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COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Ann O'Leary
OA/Box Number: 19584

FOLDER TITLE:
Prescription Drug Event November 8, 1999 [2]

2013-0436-S
rc1249

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
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Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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Investigation of Prescription Drug Price Discrimination

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

The high cost of prescription drugs is a critical issue for senior citizens across the country. Seniors have the greatest need for prescription drugs, accounting for one-third of all prescription drug sales, but often live on fixed incomes and have no, or inadequate, prescription drug coverage. As a result of the high prescription drug prices, many senior citizens are forced to choose between buying food and paying for the medication they need.

The Prescription Drug Studies

Last year at the request of Congressman Henry Waxman, the ranking Democrat on the Government Reform Committee, the minority staff began an investigation of drug companies' pricing practices and their impact on senior citizens without prescription drug coverage. The initial study was completed in the 1st District of Maine and was quickly followed by studies in Texas and California.

To date, the minority staff has completed over 140 prescription drug pricing reports at the request of individual members of Congress. These studies have been conducted in 90 congressional districts across the country, from the most rural areas in North Dakota to the largest urban areas in California. The surveys have been conducted in 39 states,[1] in which 86% of the U.S. population resides.

The studies find that senior citizens in the United States who pay for their own prescription drugs are charged, on average, 134% more -- or over twice as much -- for prescription drugs as the drug companies' favored customers. The studies have also found that American seniors must pay on average 85% more than consumers in Canada and 83% more than consumers in Mexico.

These price differentials are a form of price discrimination. In effect, the drug manufacturers are discriminating against seniors citizens by denying them access to prescription drugs at the low prices available to favored U.S. customers, such as HMOs and the federal government, and individual consumers in Canada and Mexico.

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[1] This includes the District of Columbia.

Domestic Price Discrimination Studies

The first set of price discrimination reports examines the difference between the price charged to the drug companies' most favored domestic customers, such as HMOs and the federal government, and the price charged to seniors who buy their own prescription drugs. This series investigates the pricing of the five brand name prescription drugs with the highest dollar sales to the elderly in 1997. These drugs are Prilosec, an ulcer and heartburn medication; Norvasc, a blood pressure medication; Zocor, a cholesterol-reducing medication; Zoloft, a medication used to treat depression; and Procardia XL, a heart medication. The results are based on a survey of retail prescription drug prices in chain and independently owned drug stores in congressional districts across the country.

To date, 99 domestic studies have been completed. For the top five drugs investigated in the studies, the average price differential was 134%. This means that senior citizens pay more than twice as much for these drugs than do the drug companies' most favored customers. In dollar terms, senior citizens must pay $58 to $97 more per prescription for these five drugs than favored customers. Table 1 summarizes these results.

Table 1: Average Prices in the United States 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	Dosage and Form	Manufacturer	Use	Prices For Favored Customers	Prices For Seniors	Differential For Senior Citizens	
						Percent	Dollar
Zocor	5 mg., 60 tbs.	Merck	Cholesterol	$27.00	$107.65	299%	$80.65
Norvasc	5 mg., 90 tb.	Pfizer Inc.	Hypertension	$59.71	$118.90	99%	$59.19
Prilosec	20 mg., 20 cps.	Astra/Merck	Ulcers	$59.10	$117.48	99%	$58.38
Procardia XL	30 mg., 100 tbs.	Pfizer Inc.	Heart Problems	$68.35	$133.30	95%	$64.95
Zoloft	50 mg., 100 tbs.	Pfizer, Inc.	Depression	$125.73	$223.56	78%	$97.83
Average Price Differential						**134%**	

For other popular medications, the price differential is even higher. For Synthroid, a commonly used hormone treatment produced by Knoll Pharmaceuticals, preferred customers would pay only $1.75 for 100 pills while seniors would pay $29.12 for the same amount. This is a price differential of 1,564%.

International Price Discrimination

The second set of studies compares the prices that seniors citizens who buy their own prescription drugs must pay for their medication with the prices that consumers who buy their own drugs must pay in Canada and Mexico. These studies also focus on the five brand name

drugs with the highest dollar sales to older Americans in 1997. To date, 43 international studies have been completed.

On average, the studies find that the prices that American senior citizens must pay are 85% higher than the prices that Canadian consumers pay and 83% higher than the prices that Mexican consumers pay. Table 2 summarizes these results.

Table 2: Seniors in the United States Pay Significantly Higher Prices for Prescription Drugs Than Consumers in Canada or Mexico.[2]

Prescription Drug	Manufacturer	Canadian Price	Mexican Price	U.S. Price	U.S. - Canada Price Differential		U.S. - Mexico Price Differential	
					Percent	Dollar	Percent	Dollar
Zocor	Merck	$46.17	$67.65	$106.68	131%	$60.51	58%	$39.03
Prilosec	Astra/Merck	$55.10	$32.10	$116.52	111%	$61.42	263%	$84.42
Procardia XL	Pfizer, Inc.	$74.25	$76.60	$132.48	78%	$58.23	73%	$55.88
Zoloft	Pfizer, Inc.	$129.05	$219.35	$222.19	72%	$93.14	1%	$2.84
Norvasc	Pfizer, Inc.	$89.91	$99.32	$118.18	31%	$28.27	19%	$18.86
Average Differential					**85%**		**83%**	

Other Findings

The price differentials found in these reports are far higher for drugs than for other consumer items. Because preferred customers buy in bulk, some difference in retail and "favored customer" prices would be expected. But the reports find that the average differential between the price charged to favored customers and the price charged to individual consumers for other consumer items such as rubber bands or paper towels is only 22% -- far less than the 134% price differential for prescription drug.

The reports also find that pharmaceutical manufacturers, not drug stores, are primarily responsible for the discriminatory prices that older Americans pay for prescription drugs. Pharmacies have relatively small markups between the prices at which they buy drugs and the prices at which they sell them. A typical pharmacy markup is 21%. This indicates that it is the drug company pricing policies that appear to account for the inflated prices charged to uninsured seniors.

Taken together these studies indicate that drug manufacturers engage in a consistent pattern of price discrimination, resulting in prices for senior citizens who buy their own drugs that far exceed those paid by other purchasers in the United States and consumers in other countries. The effect of these pricing practices is to victimize those who are least able to afford prescription drugs -- senior citizens with no prescription drug coverage.

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[2]U.S. prices in this chart vary slightly from U.S. prices in Table 1 due to the fact that the international price studies and the domestic price studies were conducted in different sets of congressional districts.

States in Which Drug Studies Have Been Conducted

Alabama
Arkansas
Arizona
California
Colorado
Connecticut
District of Columbia
Florida
Hawaii
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
North Dakota
Nevada
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Gore & Bradley

Bill 2 of 50

GPO's PDF version of this bill	References to this bill in the Congressional Record	Link to the Bill Summary & Status file.	*Full Display* - 4,968 bytes.[Help]

International Prescription Drug Parity Act (Introduced in the Senate)

S 1191 IS

106th CONGRESS

1st Session

S. 1191

To amend the Federal Food, **Drug** , and Cosmetic Act to provide for facilitating the importation into the United States of certain drugs that have been approved by the Food and **Drug** Administration, and for other purposes.

IN THE SENATE OF THE UNITED STATES

June 9, 1999

Mr. DORGAN (for himself, Mr. WELLSTONE, Ms. SNOWE, and Mr. JOHNSON) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend the Federal Food, **Drug** , and Cosmetic Act to provide for facilitating the importation into the United States of certain drugs that have been approved by the Food and **Drug** Administration, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `**International Prescription Drug Parity** Act'.

SEC. 2. FACILITATION OF IMPORTATION OF DRUGS APPROVED BY FOOD AND DRUG ADMINISTRATION.

(a) IN GENERAL- Section 801(d) of the Federal Food, **Drug** , and Cosmetic Act (21 U.S.C. 381(d)) is amended--

(1) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively; and

(2) by striking `(d)(1)' and all that follows through the end of paragraph (2) and inserting the following:

`(d)(1) If a covered **drug** is domestically approved and is manufactured in a State and exported, or such **drug** is domestically approved and is for commercial distribution and is manufactured in a foreign establishment registered under section 510(i), the manufacturer shall, as a condition of maintaining the domestic approval of the **drug** , comply with the following:

`(A) Without regard to whether a shipment of such **drug** is intended for importation into the United States, for each shipment of such **drug** , the manufacturer shall--

`(i) maintain a record that identifies the shipment of such **drug** ;

`(ii) maintain a record that details how such shipment of such **drug** complies with current good manufacturing practice and section 501; and

`(iii) provide the labeling required for any such **drug** pursuant to section 502 and pursuant to the application for domestic approval.

`(B) Upon the request of a person who intends to import into the United States drugs from such shipment (and who meets applicable legal requirements to be an importer of covered drugs), the manufacturer shall provide to the person a copy of each of the records maintained under subparagraph (A) with respect to the shipment.

`(2) For the purpose of facilitating the importation into the United States of covered drugs, the Secretary shall promulgate by regulation the following:

`(A) Criteria regarding the records described in paragraph (1) and use of the records to demonstrate domestic approval of the drugs and compliance with sections 501 and 502.

`(B) Criteria regarding labeling requirements for the drugs that the Secretary determines to be appropriate.

`(C) Criteria regarding the amount of charges that may be imposed by manufacturers of the drugs for maintaining and providing the records specified in subparagraph (A).

`(3) In this subsection:

`(A) The term `covered **drug**' means a **drug** that is described in section 503(b)(1) or is

composed wholly or partly of insulin.

`(B) The term `domestically approved', with respect to a **drug** , means a **drug** for which an application is approved under section 505, or as applicable, under section 351 of the Public Health Service Act (42 U.S.C. 262). The term `domestic approval', with respect to a **drug** , means approval of an application for a **drug** under such a section.'.

(b) CONFORMING AMENDMENTS-

(1) Section 801(d) of the Federal Food, **Drug** , and Cosmetic Act (21 U.S.C. 381(d)) is amended in paragraph (5) (as redesignated by subsection (a)(1)) by striking `paragraph (3)' each place such term appears and inserting `paragraph (4)'.

(2) Section 301(w) of the Federal Food, **Drug** , and Cosmetic Act (21 U.S.C. 331(w)) is amended--

(A) by striking `801(d)(3)' each place it appears and inserting `801(d)(4)';

(B) by striking `801(d)(3)(A)' and inserting `801(d)(4)(A)'; and

(C) by striking `801(d)(3)(B)' and inserting `801(d)(4)(B)'.

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 House companion Bill

Bill Summary & Status for the 106th Congress

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H.R.1885

Sponsor: Rep Berry, Marion (introduced 5/20/1999)
Latest Major Action: 6/15/1999 Referred to House subcommittee
Title: To amend the Federal Food, Drug, and Cosmetic Act to provide for facilitating the importation into the United States of certain drugs that have been approved by the Food and Drug Administration.

COSPONSORS(53), ALPHABETICAL: (Sort: by date)

Rep Abercrombie, Neil - 5/20/1999
Rep Allen, Thomas H. - 7/1/1999
Rep Baker, Richard H. - 5/26/1999
Rep Baldacci, John Elias - 7/14/1999
Rep Baldwin, Tammy - 11/1/1999
Rep Barrett, Thomas M. - 5/26/1999
Rep Bereuter, Doug - 7/19/1999
Rep Bonior, David E. - 11/16/1999
Rep Boswell, Leonard L. - 8/5/1999
Rep Brown, Sherrod - 7/29/1999
Rep Campbell, Tom - 10/27/1999
Rep Capps, Lois - 11/15/1999
Rep Conyers, John, Jr. - 11/4/1999
Rep Cramer, Robert E. (Bud) Jr. - 9/21/1999
Rep DeFazio, Peter A. - 7/1/1999
Rep Delahunt, William D. - 6/8/1999
Rep Emerson, Jo Ann - 5/20/1999
Rep Filner, Bob - 11/2/1999
Rep Gilman, Benjamin A. - 11/17/1999
Rep Hilliard, Earl F. - 7/29/1999
Rep Hinchey, Maurice D. - 7/1/1999
Rep Hinojosa, Ruben - 9/29/1999
Rep Hoekstra, Peter - 6/14/1999
Rep Hooley, Darlene - 8/5/1999
Rep Hutchinson, Asa - 7/13/1999
Rep Jackson, Jesse L., Jr. - 11/16/1999
Rep Jackson-Lee, Sheila - 9/29/1999
Rep Kilpatrick, Carolyn C. - 7/1/1999
Rep Kucinich, Dennis J. - 7/1/1999
Rep LaFalce, John J. - 10/20/1999
Rep Larson, John B. - 11/2/1999
Rep Lee, Barbara - 11/18/1999
Rep Lewis, John - 5/20/1999
Rep Luther, Bill - 7/12/1999
Rep Martinez, Matthew G. - 9/14/1999
Rep McHugh, John M. - 10/27/1999
Rep McKinney, Cynthia A. - 11/15/1999
Rep Millender-McDonald, Juanita - 11/8/1999
Rep Miller, George - 11/16/1999
Rep Nadler, Jerrold - 11/2/1999
Rep Olver, John W. - 11/1/1999
Rep Rivers, Lynn N. - 10/20/1999
Rep Rohrabacher, Dana - 5/20/1999
Rep Sanders, Bernard - 5/20/1999
Rep Sandlin, Max - 7/29/1999
Rep Schakowsky, Janice D. - 10/20/1999
Rep Shows, Ronnie - 5/24/1999
Rep Slaughter, Louise McIntosh - 7/13/1999
Rep Stark, Fortney Pete - 5/26/1999
Rep Strickland, Ted - 5/26/1999
Rep Tierney, John F. - 11/16/1999
Rep Vento, Bruce F. - 7/19/1999
Rep Weiner, Anthony D. - 6/8/1999

Taxpayers have been hit hard, too, by paying for the prescription drugs of 36 million poor people covered by Medicaid.

The United States actually does have a price control system similar to other nations', but it applies to only one customer: the federal government. Pharmaceutical companies are required by law to sell drugs to the government at the best wholesale price given to other large U.S. customers. Then, the four biggest federal customers -- the Veterans Administration, Defense Department, Coast Guard and the Public Health Service/Indian Health Service -- get an additional 24% discount. This essentially gets international prices for the federal government.

But these four departments account for only 1.5% of the U.S. market. Medicaid prescriptions account for another 10% of the market and are covered by a weaker form of price control: Drug companies pay rebates to the federal and state governments of 11% to 15% of the average wholesale price.

States pay 44% of Medicaid costs, which has prompted more than a dozen state legislatures to consider legislation to control prices. Proposals include having the state governments buy Medicaid drugs from Indian tribes, which get prescription drugs at the best federal price, or pooling resources to negotiate better deals. The proposals have met stiff opposition from the pharmaceutical industry, and so far nothing has been approved.

Prescription drugs cheaper in other nations

The 10 best-selling prescription drugs in the USA cost much more than they do in four other countries surveyed by USA TODAY. Retail price of the most commonly prescribed dose of each drug, converted to U.S. dollars:

<>Rank(1)DrugConditionU.S.CanadaGreat BritainAustraliaMexico
<> 1PrilosecHeartburn/Ulcer $3.31$1.47 $1.67 $1.29 $.99
2ProzacDepression $2.27$1.07 $1.08 $.82 $.79
3LipitorHigh cholesterol $2.54$1.34 $1.67 $1.32$3.60
4PrevacidUlcer $3.13$1.34 $.82 $.83$1.18
5EpogenAnemia $23.40 $21.44 $27.48 $29.24 N/A
6ZocorHigh cholesterol $3.16$1.47 $1.73 $1.75$3.66
7ZoloftDepression $1.98$1.07 $.95 $.84$1.96
8ZyprexaMood disorder $5.27$3.39 $2.86 $2.63 N/A
9ClaritinAllergies $1.96$1.11 $.41 $.48 $.92

10PaxilDepression $2.22$1.13 $1.70 $.82$1.83

1 -- Ranked by sales during the first eight months of 1999, according to IMS Health, a consulting company.

