THE WHITE HOUSE

OFFICE OF LEGISLATIVE AFFAIRS
HOUSE LIAISON
—FAX COVER SHEET—

DATE: 10/14

TO: Chris Jennings
D. P. C.

FAX: 6-5557

FROM:

___ BRODERICK JOHNSON	___ JOSH ACKIL
___ AL MALDON	___ ERICA MORRIS
_✓_ LISA KOUNTOUPES	___ LAUREN GILLESPIE
___ JANELLE ERICKSON	___ BRIAN MASON

(202)456-6620 (TELEPHONE)
(202)456-2604 (FAX)

SUBJECT: Attached please find West letter on Allen bill. Would like to discuss our next steps on this/our response

1 OF 4

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

AUG 13 1999

AUG 11 1999

In Reply Refer To:

The Honorable Cliff Stearns
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your letter on the impact on the Department of Veterans Affairs (VA) of H.R. 684, which would extend favorable government prices for pharmaceuticals to the Medicare population.

We are very concerned that this proposed legislation would have an indirect, negative impact on VA pharmaceutical budgets. Section 3(c) of the bill would force covered outpatient drug manufacturers to sell to Medicare-affiliated pharmacies at the lower of the Medicaid reported best price or the "lowest price paid for [the drug] by any agency or department of the United States". The latter benchmark would include not only low Federal Supply Schedule (FSS) and FSS Blanket Purchase Agreement (BPA) prices negotiated by VA for the Government, but also large volume committed use national contract prices obtained by VA and/or Department of Defense (DOD) in head-to-head competitive procurements. Perhaps most importantly, the "lowest price paid" benchmark would include many Federal ceiling prices (FCPs) already imposed on manufacturers by the Veterans Healthcare Act of 1992. Section 603 (Public Law 102-585; 38 U.S.C. 8126).

By way of further information, through many recent inquiries by drug manufacturers regarding this bill, we have been informally informed that manufacturers may no longer offer lower-than-FCP prices to VA and DOD in BPA and national contract negotiations. They may also invoke 30-day cancellation clauses in FSS contracts and BPAs, to the extent allowed by Public Law 102-585, which would force Government healthcare agencies to buy drugs in the open market at much higher retail prices or AWPs (average wholesale prices).

The Honorable Cliff Stearns

In summary, we believe enactment of H.R. 664 would increase VA's annual pharmaceutical costs by $500-600 million. We would be pleased to discuss this matter further with you. If you have additional questions, please contact me or Mr. John Ogden, Chief Consultant for Pharmacy Benefits Management, at 202.273.8429/8426.

Sincerely,

Thomas L. Garthwaite, M.D.
Acting Under Secretary for Health

Bangor Daily News 10/5/99

VA calls Allen's prescription drug bill too costly

By Jill Carroll
States News Service

WASHINGTON — Rep. Tom Allen's measure to reduce the price of prescription drugs for seniors was criticized by the U.S. Veterans Affairs department for costing the VA millions of dollars, a key House panel announced Monday.

The measure would cost the Veterans Affairs department $500 million-600 million stated Thomas Garthwaite, VA acting undersecretary for health, in an August letter to Rep. Cliff Stearns, R-Fla., chairman of a House subcommittee on health.

But the Democrat from Portland, who attended the Veterans Affairs Subcommittee on Health hearing to answer questions with other House members about prescription drug benefits, said the numbers were baseless.

"There is no evidence in the letter of how they got that number," Allen said.

He also said there is no way to know the price for prescription drugs the government and drug makers will agree on, therefore the VA can't know they will lose a certain amount of money.

But Garthwaite said in the letter that drug makers have informally told the VA that because of the bill they may take actions that "would force government [health care] agencies to buy drugs in the open market at much higher retail prices."

Allen's measure is aimed at lowering the costs of medicines for the elderly on Medicare. It allows pharmacies to buy prescription drugs for Medicare recipients at the lowest rate given to the federal government.

The federal government purchases the medicines at half the retail price consumers pay, Allen said.

Allen expects the pharmacies to pass on their savings to the elderly on Medicare. But the House panel asked Allen how he could be sure the companies would choose to give Medicare recipients a lower price for drugs rather than beef up their bottom line.

"[Seniors] are checking around at pharmacies in their area to get the lowest price," Allen said, adding that pharmacies will be able to afford lower prices and will do so because of competition.

Sen. Olympia Snowe has also introduced a prescription drug measure that would benefit Medicare recipients.

The measure would allow seniors to have a choice in insurance plans with varying prescription drug benefits.

Medicare recipients would be covered for outpatient prescription drugs with co-payments and annual deductibles. Seniors will be able to choose between Medicare Choice or supplemental drug plans.

Money for the measure would come from tobacco taxes proposed in the president's budget.

Seniors making below 150 percent of the poverty level, $12,075 for a single person, won't have to pay any premiums for prescription drug insurance under the plan.

Those making between 150 and 175 percent of the poverty level, $14,088 for a single person, will have money helping with premiums lowered from 100 percent to 25 percent.

Seniors that don't fall in these ranges will have 25 percent of their premiums paid for by the government, under Snowe's measure.

Snowe's bill is still in committee.

UNITED STATES SENATOR JOHN BREAUX

Facsimile Transmission

TO: Chris Jennings

FROM: Sarah Walter

FAX NUMBER TRANSMITTED TO: _____

DATE: _____ TIME: _____

NUMBER OF PAGES INCLUDING COVER SHEET: 5

RE: _____

PLEASE DELIVER THIS INFORMATION AS SOON AS POSSIBLE

UNITED STATES SENATE
WASHINGTON, D.C. 20510
(202) 224-4623

SUMMARY OF BREAUX-FRIST LEGISLATIVE PROPOSAL
COMPETITIVE MEDICARE PREMIUM SYSTEM

Establishment of Competitive Medicare Premium System

Beginning January 1, 2003, a new title (Title 22) is created to establish a competitive Medicare premium system for Medicare. Title 18 (the current Medicare title) is preserved to the extent it does not conflict with new provisions in Title 22. Beneficiaries will continue to be entitled to benefits under Title 18 through enrollment in a Medicare plan.

Medicare Board

The President, with the advice and consent of the Senate, will appoint a 7-member Medicare Board. The Board will administer the competitive environment and will be responsible for coordinating and determining beneficiary eligibility and enrollment; negotiating contracts with entities offering Medicare plans, including HCFA; and disseminating information to beneficiaries with respect to benefits, cost-sharing, and quality indicators under Medicare plans.

Under current law, HCFA runs the fee-for-service and Medicare+Choice programs and controls the terms of competition between private plans. With the establishment of the Medicare Board, HCFA will be responsible for administering its own standard and high-option plans and the Board will oversee competition between HCFA's plans and private plans.

The first Board appointees will serve staggered terms, with all appointees limited to two terms on the Board. Following the first set of staggered terms, each term would run seven years.

Benefit Package

All Medicare beneficiaries will at a minimum continue to be entitled to the same benefits they are entitled to today. Beneficiaries may choose from a variety of plans, including private standard plans, private high option plans, the HCFA-sponsored standard plan, or HCFA-sponsored high option plans. No plan can be approved by the Medicare Board unless it covers at least the same benefits that beneficiaries have today. The Board may not approve any benefit package designed to result in favorable selection of beneficiaries.

Standard and High-Option Plans

All entities offering Medicare plans must also offer a high-option plan. High-option plans include the standard core Medicare benefits plus outpatient prescription drug coverage and stop-loss protection for standard benefits. Outpatient prescription drug coverage must meet an actuarially equivalent value of $800 in 2003 (adjusted annually for increases in reasonable drug costs). In any given year a beneficiary's out-of-pocket costs for current Medicare benefits cannot exceed $2,000.

HCFA-Sponsored Standard and High-Option Plans

HCFA will offer a nationwide standard plan to include all Title 18 benefits currently available under the Medicare fee-for-service program. HCFA will submit premium information for this plan to the Board as other plans do. Current payment and coverage rules and regulations applicable under the fee-for-service program will also apply to the HCFA-sponsored standard plan. HCFA will bear the full financial risk for its standard plan offering.

Beginning in 2003, HCFA will offer one or more high option plans, in addition to the standard plan, through partnerships with private entities. Insurers, pharmaceutical benefit

managers, chain pharmacies, Medigap insurers, groups of independent pharmacies, or other qualified private entities may partner with HCFA to offer drug coverage as part of a HCFA-sponsored high option plan. The HCFA-sponsored high-option plan must meet the same minimum actuarial value of drug benefits as other private high-option plans. HCFA may not exclude qualified private entities offering to partner with HCFA to form a high option plan, as long as the Medicare Board approves the arrangement.

Only beneficiaries enrolled in the HCFA-sponsored standard plan will continue to be able to purchase Medicare supplemental insurance.

Qualifications to Offer a Medicare Plan

In order to offer a Medicare plan, a plan must meet the requirements currently applicable to Medicare+Choice plans and organizations, including the offering of benefits and protections for Medicare beneficiaries. Plans must submit to the Medicare Board a description of benefits, the bid for the package of benefits, and the proposed service areas. The Medicare Board will review the information submitted and negotiate premium and benefit design with the plans.

Payments to Medicare Plans and Computation of the Beneficiary Premium

- **Step 1:** The Board publishes, with a reasonable amount of notification to plans, geographic and risk adjusters.
- **Step 2:** An entity submits a bid for a package of benefits to the Medicare Board.
- **Step 3:** The Board computes a premium for core benefits (by carving out the core benefits plus any de minimis additional benefits).
- **Step 4:** The Medicare Board calculates a premium schedule based on computation of the national weighted average premium (NWA). The NWA premium is equal to the weighted average of the premium for core benefits, with the weight for each plan being equal to the average number of beneficiaries enrolled in that plan in the previous year.
- **Step 5:** Beneficiary premiums are determined for both standard and high option plans (as described below).
- **Step 6:** The amount of payment to a Medicare plan per enrollee is equal to the premium for the plan as approved by the Medicare Board. That portion of the premium associated with core benefits is subject to geographic and risk adjustment.

Computation of Beneficiary Premiums

- The beneficiary pays no premium if the premium for the plan selected is less than 85% of the NWA premium.
- If the premium for a plan exceeds 85% (but is less than 100%) of the NWA premium, the beneficiary premium will be equal to 80% of the amount by which the plan premium exceeds 85% of the NWA premium.
- If the premium for a plan is equal to or greater than 100% of the NWA premium, the beneficiary premium is equal to 12% of the NWA premium, plus the amount (if any) by which the plan premium exceeds the NWA premium.

Premium collection for low-income beneficiaries shall occur in the same manner as under current law, so that a beneficiary's share of the premium for Medicare benefits is deducted from their Social Security check. Medicare plans are not responsible for collection of premiums.

Unified Medicare Trust Fund; Combining Parts A and B

Effective January 1, 2003, a single trust fund, known as the Medicare Trust Fund, is created. This unified trust fund will include all three current sources of funds (payroll taxes, premiums, and general revenue contributions) and any additional fees imposed on plans by the Medicare Board.

The Medicare Board is responsible for reporting to Congress annually the percentage of total Medicare expenditures from the Medicare Trust Fund through general revenues; the first fiscal year the Medicare Trust Fund is determined to be programmatically insolvent; and the first fiscal year in which the Medicare Trust Fund will be insufficient to pay for the total expenses incurred. In any year in which general revenue contributions would otherwise exceed 40% of total Medicare expenditures, the Medicare Trust Fund will be deemed programmatically insolvent and Congressional approval will be required prior to additional general revenue transfers into the Medicare Trust Fund.

Division of HCFA-Sponsored Plans

HCFA will be divided into two divisions, the Division of HCFA-Sponsored Plans and the Division of Health Programs. The Division of HCFA-Sponsored Plans will only be responsible for administering HCFA's standard and high option plans under the competitive premium system. The Division of Health Programs will continue to maintain all other non-plan and non-insurance functions, such as the Medicaid program, the State Children's Health Insurance Program, disproportionate share hospital payments and graduate medical education payments. Within six months of enactment, a director shall be appointed to oversee each division.

HCFA Business Planning and Administrative Flexibility

Beginning on January 1 of each year, and no later than January 1, 2002, the Director of HCFA-Sponsored Plans must submit a business plan to Congress. This plan must include a comprehensive payment and management plan for all aspects of offering core benefits, information about partnership arrangements with private entities for prescription drug coverage in high option plans, and recommendations for benefit coordination and improvements. The plan must include legislative specifications necessary to enact the business plan. The business planning process will be exempt from OMB oversight and APA requirements, provided that the division establishes procedures for public comment. The CBO, GAO, and MedPAC must submit reports to Congress evaluating the business plan's impact on cost, providers, and beneficiary access to care.

Each year, Congress must hold Congressional hearings on the business plan. HCFA's business plan will be guaranteed an up or down vote by Congress under fast track procedures by 2005. After 2008, the HCFA-sponsored business plan and recommendations for benefit improvements will take effect without the explicit approval of Congress.

