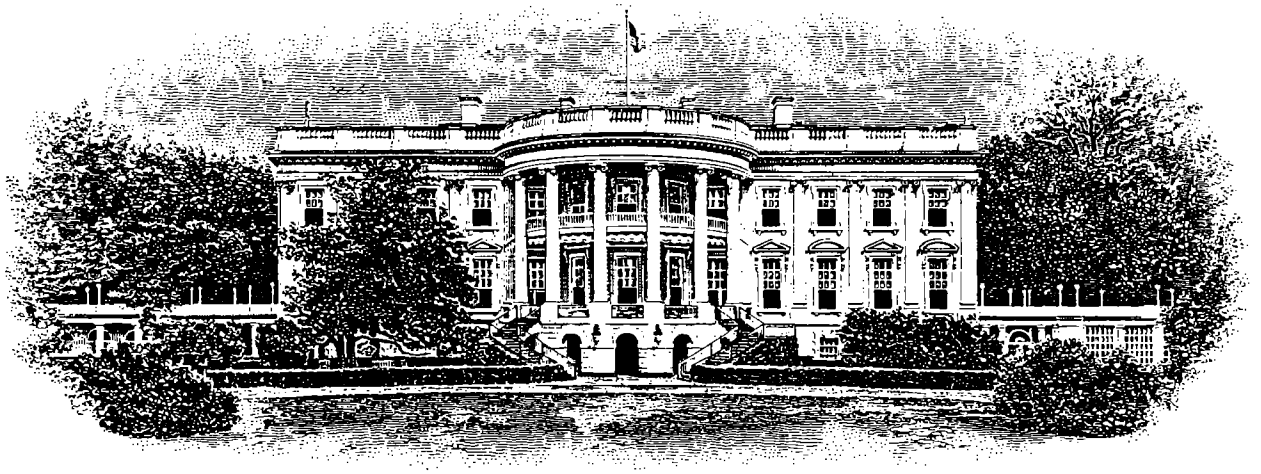
MEDICARE
DRUGS

The White House



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PRESIDENT WILLIAM J. CLINTON
DEPARTURE STATEMENT
PRESCRIPTION DRUGS REPORT
THE WHITE HOUSE, WASHINGTON DC
April 26, 2000

Before I leave, I want to say a few words about an important new study that Senator Daschle, Congressman Gephardt and I have just been briefed on, regarding the growing costs of prescription drugs, and the burden these costs are placing on senior and disabled Americans. The study is from Families U.S.A. It is a careful and compelling piece of work, and I want to thank the Families U.S.A President Ron Pollack for providing it.

For over a year now, I have been arguing that we as a nation ought to use this historic moment of strength and prosperity to meet America's long-term challenges—especially the challenge of helping all seniors afford prescription drugs that can lengthen and enrich their lives. More than three in five American seniors today lack affordable and dependable prescription drug coverage. Today's report shows that the burden on these seniors is getting worse.

According to the report, the price of the prescription drugs most often used by seniors has risen at double the rate of inflation for six years, including this past year. The burden of these rapidly rising prices falls hardest on seniors who lack drug coverage, because they do not receive the benefits of price discounts that most insurers negotiate. Indeed, the gap between drug prices for people with insurance versus those without insurance nearly doubled, from 8 to 15 percent, between 1996 and 1999.

Seniors living on fixed incomes simply cannot continue to cope with these kinds of price increases. That is why we must take action to help them—not next year or the year after that, but this year.

In my budget, I have proposed a comprehensive plan to provide a prescription drug benefit that is optional, affordable, and accessible for all. A plan based on price competition, not on price controls. A plan that will boost seniors' bargaining power to get the best prices possible. A plan that is part of an overall effort to strengthen and modernize Medicare – so we will never have to ask our children to shoulder our burden when we retire.

I am gratified to see growing bipartisan support for adding a prescription drug option to Medicare since I raised the idea last. Earlier this month, Republican leaders in the House put forth the outlines of a plan that has, as a stated goal, providing access to affordable coverage for all seniors. It's good if the leadership now agrees with our goal. Unfortunately, their current plan won't meet that goal. It would subsidize insurance companies to offer prescription-drug-only policies for middle-income seniors—policies the insurance industry itself has already said it won't offer.