GRAPHIC: GRAPHIC, b/w, Alejandro Gonzales, USA TODAY, Sources:IMS Health; drugstore.com; Ontario Ministry of Health; November Monthly Index of Medical Specialties, Haymarket Medical Ltd., London; Australia Health Insurance Commission; Farmacia Rio Grande, Ciudad Juarez, Mexico; USA TODAY research(Chart); PHOTO, color, Andy Sawyer, Tribune Newspapers; PHOTO, b/w, Raj Chawla, The Burlington Free Press; Traveling for medicine: Dorothy Carlson, 78, of Mesa, Ariz., headed for the first pharmacy she could find in Nogales, Mexico. Treatment she can afford: Ruthmary Jeffries, 75, of St. Albans, Vt., pays $15 a month to a Canadian pharmacy for her medication.

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LONG-TERM CARE

REVIEW™

$6.00 April 1999

FROM THE EDITOR

William H. Thomas, M.D., geriatrician, author, founder of the "Eden Alternative" approach to long-term care, advocate for change in eldercare, and winner of the America's Award, is planning a crusade.

With his wife and partner, Judy Meyers-Thomas, and their five children, this master storyteller will be touring North America to spread a refreshing, even radical, message about aging and the elderly.

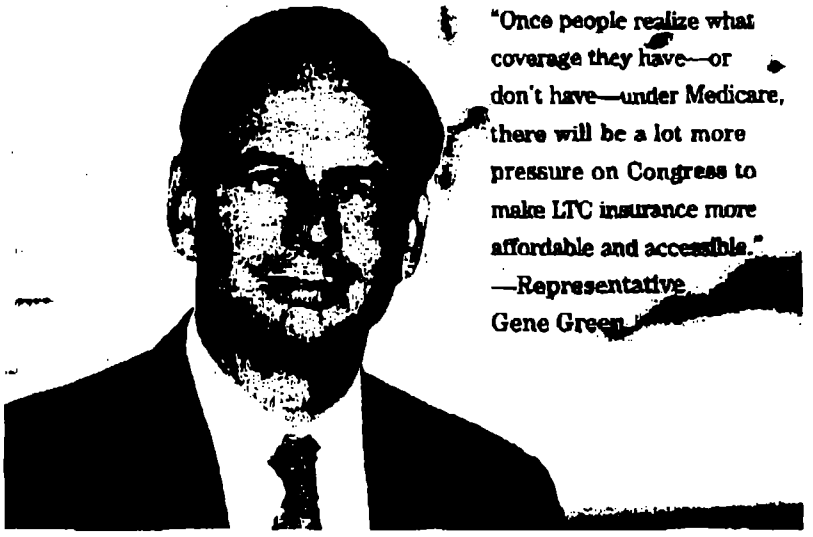
Trekking 10,000 miles in a 45-foot coach, the family will visit 25 cities in July. What a way to celebrate "The United Nations Year of the Older Adult"!

Dr. Thomas will share his teachings at public gatherings and meetings, topped off by a one-man theatrical performance of "Learning From Hannah." Based on his latest book, the show tells a story of love and adventure in an undiscovered country where elders are accorded respect and dignity.

Proceeds from each city performance will be donated to a local charity that helps the elderly. Watch for tour details from area sponsors or check this Web site: www.edenalt.com.

Martin K Bayne

Martin K. Bayne, Editor



"Once people realize what coverage they have—or don't have—under Medicare, there will be a lot more pressure on Congress to make LTC insurance more affordable and accessible."
—Representative Gene Green

EXCLUSIVE LTCR speaks with a long-term care insurance advocate and congressman who is sponsoring legislation to make this option more attractive—and affordable—for American consumers.

See page 4 for highlights of the interview.

Inside This Issue

Insurance Can Save LTC Financial Woes

Editor's note: In February, **LTCR** interviewed Representative Gene Green, a Texas legislator who serves as Deputy Whip and was recently appointed to the Democratic Caucus Steering and Policy Committee.

Q: Why do you feel there is a need to make LTC insurance more attractive to consumers?

A: Long-term care costs are simply too high and too few people have adequate insurance. The result is that as people age and need specialized care, they are forced to spend down their savings until they qualify for Medicaid. But with the high cost of LTC, it typically takes less than one year to spend what it took a lifetime to earn.

Unfortunately, most people do not consider LTC needs when planning for retirement. In fact, many falsely assume Medicare will cover their health needs indefinitely. Therefore, it is important to increase public awareness and education so people have accurate expectations when they or loved ones require LTC.

Q: President Clinton has expressed the need for a "bipartisan effort to tackle long-term health care" in the 106th session. Last year, a number of your colleagues introduced LTC bills and resolutions that never made it out of committee. Are you hopeful this session will be more productive?

A: Our legislative system was designed by our founding fathers to prevent fast and sweeping changes.

"Insurance is the best way to preempt financial problems caused by LTC needs, yet as baby boomers age, everyone is focusing on Medicare and Social Security."
—Representative Gene Green

This can be both good and bad—it prevents changes that could harm the country, but it also takes longer to pass needed reforms.

I am optimistic LTC has finally made its way to the national spotlight. Many members of Congress, both democrats and republicans, as well as President Clinton, have indicated they want to address this issue this year.

Q: What are your plans for this legislative session regarding long-term health care?

A: To make LTC insurance more affordable, and thus more attractive, I have introduced H.R. 145—the Health Insurance Tax Deductibility Act of 1999. This bill would allow individuals not only to deduct their costs of purchasing conventional health insurance for themselves and their families, but also their portion of LTC insurance premiums.

I believe this is too important for Congress to ignore, and I also will support other proposals that effectively help Americans purchase LTC insurance.

Q: If I handed you a megaphone, and you could speak to all Americans about long-term health care finances, what would you say?

A: Before LTC insurance becomes more common, I think it is critical that the American public have a better understanding of what will happen to them if they don't get it.

With every public health initiative or program, outreach and education are key. Once people realize what is at stake, and what coverage they have—or don't have—under Medicare, there will be a lot more pressure on Congress to make LTC insurance more affordable and accessible.

Q: Medicaid Estate Planning (MEP) creates adverse pressure on a health care system already weakened by myriad political, social, and financial challenges. Would you support legislation to curb MEP, thus encouraging private-sector financing of LTC costs through tax-qualified insurance programs?

A: I believe the private sector plays a critical role in meeting all the health care needs of the American people. Their role in LTC is no different.

AHCA
American Health Care Association

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Writer's Telephone: 202-898-2858
Writer's E-mail: byarwood@ahca.org

February 17, 1999

The Honorable Gene Green
U.S. House of Representatives
2429 Rayburn House Office Building
Washington, DC 20515-4329

Dear Congressman Green:

On behalf of the American Health Care Association, the nation's largest association of long term care providers, I am writing to express our strong support for your bill H.R. 145.

By providing for the phased-in, full deduction of the premium costs of "qualified" long term care insurance and medical care, H.R. 145 provides important tools and strong incentive for a greater number of Americans to take responsibility for providing for their own long term care needs. This legislation also enhances an individual's or a family's ability to plan for and ensure their retirement security.

H.R. 145 is a measure that will help protect an individual's retirement income and assets against the risk of needing long term care which averages $41,000 per year. Each person covered today with private long term care insurance is one less person who will be seeking government assistance tomorrow through the Federal and State Medicaid programs which are now struggling to meet the needs of our nation's rapidly aging population.

Congressman Green, we support H.R. 145 and commend your legislative efforts to encourage greater personal responsibility in long term care planning.

Sincerely,

Bruce Yarwood
Legislative Counsel

cc: Tom Sushs
Sandy Klein

Extension of Remarks

Wednesday, January 6, 1999

Congressman Gene Green

MR. GREEN. Mr. Speaker. Today I am reintroducing the Health Insurance Tax Deductibility Act of 1998. This bill is the same simple, common sense solution to a very complex and destructive problem in our society.

Since I came to Congress in 1992, we have debated health care reform and considered a wide range of proposals -- all designed to insure a greater number of Americans. When President Clinton signed the Health Insurance Portability and Accountability Act (HIPAA) into law in 1996, everyone said Congress had taken the first step towards ensuring access to health insurance to more individuals and families.

Unfortunately, a study completed last year by the General Accounting Office shows us this goal has not been achieved. Although HIPAA did expand access to health insurance, it did nothing to ensure that Americans can afford health insurance. And as the GAO study recognized, affordability has become the major hurdle for the American family to clear.

In the past, Congress has passed initiatives to encourage and assist people to get health insurance. We allow employers who sponsor health insurance for their employees to deduct the employer's share of the premium as a business expense. We allow self employed people to deduct a percentage of the health insurance premium they purchase. Yet we provide no assistance or incentive for individuals whose employers do not provide health insurance.

The Health Insurance Tax Deductibility Act of 1999 will do just this. Under this legislation, individuals will be able to deduct a portion -- linked to the deduction for the self insured -- of the money they pay for health and long-term care insurance. This proposal will make health insurance more affordable for individuals and their families, which in turn, will give American families greater piece of mind.

November 8, 1999

PRESCRIPTION DRUG EVENT

Date:	**Tuesday, November 9, 1999**
Time:	**11:00 a.m. -12:00 p.m.**
Location:	**Rayburn House Office Building**
	Room 2168
From:	**Chris Jennings**
	Devorah Adler
	Ann O'Leary

I. PURPOSE

To join House Democratic Leader Richard Gephardt, House Democratic Whip David Bonior, and Representatives Henry Waxman (D-CA), Pete Stark (D-CA) and Ronnie Shows (D-MS) in calling for Congressional action to address the problem of prescription drug costs for seniors.

The House will also be using the event to release a study of drug companies pricing practices and their impact on senior citizens without prescription drug coverage. The event will also allow the Democrats to announce their intent to collect signatures for a discharge petition.

II. BACKGROUND

As you know, in this year's State of the Union the President outlined his plan to modernize and strengthen the Medicare program. In June, he announced the specifics of the plan that included a proposal to establish a new voluntary Medicare "Part D" prescription drug benefit. Since the State of the Union address, there has been an enormous increase in interest in developing policies to address this issue. This is driven not only because it is impossible to defensibly reform Medicare without modernizing it to include at least some prescription drug coverage, but because this issue has become one of the highest priority domestic policy issues for the electorate.

It is clear, however, that the Congress will recess for the year without acting on any issue related to either prescription drug cost or coverage. The Democrats have a number of legislative proposals on the table and plan to spend the recess getting ready for the battle ahead in the next year. [Note: Interestingly, one of the reasons why the BBA provider give-back provisions have become so complicated to navigate through the Congress is that the Republican leadership fears that Democrats will offer prescription drug amendments to whatever provider give-back legislative vehicle is pending.]

President's Proposal

As a reminder, the President's drug benefit, in the context of broader reform, has a zero deductible and pays for half of all drug costs up to a $5,000 cap when fully implemented. It uses private sector purchasers to negotiate discounts for Medicare beneficiaries that are also accessible after the cap has been reached.

Legislative Proposals on the Hill

The Hill is tackling the prescription drug problem within three distinct areas: (1) expanding prescription drug coverage (2) reducing prices of prescription drugs (3) international drug parity.

Expanding Prescription Drug Coverage

Congressmen Stark and Dingell and Senators Kennedy and Rockefeller have introduced a more expensive and comprehensive but complicated prescription drug benefit. While promising front end and catastrophic coverage, it leaves seniors with drug costs of $1,500 to $3,200 exposed and vulnerable. With a 75 percent premium subsidy, our actuaries estimate that it costs nearly $300 billion over 10 years (compared to our $116 billion).

Reducing Prices of Prescription Drugs

Congressmen Allen, Waxman, Turner, and Berry have introduced legislation (the "Allen bill") that would require pharmacists serving seniors to provide them with access to the same discounts they provide to Federal and corporate purchasers. This policy is viewed by the drug industry as straight-up price controls, and this criticism has been validated by a number of businesses, insurers, and elite policy validators. Congressman Allen, a "New Democrat" from Maine, counters that this policy is not price controls, since the drug industry can choose the level of discounts it provides to large purchasers and thus the discount provided to Medicare beneficiaries through their local pharmacists. The bill, which has a broad based collection of Democratic sponsors (over 130 sponsors including Blue Dogs, New Dogs, and traditional liberals), is not going anywhere and has very few advocates in the Senate, but is attractive to many because there are no new Federal costs since it provides no new insurance coverage; rather, it simply requires access to discounts that are currently unavailable.

Congresswoman Thurman recently offered a version of the Allen bill during the Ways and Means markup of the BBA provider give-back legislation. It was rejected along party lines with subcommittee Chair Thomas arguing that this was the wrong vehicle to use for broad Medicare reform. (Parenthetically, Mr. Thomas does not appear to have problems with including GMNE reforms, which have nothing to do with the BBA and are harmful to New York teaching hospitals, in the package to submitted to the floor last week.)

International Drug Parity

Fairly recently, Congressman Sanders and Berry and Senators Dorgan and Wellstone introduced legislation permitting the re-importation of prescription drugs from Canada to pharmacies in the United States in order to access the discounts that Canadian pharmacists receive. The FDA has raised strong safety concerns about this legislation, but it can be cited as an example of the frustration members of Congress and the public at large are having with the price differentials between drugs sold in Canada and the United States, even though these medications were initially manufactured in this country.

Other Legislative Proposals

Numerous other prescription drug initiatives have either been unveiled or suggested by members of Congress. Senators Wyden and Snowe have introduced legislation to provide subsidies for HMOs and Medigap plans to offer prescription drug coverage. (We have criticized this legislation because it is a block grant approach that undermines Medicare's guarantee of coverage and does not provide for a workable fee-for-service benefit, thus making access to affordable prescription drugs impossible for millions of beneficiaries living in rural communities.)

At 10:00 a.m. just prior to your event, Senators Breaux and Frist will offer a prescription drug benefit in the context of broader Medicare reforms; at the time of the release of their plan, they had suggested a Medicaid benefit for beneficiaries up to 150 percent of the poverty level. (We have criticized this benefit as inadequate because over half of the seniors without prescription drug coverage have incomes over 150 percent of the poverty level.)

The Republican tax package included a tax deduction to offset the cost of prescription drug insurance for seniors. This proposal was widely criticized because the seniors who most need the drug benefit do not file taxes and would not be eligible for the tax deduction, and because the proposal does nothing to make affordable insurance more accessible.

Recommendation

We would advise that you use all of these bills as illustrations of the importance of moving ahead on the prescription drug cost and coverage issue. Rather than endorsing any approach – other than the President's – we would recommend that you highlight these initiatives in that context. They can be used to underscore the numerous problems Americans face in accessing affordable prescription drugs, as well as to highlight the unwillingness of this Congress to act. The Republican leadership continues to quietly support the status quo and not move any of the bills designed to address this challenge forward.

III. PARTICIPANTS

Speaking Program

Minority Leader Richard Gephardt
Representative Henry Waxman (D-CA)
First Lady
Ed Dillon, pharmacist
Representative Bonior (D-MI), House Democratic
Rep. Ronnie Shows (D-MS)
Rep. Pete Stark (D-CA)

Bios

Edward F. Dillon is a registered pharmacist who has been practicing in a community retail pharmacy in Maryland for over 25 years. His pharmacy practice emphasizes patient contact and counseling and working with other professionals to optimize patient care.

Audience

The audience will include 38 senior citizens. They come from 3 different senior groups - Older Women's League, National Committee to Preserve Social Security and Medicare, and the National Council of Senior Citizens.