Premium Discount for Drug Benefits Under High Option Plans

Low-Income Protection Package

Beneficiaries at or below 135% of poverty will pay zero premium for enrollment in the lowest cost high-option plan in their area. Beneficiaries qualifying for this subsidy include dually eligibles, qualified low-income Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), and certain qualifying individuals (QI-1s). The Medicare Board will establish an arrangement with each state to determine eligibility for these beneficiaries.

A beneficiary whose income is above 135% of poverty but less than 150% of poverty will receive a discount for drug benefits, phasing down from a 50% discount at 136% of poverty to a 25% discount at 150% of poverty.

States must maintain their current level of premiums, cost-sharing, and deductibles, as required under current law, for beneficiaries at or below 135% of poverty. States maintain their premium contributions for low-income beneficiaries by contributing the lower of 12% of the national weighted average premium for core benefits or the beneficiary premium for the HCFA-sponsored standard plan, whichever is lower.

If a qualified low-income beneficiary chooses a higher cost high option plan, the beneficiary will receive a discount based on the premium for the lowest cost high option plan.

Beneficiaries above 150% of poverty

Beneficiaries above 150% of poverty choosing a high-option plan will receive a 25% discount off the premium for that high option plan (based on the minimum actuarial value of the high option drug benefit). The value of the discount for drug premiums will be treated as taxable income for beneficiaries so that the discount is income-related.

Guaranteed Access Provisions

Under the competitive premium system, beneficiaries are protected from higher premiums in areas where there is no competition. If the only standard Medicare plan offered in an area is the HCFA-sponsored standard plan, the beneficiary premium for the HCFA-sponsored standard plan may not exceed 12 percent of the national weighted average premium or the beneficiary premium for the HCFA-sponsored standard plan, whichever is lower.

If the only high option Medicare plan offered in an area is the HCFA-sponsored high option plan, the beneficiary premium may not exceed the sum of 12 percent of the national weighted average premium plus the difference between the beneficiary premium for the HCFA-sponsored standard and high option plans.

The Medicare Board will also guarantee all beneficiaries a drug benefit package meeting the actuarial equivalence of drug benefits offered in high option plans, regardless of where they reside.

Medicare Beneficiary Outreach and Education

The Medicare Board may authorize the establishment of Medicare Consumer Coalitions (MCCs), where a non-profit organization, composed primarily of Medicare beneficiaries in a given area, is organized to provide for beneficiary outreach and education of Medicare benefit offerings. Specifically, MCCs will conduct programs to prepare and disseminate to Medicare beneficiaries comprehensive, accurate, timely and understandable information on qualified health plans or Medicare supplemental policies in which beneficiaries are eligible under the competitive premium system. All Medicare beneficiaries are eligible to enroll in an MCC.

Talking Points for Senate Democratic Caucus

- In a minute, I'm going to ask Chris to run through the major provisions of the legislation to give you a sense of where things stand as of last night.

- First, while we have some very significant outstanding concerns, let me say how pleased we are with the progress we have made since we last met, thanks to the hard work of Senate Democrats and the Administration. As you know, the President said publicly last week that Congress must complete action on the Medicare provider legislation before adjourning for the year, and he and I reiterated this commitment at our cabinet meeting yesterday. He and I also agree that one of the major reasons we have progressed so far is the leadership that Senate Democrats have shown on this issue, particularly through Senator Daschle's legislation.

- While we are still reviewing the language on individual provisions, it looks as though we have generally acceptable resolution on skilled nursing facilities, home health care, the therapy caps, and several second tier issues.

- We continue to have major concerns in other areas, and will be working closely with Senator Daschle, Senator Moynihan and their colleagues in the House to resolve these issues to our satisfaction in discussions that will resume this afternoon.

- First on the list is graduate medical education, where we are pushing to increase the annual update for indirect education and strike the House provision that would reallocate direct medical education dollars.

- We also continue to have problems with the provisions that delay risk adjustment or increase payment for managed care.

- We are also working with Congressman Dingell and others to address several Medicaid-related issues, including an increase in payments to community health centers for Medicaid patients, and restoring Medicaid eligibility for certain legal immigrants.

- We have also asked the Republicans to include a managed care demonstration program designed by Senator Mikulski that would encourage health plans to participate in unserved areas in Maryland.

- If I could, let me now turn it over to Chris to go through the individual provisions in more detail.

THE PRESIDENT HAS SEEN
11-9-99

99 NOV 9 PM 12:09

THE WHITE HOUSE
WASHINGTON

copied
Jennings
Reed
Sperling
Podesta

November 8, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings

SUBJECT: Proposal to Create a Medicare Board

CC: Bruce Reed, Gene Sperling

Secretary Shalala has drafted the attached memorandum to respond to a proposal by Senator Breaux and Congressman Thomas to create an independent board to supervise the Health Care Financing Administration's (HCFA) administration of the Medicare fee for service system, as well as to separately oversee operation of private plans participating in the Medicare program. Although it appears that proposals for a Medicare board will not be passed by this Congress, the ongoing frustration of the Congress and its constituents regarding HCFA's role in administering the Medicare program are certain to lead to future discussions about this issue.

Recognizing this, we have been strongly encouraging the Department to integrate a series of private sector practices that would hopefully lead to better coordination and administration of the agency's substantial responsibilities. Nancy-Ann Min DeParle has indicated her willingness to advocate for and implement these initiatives because she thinks that they will improve the agency's operational status and credibility, making it possible to fend off unconstructive initiatives that undermine the agency's ability to manage the program effectively.

BACKGROUND

HCFA remains one of the most passionately reviled agencies in the Federal government. This is logical, as it is responsible for denying reimbursement for desired claims from providers and state and local agencies alike. In addition, HCFA's numerous responsibilities makes it difficult for it to effectively manage, and there tends to be little time available for anything other than crisis management. Long-term planning is rare and frequently altered substantially by Congress and other outside entities, making stable and predictable management impossible.

Congressman Thomas and Senator Breaux believe that an independent board would help facilitate better management and utilize the best private sector management techniques. They believe the agency is inherently biased against private insurance plans participating in the program, causing the frustration and problems HMOs participating in the Medicare program have experienced. They also view this board as a possible vehicle to develop and implement benefit coverage and policy changes in a process independent of political intervention from the Congress and other outside sources.

THE PRESIDENT HAS SEEN
11-9-99

In the memo from the Secretary, she counters that a Medicare board would reduce beneficiary protections, dilute Presidential authority, and provide the infrastructure to end the Medicare entitlement. The Department also argues that such a structure would lead to limited accountability by the Medicare program to both the White House and the Congress, and create extreme difficulties in managing program integrity initiatives, including anti-fraud and abuse efforts, within all aspects of the agency. While these are valid arguments and should be taken seriously, the same effort that was exerted to make these arguments should also be applied to the Department's commitment to reform the agency.

While we concur with the Secretary's memo that proposals such as those developed by Congressman Thomas and Senator Breaux would be detrimental to the Medicare program and the beneficiaries it serves, this type of proposal should serve as a warning to the agency to be more efficient and responsive to both the White House, the Congress, and the various advocacy, provider, and insurer communities it deals with.

We believe that we should use this opportunity as a means to strengthen the Medicare program and push HCFA to ensure that it is more prudently managed. In so doing, the agency will have the additional benefit of strengthening its credibility when opposing harmful and poorly thought out reform proposals.

'99 NOV 1 P4:35

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 25 1999

MEMORANDUM FOR THE PRESIDENT

I am writing to express my deep concern over discussions occurring in Congress that could result in creation of a new, independent Medicare board. As envisioned by its proponents, this board would operate as an independent entity designed to oversee the Medicare+Choice program, including the competition among private plans and between private plans and fee-for-service Medicare. The creation of such a board seriously undermines your authority over Medicare, the beneficiary protections that you have worked hard to establish for this program, and the significantly improved refocused management which has reduced the Medicare error rate by over fifty percent. This new board also sets the stage for capping government expenditures for Medicare, threatening Medicare beneficiaries' entitlement to first-class medical care.

The board's advocates say they want to bring private-sector expertise into the administration of the program and say they want to avoid conflicts of interest in running a competitive system. Their first goal is being accomplished without undermining the current strengths of Medicare and their second contention is a false promise. Not only will their proposals not achieve their goals, but, for the reasons stated below, they would substantially undercut our ability to serve beneficiaries and efficiently administer the program. At the end of this memorandum, I will describe the activities that we have already undertaken to garner additional private sector expertise in administering Medicare.

Medicare Board Leads to Reduced Beneficiary Protections. Under your leadership and through the hard work of this Department, we have ensured that Medicare includes the beneficiary protections outlined in your Patients' Bill of Rights. Medicare was one of the first programs in the country to incorporate these protections and remains a model program. This would not have been possible if the Medicare+Choice program were administered by an independent board.

Given the hostility we have seen in the private sector to even the modest proposals in the Patients' Bill of Rights, I do not believe that a board comprised of private sector health officials would have taken a strong, pro-beneficiary stance. It is not surprising that the strongest proponents of a Medicare board, including managed care interests, are among the most active opponents of strong patient rights legislation. I believe that we must maintain our ability to keep Medicare in the forefront of beneficiary protection. Creation of an independent Medicare board is not consistent with that imperative.

Medicare Board Dilutes Presidential Authority. Placing the Medicare+Choice program under the control of an independent board splits accountability for the program and substantially dilutes your authority over a substantial portion of Medicare. This is a significant loss given that Medicare serves 39 million beneficiaries and makes up 11 percent of the Federal budget.

The Administration's ability to make changes to Medicare in the context of the President's Budget would be limited. This is especially true since proposals for treating traditional fee-for-service Medicare as a health plan under the structure of Medicare+Choice would allow a new board to exercise substantial authority over the entire program. In particular, a board could be given substantial authority over what private health plans would be paid by Medicare. It could also be given authority to oversee aspects of traditional Medicare, including benefits and, under some proposals, total spending by traditional Medicare.

As a result, the presence of a board would have hampered our ability to exert strong budget discipline, such as the steps we have taken to extend the life of the Medicare Part A Trust Fund to 2015. Similarly, it would not have been possible to use Medicare changes to help finance key domestic initiatives to improve the health of the nation, such as the Children's Health Insurance Program.

Furthermore, creation of a board would limit the Administration's authority to make key program changes to address Medicare problems identified by beneficiaries, providers, or other segments of the American public.

Medicare Board Diffuses Accountability for Medicare. Authority over certain key functions would be unnecessarily complicated by bifurcating control of Medicare between a board and the Health Care Financing Administration (HCFA).

For example, Administration efforts to reduce fraud and abuse in Medicare have been successful because we have provided clear, consistent policy guidance and because we have been willing to take the political heat generated by our aggressive stance. I do not believe that an independent board (especially one that includes private sector health care executives, as would be likely with any congressionally created board) would have initiated or sustained such a controversial, yet productive, program. Specifically, the HCFA actuaries credit aggressive fraud control efforts with bringing down the Medicare baseline through reducing either the rate of growth or the actual level of spending on inpatient hospital services, home health, and lab services. Our efforts have also led to the first-ever decline in hospital upcoding since the inception of a prospective payment system in 1984. The bifurcation of authority under a board would threaten the significant advances made by this Administration by complicating the relationship between the program and the HHS Inspector General and between Medicare and the Department of Justice.

Similarly, this Administration has taken significant steps to measure and hold health plans and providers accountable for quality of care for seniors and other vulnerable populations. The diffusion of accountability threatens our ability to move aggressively in this area as we have on the Patients' Bill of Rights.

Medicare Board Creates Potential Confusion of Authority That Would Be Detrimental to Beneficiaries. HCFA is currently responsible for a wide range of activities that might become the responsibility of either the board or HCFA, or both. These functions include beneficiary education, procedures for appeals and grievances, provider enrollment, survey and certification of providers, and quality assurance. If these functions were assigned to HCFA, their applicability to private plans would become uncertain; if assigned to the board, more functions would be removed from the lines of public accountability. If assigned to both, there would be confusion and uncertainty among all parties involved.

A Medicare Board Provides the Infrastructure for Ending the Medicare Entitlement. Although the proponents of a board deny that they intend to fundamentally change Medicare, it is clear that creation of an independent board would establish the administrative framework for a defined contribution plan, which specifies the government's financial contribution toward beneficiaries' health care but does not specify the benefits to which beneficiaries are entitled. Creating an independent board is an ideal first step toward capping government contributions for Medicare, and beneficiary advocates will see it as such. It is not surprising that some of the strongest advocates in Congress for a board are the same Members who tried to cap Medicare spending in the 1995 budget bill that you vetoed.

Claims About Current Conflicts of Interest in Managing Medicare Are Not Legitimate. Advocates for a board argue that HCFA has an inherent conflict of interest in both managing the competition among private health plans and fee-for-service Medicare and operating the fee-for-service Medicare program. In fact, the risk of conflict of interest could be greater if managed care executives, hospital administrators, physicians, durable medical equipment suppliers, or any other individual who benefits from Medicare payments were given statutory powers through participation on the board.