And because the plan would provide direct premium support only to low-income seniors and disabled Americans, it would do nothing for those with modest, middle-class incomes between $15,000 and $50,000. Nearly half of all Medicare beneficiaries who lack prescription drug coverage fall into that category. For them, rising drug prices are eating away at their financial independence. For instance, according to this new report, a widow taking medication for diabetes, hypertension, and high cholesterol, who lives on $16,700 a year must spend about $2000 a year--nearly 14 percent of her income--on those prescription drugs. That's not unusual--and for a nation that cares about its seniors, it's unacceptable.

Moreover, the majority's plan is a phantom as long as the leadership insists on moving forward with a budget resolution that would spend every dime of the surplus and then some over the next ten years on tax cuts. If the irresponsible and unrealistic spending cuts this budget calls for don't materialize, then the tax cuts will make it impossible to pay down the debt, and would leave nothing left for a prescription drug benefit. Any prescription drug plan that is not adequately financed, is not available to all, and is not affordable to all, is not a real plan at all.

The balanced budget I have proposed would provide a voluntary drug benefit for all seniors, with plenty left over to pay down the debt; lengthen the life of Social Security and Medicare; and increase investments in education and other areas. It provides a prescription drug benefit all seniors can afford, in a way America can afford.

I am truly encouraged by the progress we have made on this issue. Both parties have come to support the idea of adding a voluntary prescription drug benefit to Medicare. Both parties have agreed to the principle that this benefit should be available and affordable to all Americans. There is no reason we can't come to an agreement on the details of how to provide it. Because fundamentally, this is not a Democrat or Republican issue. It's an American issue.

I want to thank my good friends Sen. Daschle and Rep. Gephardt for their support on this, and I want to invite them to say a few words. First, Rep. Gephardt.

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I. Insurance Gaps for Medicare Beneficiaries

II. Implications of Lack of Drug Coverage

III. President's Proposal

April 20, 2000

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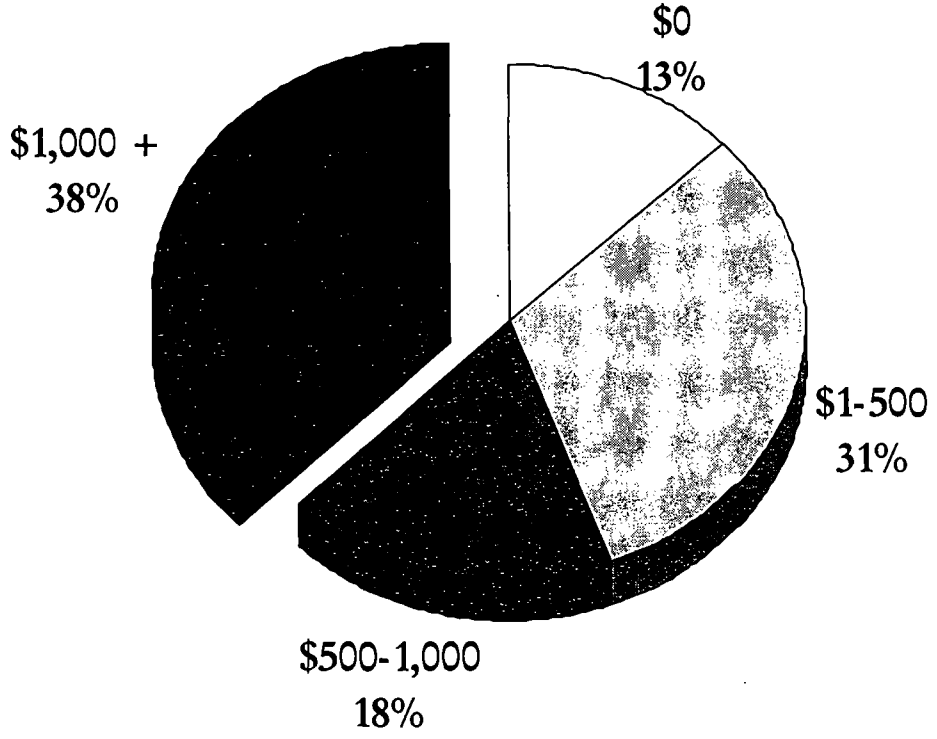
Beneficiaries By Total Drug Spending, 2000