Press and Hill staff will also be in the audience.

IV. SEQUENCE OF EVENTS

Speaking Program

- Gephardt will open by welcoming you and give the broad overview of the need for
- Representative Henry Waxman (D-CA) will release the investigative study that was conducted in over 100 congressional districts examining the price differentials between the manufactures, preferred customers, seniors, and international comparisons. The studies find that senior citizens who pay for their own drugs pay, on average, 134% more.
- You will then outline the problem, applaud the Democrats for putting forward solutions, call for the Majority to act, and introduce the pharmacist.
- Ed Dillon, pharmacist, will talk about problems seniors face every day in accessing affordable prescription drugs
- Representative Bonior (D-MI), House Democratic Whip, will announce the intent to file a discharge petition for the Allen Bill and the Stark bill.
- Rep. Ronnie Shows (D-MS) will talk about the importance of the Allen bill and the need for lower prices.
- Rep. Pete Stark (D-CA) will talk about the Stark bill and the need for comprehensive coverage.
- Gephardt will close the event and will excuse you before they take press questions.

V. PRESS PLAN

- Open press
- No Q&As

VI. REMARKS

- Talking Points Attached

certain set of standards and will guarantee quality control. They will provide information to the Medicare beneficiaries in order for them to make a decision whether it's the best plan for them to choose from."

Breaux also talked about including a prescription drug benefit, saying, "In addition, we, for the first time, can adopt a prescription drug program, which will be available to all Medicare beneficiaries. Now how does that work? Well, we take what we did in the Breaux-Thomas commission recommendation and say that if all those who are below 135 percent of poverty – which is about $11,000 a year – will be able to receive as our option prescription drug plan at no charge, no premium for the Medicare benefits as well as no premium for the prescription drug program. But any Medicare beneficiary between 135 percent of poverty and 150 percent of poverty, we give them some help. We give them a discount on purchasing a prescription drug program. That discount ranges from 50 percent of the cost of the plan, phase them down to 25 percent of the cost of the program, which will kick in when they reach 150 percent of the level of poverty." Breaux continued, "For all those beneficiaries over 150 percent of poverty, our plan continues to give them a prescription drug plan that they can buy at their option – they're not required to buy it – and we will continue to give them a discount. And it'll give people a discount, the hospitals, the doctors, the nursing homes, the home health care and everything else. And that discount, for instance, in a package which we require an $800 actuarial value for a prescription drug package. The average person in this country as a Medicare beneficiary spends about $600 a year. We give them $800 actuarial value – $800 in the year 2000 as a value of their prescription drug program. If they get it at 25 percent discount, in effect they would be paying the premium on a package worth $600 instead of $800...package."

- **Democrats Lobby For Prescription Drug Plan For Seniors.** First Lady Hillary Rodham Clinton, along with House Minority Leader Richard Gephardt and other House Democrats today held a press conference in support of a prescription drug plan for senior citizens. Assailing House Republicans, Gephardt said, "Our efforts have been bottled up and frankly buried in a conference committee by the Republican leadership that puts the needs of insurance companies ahead of the needs of America's families. A narrow extreme view in Congress too often stands in the way of real progress, preventing us from enacting the strong yet sensible reforms that are necessary to ensure that the quality of health care that Americans receive goes up, not down. Seniors are feeling the impact of the status quo on their pocketbook and on their health. Medicare has served seniors well over the last three decades. This program really works. But changes in the marketplace are pricing quality health care out of the reach of more and more seniors. A Medicare prescription drug plan and help for seniors in obtaining the best price for their drugs are now an absolute necessity to millions of seniors who are currently put in the position of choosing food or medicine or rent or medicine or heat or medicine. The pharmaceutical industry and their allies in the Republican leadership are committed to making sure that this legislation never sees the light of day, but Democrats are not going to accept their obstructionism." Gephardt added, "We won't stop until we break down the walls of resistance and succeed in bringing a prescription drug plan up for a debate in the next session next year in Congress. We forced HMO reform onto the agenda. And believe me, it wouldn't be there without these members and Democrats like them and some Republicans who said we've got to have this reform. And we forced it on with a discharge petition, and we're going to do the same thing next year for prescription drugs."

  The First Lady said today, "We come together today for a very simple reason: Millions of older Americans cannot afford the prescription drugs they need to live their lives in dignity. ... Many others...have joined with the Democrats in Congress to make as clear as we can that this is an issue that is not going away, that it is an issue that will be with us this year and next year. And that's because the facts are so compelling. More than two-thirds of all Medicare beneficiaries have no coverage or inadequate Medigap coverage. This is not just a problem for low-income beneficiaries. Over half of Medicare beneficiaries without drug coverage have incomes greater than 150 percent of the poverty level. And the problem is getting worse. The number of firms offering health insurance for retirees has dropped 25 percent over the past four years. And Medigap premiums – which increase with age – have been rising at double-digit rates. Now the drug industry can buy all the ads they want to provide

cover for their inaction, but the one thing their ads cannot deny is that the problem is real and the time for action is now. I wish these companies running the ads would respond to the kind of letters that I receive and the president receives and I know every member of Congress standing here receives." Mrs. Clinton added, "Now the president in his comprehensive Medicare reform plan has proposed a prescription drug benefit that has no deductible and pays for half of all drug costs up to $5,000. It uses private sector buyers to negotiate discounts for Medicare beneficiaries, including those who have exceeded the cap. It is a sound plan. And the more I travel and speak with Americans about their hopes and concerns, the more I understand that the Republicans in Congress and Republicans throughout the country just don't get it. You know, the Republican-led Congress, as Dick said, can pass a huge tax scheme that Americans don't want and that would undermine our economy, but for some reason, they put off even having a debate over prescription drug cost and coverage. Providing access to affordable prescription drugs should not be a Democratic or Republican issue. This is an American issue. And I don't know what the Republican leadership is afraid of. The time for waiting has ended and the time for debating has come. And I know that if we follow the lead of the Democrats gathered here today, we will succeed in meeting this challenge, and we cannot afford to fail."

- **Flap Erupts Over Financial Services Signing Ceremony.** Congressional GOP sources are talking this morning about an apparent dispute between Treasury Secretary Lawrence Summers and NEC Chairman Gene Sperling over whether or not to hold a signing ceremony on the bipartisan financial services modernization bill. The flap arose over political considerations, according to the GOP sources, who say Sperling does not want a high-profile, bipartisan event while contentious budget negotiations continue. Summers, who personally negotiated the final details of the bill in several late-night sessions, is said to be pushing for a ceremony highlighting Treasury's new role in the modern financial world.

  A White House official this morning downplayed talk of a flap between the two Administration figures, and said Sperling does not object to a ceremony. Asked about a White House request that the Senate hold the bill one day so the President could decide whether or not to have a signing ceremony, the official said the Senate sent the bill to the White House this morning. Any request for a delay, the official said, would have been to give White House planners more time to prepare for an event. The official noted that the President has a major international trip on the horizon and the 10-day clock has now started ticking, giving White House staff little time to organize an event if it is so inclined.

- **NAM Chair Discusses Manufacturing's Role In Technology.** At a speech to the National Press Club this morning, National Association of Manufacturers Chairman James H. Keyes said NAM "will continue to push for an improved employment visa program with higher caps for highly-skilled foreign workers, a permanent extension of the R&D tax credit, reform of patent law, modernization of export control laws on all high tech products, and policies that promote electronic commerce by allowing user choice in encryption and by making electronic signatures legally valid." Keyes continued, "Technological advances account for nearly 40 percent of our long-term economic growth. And manufacturing is a leader on the technology front. In roughly the last decade, manufacturing growth has significantly exceeded the growth of the economy at large and of every other economic sector. From 1992 through 1997, GDP in manufacturing grew by over five percent a year, compared to slightly over three percent growth in the overall economy. As a result, manufacturing has accounted for one-third of US economic growth over the past decade. The fact that manufacturing employees contribute only about 18 percent of the total hours Americans work every year underscores how manufacturing has become the nation's engine for productivity."

- **Energy Information Administration Releases Energy Outlook.** At a news conference this morning, Jay Hakes, Administrator of the Energy Information Administration, presented the Annual Energy Outlook 2000 (AEO2000). According to an EIA fact sheet, the report reflects the restructuring of US electricity markets and the shift to increased competition by assuming changes in the financial structure of the industry. The provisions of the California legislation regarding stranded cost recovery and price caps are included. In other regions, stranded cost recovery is assumed to be phased out by 2008.

  Among the report's findings:

FAX COVER

COMMITTEE ON GOVERNMENT REFORM

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DATE: 11-8-99

TO: Anne O'Leary 456-2878

FROM: Karen Lightfoot

SUBJECT: Bio of Pharmacist for Tomorrow's Event

NO. OF PAGES 3
(INCLUDING COVER SHEET)

COMMENT:

IF THERE IS A PROBLEM WITH THIS TRANSMITTAL, PLEASE CALL OFFICE A.S.A.P.

Edward F.Dillon R.Ph.

5603 Ruatan Street
Berwyn Heights MD 20740
(301) 220-0230

Overview

A Registered Pharmacist practicing in a community retail Pharmacy for over 25 years. Active in local Pharmacy organizations, Pharmacy co-ops and other inter-professional groups. Developed a Pharmacy practice emphasizing Patient contact and counseling and working with other professionals to optimize patient care. Actively participates in programs with Dialysis Clinics, Hospices, Visiting Nurses and Diabetic Specialists. Partner in a Medical Equipment Company serving the Greater Metropolitan Washington area. Helped develop and co-ordinate an exclusive contract with the D.C.Care Consortium to provide Pharmacy Services for HIV patients for 1994-96. A principal in developing and implementing a current HIV-AIDS program, coordinating the purchase of Pharmaceuticals thru the DC Gen Hospital trust and the dispensing of those products at the local level on a fee for service only basis. A developer of, and a provider in, the OASIS program, providing a network for Methadone Maintenance on a capitated basis for out-patients. Co-Ordinated the program to provide the exclusive distribution mechanism for Crixivan to D.C. ADAP clients. Currently President of Mid-Atlantic Care Inc, a Pharmacy Group to providing Enhanced Patient Counseling and Disease State Management in the Washington D.C. area.

Professional Education

Brooklyn College of Pharmacy
Bachelor of Science 1963
Major: Pharmacy
NARD Certified Fitter 1988
NARD Certified Diabetic Specialist 1992
Various Professional Seminars and Certificates
Registered Pharmacist in Washington DC and New York State.

Professional Experience

Pharmacy Intern - Stevens Pharmacy - Brooklyn N.Y. 1961 - 1963
Registered Pharmacist - Stevens Pharmacy Brooklyn N.Y. 1963 - 1965
Staff Pharmacist - Head of Ward Operations - Walter Reed Army Hospital 1965-1967
Head Pharmacist - Grubbs Pharmacy 1967 - 1969
Owner-Pharmacist - Grubbs Care Pharmacy 1970 to Present
Partner - Pharmacist - Embassy Care Drug Center 1984 - 1992

Committees/Honors/Awards

Board Member - Care Drug Centers 1981 to 1999
Vice-President - Care Drug Centers 1987-1989
President Care Drug Centers - 1989-1997
District of Columbia Innovative Pharmacist of the Year Award 1998
Care Drug Centers Presidents Award 1998
Assistant Professor Howard University 1998-1999
Member Hospice Care of D.C. Professional Advisory Committee 1994-1999
Member Board of Directors Washington Wholesale Drug Exchange 1972
Member District of Columbia ADAP Pharmacy Development Committee
Member Agency HIV-AIDS/Care Drug Center Program Development Committee 1996
Member Washington - District of Columbia Pharmacy Medicaid Task Force 1995-1997
Howard University Preceptor 1997-1999
Howard University Lecturer on Pharmacy Management 1998-1999
Member Merck Crixivan Retail Distribution Task Force 1996-1997
Member Board of Directors Capitol Hill Association of Merchants & Professionals
Member Hospice Care of D.C. Pain Management Committee
Guest Lecturer at George Washington University 1994-1999
Member Hospice Alliance of Washington Advisory Committee
Member of Merck National Community Pharmacy Panel 1996-1998
Speaker Midwest Primary Health Care Annual Conference 1998
Volunteer Staff Pharmacist Whitman-Walker Clinic 1996-1997
Member Mercks Special Crixivan Committee 1996-1997

OVERVIEW:
PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21st CENTURY

On June 29, 1999, President Clinton unveiled his plan to modernize and strengthen the Medicare program to prepare it for the health, demographic, and financing challenges it faces in the 21st century. This historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the estimated life of the Medicare Trust Fund until at least 2027. The President called on the Congress to work with him to reach a bipartisan consensus on needed reforms this year.

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. Since taking office, President Clinton has worked to pass and implement Medicare reforms that, coupled with the strong economy and the Administration's aggressive anti-fraud and abuse enforcement efforts, have saved hundreds of billions of dollars and helped to extend the life of the Medicare Trust Fund from 1999 to 2015. Building on this success, his plan:

- **Gives traditional Medicare new private sector purchasing and quality improvement tools.** The President's proposal would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs. It would provide new or broader authority for competitive pricing within the existing Medicare program, incentives for beneficiaries to use physicians who provide high quality care at reasonable costs, coordinating care for beneficiaries with chronic illnesses, and other best-practice private sector purchasing mechanisms. Savings: $25 billion over the next 10 years.

- **Extends competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" while maintaining a viable traditional program.** The Competitive Defined Benefit (CDB) proposal would, for the first time, inject true price competition among managed care plans into Medicare. Plans would be paid for covering Medicare's defined benefits, including the new drug benefit, and would compete over cost and quality. Price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. The CDB would do so by reducing beneficiaries' premium by 75 cents of every dollar of savings that result from choosing plans that cost less than traditional Medicare. Beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums. Savings: $8 billion over the next 10 years, starting in 2003.

- **Constrains out-year program growth, but more moderately than the Balanced Budget Act (BBA) of 1997.** To ensure that program growth does not significantly increase after most of the Medicare provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to excessive growth rates, but are more modest than those included in the BBA. These proposals along with the modernization of traditional Medicare would reduce average annual Medicare spending growth from an estimated 4.9 percent to 4.3 percent per beneficiary between 2002 and 2009. Savings: $39 billion over next 10 years (including interactions and premium offsets).

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- **Takes administrative and legislative action to smooth out the BBA provider payment reductions.** The proposal includes a 7.5 billion "quality assurance fund" to smooth out provisions in the BBA that may be affecting Medicare beneficiaries' access to quality services. The Administration will work with Congress, outside groups, and experts to identify real access problems and the appropriate policy solutions. The plan also includes a number of administrative actions to moderate the impact of the BBA on some health care providers' ability to deliver quality services to beneficiaries. Finally, it contains a legislative proposal to better target disproportionate share hospitals. Cost: $7.5 billion over 10 years.

MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President's plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drugs and preventive services that have become essential elements of high-quality medicine. It also would address excess utilization and waste associated with first-dollar coverage of clinical lab services and would reform the current Medigap market. Finally, it integrates the FY 2000 President's Budget Medicare Buy-In proposal to provide an affordable coverage option for vulnerable Americans between the ages of 55 and 65. Specifically, his plan:

- **Establishes a new voluntary Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries.** The historic outpatient prescription drug benefit would:

  - Have no deductible and pay for half of the beneficiary's drug costs from the first prescription filled each year up to $5,000 in spending ($2,500 in Medicare payments) when fully phased-in by 2008.

  - Ensure beneficiaries a price discount similar to that offered by many employer-sponsored plans for each prescription purchased – even after the $5,000 limit is reached.

  - Cost about $24 per month beginning in 2002 (when the coverage is capped at $2,000 in spending) and $44 per month when fully phased-in by 2008. (This is one-half to one-third of the typical cost of private Medigap premiums.)