Today, HCFA manages both original Medicare and Medicare+Choice, having successfully supervised the growth of Medicare+Choice to a program that enrolls about one of every six beneficiaries. HCFA's role is not unique – conflicts of interest are successfully avoided by CalPERS and many private employers that run self-insured plans while contracting with competing health plans.

The assertion that HCFA's dual role creates a conflict of interest may stem from certain decisions that private plans may find onerous, such as those in setting standards for consumer protection and quality assurance. Such decisions stem directly from HCFA's primary concern for serving the needs of beneficiaries, not from any desire to bias the competition. If a Medicare board also places serving the needs of beneficiaries as its core mission, it will inevitably make similar decisions. Thus, it will also be subject to the same charges of conflict of interest.

Under your proposal for a competitive defined benefit, traditional Medicare and private health plans would compete on an equal footing, allowing both Medicare and beneficiaries to save when beneficiaries choose efficient health plans. As discussed above, I believe that many board proponents are using the conflict of interest accusation as an excuse to take the first step toward ending the entitlement.

Private Sector Involvement Can be Achieved Without a Medicare Board. While I am deeply concerned about the proposals to create an independent board to administer a portion of Medicare, I am committed to expanding the program's access to private sector expertise. In September, we chartered a Management Advisory Committee for HCFA. This step was part of HCFA management modernizations contained in your budget. The committee allows HCFA to get expert advice from individuals in the public and private sector regarding innovations in management practices. It also will allow HCFA to maintain critical relationships with public and private sector experts in management, leadership, and purchasing strategies. The committee will address issues including how HCFA can better manage its private sector contractors and how it can be a more prudent purchaser of fee-for-service Medicare services. The committee need not make recommendations regarding payment or coverage policy, because the Medicare Payment Advisory Commission (MedPAC) and the recently established Medicare Coverage Advisory Committee already fulfill these functions.

I will chair the committee, which will include up to 11 additional members that I will appoint. The members will be selected from among nationally recognized authorities in academia, private consulting, public and private sector health purchasing entities, and private companies. The committee would not include provider or beneficiary representatives since they are already represented in many advisory committees to the Congress and the Department.

If Medicare reform is successful, this committee could also easily be adapted to serve as an advisory body for the implementation of the fee-for-service modernization reforms included in your Medicare plan. Experts from private and public sector organizations that purchase health care for their employees and beneficiaries, as well as experts in public administration, would provide recommendations to the Secretary on how to implement these reforms to purchase services more competitively. HCFA would benefit from the advice of these experts in a forum open to public participation.

In Conclusion, Creation of a Medicare Board to Oversee a Portion of the Program Would Be a Grave Mistake. It would be a disservice to our successors and to future generations of beneficiaries if we were to weaken the executive management of Medicare, not only because it is a substantial and growing proportion of federal outlays, but because older and disabled Americans are particularly vulnerable and need government protection. This Administration has strengthened Medicare in innumerable ways: extending solvency, increasing benefits, advancing new beneficiary protections, and strengthening program integrity. The Medicare program would most likely not be experiencing the benefits of the Administration's improvements had the Medicare board, as proposed, been in existence.

Donna E. Shalala

UNITED STATES SENATOR JOHN BREAUX

Facsimile Transmission

TO: Chris Jennings

FROM: Sarah Walter

FAX NUMBER TRANSMITTED TO: _____

DATE: _____ **TIME:** _____

NUMBER OF PAGES INCLUDING COVER SHEET: 5

RE: _____

PLEASE DELIVER THIS INFORMATION AS SOON AS POSSIBLE

UNITED STATES SENATE
WASHINGTON, D.C. 20510
(202) 224-4623

SUMMARY OF BREAUX-FRIST LEGISLATIVE PROPOSAL
COMPETITIVE MEDICARE PREMIUM SYSTEM

Establishment of Competitive Medicare Premium System

Beginning January 1, 2003, a new title (Title 22) is created to establish a competitive Medicare premium system for Medicare. Title 18 (the current Medicare title) is preserved to the extent it does not conflict with new provisions in Title 22. Beneficiaries will continue to be entitled to benefits under Title 18 through enrollment in a Medicare plan.

Medicare Board

The President, with the advice and consent of the Senate, will appoint a 7-member Medicare Board. The Board will administer the competitive environment and will be responsible for coordinating and determining beneficiary eligibility and enrollment; negotiating contracts with entities offering Medicare plans, including HCFA; and disseminating information to beneficiaries with respect to benefits, cost-sharing, and quality indicators under Medicare plans.

Under current law, HCFA runs the fee-for-service and Medicare+Choice programs and controls the terms of competition between private plans. With the establishment of the Medicare Board, HCFA will be responsible for administering its own standard and high-option plans and the Board will oversee competition between HCFA's plans and private plans.

The first Board appointees will serve staggered terms, with all appointees limited to two terms on the Board. Following the first set of staggered terms, each term would run seven years.

Benefit Package

All Medicare beneficiaries will at a minimum continue to be entitled to the same benefits they are entitled to today. Beneficiaries may choose from a variety of plans, including private standard plans, private high option plans, the HCFA-sponsored standard plan, or HCFA-sponsored high option plans. No plan can be approved by the Medicare Board unless it covers at least the same benefits that beneficiaries have today. The Board may not approve any benefit package designed to result in favorable selection of beneficiaries.

Standard and High-Option Plans

All entities offering Medicare plans must also offer a high-option plan. High-option plans include the standard core Medicare benefits plus outpatient prescription drug coverage and stop-loss protection for standard benefits. Outpatient prescription drug coverage must meet an actuarially equivalent value of $800 in 2003 (adjusted annually for increases in reasonable drug costs). In any given year a beneficiary's out-of-pocket costs for current Medicare benefits cannot exceed $2,000.

HCFA-Sponsored Standard and High-Option Plans

HCFA will offer a nationwide standard plan to include all Title 18 benefits currently available under the Medicare fee-for-service program. HCFA will submit premium information for this plan to the Board as other plans do. Current payment and coverage rules and regulations applicable under the fee-for-service program will also apply to the HCFA-sponsored standard plan. HCFA will bear the full financial risk for its standard plan offering.

Beginning in 2003, HCFA will offer one or more high option plans, in addition to the standard plan, through partnerships with private entities. Insurers, pharmaceutical benefit

managers, chain pharmacies, Medigap insurers, groups of independent pharmacies, or other qualified private entities may partner with HCFA to offer drug coverage as part of a HCFA-sponsored high option plan. The HCFA-sponsored high-option plan must meet the same minimum actuarial value of drug benefits as other private high-option plans. HCFA may not exclude qualified private entities offering to partner with HCFA to form a high option plan, as long as the Medicare Board approves the arrangement.

Only beneficiaries enrolled in the HCFA-sponsored standard plan will continue to be able to purchase Medicare supplemental insurance.

Qualifications to Offer a Medicare Plan

In order to offer a Medicare plan, a plan must meet the requirements currently applicable to Medicare+Choice plans and organizations, including the offering of benefits and protections for Medicare beneficiaries. Plans must submit to the Medicare Board a description of benefits, the bid for the package of benefits, and the proposed service areas. The Medicare Board will review the information submitted and negotiate premium and benefit design with the plans.

Payments to Medicare Plans and Computation of the Beneficiary Premium

- **Step 1:** The Board publishes, with a reasonable amount of notification to plans, geographic and risk adjusters.
- **Step 2:** An entity submits a bid for a package of benefits to the Medicare Board.
- **Step 3:** The Board computes a premium for core benefits (by carving out the core benefits plus any de minimis additional benefits).
- **Step 4:** The Medicare Board calculates a premium schedule based on computation of the national weighted average premium (NWA). The NWA premium is equal to the weighted average of the premium for core benefits, with the weight for each plan being equal to the average number of beneficiaries enrolled in that plan in the previous year.
- **Step 5:** Beneficiary premiums are determined for both standard and high option plans (as described below).
- **Step 6:** The amount of payment to a Medicare plan per enrollee is equal to the premium for the plan as approved by the Medicare Board. That portion of the premium associated with core benefits is subject to geographic and risk adjustment.

Computation of Beneficiary Premiums

- The beneficiary pays no premium if the premium for the plan selected is less than 85% of the NWA premium.
- If the premium for a plan exceeds 85% (but is less than 100%) of the NWA premium, the beneficiary premium will be equal to 80% of the amount by which the plan premium exceeds 85% of the NWA premium.
- If the premium for a plan is equal to or greater than 100% of the NWA premium, the beneficiary premium is equal to 12% of the NWA premium, plus the amount (if any) by which the plan premium exceeds the NWA premium.

Premium collection for low-income beneficiaries shall occur in the same manner as under current law, so that a beneficiary's share of the premium for Medicare benefits is deducted from their Social Security check. Medicare plans are not responsible for collection of premiums.

Unified Medicare Trust Fund; Combining Parts A and B

Effective January 1, 2003, a single trust fund, known as the Medicare Trust Fund, is created. This unified trust fund will include all three current sources of funds (payroll taxes, premiums, and general revenue contributions) and any additional fees imposed on plans by the Medicare Board.

The Medicare Board is responsible for reporting to Congress annually the percentage of total Medicare expenditures from the Medicare Trust Fund through general revenues; the first fiscal year the Medicare Trust Fund is determined to be programmatically insolvent; and the first fiscal year in which the Medicare Trust Fund will be insufficient to pay for the total expenses incurred. In any year in which general revenue contributions would otherwise exceed 40% of total Medicare expenditures, the Medicare Trust Fund will be deemed programmatically insolvent and Congressional approval will be required prior to additional general revenue transfers into the Medicare Trust Fund.

Division of HCFA-Sponsored Plans

HCFA will be divided into two divisions, the Division of HCFA-Sponsored Plans and the Division of Health Programs. The Division of HCFA-Sponsored Plans will only be responsible for administering HCFA's standard and high option plans under the competitive premium system. The Division of Health Programs will continue to maintain all other non-plan and non-insurance functions, such as the Medicaid program, the State Children's Health Insurance Program, disproportionate share hospital payments and graduate medical education payments. Within six months of enactment, a director shall be appointed to oversee each division.

HCFA Business Planning and Administrative Flexibility

Beginning on January 1 of each year, and no later than January 1, 2002, the Director of HCFA-Sponsored Plans must submit a business plan to Congress. This plan must include a comprehensive payment and management plan for all aspects of offering core benefits, information about partnership arrangements with private entities for prescription drug coverage in high option plans, and recommendations for benefit coordination and improvements. The plan must include legislative specifications necessary to enact the business plan. The business planning process will be exempt from OMB oversight and APA requirements, provided that the division establishes procedures for public comment. The CBO, GAO, and MedPAC must submit reports to Congress evaluating the business plan's impact on cost, providers, and beneficiary access to care.

Each year, Congress must hold Congressional hearings on the business plan. HCFA's business plan will be guaranteed an up or down vote by Congress under fast track procedures by 2005. After 2008, the HCFA-sponsored business plan and recommendations for benefit improvements will take effect without the explicit approval of Congress.

Premium Discount for Drug Benefits Under High Option Plans

Low-Income Protection Package

Beneficiaries at or below 135% of poverty will pay zero premium for enrollment in the lowest cost high-option plan in their area. Beneficiaries qualifying for this subsidy include dually eligibles, qualified low-income Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), and certain qualifying individuals (QI-1s). The Medicare Board will establish an arrangement with each state to determine eligibility for these beneficiaries.

A beneficiary whose income is above 135% of poverty but less than 150% of poverty will receive a discount for drug benefits, phasing down from a 50% discount at 136% of poverty to a 25% discount at 150% of poverty.

States must maintain their current level of premiums, cost-sharing, and deductibles, as required under current law, for beneficiaries at or below 135% of poverty. States maintain their premium contributions for low-income beneficiaries by contributing the lower of 12% of the national weighted average premium for core benefits or the beneficiary premium for the HCFA-sponsored standard plan, whichever is lower.

If a qualified low-income beneficiary chooses a higher cost high option plan, the beneficiary will receive a discount based on the premium for the lowest cost high option plan.

Beneficiaries above 150% of poverty

Beneficiaries above 150% of poverty choosing a high-option plan will receive a 25% discount off the premium for that high option plan (based on the minimum actuarial value of the high option drug benefit). The value of the discount for drug premiums will be treated as taxable income for beneficiaries so that the discount is income-related.

Guaranteed Access Provisions

Under the competitive premium system, beneficiaries are protected from higher premiums in areas where there is no competition. If the only standard Medicare plan offered in an area is the HCFA-sponsored standard plan, the beneficiary premium for the HCFA-sponsored standard plan may not exceed 12 percent of the national weighted average premium or the beneficiary premium for the HCFA-sponsored standard plan, whichever is lower.

If the only high option Medicare plan offered in an area is the HCFA-sponsored high option plan, the beneficiary premium may not exceed the sum of 12 percent of the national weighted average premium plus the difference between the beneficiary premium for the HCFA-sponsored standard and high option plans.