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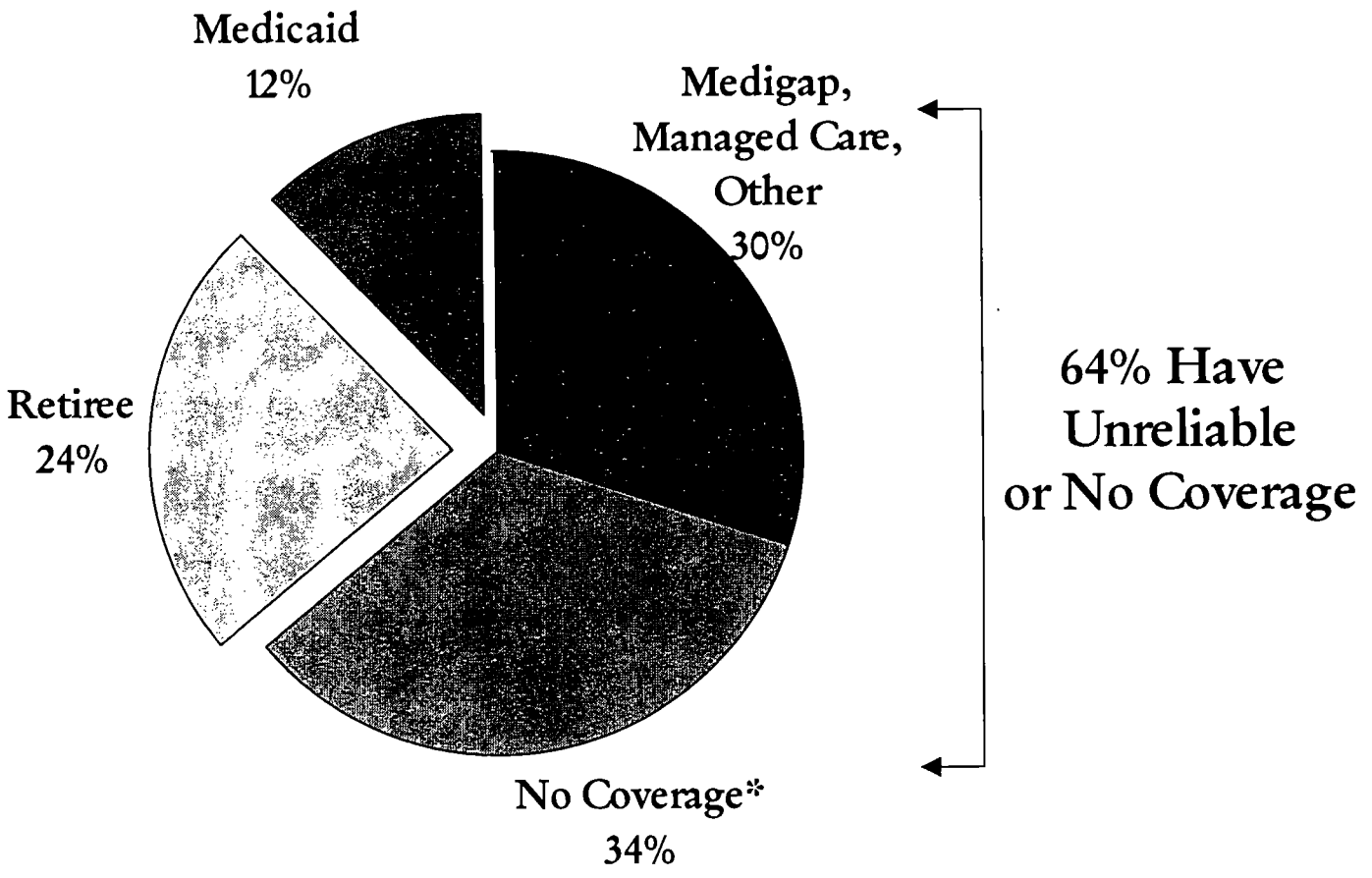