  - Ensure that beneficiaries with incomes below 135 percent of poverty ($11,000/$15,000 single/ couples) would not pay premiums or cost sharing for Medicare drug coverage. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well. The Federal government would assume all of the costs of this benefit for those above poverty.

  - Provide financial incentives for employers to develop and retain their retiree health coverage if it provides a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. This approach would save money for the program because the subsidy given would be generous enough for employers to maintain coverage yet lower than the Medicare subsidies for traditional participants.

  Most Medicare beneficiaries will probably choose this new prescription drug option because of its attractiveness and affordability. Because older and disabled Americans rely so heavily on medications, we estimate that about 31 million beneficiaries would benefit from this coverage each year. Cost: $118 billion over the next 10 years, beginning in 2002.

- **Eliminates all cost sharing for all preventive benefits in Medicare and institutes a major health promotion education campaign.** This proposal would cost $3 billion over 10 years and would:

  - Eliminate existing copayments and the deductible for preventive service covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.

  - Initiate a three-year demonstration project to provide smoking cessation services to Medicare beneficiaries.

  - Launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.

- **Rationalizes cost sharing.** To help pay for the new prescription drug and preventive benefits, the President's plan would save $11 billion over 10 years by rationalizing the current cost sharing requirements for Medicare by:

  - Adding a 20 percent copayment for clinical laboratory services. The modest lab copayment would help prevent overuse, and reduce fraud.

  - Indexing the Part B deductible for inflation. The Part B deductible index would guard against the program assuming a growing amount of Part B costs because, over time, inflation decreases the amount of the deductible in real terms. Compared to average annual Part B per capita costs, the deductible has fallen from 28 percent in 1967 to about 3 percent in 2000.

- **Reforms Medigap.** The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's proposals to strengthen Medicare; (2) directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare, including a Medigap-like plan offered by the traditional Medicare program; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expanding the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).

- **Includes the President's Medicare Buy-In proposal.** The plan includes the President's proposal to offer American between the ages of 62-65 without access to employer-based insurance the choice to buy into the Medicare program for approximately $300 per month if they agree to pay a small additional monthly payment once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately $400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment. The $1.4 billion cost over 5 years is offset in the President's FY 2000 budget.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21st CENTURY. The President's Medicare plan would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be sufficient to address the fact that the elderly population will double from almost 40 million today to 80 million over the next three decades. Every respected expert in the nation recognizes that additional financing will be necessary to maintain basic services and quality for any length of time. Because of this and his strong belief that the baby boom generation should not pass along its inevitable Medicare financing crisis to its children, the President has proposed that a significant portion of the surplus be dedicated to strengthening the program. Specifically, his plan:

- **Extends the life of the ~~Trust Fund~~ until at least 2027.** Dedicating 15 percent of the surplus ($794 billion over 15 years) to Medicare not only contributes toward extending the estimated financial health of the Trust Fund through 2027, but it will also lessen the need for future excessive cuts and radical restructuring that would be inevitable in the absence of these resources.

- **Responsibly finances the new prescription drug benefit through savings and a modest amount from the surplus.** The new drug benefit would cost about $118 billion over 10 years. Its budgetary impact would be fully offset by:

  - Savings from competition and efficiency. About 60 percent of the $118 billion Federal cost of the new Medicare prescription drug benefit would be offset through these savings.

  - Dedicating a small fraction of the surplus. About $45.5 billion of the surplus allocated to Medicare would be used to help finance the benefit. To put this amount in context, it is:

    - Less than one eighth of the amount of the surplus dedicated for Medicare (2 percent of the entire surplus); and

    - Less than the reduction in the Medicare baseline spending between January and June, 1999.

Policy experts advising the Congress (MedPAC, CBO, and the Medicare Trustees) have consistently stated their belief that much of the recent decline in Medicare spending beyond initial projections is due to our success creating a strong economy and in combating fraud and waste. Reinvesting the savings that can be reasonably attributed to our anti-fraud and waste activities into a new prescription drug benefit is completely consistent with the past actions of the Congress and the Administration utilizing such savings for programmatic improvements.

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21st CENTURY

- **Goals for Reform**:
  - Make Medicare More Competitive and Efficient
  - Modernize Medicare's Benefits
  - Strengthen Medicare's Financing for the 21st Century

Reduces Medicare spending for current services by $72 billion over 10 years. About half of these savings come from innovative proposals to adopt successful private sector tools and competition. As a result of these policies, Medicare growth per beneficiary from 2003 to 2009 would slow from 4.9 percent to 4.3 percent.

- **Adds an optional prescription drug benefit.** This benefit would cost $118 billion over 10 years. This cost is only about 5 percent of total Medicare spending in 2009 (net of premiums).

  - Over 60 percent of the costs are offset by the proposal's savings.

  - The remaining $45.5 billion would come from the Medicare allocation of the surplus. This amount is one-eighth of the $374 billion over 10 years dedicated to Medicare, and less than 2 percent of the overall surplus.

- **Extends the life of the Medicare Trust Fund to at least 2027.** The President's plan would dedicate 15 percent of the surplus to strengthen Medicare. This amount, when combined with the offset for the drug benefit and Part A savings, would extend the estimated life of the Medicare Trust Fund for a quarter century from now, through at least 2027.

DRAFT: THE PRESIDENT'S MEDICARE PRESCRIPTION DRUG BENEFIT
Medicare Beneficiaries Without Drug Coverage

- **Nearly 15 million Medicare beneficiaries have no prescription drug coverage.** The lack of drug coverage is not just a problem for low-income beneficiaries.

  ° About 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty (about $16,000 for a single, $22,000 for a couple).

  ° As the elderly age, finding and affording drug coverage becomes an even greater problem. Over 40 percent of beneficiaries over age 85 have no coverage and are charged much higher premiums or are excluded altogether from coverage because of health status.

  ° Nearly half (48 percent) of rural beneficiaries lack insurance coverage for drugs.

  ° Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs.

  ° Lack of insurance means no access to discounts -- beneficiaries pay retail prices for drugs which can be two to three times higher than what people with insurance pay.

- **Prescription drug coverage is unstable, expensive and declining**. Only about half of the over 60 percent of beneficiaries with coverage have it from the private sector. This coverage is not guaranteed, often is or becomes expensive, and can be dropped in some instances.

  ° Employer-sponsored retiree health insurance, the most generous type of drug coverage for beneficiaries, covers less than 30 percent of beneficiaries, but is declining rapidly. Between 1993 and 1998, the percent of large firms offering retiree health benefits for Medicare eligibles dropped 20 percent. This trend was more pronounced among employers with greater than 5,000 employees, over a fourth of whom dropped coverage.

  ° Medigap, the standardized private insurance supplement for Medicare, covers about 8 percent of beneficiaries. Its drug benefit (offered in some of its plans) has a $250 deductible, 50 percent coinsurance, and a cap on benefits spending of $1,250 or $3,000. Premiums are almost always underwritten, meaning that premiums can be significnatly higher for older, sicker populations of seniors. The premium for a plan with drug coverage is typically $90 more per month than a plan without drug coverage. Medigap premiums have been rising at double-digit inflation and coverage has been declining.

  ° Medicare managed care: Less than 10 percent of beneficiaries get drug coverage by joining Medicare managed care plans, which use drug coverage to attract beneficiaries. This coverage typically has no deductibles and relatively low copays, but 55 percent limit the amount that they pay for benefits -- about 65 percent of these plans have limits of $1,000 or less. Reports suggest that benefits are likely to decline in the future. Already,

11 million beneficiaries lack access to managed care.

Prescription Drugs are Especially Important to Medicare Beneficiaries

- **The elderly and people with disabilities are most reliant on prescription drugs.** Not only do the elderly and people with disabilities experience greater health problems, but these health problems are typically chronic diseases like hypertension, diabetes or arthritis that can be managed through medications. As a result, over 85 percent of Medicare beneficiaries use at least one prescription drug annually. The elderly's per capita spending on drugs is over three times higher than that of non-elderly adults. While only 12 percent of the population, the elderly account for 33 percent of drug spending.

- **Many beneficiaries need drugs but do not use them because they have no or inadequate insurance.** Most research has found that drug coverage influences use of needed drugs:

    - Decreased use of needed medications. Elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited. Many elderly must choose between prescriptions and other basic household needs.

    - Increased nursing home use. Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes.

    - Less protection against drug complications. Even though the elderly and disabled take more prescription drugs and have more complex medical problems, Medicare beneficiaries without coverage do not benefit from drug management. This could lead to adverse drug reactions, inappropriate use of drugs, or discontinuation of needed drugs.

- **Medicare beneficiaries' spending on prescription drugs is high.** In 1997, spending on prescription drugs accounted for 16 percent of total out-of-pocket medical expenditures by Medicare fee-for-service beneficiaries, higher than any other single spending category except payments for Medicare Part B and supplemental premiums. Over one-third of Medicare beneficiaries 30 percent pay more than $1,000 each year for prescription drugs. Notably, out-of-pocket spending for drugs is growing more rapidly than any other type of medical expenditure by the elderly.

- **Drug spending is a larger financial burden**. Elderly without private insurance for drugs spend about twice as much out-of-pocket for drugs than those with drug coverage. This burden is on average 35 percent higher for rural than urban elderly since they are less likely to have coverage for drugs. Women's average out-of-pocket costs as a percent of income is 20 percent higher than men because many are widowed, have lower income, and are disproportionately chronically ill.

- **Elderly without coverage pay higher prices.** Because they do not benefit from drug purchasing programs, Medicare beneficiaries without drug coverage pay prices that are at least 15-30 percent higher than large HMOs and employers. One study found that, for the 10

most prescribed drugs, seniors are often charged twice as much as other payers.

Medicare Prescription Drug Benefit

The President's plan to modernize Medicare would include a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002. This benefit would cost about $118 billion over 10 years. It would be fully offset, primarily through savings and efficiencies in Medicare and, to a small degree, from the surplus amount dedicated to Medicare.

- **Meaningful coverage**. Beginning in 2002, beneficiaries would have the option of participating in the new Medicare Part D program. It would have:

  - No deductible – coverage begins with the first prescription filled and
  - 50 percent coinsurance, with access to discounts negotiated by private pharmacy managers after the limit is reached.

  The benefit would be limited to $5,000 in costs ($2,500 in Medicare payments) in 2008. It would phase it a $2,000 for 2002-03; $3,000 for 2004-05; $4,000 for 2006-07; and $5,000 in 2008 (indexed to inflation in subsequent years).

- **Affordable premiums.** Beneficiaries who opt for Part D would a pay separate premium for Medicare Part D -- an estimated $24 per month in 2002, and $44 per month in 2008, when fully implemented. This premium represents 50 percent of program costs. Enrollment would be optional and would occur, after an initial open enrollment for all beneficiaries, when a beneficiary becomes eligible for the program or when they transition out of employer-based coverage. Premiums would be deducted from Social Security checks.

  - **Low-income protections.** Beneficiaries with income up to 150 percent of poverty ($17,000 for a couple) would pay no Part D premium. Those with income below 135 percent of poverty ($15,000 for couples) would pay no premiums or cost sharing. This assistance would administered through Medicaid, with the Federal government assuming all of the premium and cost sharing costs for beneficiaries with incomes above poverty.

- **Private management.** Beneficiaries in managed care plans would continue to receive their benefit through their plan. For enrollees in the traditional program, Medicare would contract out with numerous private pharmacy benefit managers (PBMs) or similar entities. Medicare would use competitive bidding to award contracts for drug management. The private managers would use the latest, effective cost containment tools, drug utilization review programs, and meet quality and consumer access standards. No price controls would be imposed.

- **Incentives to develop and retain retiree coverage.** Employers that choose to offer or continue retiree drug coverage would be provided a financial incentive to do so.

PRESIDENT CLINTON HIGHLIGHTS MODERNIZED MEDICARE BENEFITS
A New Prescription Drug Benefit and Cost Sharing Protections for Preventive Services
June 30, 1999

Today, President Clinton met with seniors at the Chicago Cultural Center to discuss the importance of modernizing the Medicare benefit package to include a long-overdue prescription drug benefit and eliminate all cost sharing barriers for preventive care. As he summarized his plan to strengthen and modernize the Medicare program, the President emphasized that affordable prescription drug and preventive services have become essential elements of high-quality medicine. At this event, the President heard firsthand about the difficult choices and financial burdens seniors face when they do not have prescription drug coverage.

MEDICARE'S BENEFITS NEED TO BE MODERNIZED. Prescription drugs and preventive care have become central to modern medicine.

- **Millions of beneficiaries have no prescription drug coverage and millions more are at risk of losing coverage.** Nearly 15 million Medicare beneficiaries have no prescription drug coverage. And, millions more are at risk of losing coverage or have inadequate, expensive coverage. Lack of drug coverage is not just a problem for low-income beneficiaries; about 40 percent of beneficiaries without drug coverage have incomes above 200 percent of the poverty level (about $16,000 for a single, $22,000 for a couple). Nearly one in three of non-elderly Medicare beneficiaries, almost half of rural beneficiaries, and about 41 percent of beneficiaries older than the age of 85 do not have coverage for prescription drugs.

- **Current prescription drug coverage is unstable and declining.** About 37 percent of Medicare beneficiaries had private employer-based or Medigap insurance for drug coverage in 1995. Both sources of coverage have been declining as the cost of coverage rises. The number of firms offering retiree health insurance coverage dropped by 20 percent between 1993 and 1997, and Medigap premiums have been rising at double-digit inflation.

- **Medicare managed care plans have limited coverage and are not accessible to millions of the elderly.** While Medicare managed care plans usually offer some drug coverage, it is typically limited (eg, $,1000 cap). In addition, 11 million beneficiaries, who disproportionately reside in rural areas, have no access to managed care plans.

- **Opponents arguments against a prescription drug benefit that is available to all beneficiaries resembles the opposition to the enactment of Medicare.** Although 56 percent of the elderly had insurance before Medicare, this coverage was expensive, inadequate, and unreliable – much like drug coverage today. Medicare would not have been created if this "coverage" was considered acceptable.

- **Preventive benefits are a necessary part of modern health care.** According to recent studies, Medicare preventive services are underutilized. For example, studies indicated that only one in four women in their sixties are tested as recommended for breast cancer. In the first two years that Medicare covered screening mammographies, only 14 percent of eligible women without supplemental insurance received a mammogram.

The President's plan to modernize Medicare's benefit package addresses these critical issues by:

MODERNIZING MEDICARE'S BENEFITS TO INCLUDE A NEW PRESCRIPTION DRUG BENEFIT. The President's plan includes a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high quality prescription drug coverage beginning in 2002. This new benefit would provide:

- **Meaningful coverage that is available to all beneficiaries.** Medicare would cover half of drug costs from the first prescription up to $5,000 in spending per year ($2,500 in plan payments). The spending limit would be phased in from 2002 to 2008 and, in subsequent years, adjusted for inflation. Beneficiaries would have access to discounts negotiated by private managers. For the nearly 15 million beneficiaries who have absolutely no coverage, it would provide significant financial relief. For the several million beneficiaries who rely on Medigap or Medicare managed care, this benefit would ensure that their coverage will always be there, without excessive rate increases or reductions in the generosity of the benefit.

- **Affordable premiums.** Beneficiaries would pay separate premium for Medicare Part D -- an estimated $24 per month in 2002, and $44 per month in 2008, when fully implemented. Cost sharing protections for low-income beneficiaries would be expanded.

- **Low income protections.** Beneficiaries with incomes up to 135 percent of poverty ($11,000 for singles, $15,000 for couples) would pay no premiums or cost sharing, with the premium subsidy phased out from 135 to 150 percent of poverty. The Federal government would pay for all of the costs associated with beneficiaries with incomes above poverty.