The Medicare Board will also guarantee all beneficiaries a drug benefit package meeting the actuarial equivalence of drug benefits offered in high option plans, regardless of where they reside.

Medicare Beneficiary Outreach and Education

The Medicare Board may authorize the establishment of Medicare Consumer Coalitions (MCCs), where a non-profit organization, composed primarily of Medicare beneficiaries in a given area, is organized to provide for beneficiary outreach and education of Medicare benefit offerings. Specifically, MCCs will conduct programs to prepare and disseminate to Medicare beneficiaries comprehensive, accurate, timely and understandable information on qualified health plans or Medicare supplemental policies in which beneficiaries are eligible under the competitive premium system. All Medicare beneficiaries are eligible to enroll in an MCC.

FamiliesUSA
The Voice for Health Care Consumers

PRESS RELEASE

Contact: Lorie Slass, 202-628-3030

Drug Companies Put the Squeeze on Older Americans

Seniors' Most Popular Drugs Increase in Cost Four Times the Rate of Inflation

Every year for the last five years, the prices of the 50 drugs most used by older Americans have increased faster than the rate of inflation, with increases in 1998, on average, four times the rate of inflation, according to a new report by the consumer watchdog group Families USA. From January 1998 to January 1999 the rate of inflation increased 1.6 percent and the prices of the 50 most prescribed drugs for older Americans increased 6.6 percent.

"While the pharmaceutical industry continues to be the most profitable industry in America, it keeps drastically raising the prices of the drugs most commonly used by seniors," said Ron Pollack, executive director of Families USA. "Pharmaceutical companies are raising drug prices on the backs of America's seniors and these vital medicines are increasingly unaffordable for older Americans."

Among the drugs examined in the new report by Families USA, Hard To Swallow: Rising Drug Prices for America's Seniors:

- Lorazepam, used to treat Parkinson's disease, cost $97 for a year's supply in 1994, now costs $469 per year. The cost increased by 279 percent from January 1998 to January 1999 (179 times the rate of inflation) and by over 385 percent in the last five years (30 times the rate of inflation).
- Imdur, used to treat angina and the seventh most prescribed drug for seniors, increased in price ten times over the last five years, going from $237 per year in 1994 to $525 per year in 1999. It increased in cost by more than 111 percent over the last five years (almost nine times the rate of inflation).
- Lanoxin, used to treat congestive heart disease and the most prescribed drug for seniors, increased in price by over 87 percent in the last five years (almost 7 times the rate of inflation), increasing 15 percent from 1998-1999 alone (almost ten times the rate of inflation).
- Atrovent, used to treat respiratory illnesses, increased in price eight times and went from $382 per year in 1994 to $546 per year in 1999. From January 1994 to January 1999, the drug increased over 37 percent in price, almost three times the rate of inflation. In calendar year 1998 alone, the drug increased over 14 percent in price (nine times the rate of inflation).
- Propulsid, used to treat gastrointestinal problems, went from $876 per year in 1994 to $1,171 per year in 1999. From January 1994 to January 1999 the drug increased in cost almost 30 percent, over two times the rate of inflation. Propulsid increased in cost by nine percent from 1998-1999 alone, almost six times the rate of inflation.

While older Americans fill over 18 prescriptions per year, and nearly half of all Medicare beneficiaries live on less than $15,000 per year, the elderly are the last major insured consumer group without access to prescription drugs as a standard benefit.

"It is unconscionable that the sickest and oldest Americans go without prescription drug coverage as part of their basic benefit package," added Pollack. "Each year their social security checks increase only at the rate of inflation, while the costs of the drugs they take rise at two, three or four times the rate of inflation."

The report found that, in the last year, among the 50 most prescribed drugs for seniors :

- forty-two of the 50 drugs increased in price faster than the rate of inflation (tables 1 & 2);
- more than two-thirds (36 out of 50) rose two or more times faster than the rate of inflation;
- nearly half (23 out of 50) rose at more than three times the rate of inflation; and
- one-third (17 out of 50) rose at more than four times the rate of inflation.

While the median profit for all Fortune 500 companies was 4.4 percent in 1998, for the manufacturers of the 50 most prescribed drugs for seniors their median profits were almost five times higher at 20 percent (table 3). Astra, Pfizer, Schering, Eli Lilly and Merck, which manufacture 19 of the 50 most prescribed drugs for seniors, enjoyed profits at or above 20 percent in 1998.

"Seniors can't take advantage of the many discounts in the marketplace for prescription drugs," added Pollack. "HMOs and other institutional purchasers get sharp discounts on prescription drug prices, but for most seniors who don't have a prescription plan or have a very expensive one, they can't reap the reward of these benefits and have to pay full, not discounted, prices for drugs."

The price increase data in the report are based on price increases in average wholesale prices. Data for the report were prepared for Families USA by the PRIME Institute of the University of Minnesota.

Hard to Swallow
Rising Drug Prices for America's Seniors

a report by Families USA

November, 1999

The following are the introduction and key findings from this report by Families USA. To access the complete report, you may download the PDF version. In order to read the PDF version, you must have the *Adobe Acrobat Reader* VERSION 4.0 software on your computer. This software may be **downloaded for FREE** from the Adobe web site.

A hard copy of the report is available at a cost of $20.00. To order, send check or money order payable to Families USA Foundation to: "Hard to Swallow" c/o Families USA, 1334 G St. NW, Washington, DC 20005.

For older Americans, the affordability of prescription drugs has long been a pressing concern. Outpatient prescription drug coverage is one of the last major benefits still excluded from Medicare, and the elderly are the last major insured consumer group without access to prescription drugs as a standard benefit. Although many Medicare beneficiaries have access to supplemental prescription drug coverage, too often that coverage is very expensive and very limited in scope. What is more, such coverage is on the decline. As a result, older Americans-who are by far the greatest consumers of prescription drugs-pay a larger share of drug costs out of their own pockets than do those who are under 65. This means the prices of prescription drugs have a greater impact on older Americans than on younger persons.

Four years ago, Families USA found that the prices of prescription drugs commonly used by older Americans were rising faster than the rate of inflation.1 To determine if this trend of steadily increasing prices for prescription drugs has improved, remained the same, or worsened, Families USA gathered information on the prices of the prescription drugs most heavily used by older Americans over the past five years. Using data from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program, we analyzed the prices of the 50 top-selling prescription drugs most heavily used by older persons.

Our analysis shows that, in each of the past five years, the prices of the 50 prescription drugs most used by older Americans have increased considerably faster than inflation. While senior citizens generally live on fixed incomes that are adjusted to keep up with the rate of inflation, the cost of the prescription drugs they purchase most frequently has risen at approximately two times the rate of inflation over the past five years and more than four times the rate of inflation in the last year.

FINDINGS

■ The prices of the 50 prescription drugs2 most frequently used by the elderly rose by more than four times the rate of inflation during calendar year 1998.* On average, the prices of these top 50 drugs increased by 6.6 percent from January 1998 to January 1999, though the general rate of inflation in that period was 1.6 percent. (See Table 1.)

■ From January 1998 to January 1999, of the 50 drugs most commonly used by the elderly:

■ More than two-thirds of these drugs (36 out of 50) rose two or more times faster than the rate of inflation.

■ Nearly half of these drugs (23 out of 50) rose at more than three times the rate of inflation.

■ Over one-third of these drugs (17 out of 50) rose at more than four times the rate of inflation.

■ Among the 50 drugs most frequently used by seniors, the following drugs rose most significantly in price from January 1998 to January 1999:

- Lorazepam (manufactured by Mylan and used to treat conditions such as anxiety, convulsions, and Parkinson's), which rose by over 279.4 percent (more than 179 times the rate of inflation);

- Furosemide (a diuretic manufactured by Watson that is used to treat conditions such as hypertension and congestive heart failure), which rose by 106.6 percent (more than 68 times the rate of inflation);

- Lanoxin (manufactured by Glaxo Wellcome and used to treat congestive heart failure), which rose by 15.4 percent (almost 10 times the rate of inflation);

- Xalatan (manufactured by Pharmacia & Upjohn and used to treat glaucoma), which rose by 14.5 percent (more than nine times the rate of inflation); and

- Atrovent (manufactured by Boehringer Ingelheim and used as a respiratory agent in the treatment of asthma, bronchitis, and emphysema), which rose by 14.1 percent (more than nine times the rate of inflation).

- Over the five years from January 1994 to January 1999, the prices of the 50 prescription drugs most frequently used by older Americans rose twice as fast as the rate of inflation. On average, the prices of these drugs rose by 25.2 percent-twice the rate of inflation, which was 12.8 percent over that period. (See Table 2.)

- Of the 50 drugs most frequently used by older Americans, 39 have been on the market for the five-year period from January 1994 to January 1999.

- The prices of 36 of those 39 drugs increased faster than the rate of inflation over the five-year period.

- More than two-thirds of those drugs (28 out of 39) rose at least 1.5 times as fast as the rate of inflation over the five-year period.

- Nearly half of those drugs (19 out of 39) rose at more than two times the rate of inflation over the five-year period.

- More than one-fourth of those drugs (10 out of 39) rose at least three times the rate of inflation over the five-year period.

- Of the 39 drugs that were used most frequently by seniors and that were on the market for the period from January 1994 to January 1999, the drugs that rose most significantly in price are:

- Lorazepam, which rose by over 385 percent (more than 30 times the rate of inflation);

- Imdur (manufactured by Schering and used to treat angina), which rose by 111 percent (almost nine times the rate of inflation);

- Furosemide, which rose by 107 percent (more than eight times the rate of inflation);

- Lanoxin, which rose by 88 percent (almost seven times the rate of inflation); and

- Klor-Con 10 (manufactured by Upsher-Smith and used as a potassium replacement), which rose by 84 percent (more than six times the rate of inflation).

- Of the 39 drugs that were used most frequently by seniors and that were on the market for the period from January 1994 to January 1999, 31 increased in price on at least five occasions during those five years. During those years, the following drugs increased in price at least seven times:

- Imdur, which increased 10 times;

- Premarin (manufactured by Wyeth-Ayerst and used as an estrogen replacement), which increased eight times;

- Atrovent, which increased eight times;

- Pravachol (manufactured by Bristol-Myers Squibb and used to reduce cholesterol), which increased seven times;

- Synthroid (manufactured by Knoll and used as a synthetic thyroid agent), which increased seven times; and

- K-Dur 20 (manufactured by Schering and used as a potassium replacement), which increased seven times.

- During the last two years, there has been an acceleration in price increases of the drugs most commonly used by seniors. From 1995 to 1996 and 1996 to 1997, those drug prices rose 1.3 and 1.2 times faster, respectively, than the rate of inflation. From 1997 to 1998 and 1998 to 1999, those drug prices rose 1.7 and 4.2 times faster, respectively, than the rate of inflation.

- The median net profit for manufacturers of the 50 most prescribed drugs for senior citizens was 20.0 percent in 1998-4.5 times larger than the median net profit of 4.4 percent for all Fortune 500 companies

---

FAMILIES USA HOME PAGE | NEW RELEASES | PUBLICATIONS | CHILD HEALTH | MEDICARE

MEDIA CENTER | WEB HEALTH LINKS | GET INVOLVED!| NATIONAL JOB BANK | SEARCH

MANAGED CARE CENTRAL | THE MEDICAID CLEARINGHOUSE | THE LEGISLATIVE ACTION CENTER

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

---

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

---

[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]

---

[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.

---

[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.

---

[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

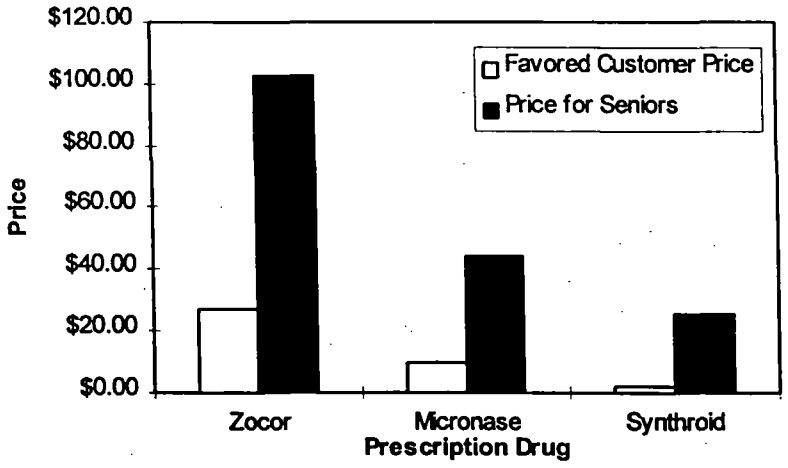
---

[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.