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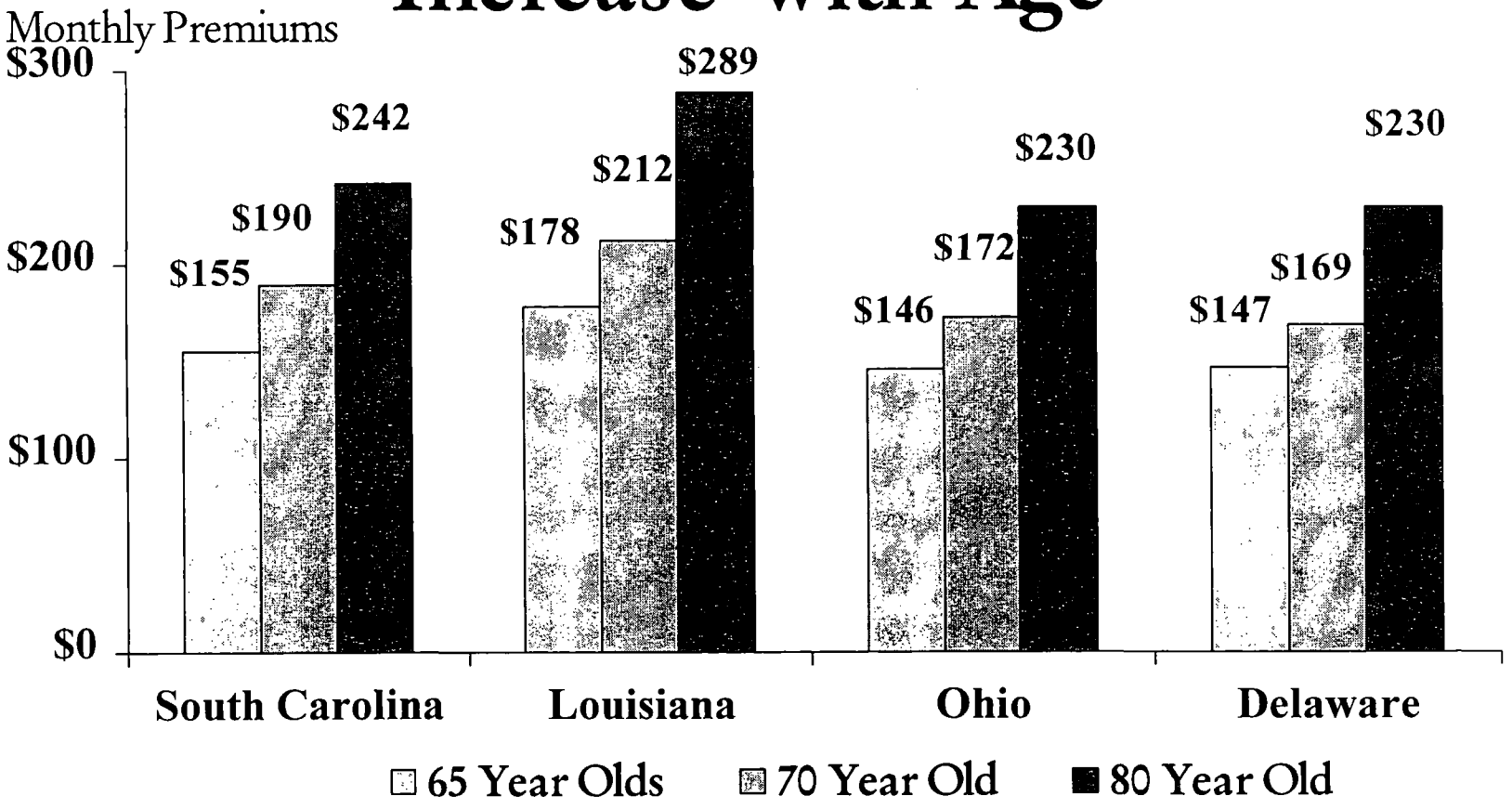