- **Private management.** Beneficiaries in managed care would be covered through their plan. For the rest, Medicare would contract out with numerous private pharmacy benefit managers (PBMs) or similar entities to manage the benefit. This partnership would provide beneficiaries with the same high quality benefits they expect from Medicare while allowing for more flexibility and innovation in program management over time. No price controls would be used.

IMPROVING PREVENTIVE BENEFITS AND ELIMINATING COST SHARING. This proposal, which costs $3 billion over 10 years, would take a number of steps to make preventive services more affordable as well as to raise awareness of services. It would:

- **Eliminate all existing preventive services cost sharing.** Eliminate existing copayments and the deductible for every preventive service covered by Medicare, including hepatitis B, colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.

- **Launch a smoking cessation demonstration project.** Initiate a three-year demonstration project to provide cost-effective smoking cessation services to Medicare beneficiaries.

- **Create a new health promotion education campaign.** This new, nationwide health promotion education campaign would be targeted to all Americans over the age of 50.

DISTURBING TRUTHS AND DANGEROUS TRENDS:

The Facts About Medicare Beneficiaries and Prescription Drug Coverage

National Economic Council
Domestic Policy Council

July 22, 1999

DISTURBING TRUTHS AND DANGEROUS TRENDS:
The Facts About Medicare Beneficiaries and Prescription Drug

Table of Contents

OVERVIEW

DISTURBING TRUTHS AND DANGEROUS TRENDS:
The Facts About Medicare Beneficiaries and Prescription Drug

This report describes the inadequate and unstable nature of the prescription drug coverage currently available to Medicare beneficiaries. Prescription drugs have never been more important, but the people who rely on them most – the elderly and people with disabilities – increasingly find themselves uninsured or with coverage that is becoming more expensive and less meaningful. This report shows that the accessing essential prescription drugs is not only a problem for the millions of Medicare beneficiaries without any insurance – it is an increasing challenge for beneficiaries who have coverage. Key findings of the report include:

- **Prescription drug coverage is good medicine**.

  ° Part of modern medicine. Prescription drugs serve as complements to medical procedures, such as anti-coagulants, used with heart valve replacement surgery; substitutes for surgery, such as lipid lowering drugs that reduce the need for bypass surgery; and new treatments where there previously were none, such as medications used to manage Parkinson's disease. In addition, as our understanding of genetics grows, the possibility for breakthrough pharmaceutical and biotechnology will increase exponentially.

  ° Medicare beneficiaries are particularly reliant on prescription drugs. Not only do the elderly and people with disabilities have more problems with their health, but these problems tend to include conditions that respond to drug therapy. Not surprisingly, about 85 percent of beneficiaries fill at least one prescription a year for such conditions as osteoporosis, hypertension, myocardial infarction (heart attacks), diabetes, and depression.

  ° The lack of drug coverage has led to inappropriate use of medications which can result in increased costs and unnecessary institutionalization. Recent research has determined that being uninsured leads to significant declines in the use of necessary medications. The consequence of inappropriate and underutilization of prescription drugs has also been found to double the likelihood that low-income beneficiaries entering nursing homes. One study concluded that drug-related hospitalization accounted for 6.4 percent of all admissions of the over 65 population and estimated that over three-fourths of these admissions could have been avoided with proper use of necessary medications.

- **About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drug coverage.**

  ° Only one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage.

  ° Over three-fourths of beneficiaries lack decent, dependable. At least one-third of Medicare beneficiaries have no drug coverage at all. Another 8 percent purchase

Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries. About 17 percent have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable. Drug coverage in managed care can only be assured if it becomes part of Medicare's basic benefits and is explicitly paid for in managed care rates. The remaining 17 percent are covered through Medicaid, Veterans' Affairs and other public programs.

- **Private trends: Decline in coverage and affordability.**

  - The proportion of firms offering retiree health coverage has declined by 25 percent in the last four years. Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage. The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.

  - Medigap premiums for drugs are high and increase with age. Medigap premiums vary widely throughout the nation but are consistently two to three times higher than the Medicare premium proposed by the President. Moreover, unlike the President's proposal, premiums substantially increase with age as virtually every Medigap plan "age rates" the cost of the premium. This means that just as beneficiaries need prescription drug coverage most and are the least likely to be able to afford it, this drug coverage is being priced out of reach. This cost burden will particularly affect women, who make up 73 percent of people over age 85.

- **Public drug coverage trends: managed care benefits reduced.**

  - The value of Medicare managed care drug benefits is declining. Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below $1,000 in the year 2000. This is part of a troubling trend of plans to severely limit benefits through low caps. In fact, the proportion of plans with $500 or lower benefit caps will increase by over 50 percent between 1998 and 2000.

  - Participation by Medicaid eligible populations remains low. Millions of Medicare beneficiaries under 75 percent of poverty (about $6,000 for a single, $8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent. This contrasts with an almost 100 percent participation rate in Medicare Part B for beneficiaries. Inadequate outreach and welfare stigma contributes to these low participation levels and raise serious questions about the feasibility and advisability of using the Medicaid program to provide needed coverage for a population at higher income levels.

- **Millions of beneficiaries have no drug coverage.**

  - At least 13 million Medicare beneficiaries have absolutely no prescription drug

coverage. The number of the uninsured is not concentrated among the low income. In fact, the income distribution of uninsured Medicare beneficiaries is almost exactly the same for beneficiaries at all income levels.

- More than half of Medicare beneficiaries without drug coverage are middle class. Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately $17,000 for couples. This clearly indicates that any prescription drug coverage policy that limits coverage to below 150 percent of poverty, as some in Congress suggest, will leave the vast majority of the Medicare population unprotected.

IMPORTANCE OF PRESCRIPTION DRUGS TO MEDICARE BENEFICIARIES

Part of modern medicine. Prescription drugs serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other medical procedures (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for HIV and Parkinson's). Some of the major advances in public health -- the near eradication of polio and measles and the decline in infectious diseases -- are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.

- **Greatest need for prescription drugs.** The elderly and people with disabilities are particularly reliant on prescription drugs. Not only do they experience greater health problems, but these problems tend to include conditions that respond to drug therapy. As a result, about 85 percent of beneficiaries fill at least one prescription a year. Some examples of common conditions include:

  ° Osteoporosis: Over 1 in 5 older women have osteoporosis and about 15 percent have suffered a fracture as a result. It is a leading risk factor for hip fractures, which affects 225,000 people over the age of 50. Estrogen replacement can reduce the risk of osteoporosis as well as that of cardiovascular disease. One commonly used drug costs $20 per month, $240 per year.

  ° Hypertension: About 60 percent of people over age 65 have hypertension. African Americans are more likely to have hypertension. For a person over age 55, hypertension increases the risk of a heart attack or other heart problem over 10 years by 10 percent. Hypertension roughly doubles the risk of cardiovascular disease and is the leading factor for stroke. According to one study, treatment results in a one-third reduction in the probability of stroke and a one-quarter reduction in the probability of a heart attack. ACE inhibitors which typically cost $40 per month, $480 per year are commonly prescribed to control hypertension, and are frequently used in combination with diuretics and /or beta-blockers.

  ° Myocardial Infarction (Heart Attack): Heart disease is the leading cause of death for persons 65 and over. About 1.5 million Americans each year have heart attacks, which are fatal in about 30 percent of patients. Since people who survive heart attacks are much more likely to have subsequent attacks, disease management including drugs can significantly improve health and longevity. For example, a study of the use of a lipid lowering drug by people who had an acuate myocardial infarction found a 42 percent reduction in coronary mortality after 5 years of follow-up. A common lipid reduction drug costs about $85 per month, $1,020 per year. A beta-blocker costs about $30 per month, $360 per year, and can reduce long-term mortality by 25 percent.

  ° Adult-Onset Diabetes: About 1 in 10 elderly have Type I or II diabetes. Diabetes

can lead to blindness, kidney disease and nerve damage. Glucose (blood sugar) control can prevent or delay these conditions. Commonly used medications include cost around $60 per month, $720 per year.

- Depression: An estimated 1 in 10 to 1 in 20 community-based elderly experience depression. Depression can lead to institutionalization and other health problems. From 60 to 75 percent of patients respond to drug therapy. New therapies can cost from $130 to $290 per month or $1,560 to $3,480 per year.

- **Many beneficiaries need drugs but do not use them as prescribed because they do not have well managed, affordable drug insurance.** Most research has found that drug coverage influences use of needed drugs:

  - Decreased use of needed medications. Elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited. Many elderly must choose between prescriptions and other basic household needs.

  - Increased nursing home use. Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes.

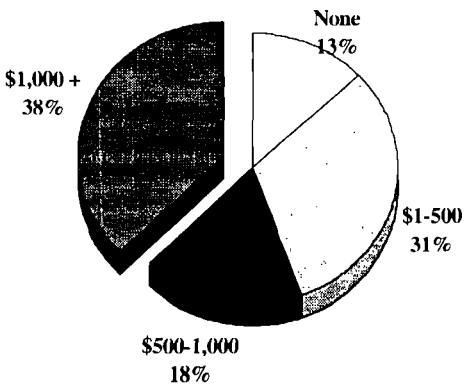
  - Less protection against drug complications. Even though the elderly and disabled take more prescription drugs and have more complex medical problems, Medicare beneficiaries without coverage do not benefit from drug management. This could lead to adverse drug reactions, inappropriate use of drugs, or discontinuation of needed drugs. One study which classified the geriatric admissions to a community hospital found that drug-related hospitalization accounted for 6.4 percent of all admissions among the over 65 population. The study estimated that 76 percent of these admissions were avoidable.

PRESCRIPTION DRUG SPENDING BY MEDICARE BENEFICIARIES

- **Because of their greater need, the elderly and people with disabilities have greater health care costs.** The elderly's per capita spending on drugs is over three times higher than that of non-elderly adults. While only 12 percent of the entire population, the elderly account for about one-third of drug spending.

Medicare Beneficiaries Need Prescription Drugs

Beneficiaries By Total Drug Spending



SOURCE: Actuarial Research Corporation for HHS, 2000

- **Over one-third (38%) of Medicare beneficiaries will spend more than $1,000 on prescription drugs.** Less than 5 percent will spend more than $5,000.

- **The average total drug costs for Medicare beneficiaries is estimated to approach $1,100 in 2000.** Over 85 percent of Medicare beneficiaries will spend money on

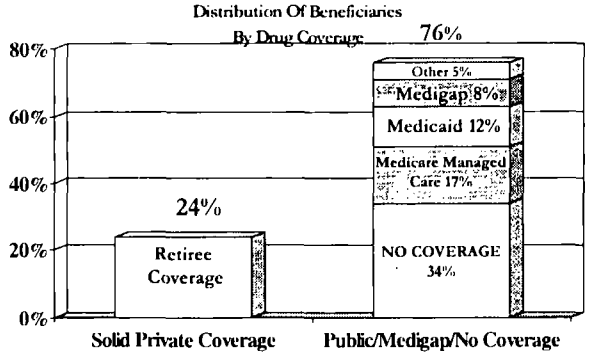
prescription drugs, and more than half will spend more than $500.

- **Spending is higher for women.** Because of their greater likelihood of living longer and having chronic illness, women on Medicare spend nearly 20 percent more on prescription drugs than men.

- **Out-of-pocket spending is also high.** In 2000, Medicare beneficiaries are estimated to spend about $525 on prescription drugs out-of-pocket. This spending is linked to insurance coverage – it is much higher for those with no coverage ($800) and people with Medigap ($650) than those with retiree coverage ($400).

COVERAGE FOR PRESCRIPTION DRUGS FOR MEDICARE BENEFICIARIES

Three-Fourths Of Medicare Beneficiaries Lack Decent, Dependable, Private-Sector Coverage of Prescription Drugs



- SOURCE: Actuarial Research Corporation for HHS, point-in-time, 2000

Unlike virtually all private health insurance plans, Medicare does not cover prescription drugs. As a result, a fragmented, unstable system of coverage has emerged as beneficiaries attempt to insure against the costs of medications.

- **Only one-fourth of Medicare beneficiaries have retiree drug coverage.** Employers

provide health insurance for most Americans under the age of 65, but pay for supplemental coverage for only a fraction of their elderly retirees. When available, this coverage tends to have reasonable cost sharing and affordable premiums.

- **About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drugs.** These beneficiaries include those with:

  - Medigap. About 8 percent of beneficiaries purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries.

  - Medicare managed care. About 17 percent of beneficiaries have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable.

  - Medicaid and other public programs. Medicaid covers about 12 percent of beneficiaries and programs like the Veterans' Administration cover another 5 percent of beneficiaries. Eligibility for these programs is very restrictive.

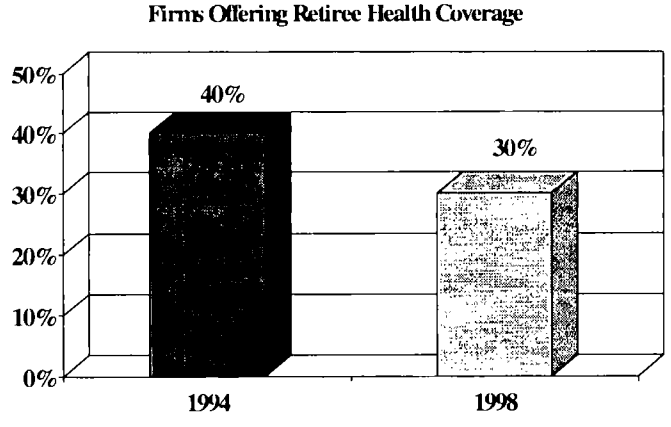
  - No coverage at all. 34 percent of Medicare beneficiaries has no drug coverage.

RETIREE HEALTH COVERAGE

- **About one in four Medicare beneficiaries has prescription drug coverage through their retiree health plan.** These employer-based plans offer decent, affordable coverage.

Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

- **Firms offering retiree health coverage have declined by 25 percent in the last four years.** Retiree health coverage is declining substantially because many firms previously

providing it are opting to drop their coverage.

- The decline was

  employees), over a third of whom dropped coverage in this period.

- **Most serious effect will occur when the baby boom generation retires.** Although there are employers who are dropping health coverage for current retirees, most are restricting coverage for future retirees. This means that the access problems that are emerging now could be more severe in the future.

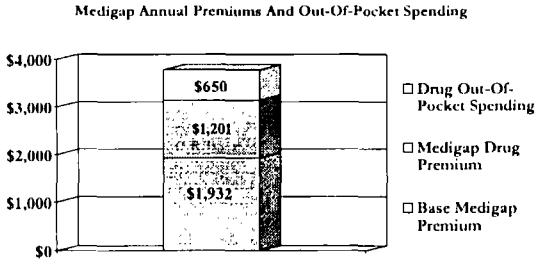
- **Firms are increasingly moving their retirees to Medicare managed care.** To help constrain costs, a number of employers are providing incentives for their retirees to join managed care. The number of large employers offering Medicare managed care plans rose from 7 percent in 1993 to 38 percent in 1996.

MEDIGAP PRESCRIPTION DRUG COVERAGE

- **Because of its high cost relative to its benefit, less than one in ten Medicare beneficiaries purchases a Medigap plan with prescription drugs.** Three of the ten standardized Medicare supplemental plans, (plans H, I, and J) include prescription drug coverage. All three plan types have a $250 deductible for the drug benefit and require 50 percent coinsurance. The H and I plans have a cap on drug benefits of $1,250 while the J plan caps the benefit at $3,000. The typical premium for a plan with the lower cap costs about $90 per month or $1,080 per year.