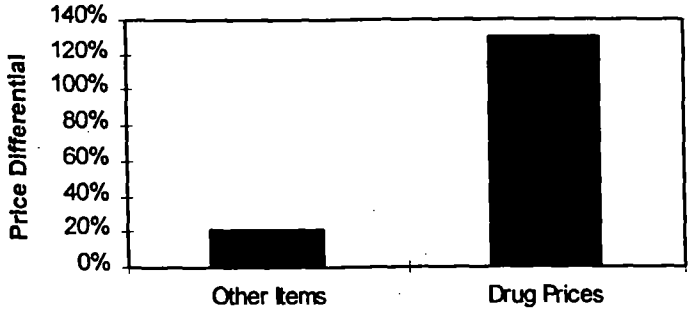


In dollar terms, Zoloft, an antidepressant, had the highest price differential. Senior citizens in Mr. Obey's district must pay over $100.00 more for 100 tablets of Zoloft than a favored customer. The difference between seniors' prices and prices for favored customers was more than $75.00 for 60 tablets 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

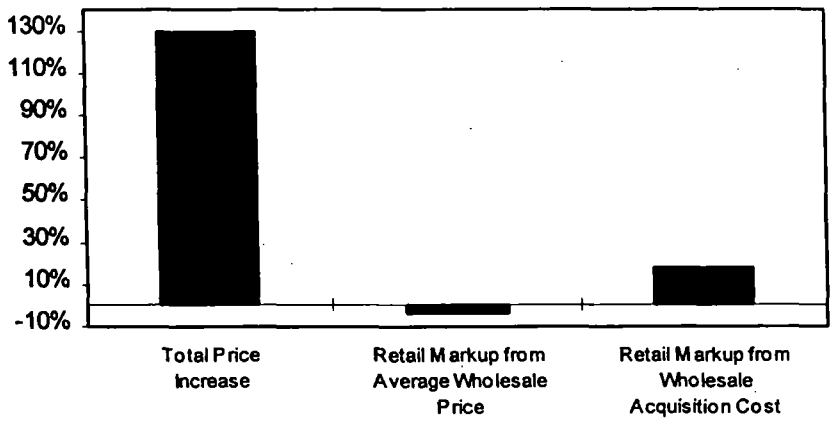
The study also sought to determine whether drug companies or retail pharmacies are responsible for the high prices being paid by older Americans. To do this, the study compared the average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison 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]

---

[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%

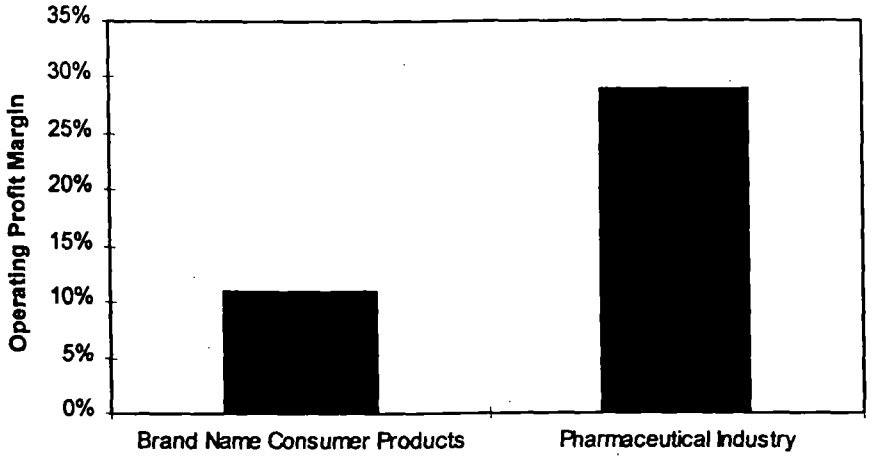
1995).

[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]

---

[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

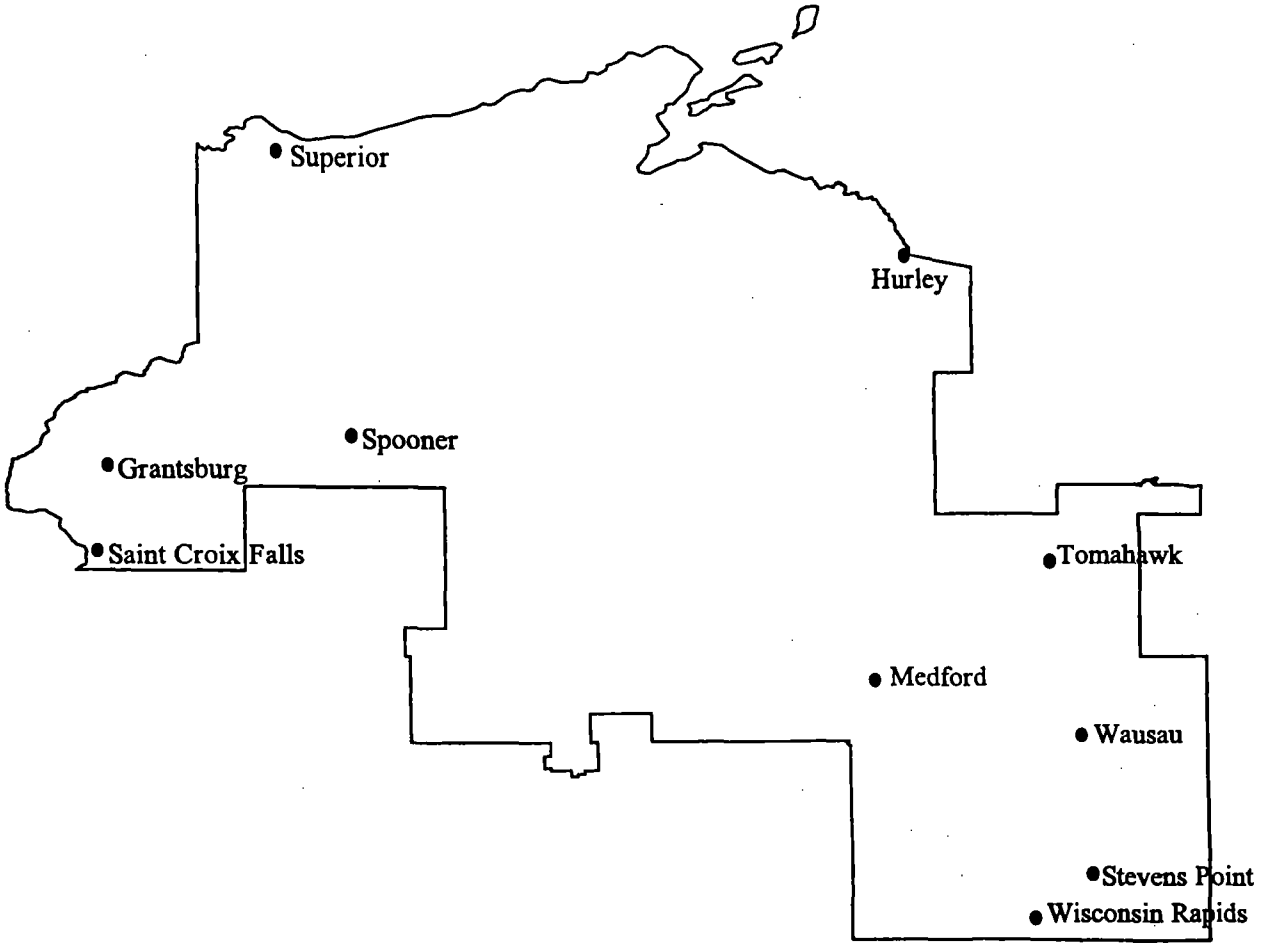
			Prices (Dollars)				
Brand Name Drug	Dosage and Form	Indication	Favored Customer Price	Wholesale Acquisition Cost	Average Wholesale Price	Average Retail Price	Price Differential (Average Retail Price vs. Favored Customer Price)
Zocor	5 mg, 60 tablets	Cholesterol reducer	$27.00	$86.07	$106.84	$102.79	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

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.

---

[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.

---

[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
New Mexico
New York
Ohio
Oregon
Pennsylvania
South Carolina
South Dakota
Tennessee
Texas
Vermont
Virginia
Washington
West Virginia
Wisconsin

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

---

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.

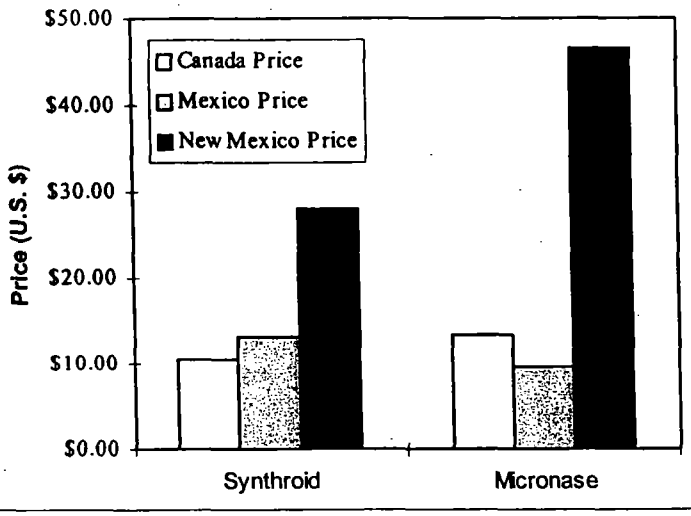
Prescription Drug	U.S. Dosage and Form	Canadian Price	Mexican Price	New Mexico Price	Canada-New Mexico Price Differential		Mexico-New Mexico Price Differential	
					Percent	Dollar	Percent	Dollar
Zocor	5 mg, 60 tab.	$46.17	$67.65	$102.52	122%	$56.35	52%	$34.87
Prilosec	20 mg, 30 cap.	$55.10	$32.10	$112.40	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

---

[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

---

[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

---

[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

---

[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.

---

[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.

---

[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.

---

[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]

---

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

DRAFT: BALANCED BUDGET REFINEMENT ACT: HIGHLIGHTS

The bipartisan Balanced Budget Adjustment Act of 1999 provides needed changes to address flawed policy and excessive payment health care payment reductions resulting from the Balanced Budget Act (BBA) of 1997. Complementing the numerous administration actions taken by the Administration, this bill provides funding for hospitals, nursing homes, home health agencies, managed care plans, and other Medicare providers. It also includes several important adjustments to Medicaid and the State Children's Health Insurance Program. Some of the major provisions include:

HOSPITALS:

- **Increases Indirect Medical Education Payments.** Under the BBA, teaching hospital's indirect medical education (IME) payment add-on was reduced from 7.7 percent to 7.0 percent in FY 1998, 6.5 percent in 1999, 6.0 percent in 2000, and 5.5 percent in 2001 and subsequent years.

  This proposal would keep the FY 2000 update at 6.5 percent (the 1999 add-on) in 2000 and set it at 6.25 percent in 2001. This provides critical assistance to teaching hospitals as they adjust to the changes implemented in the BBA.

- **Takes Steps Towards Reforming Direct Medical Education**. Currently, there is wide variation in payments for direct medical education (DME) that is difficult to explain. Although not directly attributable to the BBA of 1997, that act acknowledged the need to address this issue.

  This proposal takes steps toward reforming medical education payments by reducing this geographic disparity. It does this in two steps. First, it raises the minimum payment for hospitals to 70 percent of the national, geographically adjusted average payment. Second, it limits growth in payments for hospitals with costs above 140 percent of the geographically adjusted average payment. This growth limitation would be a freeze for 2000 and 2001 and an increase of inflation (consumer price index (CPI)) minus 2 for 2002 through 2004).

- **Disproportionate share hospital (DSH) payments**: The BBA cut DSH payments by 3 percent in 2000, 4 percent in 2001, and 5 percent in 2002.

  This proposal increases the payment rates by reducing the BBA-specified reductions. These reductions would be 3 percent in 2001 (compared to 4 percent in current law) and 4 percent in 2002 (compared to 5 percent). This restoration provides about $100 million over 5 years to help these hospitals care for the growing number of uninsured.

- **Outpatient department policies**: The BBA created a new prospective payment system (PPS) for hospital outpatient care. This PPS pays hospitals the same amount for a particular type of service delivered in an outpatient setting, similar to what is

done for inpatient care. This bill includes a number of provisions to modify the new PPS, including:

- **Budget-neutral PPS (5.7 percent reduction issue).** Agreement on the Balanced Budget Refinement bill assumes resolution that ensures that there is no additional reduction in aggregate payments to hospital outpatient departments. No such reduction was contemplated when the BBA was negotiated.

- **Protects hospitals from dramatic changes during the transition to PPS.** During the first 3 years of the PPS, this bill creates payment floors to minimize the disruption of the new system (similar to what the Administration intended to propose in regulation). Rural hospitals would be held harmless (i.e., have no losses relative to their base year) for 4 years while cancer hospitals are exempted from the PPS. In addition, there will be a 3-year pass-through for certain drugs and devices and a budget-neutral outlier policy for high-cost cases.

- **Limits beneficiary coinsurance**. The BBA included a provision to reduce the Medicare beneficiary coinsurance from its current 50 percent to 20 percent over a number of years. This policy would provide an additional protection by limiting the amount of coinsurance that a beneficiary pays for outpatient care to the Part A deductible ($776 in 2000).

