIGHER than the MAXIMUM prescription drug benefit that they could get.

All of these factors have important ***implications for legislation.***

1. **Prescription drug benefits should be *universal* -- they should be built into the basic Medicare benefit.**
   - The medigap experience demonstrates what can happen when people self-select into the benefit plans that they think they will need.
   - The data showing the variation in risk and the fact that most seniors, as of 1996, have prescription drug costs of less than $500 shows that a voluntary system -- especially when the benefits are capped and premiums are high -- might appeal only to a small percent of the potential beneficiaries.

2. **We need to pay a lot of attention to PRICES. We would not be making real progress if out-of-pocket costs grow if prescription drug prices continue to rise faster than inflation.**

   CHART 3
   - Public Citizen has estimated that because of rising prescription drug expenditures, a senior with average drug expenditures will have higher inflation adjusted out-of-pocket expenditures after the 4th year of the

Clinton plan.

3. **Design matters. In addition to the public policy goal of providing access to fairly priced prescription drugs, there are two other important public policy goals -- goals that will be in conflict in light of limited funds.** USE Chart 4 to illustrate:

(1) Provide a broad benefit that provides relief to a large portion of the population, in order to help build public support of the program.

(2) Provide benefits that are targeted to provide relief to those with the largest needs.

- To provide a broad benefit, with a limited budget, there might be no deductible, a maximum benefit level (cap) , and cost-sharing of 50%.
- To provide relief targeted to those with the most need, there might be a $500 deductible, 25% cost-sharing, and a stop-loss that protects beneficiaries against unlimited out-of-pocket costs.

- *Lehrer NewsHour: 67 year old woman, Bessie Johnson, has congestive heart disease and high blood pressure. PD's have helped at a cost of $450/month. [$5400/year] (Her income is $13,000/year). She has to juggle her prescriptions and decide which to buy and which to skip.*

A few points to make in conclusion:

- There are several constructive lessons from the *catastrophic health care legislation*. That experience should not be held up as a reason NOT to take care of this pressing need. But it does argue for subsidies for the poor should be spread broadly, not paid solely by upper income seniors.
- We continue to believe that it is appropriate to ask seniors to pay -- through higher Medicare premiums -- for a significant percent of any new benefits.

- A new program should be *universal* -- if not built in to Medicare benefits, then "voluntary" the way that Part B is voluntary -- an offer that very few would refuse. The social insurance model is a sound model for prescription drug benefits.
- Keeping a lid on prices will be an important part of any new proposal. If benefits are 50% of skyrocketing prices --then the remaining out-of-pocket costs would continue to be burdensome for most Medicare beneficiaries.
- We should keep a focus on the goal -- of softening the financial hardship too often associated with the need for expensive prescription drugs, and give special consideration to including stop-loss protection that will limit out-of-pocket drug costs for those most in need.
- We need to anticipate Flo's next line of attack: keeping big government out of your medicine cabinet theme is likely to return. Also -- the pharmaceutical industry will no doubt play to concerns that limits on their prices will limit their research and discoveries of new drugs. They will raise concerns that the government will **RATION** prescription drugs and deny you the medicines that you need. Flo and the pharmaceutical industry is hard at work developing a strategy to kill any proposal that threatens their profits!
- We must use the right language! Congressman Waxman, Congressman Stark and others worked for years to fight problems in the medigap market. For years we all talked about the importance of **medigap standardization**, which I must admit does sound like the heavy hand of Big Brother imposing nasty regulation. Eyes glazed over and the public did not understand. When we started to talk about **medigap simplification -- and meeting the kitchen table test** -- Congress was able to enact what continues to be regarded as successful reforms -- from OBRA 1990. In the Medicare prescription drug benefit debate, we should avoid talking about **price controls** and instead talk about building a system that is **accountable to the public**-- to consumers -- to voters -- to those on Medicare.

- Urge you all to ask your Medicare consituents (perhaps on your website) to tell you their own prescription drug stories.
- One of the biggest challenges will be to find the best way to put the forces of competition in the private marketplace to work on behalf of consumers -- to rein in rapidly rising prescription drug bills -- without giving ammunition to Flo to return to her negative message. (I might add that I believe that Flo is poised and ready to return to go to battle against the evil forces of **the big bad government**.)