- **Medigap is expensive, inefficient, and often uses higher prices to discriminate against the oldest beneficiaries.**

Beneficiaries With Medigap Still Pay High Out-Of-Pocket Drug Costs

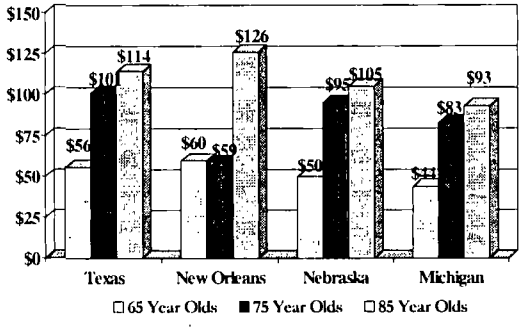


SOURCE: Actuarial Research Corporation for HHS. Premium quote for a 75 year old. Base is $161 per month; drug addition is $101 per month.

- Expensive. Medigap policies that cover prescription drugs are expensive relative to

comparable policies that do not cover drugs. Additionally, premiums vary tremendously from place to place, and from beneficiary to beneficiary. Finally, a beneficiary cannot only pay for prescription drugs – they must also buy the other benefits in the package.

Medigap Premiums For Drugs Are High And Increase With Age, 1999



Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and H, which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

Inefficient. Because it is sold to individuals, Medigap does not offer beneficiaries the kind of premiums that result from group purchasing. This also adds to the administrative costs per policy, which are typically two to three times more than that of group coverage.

Costs increase with age as well as health inflation. This "attained age" pricing practice causes excessive premiums for those who need it most – the very old. It also disproportionately affects women since they comprise nearly three-fourths of people over age 85.

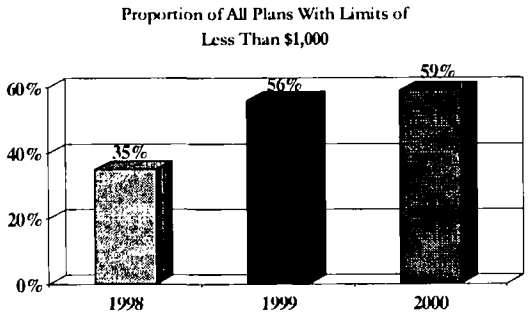
MEDICARE MANAGED CARE

- **The number of beneficiaries with drug coverage through Medicare managed care has risen to 17 percent.** Most Medicare managed care plans offer prescription drugs. Drug coverage is one of the major attractions for beneficiaries to enroll in these plans.

- **Drug coverage under Medicare+Choice is unstable.** Managed care plans are not required to offer a drug benefit, but can do so with any excess Medicare payments or by charging a premium. This results in wide variation across areas, since payments vary by area, and over time.

Value of Medicare Managed Care Drug Benefits Is Declining

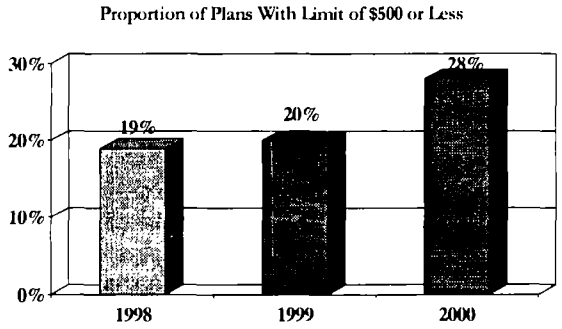
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



Source: HHS analysis of plan submissions for 2000, preliminary. This includes plans with unlimited generics and limited brand name drug spending.

Limits on Medicare Managed Care Drug Benefit Are Getting Lower

Proportion Of Plans With A $500 Or Lower Limit Has Increased By 50%



- Source: HHS analysis of plan submissions for 2000, preliminary. This includes plans with unlimited generics and limited brand name drug spending

The value of Medicare managed care drug benefits is declining. Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below $1,000 in the year 2000. The proportion of plans with $500 or lower benefit caps will increase by over 50 percent between 1998 and 2000. This is part of a troubling trend of plans to severely limit benefits through low caps.

- **Plans dropping out of Medicare limit access to drugs.** Nearly 50,000 Medicare beneficiaries will lose access to Medicare managed care next year as plans withdraw from particular areas or Medicare altogether.

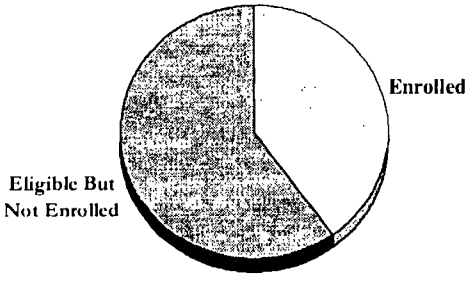
MEDICAID

- **About 12 percent of Medicare beneficiaries are also fully eligible for Medicaid and its drug benefit.** Most of these "dual eligibles" qualify for Medicaid because they receive Supplemental Security Income due to low income (on average, about 73 percent of poverty -- $6,200 for a single, $8,300 for a couple in 2000). States have other options for covering the elderly and disabled, including "medically needy" or "spend-down" programs that extend eligibility to sick and/or institutionalized people.

Participation In Medicaid Is Low

Only 40% Of Eligible Beneficiaries Are Enrolled in Medicaid

Eligible Medicare Beneficiaries' Enrollment in Medicaid



SOURCE: Actuarial Research Corporation for HHS. Calculated assuming that beneficiaries below 73% of poverty are eligible for full Medicaid benefits through SSI (Kaiser Commission on Medicaid & the Uninsured, May 1999)

- **Participation by Medicaid eligible populations remains low.** Millions of Medicare beneficiaries under 75 percent of poverty (about $6,000 for a single, $8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent.

- Lack of information, ineffective outreach and welfare stigma contributes to these low participation levels.

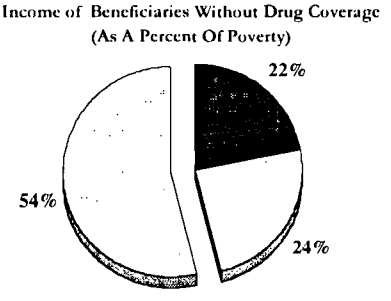
- This contrasts with an almost 100 percent participation rate in Medicare Part B for beneficiaries.

BENEFICIARIES LACKING DRUG COVERAGE

- **At least 13 million or 34 percent of Medicare beneficiaries have no insurance coverage for prescription drugs.** These beneficiaries pay retail prices for prescription drugs, which can often be significantly more expensive than what large firms or public programs pay for the same drugs.

Many Uninsured In Middle Class

Over Half of Medicare Beneficiaries Who Lack Prescription Drug Coverage Are In The Middle Class



SOURCE: Annual Research Corporation for HHS, 2000
In 2000, poverty for a single person is about $8,500, for a couple is about $11,400

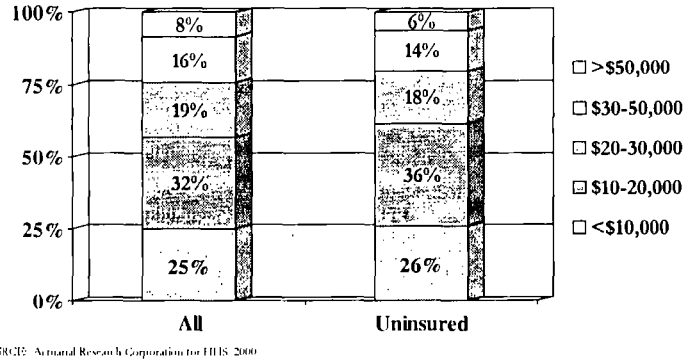
- **More than half of Medicare beneficiaries without drug coverage are middle class.** Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately $17,000 for couples. This indicates that targeting a drug benefit only to the low-income cannot address even half of the

problem.

- **The income distribution of beneficiaries lacking drug coverage closely parallels that of all beneficiaries.** This lack of difference suggests that everyone is at risk of losing their health insurance.

Lack of Insurance Affects All Medicare Beneficiaries

Income of Beneficiaries Lacking Coverage Matches That Of All Beneficiaries



SOURCE: Actuarial Research Corporation for HHS 2000

PRESIDENT'S PROPOSED PRESCRIPTION DRUG BENEFIT

The President's plan to modernize Medicare would include a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002. This benefit would cost the Federal government about $118 billion from 2000 to 2009. It would be fully offset, primarily through savings and efficiencies in Medicare and, to a small degree, from the surplus amount dedicated to Medicare.

- **Meaningful coverage**. Beginning in 2002, beneficiaries would have the option of participating in the new Medicare Part D program. It would have:

    - No deductible – coverage begins with the first prescription filled and

    - 50 percent coinsurance, with access to discounts negotiated by private pharmacy managers after the limit is reached.

  The benefit would be limited to $5,000 in costs ($2,500 in Medicare payments) in 2008. It would phase it a $2,000 for 2002-2003; $3,000 for 2004-2005; $4,000 for 2006-2007; and $5,000 in 2008 (indexed to inflation in subsequent years).

- **Affordable premiums.** Beneficiaries who opt for Part D would a pay separate premium for Medicare Part D -- an estimated $24 per month in 2002, and $44 per month in 2008 when fully implemented. This premium represents 50 percent of program costs. Enrollment would be optional and, after an initial open enrollment for all beneficiaries in 2001, would occur when a beneficiary becomes eligible for the program or when they transition out of employer-based coverage. Premiums would generally be deducted from Social Security checks.

    - **Low-income protections.** Beneficiaries with income up to 150 percent of poverty ($17,000 for a couple) would pay no Part D premium. Those with income below 135 percent of poverty ($15,000 for couples) would pay no premiums or cost sharing. This assistance would be administered through Medicaid, with the Federal government assuming all of the premium and cost sharing costs for beneficiaries with incomes above poverty.

- **Private management.** Beneficiaries in managed care plans would continue to receive their benefit through their plan. For enrollees in the traditional program, Medicare would contract with numerous private pharmacy benefit managers (PBMs) or similar entities. Medicare would use competitive bidding to award contracts for drug management. The private managers would use the latest, effective cost containment tools, drug utilization review programs, and meet quality and consumer access standards. No price controls would be imposed.

- **Incentives to develop and retain retiree coverage.** Employers that choose to offer or continue retiree drug coverage would be provided a financial incentive to do so.

APPENDIX: METHODOLOGY & ENDNOTES

Methodology. The Actuarial Research Corporation under contract with the Department of Health and Human Services conducted most of the analysis. The basis for the estimates is the Medicare Current Beneficiary Survey (MCBS) for 1995. These data were aged to CY 2000, converted to a point-in-time estimate, and adjusted for the increase in managed care enrollment. This enrollment increase was estimated by moving beneficiaries from retiree health coverage, Medigap and the uninsured to managed care in proportion to their enrollment in those plans.

Endnotes.

Hazzard WR; Blass JP (Editor); Ettinger WH; Halter JB; Ouslander JG. (1998). *Principles of Geriatric Medicine and Gerontology.* New York: McGraw Hill.

Centers for Disease Control and Prevention, National Center for Health Statistics. (1993). (National High Blood Pressure Education Working Group): Report on primary prevention of hypertension. *Archives of Internal Medicine.* 153: 186.

Wilson PWF. (1991). Established risk factors and coronary artery disease: The Framingham Study. American Journal of Hypertension. 7: 75.

SHEP Cooperative Research Group. (1991). Prevention of stroke by hypertensive treatment in older patients with isolated systolic hypertension. *JAMA*, 265: 3255-3264.

Randomized trial of cholesterol lowering in 4444 patients with coronary heart disease: The Scandinavian Simvastatin Survival Study (45). Lancet 1994; 344: 1388-1389.

The beta-blocker heart attack trial: Beta-Blocker Heart Attack Study Group. JAMA. 1981; 246: 2073-2074.

National Health Interview Survey.

Tierney LM; McPhee SJ; Papadakis MA (editors). (1998). *Current Medical Diagnosis and Treatment 1998.* Appleton and Lange.

Tierney LM, et al.; ibid.

Soumerai SB; Ross-Degnan D; Avorn J; McLaughlin TJ; Choodnovskiy I. (1987). Payment restrictions for prescription drugs under Medicaid: Effects on therapy, cost and equity. *The New England Journal of Medicine*, 317: 550-556.

Families USA, 1994.

Soumerai SB; Ross-Degnan D; Avorn J; McLaughlin TJ; Choodnovskiy I. (1991). Effects of Medicaid drug-payment limits on admissions to hospitals and nursing homes. *The New England Journal of Medicine*, 325: 1072-1077.

Bero LA.; Lipton HL; Bird, JA.. (1991). Characterization of Geriatric Drug-Related Hospital Readmissions. *Medical Care*, 29 (10): 989-1003.

Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1998.

Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1996. As reported in Hewitt Associates. (1997). Retiree Health Trends and Implications of Possible Medicare Reforms. Washington, DC: The Kaiser Medicaid Project.

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

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Prepared for Rep. David R. Obey

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

August 6, 1999

Table of Contents

EXECUTIVE SUMMARY

This staff report was prepared at the request of Rep. David R. Obey of Wisconsin. In Mr. Obey'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. Obey 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. Obey'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. Obey'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 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 Mr. Obey's congressional district in Wisconsin. 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 130% (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 $55.16 to $100.78 more per prescription for these five drugs than favored customers.

Table 1: Average Prices in Mr. Obey'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	$102.79	281%	$75.79
Prilosec	Astra/Merck	Ulcers	$59.10	$114.69	94%	$55.59
Procardia XL	Pfizer Inc.	Heart Problems	$68.35	$132.42	94%	$64.07
Norvasc	Pfizer Inc.	High Blood Pressure	$59.71	$114.87	92%	$55.16
Zoloft	Pfizer, Inc.	Depression	$115.70	$216.48	87%	$100.78
Average Price Differential					**130%**	

- **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. Obey's congressional district was 1,367%. An equivalent quantity of this drug would cost the manufacturers' favored customers only $1.75, but would cost the average senior citizen in Mr. Obey's district over $25.00. For Micronase, a diabetes treatment manufactured by Upjohn, an equivalent dose would cost the favored customers $10.05, while seniors in Mr. Obey's district are charged an average of $44.70. The price differential was 345%.

- **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 More Than 1,350%.

Prescription Drug	Manufacturer	Use	Prices for Favored Customers	Prices for Seniors	Price Differential for Seniors
Synthroid	Knoll Pharmaceuticals	Hormone Treatment	$1.75	$25.67	1367%
Micronase	Upjohn	Diabetes	$10.05	$44.70	345%

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 130%, 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. Obey'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. Obey'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. Obey's district 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. 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. David R. Obey of Wisconsin 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. Obey'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 Wisconsin.

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 Retail Drug Prices for Seniors

In order to determine the prices that senior citizens are paying for prescription drugs in Mr. Obey's congressional district, the minority staff and the staff of Mr. Obey's congressional office conducted a survey of ten drug stores -- including both independent and chain stores. Mr. Obey represents the 7th Congressional District in northwestern Wisconsin, which includes 19 counties and the cities of Wausau, Stevens Point, Wisconsin Rapids, Marshfield, Chippewa Falls, and Superior. 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 June 1999 to reflect current pricing.

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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, 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.