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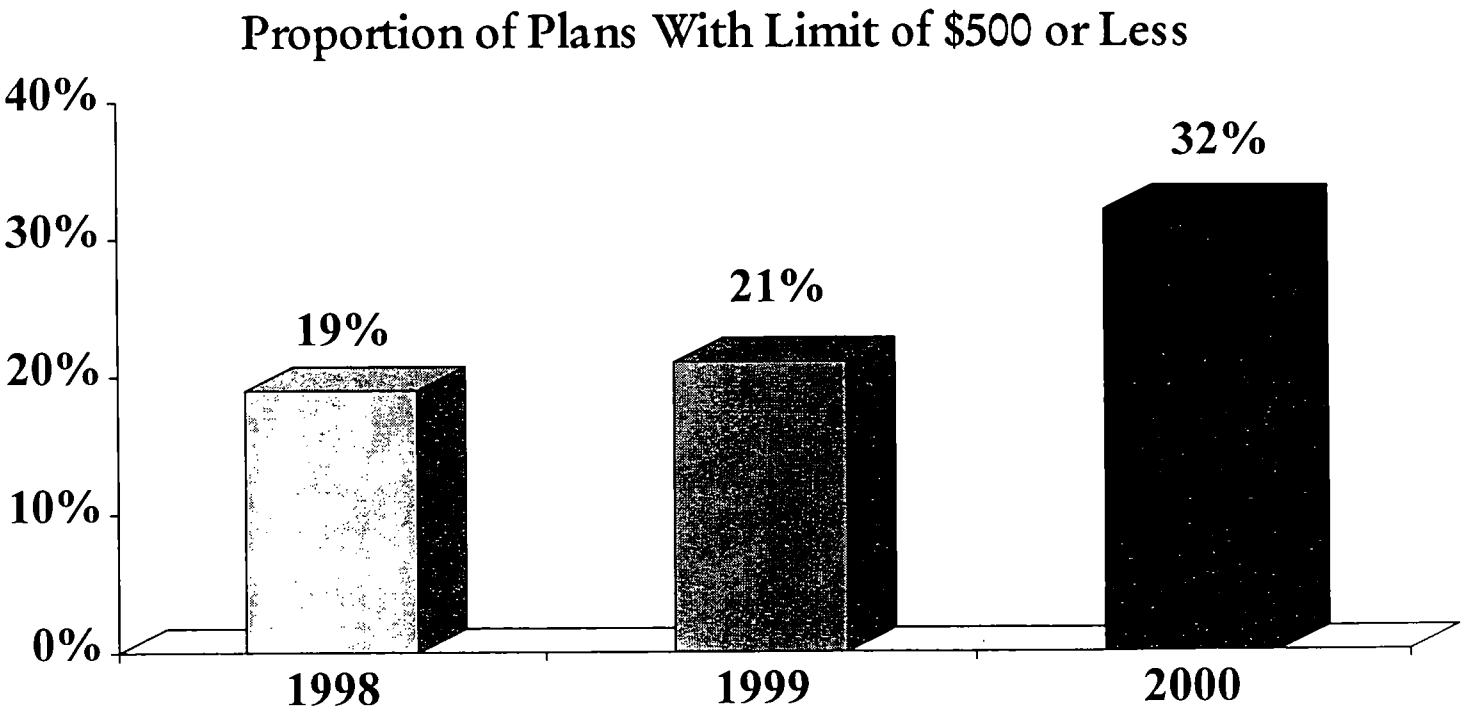