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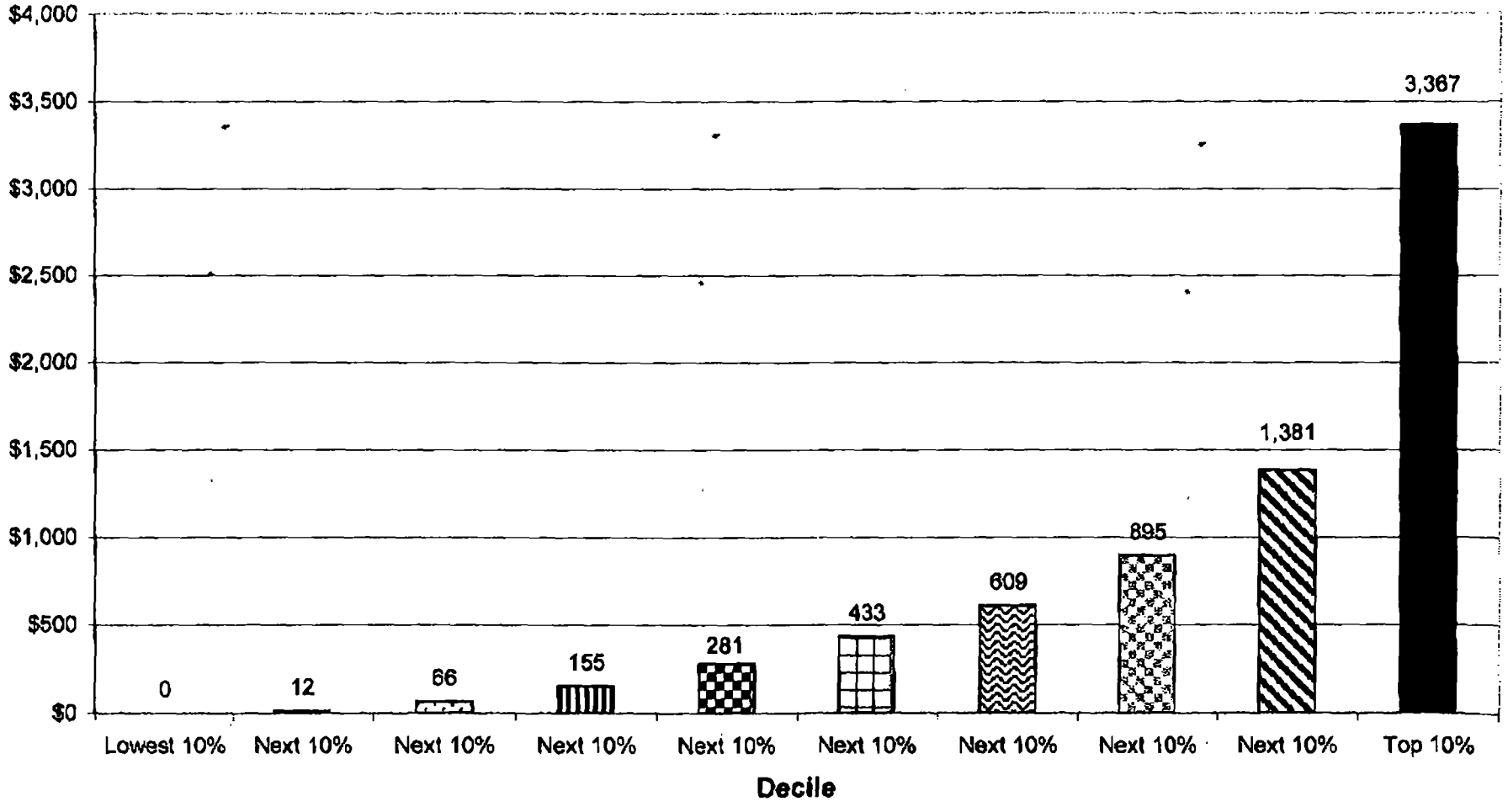
Chart 1

Actual Prescription Drug Expenditures
1996 By Decile
People 65 and over



Source: MEPS 1996, Agency for Health Care Quality (2000)