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.[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 Mr. Obey's congressional district and the price that would be paid by the drug companies' most favored customers was 130% (Table 1). The study thus showed that the average price that older Americans and other

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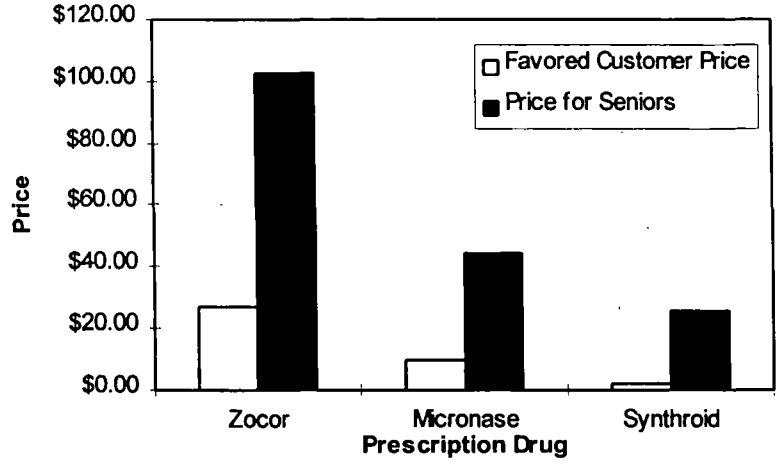
[23] The items used were paper towels, envelopes, rubber bands, toilet paper, pencils, Rolodexes, tape dispensers, waste baskets, correction fluid, post-it notes, paper clips, and scissors.

individual consumers in Mr. Obey'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.

For individual drugs, the price differential was even higher. Among the five best selling drugs, the highest price differential was 281% 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. Obey's district was more than 1,350%. An equivalent quantity of this drug would cost the most favored customers only $1.75, but would cost the average senior citizen in Mr. Obey's congressional district $25.67. For Micronase, a diabetes treatment manufactured by Upjohn, the price differential was 345% (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 exceeded 90%. The lowest price difference was still high -- 87%, for Zoloft.

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

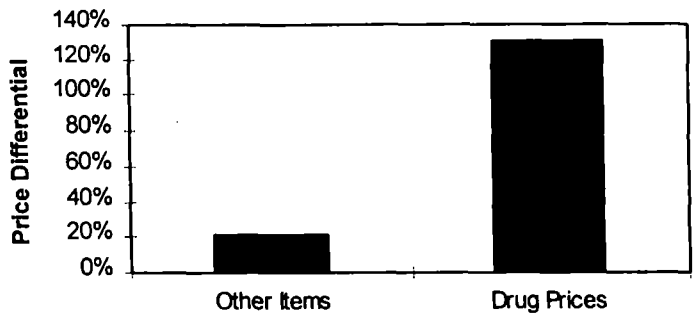


In dollar terms, Zoloft, an antidepressant, had the highest price differential. Senior citizens in Mr. Obey's district must pay over $100.00 more for 100 tablets of Zoloft than a favored customer. The difference between seniors' prices and prices for favored customers was more than $75.00 for 60 tablets of Zocor and over $50.00 per prescription for each of the remaining three best selling drugs (Procardia XL, 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 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.[24]

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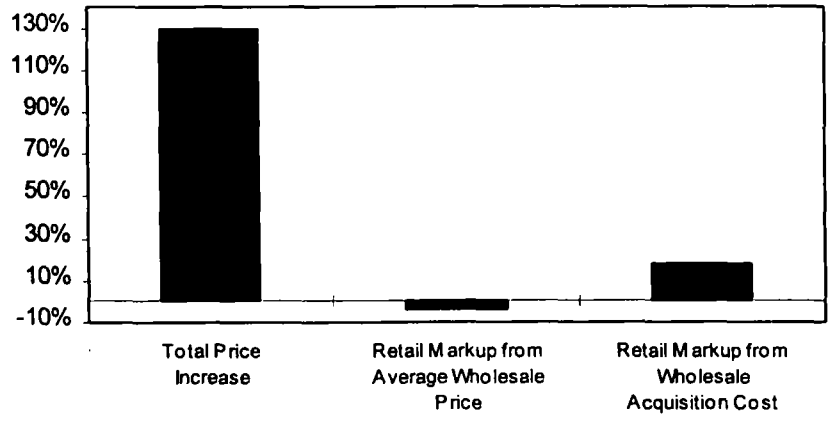
[24] National Association of Chain Drug Stores, *Did You Know . . .* (pamphlet) (citing financial data assembled by Keller Bruner & Company, P.C., Certified Public Accountants

The study found few significant differences in retail prices between pharmacies in different parts of Mr. Obey'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.[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 study. For instance, Merck, the country's largest pharmaceutical manufacturer, had a 24%

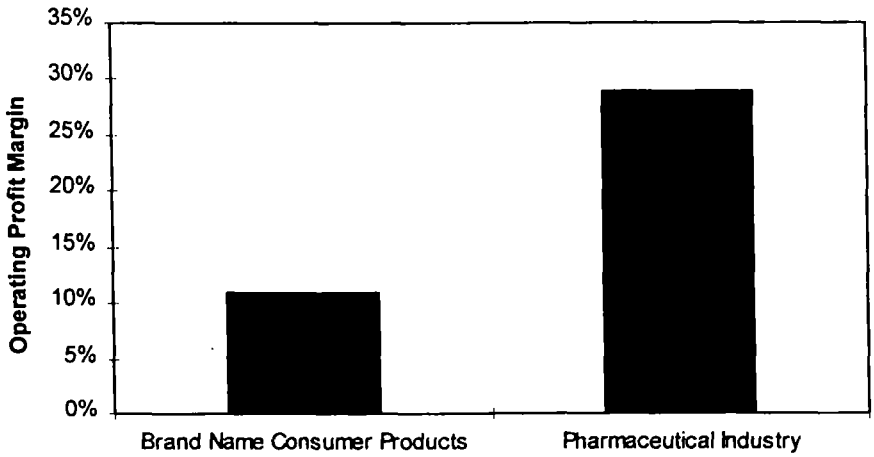
1995).

[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).

increase in sales and a 12% increase in profits in the first quarter of 1999.[27] According to industry analysts, Merck's increased profits were due in large part to sales of Zocor,[28] which is sold in Mr. Obey's district at a price differential of 281%. 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. 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.[30] The price of Synthroid, which is sold in Mr. Obey's district at a price differential of nearly 1,350%, increased 20.4% in 1998.[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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[27] AP, *Merck Sales Jump by 24 Percent* (April 23, 1999).

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

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

[30] Express Scripts, Inc., *1998 Drug Trend Report* (June 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

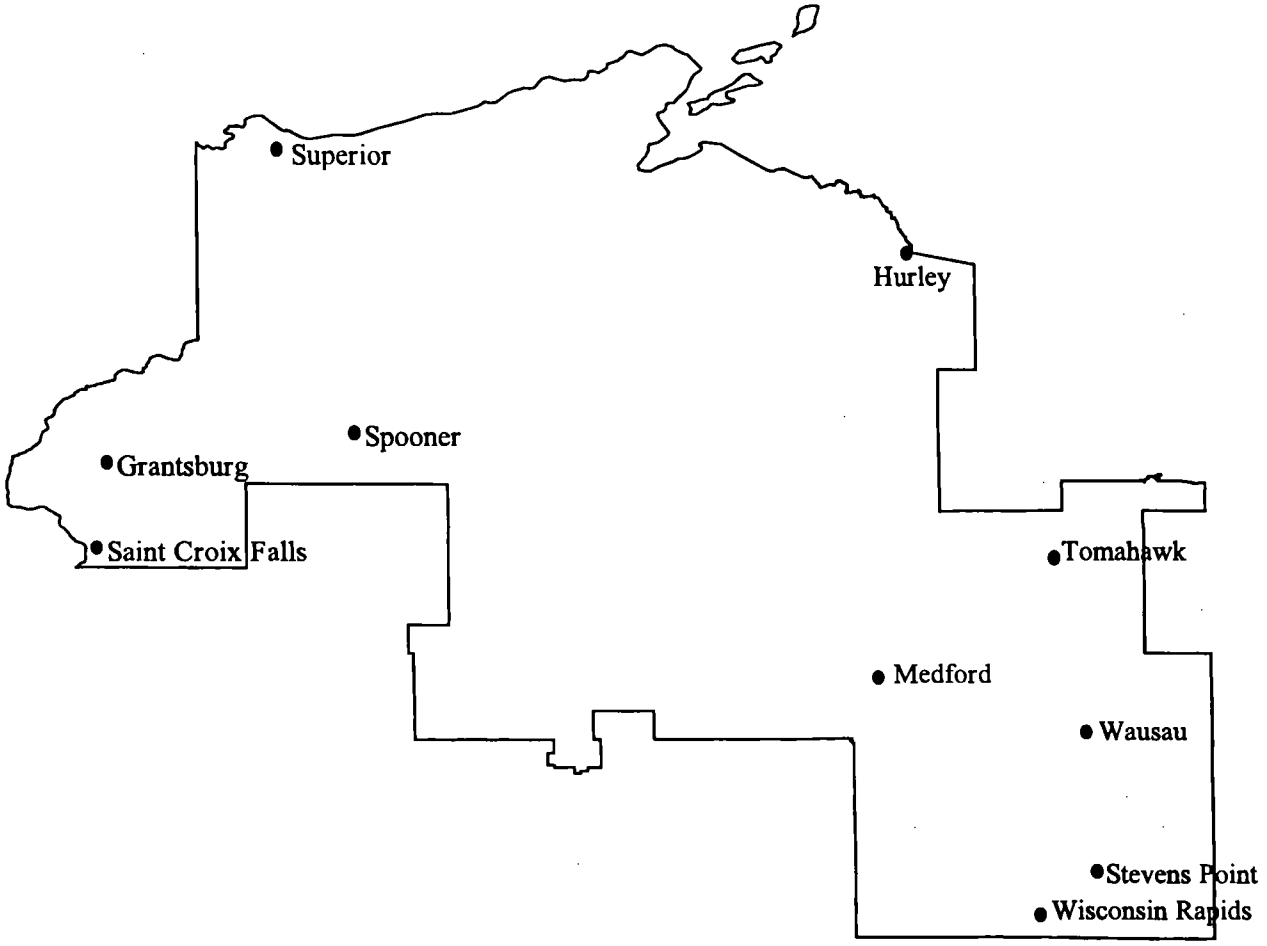
			Prices (Dollars)				
Brand Name Drug	**Dosage and Form**	**Indication**	**Favored Customer Price**	**Wholesale Acquisition Cost**	**Average Wholesale Price**	**Average Retail Price**	**Price Differential (Average Retail Price vs. Favored Customer Price)**
Zocor	5 mg, 60 tablets	Cholesterol reducer	$27.00	$86.07	$106.84	$102.79	281%
Prilosec	20 mg, 30 cap.	Ulcer	$59.10	$100.34	$119.57	$114.69	94%
Procardia XL	30 mg, 100 tab.	Heart Problems	$68.35	$111.46	$138.37	$132.42	94%
Norvasc	5 mg, 90 tablets	High Blood Pressure	$59.71	$96.00	$119.17	$114.87	92%
Zoloft	50 mg, 100 tab.	Depression	$115.70	$182.98	$227.13	$216.48	87%
Average Price Differential							**130%**

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 Wisconsin's 7th Congressional District



Library of Congress, Geography and Map Division, August 1999

Prescription Drug Pricing in the 3rd Congressional District of New Mexico: An International Price Comparison

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Prepared for Rep. Tom Udall

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

September 1, 1999

Table of Contents

EXECUTIVE SUMMARY

This report, which was prepared at the request of Rep. Tom Udall, compares prescription drug prices in New Mexico's 3rd Congressional District with drug prices in Canada and Mexico. The report finds that senior citizens and other consumers in Rep. Udall's district who lack insurance coverage for prescription drugs must pay far more for prescription drugs than consumers in Canada and Mexico. These price differentials are a form of price discrimination. In effect, the drug manufacturers are discriminating against senior citizens in Rep. Udall's district by denying them access to prescription drugs at the low prices available to consumers in Canada and Mexico.

This study investigates the pricing of the five brand name prescription drugs with the highest 1997 dollar sales to the elderly in the United States. The study compares the prices that senior citizens who buy their own prescription drugs must pay for these drugs in Rep. Udall's district with the prices that consumers who buy their own drugs must pay for the same drugs in Canada or Mexico. The study finds that the average prices that senior citizens in Rep. Udall's district must pay are 80% higher than the prices that Canadian consumers pay and 78% higher than the prices that Mexican consumers pay (Table 1).

Table 1: Seniors in Rep. Udall's District Pay Significantly Higher Prices for Prescription Drugs Than Consumers in Canada or Mexico.

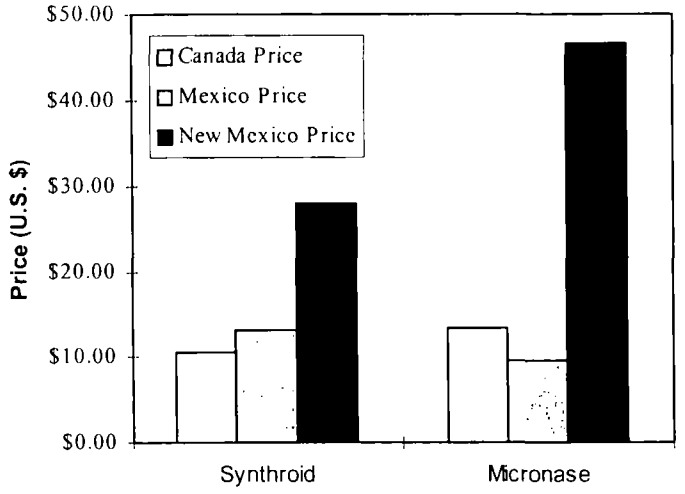
Prescription Drug	U.S. Dosage and Form	Canadian Price	Mexican Price	New Mexico Price	Canada-New Mexico Price Differential		Mexico-New Mexico Price Differential	
					Percent	Dollar	Percent	Dollar
Zocor	5 mg, 60 tab.	$46.17	$67.65	$102.52	122%	$56.35	52%	$34.87
Prilosec	20 mg, 30 cap.	$55.10	$32.10	$112.40	104%	$57.30	250%	$80.30
Procardia XL	30 mg, 100 tab.	$74.25	$76.60	$129.75	75%	$55.50	69%	$53.15
Zoloft	50 mg, 100 tab.	$129.05	$219.35	$219.34	70%	$90.29	0%	-$0.01
Norvasc	5 mg, 90 tab.	$89.91	$99.32	$115.86	29%	$25.95	17%	$16.54
Average Differential					**80%**		**78%**	

In dollar terms, an uninsured senior citizen in Rep. Udall's district pays over $80 more than a consumer in Mexico and over $55 more than a consumer in Canada for a one month supply of Prilosec. The total difference between the price a senior in Rep. Udall's district would pay for a year's supply of Prilosec compared to a similar consumer in Mexico would be over $960. The difference between the price a senior in Rep. Udall's district would pay for a year's supply of Prilosec compared to a similar consumer in Canada would be almost $700.

Similarly, a two month supply of Zocor would costs an uninsured senior in Rep. Udall's district over $55 more than it would cost a similar consumer in Canada, and almost $35 more than it would cost a similar consumer in Mexico. Annually, the price differences between the costs of Zocor for a senior in Rep. Udall's district and a similar consumer in Canada or Mexico would be $338 and $209, respectively.

In the case of two additional drugs considered in the study, Synthroid and Micronase, senior citizens in Rep. Udall's district were forced to pay at least two times, and in one case more than four times, the prices charged to Canadian or Mexican consumers (Figure 1).

Figure 1: Seniors in Rep. Udall's District Pay Up to Five Times as Much for Prescription Drugs as Purchasers in Mexico or Canada.



This is the second congressional report on drug price discrimination requested by Rep. Udall. The first report shows that senior citizens in New Mexico's 3rd Congressional District are forced to pay over twice as much for their prescription drugs as the drug companies' favored domestic customers, such as HMOs and the federal government.[1] This report shows that senior citizens in Rep. Udall's district are also forced to pay substantially more for their prescription drugs than are consumers in other countries. Taken together, the two studies indicate that drug manufacturers engage in a consistent pattern of price discrimination, resulting in prices for senior citizens and other consumers who buy their own drugs that far exceed those paid by other purchasers in the United States and other countries.