- **Improves transition to prospective payment systems for PPS-exempt hospitals**. The BBA authorized the creation of PPS systems for long-term care, psychiatric, and rehabilitation hospitals. This bill makes adjustments to the different PPS systems as well as changes payments in the interim period, including a wage adjustment of the percentile cap for PPS-exempt hospitals; enhanced payments for long-term care and psychiatric hospitals before PPS is implemented; and refinements of the new systems.

SKILLED NURSING FACILITIES

- **Provides immediate increases in payment for high-cost cases.** The BBA created a new prospective payment system (PPS) for skilled nursing facilities that was implemented on July 1, 1998. In this system, payments are based on the type of treatment that the patient needs.

  For the remainder of 2000, 15 percent will be added to 12 resource utilization groups (RUGs) for medically complex cases and 3 rehabilitation RUGs. For FY 2001, the Administration will use a study currently underway to adjust the RUGs to account for patients' acuity. The bill also creates special payments for AIDS patients for 2000-2001 and carves certain services (ambulance, prostheses, chemotherapy) out of the PPS system.

- **Increases payment rates**. To moderate the low payment updates in the BBA, this bill would increase payments across-the-board by 3.5 percent for 2001 and 2.5

percent to the rates for 2002. It also gives nursing homes the option to go to the full Federal rate without the transition.

THERAPY CAPS

- **Imposes two-year moratorium on payment caps**: The BBA limited payments for physical / speech therapy and occupational therapy to $1,500 each. This limit has proven to be low, causing a large number of therapy users to have payments exceed the caps and have to pay for services out-of-pocket.

  This bill puts a two-year moratorium on the caps, steps up medical review to prevent fraud, and initiates a study to develop an alternative, more rational system for therapy services payment.

HOME HEALTH

- **Delays 15 percent to one year after the implementation of the home health prospective payment system (PPS).** Most independent studies showed in 1997 that home health agencies were being overpaid. Thus, in addition to creating a new PPS for home health, the BBA also required a 15 percent reduction in payments.

  This bill implements the 15 percent reduction after the first year of implementation of the BBA.

- **Provides immediate adjustments.** The bill also raises the per beneficiary limit for those below average in 2000; pays $10 per beneficiary to pay for the data collection in OASIS; clarifies the surety bond provision; and excludes durable medical equipment from consolidated billings.

RURAL PROVIDERS

- Extends Medicare dependent hospital (MDH) program for five years.

- Waivers to allow hospitals to reclassify from urban to rural and update of standards applied for geographic reclassification.

- Improves the critical access hospital program.

- Provides exceptions to residency caps for rural GME programs.

- Eliminates certain restrictions on swing beds.

- Provides a full market basket increase for Sole Community Hospitals (SCH) for 2001 and allows for rebasing for certain SCHs.

MANAGED CARE

- **Alters the plan for risk adjustment for managed care plans**. The BBA requires that payments to managed care plans be risk adjusted, to prevent adverse selection and to encourage plans to enroll sicker beneficiaries. Rather than implement this immediately, the Administration developed a 5-year plan, supported by virtually all independent experts, to phase this in.

  This proposal alters the risk adjustment phase-in, basically locking in freezing the phase-in for 2001, at a cost of $1.1 billion over 5 years.

- **Increases rates**. Although the General Accounting Office and other independent experts believe that managed care plans continue to be overpaid – even after the BBA – this proposal increases rate increases from fee-for-service minus 0.5 to fee-for-service minus 0.3 in 2002. This costs $0.2 billion over 5 years. It also provides an entry bonus for plans entering counties not previously served.

- **Changes provider participation rules, beneficiary protections and demonstrations**. The bill includes a number of provisions to accommodate health plans, including: giving plans more time to submit adjusted community rates; providing greater flexibility in benefits and reducing the user fees paid for the Medicare education campaign. It also provides beneficiaries some protections in transitioning from managed care to Medigap under certain circumstances. It delays the competitive pricing demonstration project and extends the social health maintenance organization demonstration and several others.

OTHER PROVIDERS

- **Fixes the fluctuation in physician payments (sustainable growth rate).** This change stabilizes physician payments and is budget-neutral over 5 years.

- **Increases payments for Pap smears**: Sets the rate at $14.80 in 2000.

- **Increases payments for renal dialysis**. Medicare's payments for dialysis have not increased since 1991. Consistent with a recommendation from the Medicare Payment Advisory Commission, this bill increases the composite rate by 1.2 percent in 2000 and another 1.2 percent in 2001.

- **Increases coverage of immunosuppressent drugs**. Current Medicare pays for the prescription drugs that help prevent rejection of transplants for 2 years. This proposal would extend coverage of these drugs for another 6 months, at a cost of about $150 million over 5 years.

- **Increases updates for hospice, durable medical equipment, and oxygen.** Payments to these providers would be temporarily increased for 2001 and 2002.

MEDICAID & STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

- **Temporarily ends phase-out of cost-based reimbursement for community health centers.** The BBA phased out the Medicaid requirement to pay federally-qualified health centers and rural health clinics based on cost. The 2000 phase-out – where 95 percent of payments are based on costs – would be extended for 2001 and 2002, and a study would be conducted to determine how these clinics should be paid in subsequent years.

- **Extends the availability of the $500 million fund for children's health outreach.** The welfare reform law put aside a $500 million fund for states to use for the costs of simplifying their eligibility systems and conducting outreach. To date, only about 10 percent of this fund has been spent, and for nearly 30 states, the funding sunsets this year. This bill extends the availability of this fund until it runs out.

- **Stabilizes SCHIP allocation formula; adjusts allotment for territories**. Under the BBA, states receive an allotment of the total Federal funding based on their proportion of low-income uninsured children. This formula has resulted in large, annual fluctuations in state allotments. This bill alters the formula, putting floors and ceilings on the allotment changes to make funding for states more predictable. It also increase the available funding for territories.

- **Improves data collection and evaluation of SCHIP.** One of the centerpieces of the BBA was the creation of this new program to provide health insurance to children in families with incomes too high for Medicaid but too low to afford private insurance. However, the BBA did not provide funding for monitoring and evaluating the implementation and outcomes of SCHIP. This bill adds funding for data collection and evaluation of this program.

- **Changes Medicaid disproportionate share hospital (DSH) payments and rules.** The BBA implemented a number of significant changes in the Medicaid DSH program, changing states' allotments. The base year data used to set the DSH allotments in the BBA were flawed for several states. This bill adjusts the DSH allotments for DC, Minnesota, New Mexico and Wyoming. It also makes the DSH transition rule permanent and does not allow states to use enhanced Federal matching payments under the State Children's Health Insurance Program for DSH.

SCORING

'S She
putting
OUR leg language is)

DMKI, Oxygen
HOSPICE

.75

02

.5 .5

CPI.2

DEPARTMENT OF HEALTH & HUMAN SERVICES Chief of Staff

Washington, D.C. 20201

October 25, 1999

NOTE TO THURGOOD MARSHALL, JR.

I am forwarding herewith a Memorandum for the President, signed by Secretary Shalala.. In her memorandum, the Secretary provides the President with background information regarding a new, independent Medicare Board.

Mary Beth Donahue

Attachment
Memo to the President

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 25 1999

MEMORANDUM FOR THE PRESIDENT

I am writing to express my deep concern over discussions occurring in Congress that could result in creation of a new, independent Medicare board. As envisioned by its proponents, this board would operate as an independent entity designed to oversee the Medicare+Choice program, including the competition among private plans and between private plans and fee-for-service Medicare. The creation of such a board seriously undermines your authority over Medicare, the beneficiary protections that you have worked hard to establish for this program, and the significantly improved refocused management which has reduced the Medicare error rate by over fifty percent. This new board also sets the stage for capping government expenditures for Medicare, threatening Medicare beneficiaries' entitlement to first-class medical care.

The board's advocates say they want to bring private-sector expertise into the administration of the program and say they want to avoid conflicts of interest in running a competitive system. Their first goal is being accomplished without undermining the current strengths of Medicare and their second contention is a false promise. Not only will their proposals not achieve their goals, but, for the reasons stated below, they would substantially undercut our ability to serve beneficiaries and efficiently administer the program. At the end of this memorandum, I will describe the activities that we have already undertaken to garner additional private sector expertise in administering Medicare.

Medicare Board Leads to Reduced Beneficiary Protections. Under your leadership and through the hard work of this Department, we have ensured that Medicare includes the beneficiary protections outlined in your Patients' Bill of Rights. Medicare was one of the first programs in the country to incorporate these protections and remains a model program. This would not have been possible if the Medicare+Choice program were administered by an independent board.

Given the hostility we have seen in the private sector to even the modest proposals in the Patients' Bill of Rights, I do not believe that a board comprised of private sector health officials would have taken a strong, pro-beneficiary stance. It is not surprising that the strongest proponents of a Medicare board, including managed care interests, are among the most active opponents of strong patient rights legislation. I believe that we must maintain our ability to keep Medicare in the forefront of beneficiary protection. Creation of an independent Medicare board is not consistent with that imperative.

Medicare Board Dilutes Presidential Authority. Placing the Medicare+Choice program under the control of an independent board splits accountability for the program and substantially dilutes your authority over a substantial portion of Medicare. This is a significant loss given that Medicare serves 39 million beneficiaries and makes up 11 percent of the Federal budget.

The Administration's ability to make changes to Medicare in the context of the President's Budget would be limited. This is especially true since proposals for treating traditional fee-for-service Medicare as a health plan under the structure of Medicare+Choice would allow a new board to exercise substantial authority over the entire program. In particular, a board could be given substantial authority over what private health plans would be paid by Medicare. It could also be given authority to oversee aspects of traditional Medicare, including benefits and, under some proposals, total spending by traditional Medicare.

As a result, the presence of a board would have hampered our ability to exert strong budget discipline, such as the steps we have taken to extend the life of the Medicare Part A Trust Fund to 2015. Similarly, it would not have been possible to use Medicare changes to help finance key domestic initiatives to improve the health of the nation, such as the Children's Health Insurance Program.

Furthermore, creation of a board would limit the Administration's authority to make key program changes to address Medicare problems identified by beneficiaries, providers, or other segments of the American public.

Medicare Board Diffuses Accountability for Medicare. Authority over certain key functions would be unnecessarily complicated by bifurcating control of Medicare between a board and the Health Care Financing Administration (HCFA).

For example, Administration efforts to reduce fraud and abuse in Medicare have been successful because we have provided clear, consistent policy guidance and because we have been willing to take the political heat generated by our aggressive stance. I do not believe that an independent board (especially one that includes private sector health care executives, as would be likely with any congressionally created board) would have initiated or sustained such a controversial, yet productive, program. Specifically, the HCFA actuaries credit aggressive fraud control efforts with bringing down the Medicare baseline through reducing either the rate of growth or the actual level of spending on inpatient hospital services, home health, and lab services. Our efforts have also led to the first-ever decline in hospital upcoding since the inception of a prospective payment system in 1984. The bifurcation of authority under a board would threaten the significant advances made by this Administration by complicating the relationship between the program and the HHS Inspector General and between Medicare and the Department of Justice.

Similarly, this Administration has taken significant steps to measure and hold health plans and providers accountable for quality of care for seniors and other vulnerable populations. The diffusion of accountability threatens our ability to move aggressively in this area as we have on the Patients' Bill of Rights.

Medicare Board Creates Potential Confusion of Authority That Would Be Detrimental to Beneficiaries. HCFA is currently responsible for a wide range of activities that might become the responsibility of either the board or HCFA, or both. These functions include beneficiary education, procedures for appeals and grievances, provider enrollment, survey and certification of providers, and quality assurance. If these functions were assigned to HCFA, their applicability to private plans would become uncertain; if assigned to the board, more functions would be removed from the lines of public accountability. If assigned to both, there would be confusion and uncertainty among all parties involved.

A Medicare Board Provides the Infrastructure for Ending the Medicare Entitlement. Although the proponents of a board deny that they intend to fundamentally change Medicare, it is clear that creation of an independent board would establish the administrative framework for a defined contribution plan, which specifies the government's financial contribution toward beneficiaries' health care but does not specify the benefits to which beneficiaries are entitled. Creating an independent board is an ideal first step toward capping government contributions for Medicare, and beneficiary advocates will see it as such. It is not surprising that some of the strongest advocates in Congress for a board are the same Members who tried to cap Medicare spending in the 1995 budget bill that you vetoed.

Claims About Current Conflicts of Interest in Managing Medicare Are Not Legitimate. Advocates for a board argue that HCFA has an inherent conflict of interest in both managing the competition among private health plans and fee-for-service Medicare and operating the fee-for-service Medicare program. In fact, the risk of conflict of interest could be greater if managed care executives, hospital administrators, physicians, durable medical equipment suppliers, or any other individual who benefits from Medicare payments were given statutory powers through participation on the board.