Chart 2

Medigap Prescription Drug Coverage: High Premiums - Limited Coverage

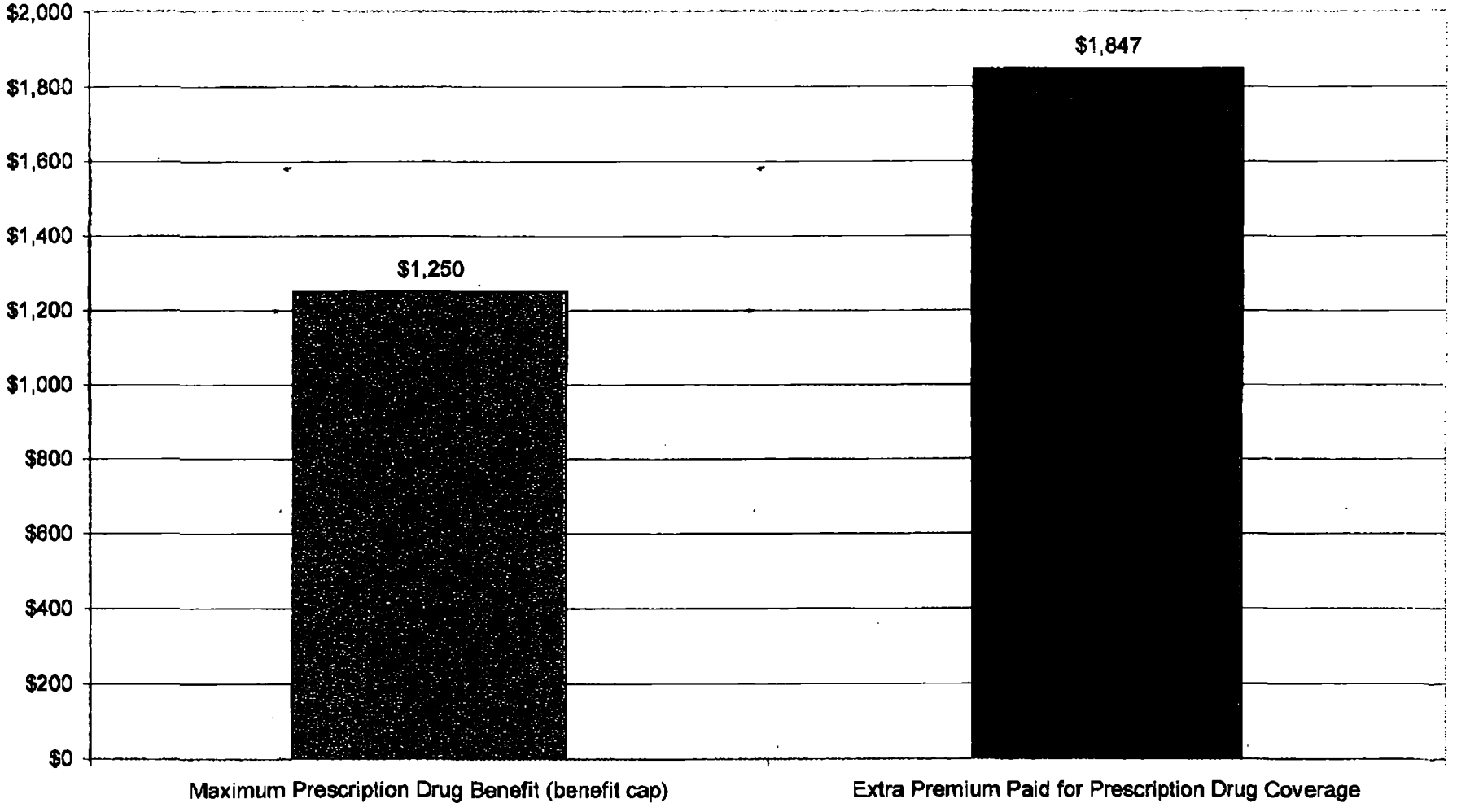
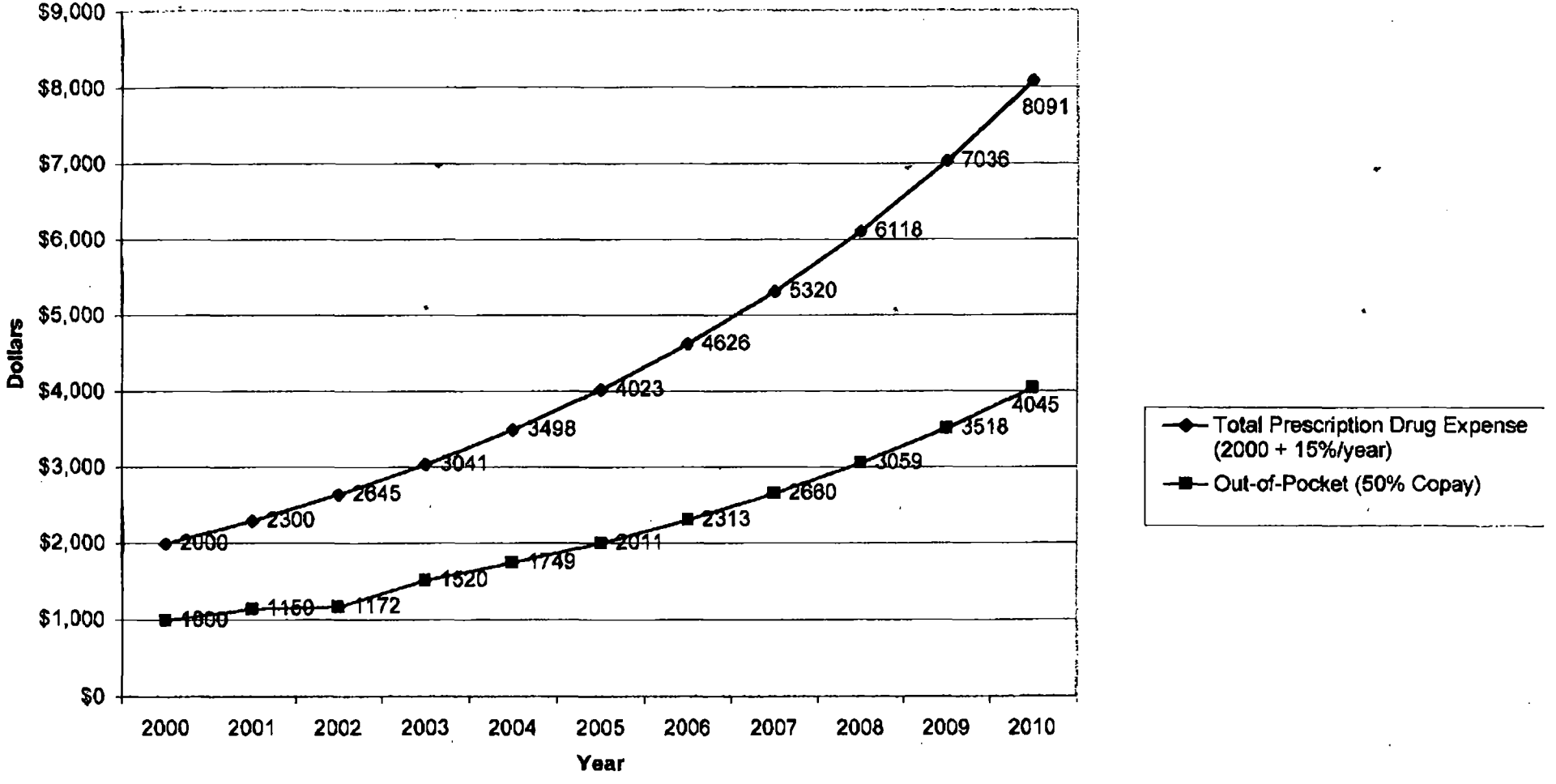