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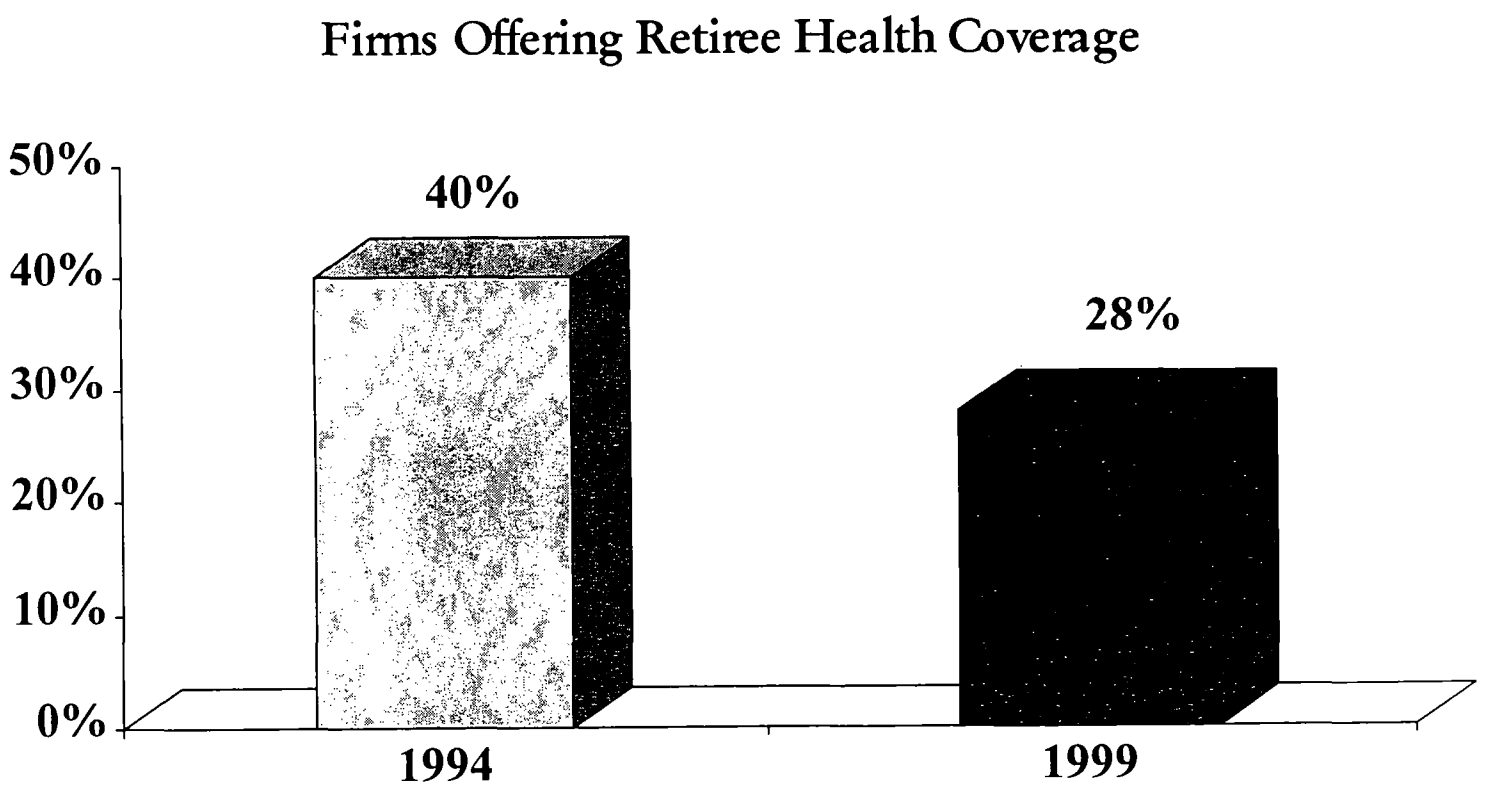