[1] Minority Staff Report of the House Committee on Government Reform and Oversight, *Prescription Drug Pricing in the 3rd Congressional District in New Mexico: Drug Companies Profit at the Expense of Older Americans* (Mar. 1999).

I. INTRODUCTION

In the United States, drug manufacturers are allowed to discriminate in drug pricing. As the Congressional Budget Office reported in a 1998 study, "[d]ifferent buyers pay different prices for brand-name prescription drugs. ... In today's market for outpatient prescription drugs, purchasers that have no insurance coverage for drugs ... pay the highest prices for brand name drugs."[2] In 1999, the Federal Trade Commission reached the same conclusion, reporting that drug manufacturers use a "two tiered pricing structure" under which they "charge higher prices to ... the uninsured."[3]

This discriminatory pricing imposes severe hardships on senior citizens. As documented in the first report requested by Rep. Udall, senior citizens often have the greatest need for prescription drugs, but the least ability to pay for them.[4] The elderly in the United States, who make up 12% of the population, use one-third of all prescription drugs,[5] with the average senior using 18.5 prescriptions annually.[6] They also frequently have inadequate insurance coverage or no insurance coverage at all to pay for these drugs. Approximately 75% of Medicare beneficiaries lack dependable, private-sector prescription drug coverage,[7] and 35% -- over 13 million seniors -- do not have any insurance coverage for prescription drugs.[8] As a result, many seniors cannot afford the high costs of prescription drugs. One study estimated that more than

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[2] Congressional Budget Office, *How Increased Competition from Generic Drugs Has Affected Prices and Returns in the Pharmaceutical Industry*, xi (July 1998).

[3] Federal Trade Commission, *The Pharmaceutical Industry: A Discussion of Competitive and Antitrust Issues in an Environment of Change*, 75 (Mar. 1999).

[4] *Prescription Drug Pricing in the 3rd Congressional District in New Mexico: Drug Companies Profit at the Expense of Older Americans*, *supra* note 1.

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

[6] Senate Special Committee on Aging, *Developments In Aging: 1996*, 103rd Cong., 1st Sess. 121 (1997) (S. Rpt. 36).

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

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

one in eight seniors were forced to choose between buying food or paying for prescription drugs.[9]

In part to protect their citizens from these hardships, the governments of Canada and Mexico do not allow drug manufacturers to engage in price discrimination. In Canada, approximately 35% of prescription drugs are paid for by the government for beneficiaries of government health care programs.[10] In Mexico, 30% of prescription drugs are paid for by the government under similar circumstances.[11] The rest of the population in these two countries must either buy their own drugs or obtain prescription drug insurance coverage. To prevent the drug companies from charging individual consumers excessive prices, both the Canadian and Mexican governments regulate prices for patented prescription drugs.[12] Drug manufacturers do not have to sell their products in Canada or Mexico, but if they do, they cannot sell their drugs at prices above the maximum prices established by the government.

This report is the first effort to compare prices that senior citizens in New Mexico's 3rd Congressional District must pay for prescription drugs with the prices at which the same drugs are available in Canada and Mexico.[13] It finds that senior citizens in Rep. Udall's district who lack prescription drug benefits must pay far more for prescription drugs than consumers in Canada and Mexico. The drug companies thus appear to engage in two distinct forms of price discrimination: (1) as documented in Rep. Udall's first report, the drug companies are forcing

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

[10] Health Canada, *National Health Expenditures in Canada 1975-1996: Fact Sheets*, 12 (June 1997).

[11] National Economic Research Associates, *Financing Health Care: The Health Care System in Mexico*, 78 (August 1998).

[12] Congressional Research Service, *Prescription Drug Price Comparisons: The United States, Canada, and Mexico* (January 1998).

[13] In a 1992 study, *Prescription Drugs: Companies Typically Charge More in the United States Than in Canada*, the U.S. General Accounting Office compared producer prices for prescription drugs in Canada and the United States. This study did not include information on retail prices. In a 1998 study, *International Comparison of Prices For Antidepressant and Antipsychotic Drugs*, Public Citizen compared wholesale prices for newly developed antipsychotic and antidepressant drugs. This study also did not compare retail prices paid by consumers, but instead looked at pharmacy acquisition costs. The study also only looked at a small class of drugs. A recent Canadian study, the Patented Medicine Prices Review Board's *Tenth Annual Report*, compared manufacturers' prices for a wide selection of drugs, but contained no information on specific drugs. None of these studies included information on prices in New Mexico.

senior citizens in Rep. Udall's district to pay more for prescription drugs than more favored U.S. customers, and (2) as documented in this report, the drug companies are forcing senior citizens in Rep. Udall's district to pay more for prescription drugs than consumers in more favored countries.

II. 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 out-patient prescription drug program for older Americans in the United States for which claims data is available. It 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.[14]

Based on the PACE data, the five patented, nongeneric drugs with the highest sales to seniors in 1997 were:

- Prilosec, an ulcer and heartburn medication manufactured by Astra/Merck.
- Norvasc, a blood pressure medication manufactured by Pfizer.
- Zocor, a cholesterol-reducing medication manufactured by Merck.
- Zoloft, a medication used to treat depression manufactured by Pfizer.
- Procardia XL, a heart medication manufactured by Pfizer.

In addition to the top five drugs for seniors, this study also analyzed two additional prescription drugs, Synthroid and Micronase. Synthroid is a hormone treatment manufactured by Knoll Pharmaceuticals, and Micronase is a diabetes medication manufactured by Upjohn. These popular prescription drugs were included in the study because the earlier analysis indicated that there is substantial discrimination in the pricing of these drugs.

B. Determination of Average Drug Prices in New Mexico's 3rd Congressional District

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

In order to determine the prices that senior citizens are paying for prescription drugs in New Mexico, the minority staff and the staff of Rep. Udall's congressional office conducted a survey of eleven drug stores -- including both independent and chain stores -- in Rep. Udall's congressional district. Rep. Udall represents the 3rd Congressional District in New Mexico, which includes the cities of Santa Fe, Rio Rancho, and Farmington.

C. Determination of Average Drug Prices in Canada and Mexico

Prices for prescription drugs in Canada and Mexico were determined via a survey of pharmacies in Canada and Mexico. At the request of the minority staff of the Committee on Government Reform, the surveys were conducted by the Office of NAFTA and Inter-American Affairs of the U.S. Department of Commerce. In Canada, pharmacies were surveyed in three provinces: Ontario, British Columbia, and Nova Scotia. In Mexico, pharmacies were surveyed in Monterrey and Guadalajara.

Prices from Canadian pharmacies were determined in Canadian dollars, and prices from Mexican pharmacies were determined in pesos. All prices were converted to U.S. dollars using commercially available exchange rates.

D. Selection of Drug Dosage and Form

In comparing drug prices, the study generally used the same drug dosage, form, and package size used by the U.S. General Accounting Office 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.*[15] The dosages, forms, and package sizes used in the study are shown in Table 1.

All prescription drugs surveyed in this report were available in Canada in the same dosage and form as in the United States. In Mexico, several drugs were not available in the same dosage and form. In these cases, prices of equivalent quantities were used for the comparison. For example, in the United States the drug Zocor is commonly available in containers containing five mg. tablets, while in Mexico Zocor is available only in containers containing ten mg. tablets. To compare Zocor prices, this report compared the cost of 60 five mg. tablets of Zocor in the United States with the cost of 30 ten mg. tablets in Mexico. Several drugs are also sold under different names in Mexico. The Mexican equivalents of U.S. brand names were determined using the 44th edition of the *Diccionario de Especialdades Farmaceuticas* (1998).

III. FINDINGS

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

A. Senior Citizens in New Mexico's 3rd Congressional District Pay More for Prescription Drugs Than Consumers in Canada

Consumers in Canada obtain prescription drugs in one of two primary ways. Approximately 35% of the prescription drugs sold in Canada are paid for by the provincial governments on behalf of senior citizens, low-income individuals, and other beneficiaries of government health care programs. The rest of the population in Canada must either buy their own drugs or obtain prescription drug insurance coverage.

The regulatory system in Canada protects individual consumers who buy their own drugs from price discrimination.[16] The Patent Medicine Prices Review Board (PMPRB), established under the Ministry of Health by a 1987 law, regulates the maximum prices at which manufacturers can sell patented medicines.[17] If the Board finds that the price of a patented drug is excessive, it may order the manufacturer to lower the price, and may also take measures to offset any revenues the manufacturer has received from the excess pricing.[18] Pharmacy dispensing fees for individual retail customers are not controlled by the government. Each pharmacy sets its usual and customary dispensing fee and must register this fee with provincial authorities.[19]

This study indicates that the Canadian system produces prescription drug prices that are substantially lower in Canada than in Rep. Udall's district. Average prices for seniors who lack insurance coverage were 80% higher in Rep. Udall's district than in Canada (Table 1).

For all five drugs, prices were higher in Rep. Udall's district. For two drugs, Zocor and Prilosec, the prices in Rep. Udall's district were more than twice as high as the Canadian prices.

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[16] Patented Medicine Prices Review Board, *Tenth Annual Report for the Year Ended December 31, 1997* (1998) (online at www.atreide.net/PMPRB).

[17] The PMPRB establishes a set of guidelines to determine if manufacturers' prices are excessive. Under these guidelines, the prices of new drugs must not exceed the maximum price of other drugs that treat the same disease. For "breakthrough" drugs, introductory prices must not exceed the median of the prices of the drugs in other industrialized countries. Subsequent price increases are limited to changes in the Consumer Price Index.

[18] These may include further reductions in the price of the drug, reductions in the price of another of the manufacturer's drugs, or additional payments directly to the Canadian government.

[19] These fees are generally only a small part of the overall prescription drug prices. In Ontario, for example, pharmacies charge usual and customary dispensing fees ranging from $1.25 to $12.00. Ontario Drug Benefit Formulary Program, *ODB Facts: Dispensing Fees* (June 1998) (dispensing fees converted to U.S. dollars).

The highest price differential among the top five drugs was 122%, for Zocor, a cholesterol medication manufactured by Merck.

For other drugs, price differentials were even higher. Synthroid is a hormone treatment manufactured by Knoll Pharmaceuticals. For this prescription drug, senior citizens in Rep. Udall's district must pay an average price of $27.97, while consumers in Canada pay only $10.53 -- a price differential of 166%. Similarly, for Micronase, a diabetes drug manufactured by Upjohn, senior citizens in Rep. Udall's district pay prices that are 246% higher than Canadian consumers.

In dollar terms, uninsured senior citizens in Rep. Udall's district pay $57.30 more than consumers in Canada for a one month supply of Prilosec -- an annual price difference of almost $700. Similarly, a senior in Rep. Udall's district pays over $55 more than a senior in Canada for a two month supply of Zocor, an annual difference of over $330, and over $90 more than a senior in Canada for a 100 day supply of Zoloft, an annual difference of over $325.

The findings in this report are consistent with the findings of other analyses. In 1992, GAO looked at the prices that drug companies charge wholesalers for prescription drugs in the United States and Canada. The results of the GAO study showed that, for the top five drugs in the United States, the average differential between the price in the United States and the price in Canada was 79%.[20] According to GAO, "government regulations and reimbursement practices contribute to lower average drug prices in Canada. In setting prices, manufacturers of patented drugs must conform to Canadian federal regulations that review prices for newly released drugs and restrain price increases for existing drugs."[21]

Similarly, in 1998, Canada's Patented Medicine Prices Review Board performed a comprehensive review of prices in Canada, the United States, and six European countries.[22] The Board found that prescription drug prices in the United States were 56% higher than prices in Canada, and that prices were even lower in other industrialized countries. Prices in the United States were 96% higher than prices in Italy, 75% higher than prices in France, 55% higher than prices in the United Kingdom, 47% higher than prices in Sweden, 40% higher than prices in Germany, and 26% higher than prices in Switzerland. The United States had the highest prices among the eight industrialized nations that were part of the survey.

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[20] U.S. General Accounting Office, *Prescription Drugs: Companies Typically Charge More in the United States Than in Canada*, 14 (September 1992) (GAO-HRD-92-110). For a broader set of 121 drugs, which included both brand name and generic drugs, GAO found that the average price differential was 32%.

[21] *Prescription Drugs: Companies Typically Charge More in the United States Than in Canada*, *supra* note 20, at 2-3.

[22] *Tenth Annual Report for the Year Ended December 31, 1997*, *supra* note 16, at 18.

GAO also investigated whether the price differential it observed was attributable to differences in the costs of production and distribution. GAO found that drug costs -- such as research and development -- are not allocated to specific countries, and the costs of production and distribution make up only a small share of the cost of any drug. The study concluded that "production and distribution costs cannot be a major source of price differentials."[23]

B. Senior Citizens in New Mexico's 3rd Congressional District Pay More for Prescription Drugs Than Consumers in Mexico

As in Canada, consumers in Mexico also obtain prescription drugs in one of two primary ways. Approximately 30% of the prescription drugs sold in Mexico are purchased by the government and provided to eligible citizens at a significant discount through the social security system.[24] The rest of the population in Mexico must either buy their own drugs or obtain prescription drug insurance coverage.

The regulatory system in Mexico, like the system in Canada, protects individual consumers who buy their own drugs from price discrimination. Drug prices and rates of price increases in Mexico are controlled by the Ministry of Commerce and Economic Development (known by its Spanish acronym, Secofi) under the Pact For Economic Stability and Growth.[25] Under the Mexican law, manufacturers and the government engage in negotiations to determine the nationwide maximum prices for prescription drugs.[26] Pharmaceutical products are prepackaged and stamped with the maximum sales price, guaranteeing consistent prices throughout the country.

This study indicates that the Mexican system produces prescription drug prices that are substantially lower in Mexico than in Rep. Udall's district. Average prices for the top five drugs for seniors were 78% higher in Rep. Udall's district than in Mexico (Table 1). Prices for four of the five most popular drugs were higher in Rep. Udall's district. The highest price differential among the top five drugs was 250%, for Prilosec, an ulcer medication manufactured by Astra/Merck.

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[23] *Prescription Drugs: Companies Typically Charge More in the United States Than in Canada*, *supra* note 20, at 14.

[24] *Financing Health Care: The Health Care System in Mexico*, *supra* note 11.

[25] Jeanne Grant, *Headaches for Pharmaceuticals*, Business Mexico, 8f (August, 1991).

[26] The final negotiated price is based on a number of factors, including the purchasing power of the Mexican population, the availability of generic substitutes or other drugs that treat similar diseases, and other economic factors, such as the manufacturers' cost to produce the product.

For other drugs, price differentials were even higher. In the case of Micronase, senior citizens in New Mexico's 3rd Congressional District pay an average price of $46.69, while consumers in Mexico pay only $9.48 -- a price differential of 393%.

In dollar terms, uninsured senior citizens in Rep. Udall's district pay over $80 more than consumers in Mexico for a one month supply of Prilosec -- an annual price difference of over $960. Similarly, a senior in Rep. Udall's district pays almost $35 more than a senior in Mexico for a two month supply of Zocor, an annual difference of over $200, and over $53 more than a senior in Mexico for a 100 day supply of Procardia XL, an annual difference of more than $190.

These findings are consistent with those of other experts. While there have been few direct comparisons of prices in the United States and Mexico, the Congressional Research Service has found that differences in the regulatory systems between the two countries result in the large price differentials. CRS concluded that "of greater importance in explaining price differentials in drug prices in Mexico and the United States is the fact that price controls and government procurement policies are in place in Mexico, and have been for some time."[27]

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[27] *Prescription Drug Price Comparisons: The United States, Canada, and Mexico*, *supra* note 12.