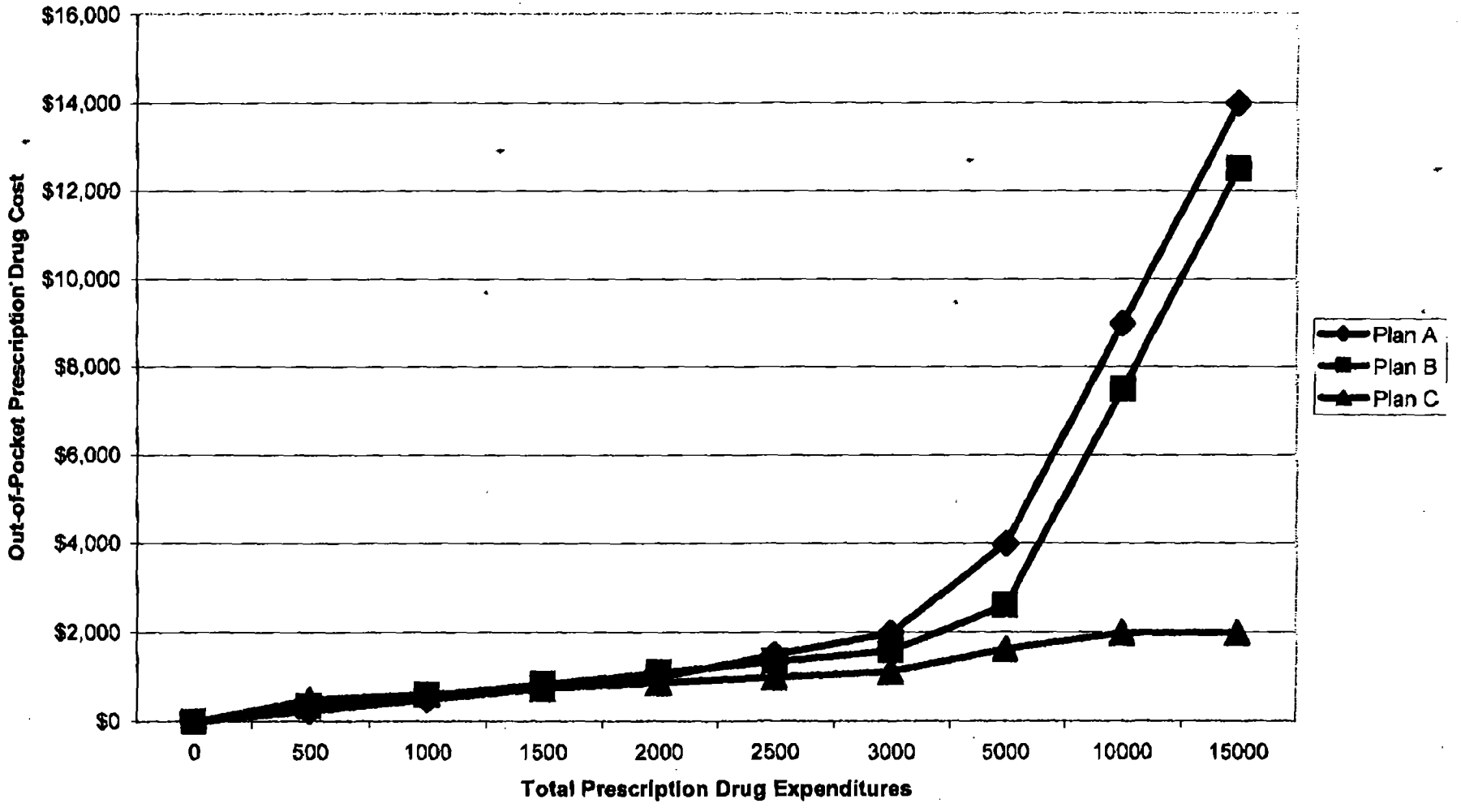
Chart 3

Growing Out-of-Pocket Costs When Prescription Drug Prices Rise at 15% per Year



* Benefit with 50% co-pay, no deductible, no benefit cap
*Total prescription drug costs: $2000 in 2000
*Average annual price increase: 15%

Out-of-Pocket Prescription Drug Costs
At Selected Expenditure Levels



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Carol M. Beach

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To:	Ann O'L	**From:**	Carol Beach
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for your eyes only !!