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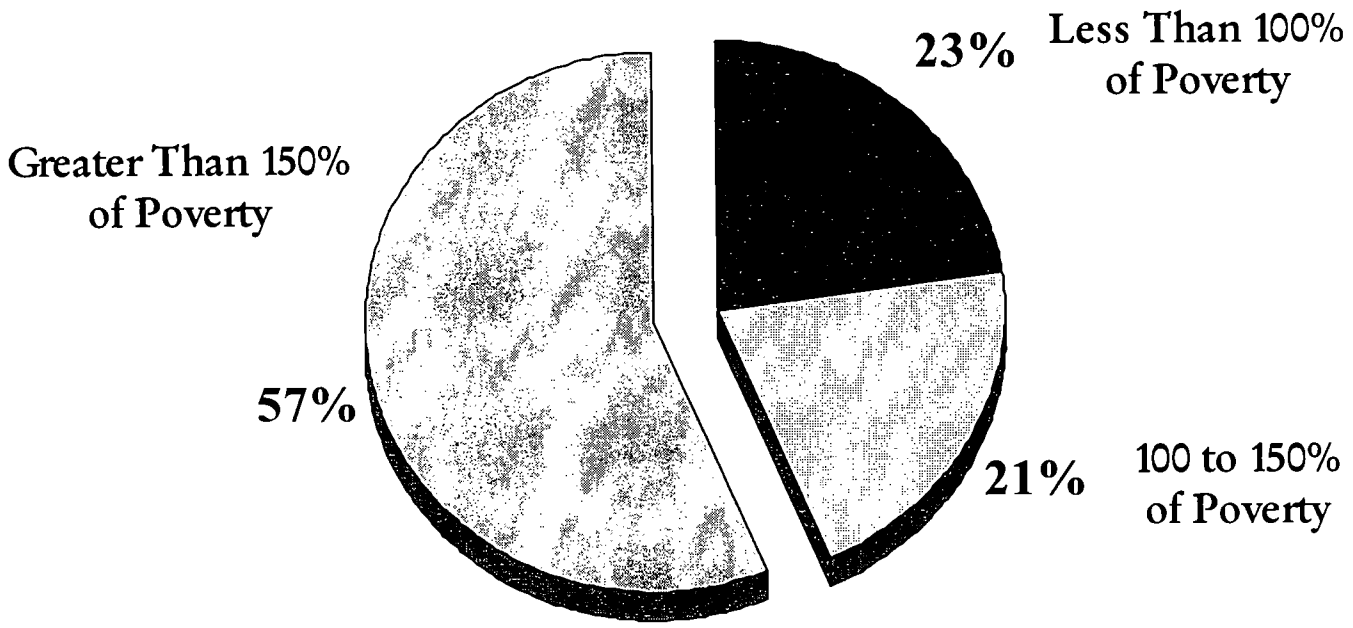

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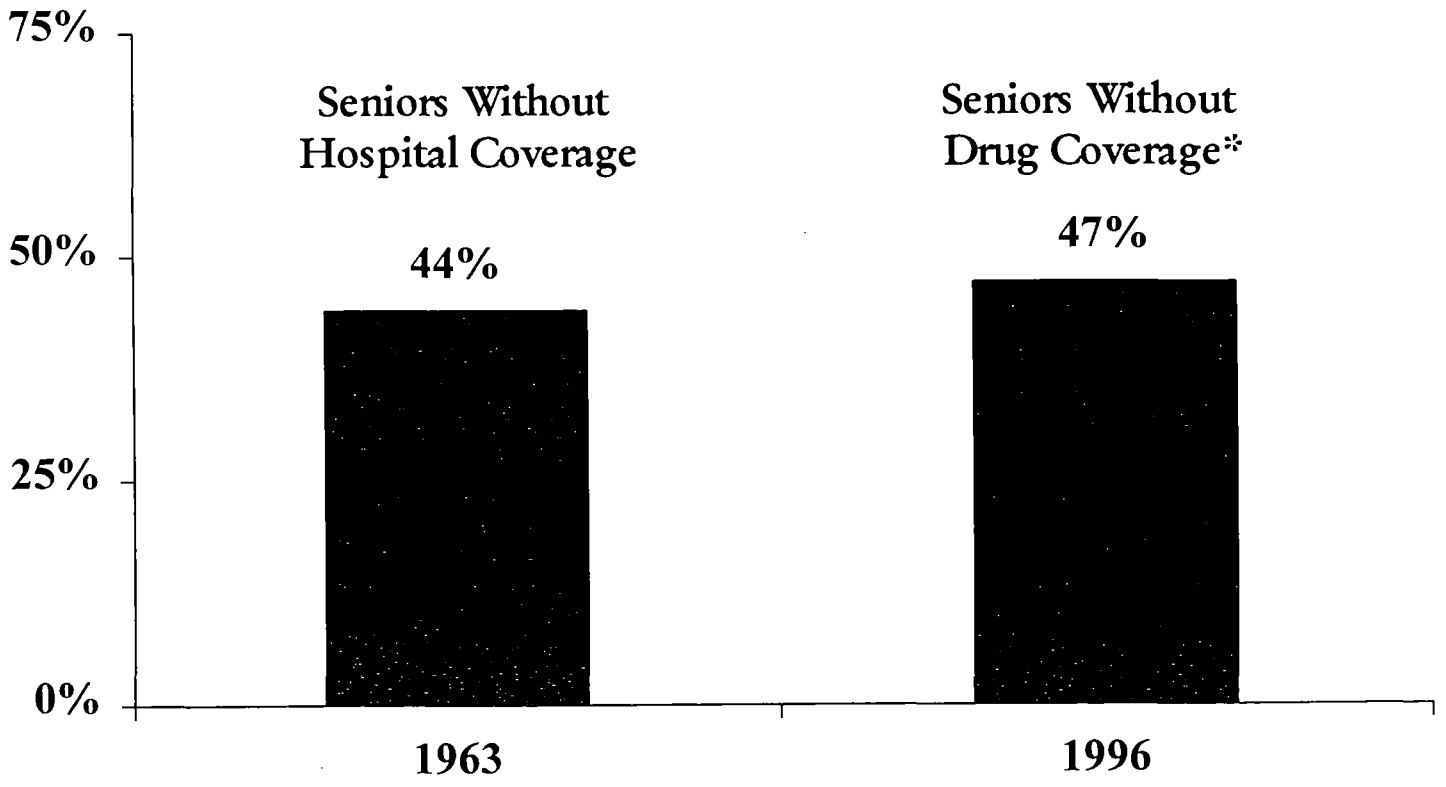