Today, HCFA manages both original Medicare and Medicare+Choice, having successfully supervised the growth of Medicare+Choice to a program that enrolls about one of every six beneficiaries. HCFA's role is not unique – conflicts of interest are successfully avoided by CalPERS and many private employers that run self-insured plans while contracting with competing health plans.

The assertion that HCFA's dual role creates a conflict of interest may stem from certain decisions that private plans may find onerous, such as those in setting standards for consumer protection and quality assurance. Such decisions stem directly from HCFA's primary concern for serving the needs of beneficiaries, not from any desire to bias the competition. If a Medicare board also places serving the needs of beneficiaries as its core mission, it will inevitably make similar decisions. Thus, it will also be subject to the same charges of conflict of interest.

Under your proposal for a competitive defined benefit, traditional Medicare and private health plans would compete on an equal footing, allowing both Medicare and beneficiaries to save when beneficiaries choose efficient health plans. As discussed above, I believe that many board proponents are using the conflict of interest accusation as an excuse to take the first step toward ending the entitlement.

Private Sector Involvement Can be Achieved Without a Medicare Board. While I am deeply concerned about the proposals to create an independent board to administer a portion of Medicare, I am committed to expanding the program's access to private sector expertise. In September, we chartered a Management Advisory Committee for HCFA. This step was part of HCFA management modernizations contained in your budget. The committee allows HCFA to get expert advice from individuals in the public and private sector regarding innovations in management practices. It also will allow HCFA to maintain critical relationships with public and private sector experts in management, leadership, and purchasing strategies. The committee will address issues including how HCFA can better manage its private sector contractors and how it can be a more prudent purchaser of fee-for-service Medicare services. The committee need not make recommendations regarding payment or coverage policy, because the Medicare Payment Advisory Commission (MedPAC) and the recently established Medicare Coverage Advisory Committee already fulfill these functions.

I will chair the committee, which will include up to 11 additional members that I will appoint. The members will be selected from among nationally recognized authorities in academia, private consulting, public and private sector health purchasing entities, and private companies. The committee would not include provider or beneficiary representatives since they are already represented in many advisory committees to the Congress and the Department.

If Medicare reform is successful, this committee could also easily be adapted to serve as an advisory body for the implementation of the fee-for-service modernization reforms included in your Medicare plan. Experts from private and public sector organizations that purchase health care for their employees and beneficiaries, as well as experts in public administration, would provide recommendations to the Secretary on how to implement these reforms to purchase services more competitively. HCFA would benefit from the advice of these experts in a forum open to public participation.

In Conclusion, Creation of a Medicare Board to Oversee a Portion of the Program Would Be a Grave Mistake. It would be a disservice to our successors and to future generations of beneficiaries if we were to weaken the executive management of Medicare, not only because it is a substantial and growing proportion of federal outlays, but because older and disabled Americans are particularly vulnerable and need government protection. This Administration has strengthened Medicare in innumerable ways: extending solvency, increasing benefits, advancing new beneficiary protections, and strengthening program integrity. The Medicare program would most likely not be experiencing the benefits of the Administration's improvements had the Medicare board, as proposed, been in existence.

Donna E. Shalala

THE WHITE HOUSE

WASHINGTON

November 9, 1999

MEMORANDUM ON BREAUX-FRIST MEDICARE REFORM PLAN

TO: John Podesta, Steve Ricchetti, Karen Tramontano, Gene Sperling, Bruce Reed, Larry Stein, Chuck Brain, Jack Lew, Joel Johnson, Charles Burson, Melanne Verveer, Dan Mendelson

FROM: Chris Jennings and Jeanne Lambrew

Senator Breaux called yesterday to let us know that he is introducing his Medicare reform plan with Senator Frist and possibly Senator Kerrey today. The proposal is notably improved but still has fundamental flaws. The improvements include a drug benefit that provides premium assistance for all beneficiaries and the lack of a proposal to raise the age eligibility for Medicare. The plan also drops the Breaux-Thomas home health and nursing home copays and BBA payment reduction extenders. It still does not dedicate any resources to extend trust fund solvency. We will provide a more detailed analysis once we get the proposal. The major elements apparently include:

- **Premium support**: This appears to be the same as the Breaux-Thomas plan, and thus will have the same effect of raising the premiums for the traditional Medicare program by 10 to 30 percent, depending on the other proposals in the plan.

- **Prescription drugs:** Unlike the original plan, this one includes a premium subsidy for all beneficiaries. Premiums are free for those with income up to 135 percent of poverty, subsidized at 50 percent for those with income between 135 and 150 percent of poverty, and subsidized at 25 percent for those with income above 150 percent of poverty. However, this subsidy is too low, according to our actuaries, to attract enough beneficiaries to make the plan affordable. Moreover, private plans, apparently, can offer any array of deductibles and copays, so long as the total value of the package does not exceed $800. Not only is this value low, but allowing this variation will further exacerbate the risk selection problem. The Senator said that he does not yet have CBO estimates – and we imagine that they will be high.

- **Merging the Part A and B trust fund:** Although this is not troubling in theory, in practice it means that we would be capping the amount of general revenues going to Medicare. This would increase, not decrease, Medicare's financial future shortfall.

- **Medicare Board**: The proposal would create a new board in charge of both the traditional program and managed care plans. Depending on its details, it could seriously undermine the Administration's oversight of Medicare.

- **Medicare modernization proposals**: It appears that, in the context of premium support and the Medicare board, the Senators support the traditional program modernization proposals. It also seems like this is on the only other source of savings.

It is worth noting that the drug industry published a full-page ad in the *Washington Post* supporting this proposal. This suggests that this plan may be designed to immunize the Republicans from not having an explicit prescription drug benefit or reforms in general.

We recommend that we publicly acknowledge the Senators' attempt to address the challenges facing Medicare and support for a Medicare prescription drug benefit with premium assistance for all beneficiaries. We should also praise them for dropping controversial policies like raising the age eligibility for Medicare. However, we should also reiterate our problems with premium support; our questions about how the drug benefit would work; and our disappointment that the Senator's plan does not dedicate resources to Medicare to address its inevitable financing shortfall.

DRAFT -- DRAFT – DRAFT – DRAFT – DRAFT – DRAFT – DRAFT

EMBARGOED UNTIL NOV. 9, 1999

Prescription Drug Pricing in the United States: Drug Companies Profit at the Expense of Older Americans

---

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

November 9, 1999

Table of Contents

EXECUTIVE SUMMARY

Many senior citizens in the United States cannot afford the high prices of prescription drugs. One of the principal causes of these high prices is price discrimination by drug manufacturers. This report by the minority staff of the Committee on Government Reform quantifies the extent of prescription drug price discrimination in the United States and its impacts on seniors.

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

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

A. Methodology

This study investigates the pricing of the five brand name prescription drugs with the highest sales to the elderly. It estimates the differential between the prices charged to the drug companies' most favored customers, such HMOs and the federal government, and the prices charged to seniors who lack prescription drug coverage. The results are based on surveys of retail prescription drug prices in over 1000 chain and independently owned drug stores in nearly 100 congressional districts in 38 states and the District of Columbia. These prices are compared to the prices paid by the drug companies' most favored customers. For comparison purposes, the study also estimates the differential between prices for favored customers and retail prices for other consumer goods.

B. Findings

Older Americans pay inflated prices for commonly used drugs. For the five drugs investigated in this study, the average price differential was 134% (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 on average $58.46 to $97.88 more per prescription for these five drugs than favored customers.

Table 1: Average Prices for the Five Best-Selling Drugs for Older Americans Are More Than Double the Prices That Drug Companies Charge Their Most Favored Customers.

Prescription Drug	Manufacturer	Use	Prices For Favored Customers	Average Prices For Seniors	Average Differential For Senior Citizens	
					Percent	Dollar
Zocor	Merck	Cholesterol	$27.00	$107.66	299%	$80.66
Norvasc	Pfizer, Inc.	High Blood Pressure	$59.71	$118.96	99%	$59.25
Prilosec	Astra/Merck	Ulcers	$59.10	$117.56	99%	$58.46
Procardia XL	Pfizer, Inc.	Heart Problems	$68.35	$133.22	95%	$64.87
Zoloft	Pfizer, Inc.	Depression	$125.73	$223.61	78%	$97.88
Average Price Differential					**134%**	

For other popular drugs, the price differential is even higher. This study also analyzed a number of other popular drugs used by older Americans, and in some cases found even higher price differentials. The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the average price differential for senior citizens was 1,566%. A typical prescription for this drug would cost the manufacturer's favored customers only $1.75, but would cost the average senior citizen over $29.00. For Micronase, a diabetes treatment manufactured by Upjohn, a prescription would cost favored customers $10.05, while seniors in the United States are charged an average of $50.52, a price differential of 403%.

Price differentials are far higher for drugs than they are for other goods. The report compared drug prices at the retail level to the prices that the pharmaceutical industry gives its most favored customers, such as HMOs and the federal government. Because these customers typically buy in bulk, some difference between retail prices and "favored customer" prices would be expected. The study found, however, that the differential was much higher for prescription drugs than it was for other consumer goods. The average price differential for the five prescription drugs was 134%, while the price differential for other goods was only 22%.

Pharmaceutical manufacturers, not drug stores, are primarily responsible for the discriminatory prices that older Americans pay for prescription drugs. In order to determine whether drug manufacturers or retail pharmacies cause the high prescription drug prices paid by seniors in the United States, the report 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 appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. Average retail prices in the United States 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 wholesalers actually pay for drugs, is only 22%. This indicates that it is drug manufacturer pricing policies that account for the inflated prices charged to older Americans and other customers.

I. THE VULNERABILITY OF OLDER AMERICANS TO HIGH DRUG PRICES

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

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

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

Although senior citizens have the greatest need for prescription drugs, they often have the most inadequate insurance coverage for the cost of these drugs. With the exception of drugs administered during inpatient hospital stays, Medicare generally does not cover prescription

---

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

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

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

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

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

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

drugs. According to a recent analysis by the National Economic Council, approximately 75% of Medicare beneficiaries lack dependable, private-sector prescription drug coverage.[7]

Thirty-five percent of Medicare recipients, over 13 million senior citizens, do not have any insurance coverage for prescription drugs.[8] In rural areas, the problem is even worse, with 48% of Medicare recipients lacking any prescription drug coverage.[9] In total, Medicare beneficiaries pay more than half of their drug costs out of their own pockets.[10]

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.[11] Medigap policies are often prohibitively expensive, while offering inadequate coverage.[12] Medicare managed care plans are also sharply reducing benefits and coverage.[13]

The high costs of prescription drugs and the lack of insurance coverage cause enormous hardships for older Americans. One survey found that 13% of older Americans -- more than one

---

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

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

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

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

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

[12] For example, one typical Medigap policy requires beneficiaries to meet a $250 deductible, and then covers only 50% of the cost of prescription drugs, up to a maximum benefit of $1,250. *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries, supra* note 3.

[13] 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.

out of every eight -- were forced to choose between buying food and buying medicine.[14] By another estimate, five million older Americans are forced to make this difficult choice.[15]

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

Independent analysts who have investigated the drug industry have concluded that drug manufacturers engage in "price discrimination." In 1998, for example, the Congressional Budget Office (CBO) conducted a detailed examination of drug pricing. CBO found that drug manufacturers employ pricing practices that force consumers without prescription drug coverage to pay the highest prices for drugs. According to CBO:

> Different 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.[16]

In March 1999, the Federal Trade Commission (FTC) released a comprehensive analysis of prescription drug pricing that reached a similar conclusion. As in the CBO study, the FTC study found that drug manufacturers engage in price discrimination. According to the FTC: "A notable example of differential pricing is the so-called 'two tiered pricing structure" under which pharmaceutical companies set lower prices to large buyers like hospitals, HMOs, and PBMs, and charge higher prices to other buyers that include the uninsured and independent and chain retail pharmacies."[17]

Although these and other analyses conclude that drug manufacturers engage in price discrimination, few analyses have sought to quantify the extent of price discrimination and its impact on senior citizens. This report investigates these issues. It analyzes whether the drug companies are exploiting the vulnerability of older Americans through discriminatory pricing practices and whether these pricing practices cause the high drug prices being paid by older Americans. The results presented in this report are a compilation of the results of prescription drug pricing studies prepared by the minority staff for nearly 100 members of Congress.

---

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

[15] 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).