House Democratic Caucus Retreat
February 6, 2000

I appreciate the honor of being on this panel, especially with 2 Members of Congress who have been leaders in advancing the cause of a health system that better serves seniors, people with disabilities, low-income consumers, and all consumers.

I have been asked to focus on the Medicare prescription drug issue from the consumer perspective. Before getting to that, I want to let you know that CU is in strong support of building a PD benefit into Medicare, and we would be very happy if this happened before more comprehensive reforms are considered. We believe that it is very important that Congress preserve the universal benefit package that was the cornerstone of Medicare when it was enacted in 1965. We believe that the introduction of Medicare HMOs and Medicare+Choice undermined the principle of universal benefits and is unfair to many consumers who by virtue of their geographical location or unwillingness to buy into the managed care structure have a different, inferior package of benefits. We believe that HMO's will continue to be a step ahead of the government's ability to measure HMOs' ability to cherry pick the healthy, and adjust their payments. We oppose the failed Breaux-Thomas premium support proposal of 1999 and support the Administration's commitment in its Medicare proposal to a **standard** Medicare benefit. I brought some handouts which go through the Breaux plan and Clinton plan in detail.

Turning to prescription drugs:
I plan to provide some figures to help set the context for the need for a new PD benefit. Highlights:

-- Medicare beneficiaries are burdened by out-of-pocket PD costs.
-- PD costs are rising much faster than inflation.
-- Medigap policies that include drug coverage are a very poor value and should

$450/month. [$5400/year] (Her income is $15,000/year). She has to choose her prescriptions and decide which to buy and which to skip.

A few points to make in conclusion:

- There are several constructive lessons from the *catastrophic health care legislation*. That experience should not be held up as a reason NOT to take care of this pressing need. But it does argue for subsidies for the poor should be spread broadly, not paid solely by upper income seniors.
- We continue to believe that it is appropriate to ask seniors to pay -- through higher Medicare premiums -- for a significant percent of any new benefits.

Draft #1

FIRST LADY HILLARY RODHAM CLINTON
"TALKING IT OVER"/CREATORS SYNDICATE
COLUMN FOR PUBLICATION FEBRUARY 8, 2000

In recent years, lifesaving drugs have become an indispensable part of modern medicine. Yet 13 million senior citizens in this country – three out of five of our elderly population – lack dependable drug coverage. Furthermore, millions of older Americans, the ones who need prescription drugs the most, pay the highest prices for them.

Pat Brown, a senior citizen from Johnson City, Tenn., knows firsthand just how hard life can be without insurance to help pay for prescription drugs. Pat, who suffers from five chronic illnesses, used to have drug coverage under her Medigap policy. But her premiums increased to the point that she had to buy a less expensive policy, one that did not cover her medicine. Today, Pat pays approximately $4,200 a year for her prescriptions drugs and, not surprisingly, she is worried about spending her life's savings and depleting the money she has put aside for her retirement.

Unfortunately, Pat is not alone.

Too many seniors in this country are forced everyday to choose between paying for food and paying for medicine. Some choose the

medically risky route of taking smaller doses of their medications than their doctors recommend – sacrificing their health and well-being in order to make their drugs last longer.

Medicare, created 35 years ago to protect the health of Americans as they grow older, is a success story. Before Medicare, nearly half of our seniors had no health coverage at all, and families were left to bear the financial burden of caring for their loved ones.

Medicare changed all that.

In the past 35 years, though, the medical landscape has changed. Today, new medicines play an increasingly important role in providing quality health care to all our citizens, but especially to our senior citizens. Prescription drugs can accomplish what once could be done only through surgery, at far less pain and far less cost. And the number of new drugs is rising every day. In 1998, pharmacists filled 2.8 billion prescriptions – a number that is expected to grow to 4 billion in the next 5 years.

Despite all this, and although Medicare covers doctor and hospital benefits, we let our seniors go without the very prescription drugs that could keep them healthy. It doesn't make sense.

If we were crafting the Medicare program today, we would never

consider proposing a program without a prescription drug benefit. It's time to do what we know is right.

This week, the President submitted his budget to Congress. In addition to making Medicare more efficient, competitive and fiscally sound – extending its solvency until at least the year 2025 – his plan creates a long-overdue, voluntary prescription drug benefit that offers high-quality prescription drugs to senior citizens at affordable prices. Furthermore, the President's budget includes a reserve fund to protect those who are confronted with catastrophic drug costs.

Beneficiaries who opt for the prescription drug coverage would pay $26 a month in the first year, an amount that would rise to $51 a month in later years. Premiums would drop – in some cases to zero – for low-income recipients. There would be no deductible and the plan would cover half of each beneficiary's drug cost, from the first prescription filled each year up to a limit of $5,000. Let me reiterate: Despite what some television ads would have you believe, the President's plan is entirely voluntary. No senior would be required to participate.

Medicare is truly at a crossroads. When the baby boom generation retires, it will be called on to care for twice as many Americans as it does

today. Yet, this important program, which, for 35 years, has played such a vital role in preserving and improving the health of our senior citizens, will not be up to the task unless we act now.

If we are to protect our children from shouldering the burden of caring for us as we age, we must strengthen and reform Medicare. We must make it fiscally sound and we must offer a prescription drug benefit to those who feel they need it.

In his State of the Union speech last month, the President had this to say: "In good conscience, we cannot let another year pass without extending to all our seniors this lifeline of affordable drugs." He has taken the first step. Now it is up to members of Congress to do their part. Pat Brown and 13 million of her fellow citizens – this country's parents and grandparents – are counting on it.

[738 words]

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HILLARY CLINTON

On Your Side: Working Hard for Available and Affordable Prescription Drugs
February, 2000

Fighting the Pharmaceutical Industry for Fairness in Drug Pricing. Hillary Clinton has a long history of fighting for available and affordable prescription drugs both to prevent diseases and to ensure the best treatment for illnesses. Over the past seven years, Hillary Clinton has continually pushed pharmaceutical companies to lower drug prices for all and fought hardest for those most in need – women, children, and seniors. Hillary Clinton is continuing her work today by fighting for lower-priced prescription drugs for seniors.

Meeting the Needs of Children. As a part of her work fighting for quality, affordable health care for children, Hillary Clinton secured funding to provide vaccines for uninsured and under-insured children and won pediatric labeling on prescription drugs.

- **Worked to Raise Child Immunization Rates to All Time High.** Hillary Clinton has worked hard to address the need for affordability and available children's vaccines. Once, during her travels throughout the country, Hillary met a woman from Vermont who ran a dairy farm with her husband who was required by law to immunize her cattle against disease, but could not afford to give her pre-school children inoculations as well. Struck by this example and many others, Hillary Clinton launched the Childhood Immunization Initiative and helped secure passage of the Vaccines for Children program designed to provide free vaccine to uninsured and under-insured children, starting in October 1994. Today, the Vaccines for Children program is going strong, with all 50 states participating in the program. Enrollment of private providers into the Vaccines for Children Program has almost doubled since the beginning of the program in October 1994. Over 31,000 private provider sites (which may include multiple providers per site) and approximately 12,000 public clinics are enrolled in the program. Additionally, childhood immunization coverage rates in 1998 were the highest ever recorded. 90 percent of toddlers in 1996, 1997 and 1998 received the most critical doses of each of the routinely recommended vaccines, surpassing the Administration's 1993 goal.

- **Promoting Regulation that Drug Companies Provide Adequate Testing for Children.** Hillary Clinton has long recognized the difficulties many parents face providing the right drugs, and the right dosage, to their children. She knew that most drugs – even those commonly used by children – had not been widely tested on pediatric populations, and that drugs are likely to have a different impact on children. In 1992, Hillary Clinton met Elizabeth Glaser and heard of her struggle with AIDS and her child's struggle with the same deadly disease. Hillary was struck by Elizabeth Glaser's story – that while she could receive appropriate prescription drugs, her child was not able to receive the same benefits. Prescription drugs were not being tested on children and the FDA had no way of knowing which prescription drugs were most effective for kids and in which dosages. With this story and may others, Hillary Clinton began to fight for appropriate testing and labeling of prescription and over-the-counter drugs for children. In early 1997, Hillary sat down with head of the Food and Drug Administration, David Kessler, to develop a strategy for making this happen. As a result, in 1997 the President directed an important Food and Drug Administration regulation requiring manufacturers to do studies on pediatric populations for new prescription drugs – and those currently on the market – to ensure that prescription drugs are adequately tested for the unique needs of children. This regulation also requires proper labeling of drugs for use by children.

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Comments: Allison —
P/S give copies to HRC & Howard
Could you check the spelling (on first page)
of "Barbara Barkley" (The schedule and briefing I had
shows it two different ways)
P/S Call with questions
Thanks
Laura

DRAFT

FIRST LADY HILLARY RODHAM CLINTON
REMARKS AT STRONG MEMORIAL HOSPITAL/
THE UNIVERSITY OF ROCHESTER MEDICAL CENTER
ROCHESTER, NEW YORK
FEBRUARY 8, 2000

Thank you all. I am delighted to join you here today. I want to thank Jay Stein and our hosts at Strong Memorial Hospital and the University of Rochester Medical Center for your extraordinary commitment to bringing cutting-edge research and care to people throughout New York.