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

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

III. METHODOLOGY

A. Selection of Drugs

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

B. Determination of Drug Prices for Seniors

In response to requests from members of Congress, the minority staff has analyzed prescription drug pricing in nearly 100 congressional districts in 38 states since July 1998.[19] In conducting these investigations, the minority staff and the staff of the members of Congress have

---

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

[19] The members of the U.S. House of Representatives who have released reports analyzing prescription drug pricing in their districts are Reps. Neil Abercrombie (HI); Thomas H. Allen (ME); Tammy Baldwin (WI); Thomas M. Barrett (WI); Ken Bentsen (TX); Shelley Berkley (NV); Marion Berry (AR); David E. Bonior (MI); Leonard L. Boswell (IA); Sherrod Brown (OH); Lois Capps (CA); Robert E. Cramer, Jr. (AL); Joseph Crowley (NY); Elijah E. Cummings (MD); Danny K. Davis (IL); Peter A. DeFazio (OR); Diana DeGette (CO); William D. Delahunt (MA); Rosa L. DeLauro (CT); Lloyd Doggett (TX); Michael F. Doyle (PA); Chet Edwards (TX); Harold E. Ford, Jr. (TN); Martin Frost (TX); Charles A. Gonzalez (TX); Gene Green (TX); Baron P. Hill (IN); Maurice D. Hinchey (NY); Ruben Hinojosa (TX); Steny H. Hoyer (MD); Eddie Bernice Johnson (TX); Dennis H. Kucinich (OH); Nick Lampson (TX); John B. Larson (CT); Barbara Lee (CA); Ken Lucas (KY); Bill Luther (MN); James H. Maloney (CT); Frank Mascara (PA); Carolyn McCarthy (NY); James P. McGovern (MA); Martin T. Meehan (MA); George Miller (CA); John P. Murtha (PA); Eleanor Holmes Norton (DC); David R. Obey (WI); Nancy Pelosi (CA); David D. Phelps (IL); Earl Pomeroy (ND); Ciro D. Rodriguez (TX); Bobby L. Rush (IL); Bernard Sanders (VT); Max Sandlin (TX); Janice D. Schakowsky (IL); Ronnie Shows (MS); Louise McIntosh Slaughter (NY); Debbie Stabenow (MI); Fortney Pete Stark (CA); Ted Strickland (OH); Bart Stupak (MI); Mike Thompson (CA); John F. Tierney (MA); Karen Thurman (FL); Jim Turner (TX); Mark Udall (CO); Tom Udall (NM); Bruce F. Vento (MN); Peter J. Visclosky (IN); Henry A. Waxman (CA); Robert E. Wise, Jr. (WV); Lynn Woolsey (CA); David Wu (OR); and Albert R. Wynn (MD). Senators Max Baucus (MT) and Tim Johnson (SD) have also released reports.

surveyed over 1000 chain and independently owned pharmacies. In this report, average drug prices for seniors are calculated by averaging the prices obtained from these pharmacies.

C. Determination of Drug Prices for Favored Customers

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

The federal government pays for prescription drugs through several different programs. One important program is the Federal Supply Schedule (FSS), which is a price catalogue containing goods available for purchase by federal agencies. Drug prices on the FSS are negotiated by the Department of Veterans Affairs (VA) and approximate the prices that the drug companies charge their most favored nonfederal 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.

---

[20] U.S. General Accounting Office, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain* 6 (June 1997) (emphasis added). In an April 21, 1999, letter to Rep. Henry A. Waxman, GAO confirmed that "federal supply schedule prices represent the best publicly available information on the prices that pharmaceutical companies charge their most favored customers." Letter from William J. Scanlon, Director, GAO Health Financing and Public Health Section.

[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.

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

D. Determination of Drug Prices for Pharmacies

The report also examines 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 pay to acquire drugs. The typical wholesaler markup on drugs for sale to pharmacies is an additional 2% - 4%.[23] Both AWP and WAC were obtained from the Medispan database and were updated in June 1999 to reflect current pricing.

E. Determination of Drug Dosages

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

F. Price Differentials for Other Consumer Goods

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

---

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

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

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

IV. DRUG COMPANIES CHARGE OLDER AMERICANS DISCRIMINATORY PRICES

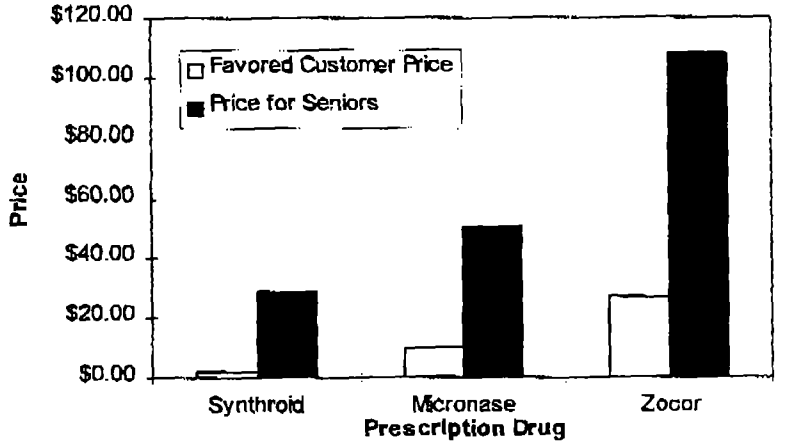
A. Discrimination in Drug Pricing

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 the United States and the price that would be paid by the drug companies' most favored customers was 134% (Table 1). This means that the average price that older Americans and other individual consumers pay for these drugs is more than double the price paid by the drug companies' favored customers, such as HMOs and the federal government.

For individual drugs, the price differential was even higher. Among the five best selling drugs, the highest price differential was 299% for Zocor, a cholesterol treatment manufactured by Merck. The average senior without drug coverage must pay $107.66 for 60 tablets of Zocor, compared to a favored customer price of just $27.00.

For other popular drugs, the study found even greater price differentials. The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the average price differential for senior citizens was more than 1,550%. One hundred tablets of this drug would cost the most favored customers only $1.75, but would cost the average senior citizen $29.15. For Micronase, a diabetes treatment manufactured by Upjohn, the average price differential was 403% (Figure 1).

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



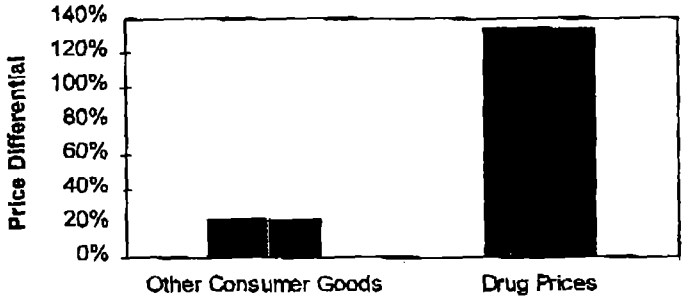
Every drug looked at in this study had a large price differential. Among the five highest selling drugs, four (Zocor, Norvasc, Prilosec, and Procardia XL) had price differentials that exceeded 90%. The lowest price difference was still high -- 78%, for Zoloft.

In dollar terms, Zoloft, an antidepressant, had the highest price differential. Senior citizens in the United States must pay nearly $100 more for 100 tablets of Zoloft than a favored customer. The difference between seniors' prices and prices for favored customers was more than $80.00 for 60 tablets of Zocor and over $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 report analyzed whether the large differentials in prescription drug pricing could be attributed to a volume effect. The drug companies' most favored customers, such as HMOs and the federal government, typically buy large volumes of drugs. Thus, it could be expected that there would be volume-related differences between the prices charged the most favored customers and retail prices. The report found, however, that the differentials in prescription drug prices were much greater than the differentials in prices for other consumer goods. The report found that, in the case of other consumer goods, the average difference between retail prices and the prices charged most favored customers, such as large corporations and institutions, was only 22%. The average price differential in the case of prescription drugs was more than six times larger than the average price differential for other consumer goods (Figure 2). This indicates that a volume effect is unlikely to explain the large differential in prescription drug pricing.

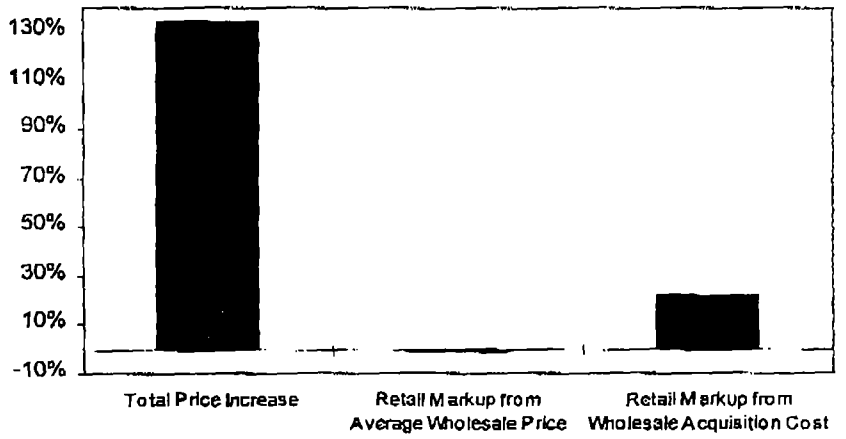
Figure 2: Price Differentials on Drugs Commonly Used by Older Americans Are Far Higher Than Differentials for Other Consumer Goods.



C. Drug Company Versus Pharmacy Responsibility

The report also sought to determine whether drug companies or retail pharmacies are responsible for the high prices being paid by older Americans. To do this, the report compared the average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that pharmacies appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. The report found that the average retail price for the five best-selling prescription drugs was actually lower than the published Average Wholesale Price, and only 22% above the Wholesale Acquisition Cost (Figure 3). This finding indicates that it is drug company pricing policies, not retail markups, that account for the inflated prices charged to older Americans and other individual customers. These findings are consistent with other experts who have concluded that because of the competitive nature of the pharmacy business at the retail level, there is a relatively small profit margin for retail pharmacists.[25]

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

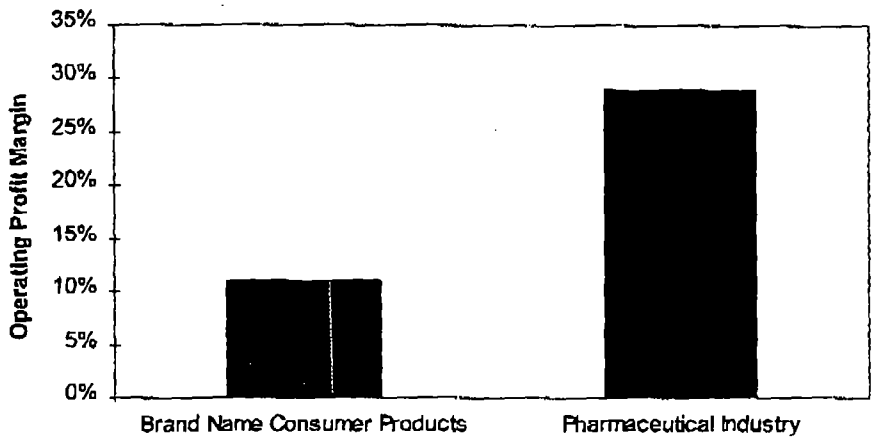


[25] National Association of Chain Drug Stores, *Did You Know . . .* (pamphlet) (citing financial data assembled by Keller Bruner & Company, P.C., Certified Public Accountants 1995).

V. DRUG MANUFACTURER PROFITABILITY

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

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



These high profits appear to be directly linked to the pricing strategies observed in this report. For instance, Merck, the country's largest pharmaceutical manufacturer, had a 24% increase in sales and a 12% increase in profits in the first quarter of 1999.[28] According to industry analysts, Merck's increased profits have been due in large part to sales of Zocor,[29] which is sold in the United States at a price differential of 299%. Zocor itself accounts for 13% of Merck's revenues.[30]

---

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

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

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

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

[30] *Merck Sales Jump by 24 Percent, supra* note 28.

Pharmaceutical companies have been rapidly increasing their prices for drugs used by senior citizens. These price hikes make it even more difficult for uninsured senior citizens to afford prescription drugs. In 1998, the prices for the 50 prescription drugs most frequently used by senior citizens increased by 6.6%, more than four times the inflation rate.[31] The price of Synthroid, which is sold at a price differential of more than 1,550%, increased by more than six times the inflation rate.[32]

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

---

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

[32] *Id.*

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

[34] *Id.*

Appendix A

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

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

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

Appendix B

Information on Prescription Drugs Analyzed in This Study

			Prices (Dollars)				
Brand Name Drug	Dosage and Form	Indication	Favored Customer Price	Wholesale Acquisition Cost	Average Wholesale Price	Average Retail Price	Price Differential (Average Retail Price vs. Favored Customer Price)
Zocor	5 mg, 60 tablets	Cholesterol reducer	$27.00	$86.07	$106.84	$107.66	299%
Norvasc	5 mg, 90 tablets	High Blood Pressure	$59.71	$96.00	$119.17	$118.96	99%
Prilosec	20 mg, 30 cap.	Ulcer	$59.10	$100.34	$119.57	$117.56	99%
Procardia XL	30 mg, 100 tab.	Heart Problems	$68.35	$111.46	$138.37	$133.22	95%
Zoloft	50 mg, 100 tab.	Depression	$125.73	$182.98	$227.13	$223.61	78%
Synthroid	.05 mg, 100 tab.	Hormone Treatment	$1.75	N/A	N/A	$29.15	1566%
Micronase	2.5 mg, 100 tab.	Diabetes	$10.05	N/A	N/A	$50.52	403%

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%**