And I want to thank Barbara Barkley, Dr. Phyliss Collins and the entire American Nurses Association and the New York State Nurses Association for this tremendous honor. I will never forget the nurses who took care of my father when he was sick.

Anyone who has ever waited nervously for test results or sat by the bedside of a loved one who has fallen sick knows that you are the lifeblood of our health care system. In the face of revolutionary changes, one thing has remained constant -- your courage and commitment, your passion and professionalism. And all of us owe you a debt of gratitude.

Over the years, we have stood together to honor our nurses and put quality care within the grasp of more Americans. We have stood together make sure that the healing of medicine is never eclipsed by the business of medicine. And I look forward to standing with you in the days and years ahead.

I thank you this endorsement. And I will work every day to live up to the confidence you have placed in me.

As I said Sunday, my first introduction to politics was when I spoke at my college commencement in 1969. I'm a little older now. A little blonder. A lot humbler. I've gone to work. I've raised a child. I've spent 30 years trying to improve the lives of children and families.

But, I often return to one thing I said way back then: that politics is the art of making possible what appears to be impossible. I still believe that today. We can do what seems impossible if we have the vision, the passion, and the will to do it together.

We've seen what's possible in the progress we've made over the last 7 years. I am proud and grateful to have been a part of it, and convinced we can meet the challenges that lie ahead. We can strengthen our families. We can protect our children. We can improve our schools. We can bring good jobs to every corner of New York. And, yes, we can bring health care to every citizen.

Because I believe we can meet these challenges together, yesterday I was honored to stand with thousands of supporters and announce my candidacy for the United States Senate.

I know some people are asking why I'm doing this here, and now. That's a fair question. This is my answer -- and why I hope you will put me to work for you. I may be new to the neighborhood. But, I am not new to your concerns.

When I ate lunch with teachers at a school in Queens, I heard how hard it is to teach and learn when 2,000 kids are crammed into a building designed for half that number.

And I thought about the work I've done for 20 years to improve our public schools. Now I want to make sure every child in New York has the best possible public education, with well-trained teachers in modern classrooms connected to the internet.

When I spoke with breast cancer survivors at Adelphi University, I thought about Bill's mother and the courageous battle she fought until her last day. I thought about the work I've done to include annual mammograms under Medicare and to increase funding for research, detection, and treatment of breast cancer.

Now, I want finally to pin down the environmental connections to cancer on Long Island or elsewhere. I want to end the practice of drive-by-mastectomies for women with breast cancer. And I want to provide the research funds we need to prevent and cure cancer, AIDS, and other deadly diseases.

For over thirty years, in many different ways, I've seen firsthand the kinds of challenges New Yorkers face today. I care deeply about these issues. I know I can make progress on them. And I want to fight for them – just as I've always done.

[When I pushed for teaching testing and higher standards in the 1980s in the face of protests and boycotts; When I went to Beijing to speak out for women's rights as human rights in the face of strong opposition to my trip, here and there; When I tried to get affordable quality health care for all Americans, against all the odds and interest groups.]

[I won the first two battles. And, as you may recall, I lost the last one. And because of that, there are probably some who thought I might shy away from talking about health care. But, that's not going to happen. And the reason is simple.]

I have always believed that health care is a human right – a right that I have worked for my entire adult life. So, instead of giving up when health care reform was defeated, I've tried a different approach.

I fought to make sure new mothers could at least stay overnight in the hospital and to protect workers from losing their insurance if they change jobs. I've fought to reverse some of the deep cuts to hospitals caused by the Balanced Budget Amendment. And I fought to make insurance more accessible to people with disabilities; to uninsured Americans between 55 and 65 who should be able to buy into Medicare; and to children. The Children's Health Insurance Program has already insured two million children with funding for three million more. But, we can never give up until we provide quality, affordable health insurance to everyone in our country.

From Great Neck to the Adirondacks, from New York City to Cooperstown, I have been in children's hospitals and community hospitals. I have been to some of the finest teaching hospitals and academic health centers in the world such as this one. And I have sat and talked with patients and listened to their concerns about ensuring quality care in our rapidly changing health care system.

I'll never forget a young woman I met in Ithaca last summer. She had been in a very serious accident the year before. She'd been helicoptered out to the nearest trauma center – and was in the hospital for many months. Now, she was in the midst of this very frustrating fight with her insurance company because they were not going to pay her $10,000 medivac helicopter bill. The reason? She had not called for permission. Never mind that she had been lying on the side of the road comatose.

We've all heard stories like that. It is time to enact a real Patient's Bill of Rights – so that people will have confidence that life and death decisions about their health are being made by their physicians, not some bureaucrat thousands of miles away. It's time to protect the privacy of our medical records and outlaw genetic discrimination. And it's time to ensure that Medicare, which has changed what it means to grow old in America, is there for generations to come. We know that the number of seniors in this State alone will increase by over 1/3 by the year 2025. We know that we must use our surplus to extend the life of the Trust Fund. We must reform Medicare. And we must modernize it by including a long-overdue prescription drug benefit.

We need to ask ourselves: What good is the promise of quality care for the two million seniors in New York who don't have a prescription drug benefit? Here we are, with record surpluses and economic growth. What better time than now to honor our obligations to older Americans and make sure that their ability to buy critical medication is never determined by the size of their savings accounts or retirement checks.

And that brings me to the main point I want to make today. If we want to make health care more affordable, we must lower the costs of prescription drugs for all Americans. Even 10 years ago, we could never have predicted the critical role that prescription drugs would play in our health care system. Today, these medications are often the only difference between surgery and less costly, less painful treatments; between sickness and health; between life and death.

Prescription drugs are a necessity – and yet they are priced as a luxury. Their costs are rising at 12 percent a year – faster than any other part of our health care system. And while our drug prices go through the roof, it is often the health of our most vulnerable citizens that plummets.

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I have met seniors and others who tell me that they cannot afford the medications they desperately need. They tell me they are being forced to choose between paying for their drugs and paying for their food, their rent, their heat and other lifelines. Some people are even being forced to choose the size of their treatments based on cost, not science.

That's what happened to (b)(6) (b)(6) He had [0011]

been sick for a long time. And even though he had insurance, he couldn't afford his deductible. So, eventually he cut down on his medication, even though he was suffering from kidney failure. Thank God, he received a transplant last week. But, it never should have come to that.

Why are drug costs breaking the budgets – and the hearts – of so many Americans? Some of it, frankly, is advertising. The industry will spend $1.8 billion this year on advertising. We're the only industrialized nation that permits prescription drugs to be advertised directly to the consumers on t.v. and in print. And the top 10 most advertised drugs are responsible for more than 20 percent of the increase in prescription drug spending since 1993.

But, some of the reason for the skyrocketing costs is that we're not allowed to import cheaper drugs. Today, people in this country are paying the highest prices in the world for the exact same drugs that others are finding at much lower prices overseas. The new breast cancer treatment, Tamoxifin costs $390 for a three-month supply here, and $150 in Canada. The allergy drug Clariton costs almost $2.00 a pill in the U.S., but only $1.00 in Canada.

Think about what that means for people like (b)(6) (b)(6) He's a retired newspaper reporter. He doesn't have very good health insurance. He has a heart condition. And, his costs have gotten so bad, he thinks his only option might be to go to Canada to buy his treatments. He wouldn't be alone.

Every day, thousands of U.S. citizens cross the border to buy drugs at a fraction of the cost. These drugs are made from the same ingredients. They offer the same benefits. They are made in the exact same factories – factories most often owned by U.S. pharmaceutical companies. The only difference is Americans are paying more than retail, while the rest of the world pays wholesale. That's wrong – and it must stop.

I am pleased to announce today that, if I go to the U.S. Senate, I will introduce a bill to allow American pharmacists to import FDA-approved drugs from Canada -- so that New Yorkers will never again have to pay far more for life-saving drugs than their neighbors across the border. The Access to Affordable Prescription Drugs Act will say to people facing sickness: You will never again have to choose between bankruptcy and health. This bill will cover drugs approved by the FDA and manufactured at FDA approved facilities. And if we come together to make it the law of the land, it will save Americans precious resources – and precious lives.

We cannot let this – or any other health care issue -- be a partisan issue. When I visit a hospital room, I don't ask patients whether they are Democrats or Republicans or Independents. I don't ask physicians and nurses that I meet what their party affiliation is. There is no room in this debate for partisanship.

If we are going to ensure quality, affordable health care for all people, then we must fight against the divisive politics of revenge and retribution. Real leadership means rolling up your sleeves, not pointing your fingers or clenching your fists.

If I have the honor of representing the people of New York in the Senate, I'll work to lift people up – not push them down.

Public service has been my life. It hasn't as yet, included public office. Over the next nine months all of you will decide whether I've earned the privilege of serving you. I can't tell you how much I appreciate the support of the nurses and so many others in this room and throughout this region. I want this to be a people's campaign. A grassroots campaign. I know it's not going to be an easy campaign. But, nothing worth doing ever is.

In 1998, I went on a bus trip as part of our Millennial effort to honor the past and imagine the future. I remember a warm July afternoon when we drove through the beautiful New York countryside, going from George Washington's Revolutionary War headquarters in Newburgh to Harriet Tubman's home in Auburn to the site of the first women's rights convention in Seneca Falls.

As I visited these places that captured the greatness of New York's past, I also saw in the eyes of children their dreams for New York's future. To people all over the world, New York is more than just a great State. It represents the best of America, the golden door, the doorway to tomorrow.

New York deserves a future worthy of its past.

Thank you for helping to define what was possible in the 20th century. Together, we can make what seems impossible today, possible tomorrow.

And, that's why I want to be your Senator.

Thank you.