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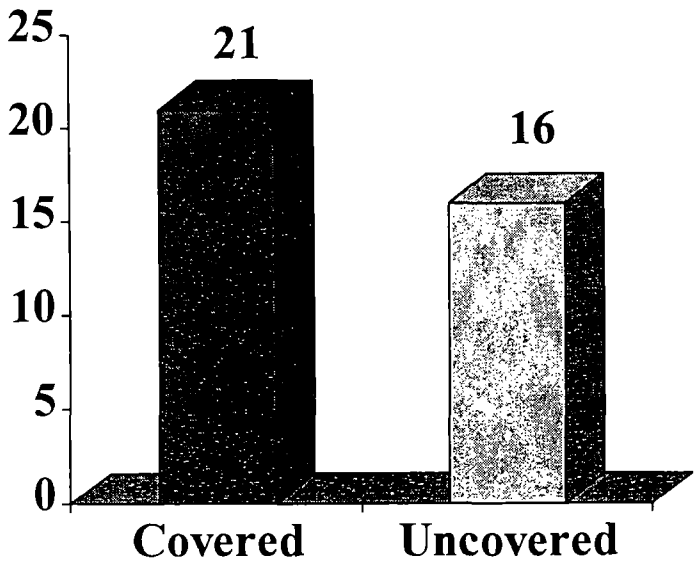

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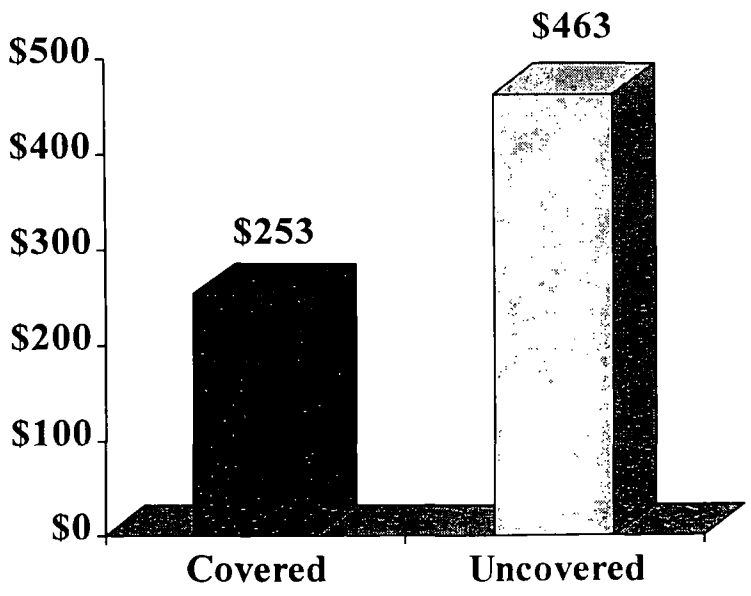

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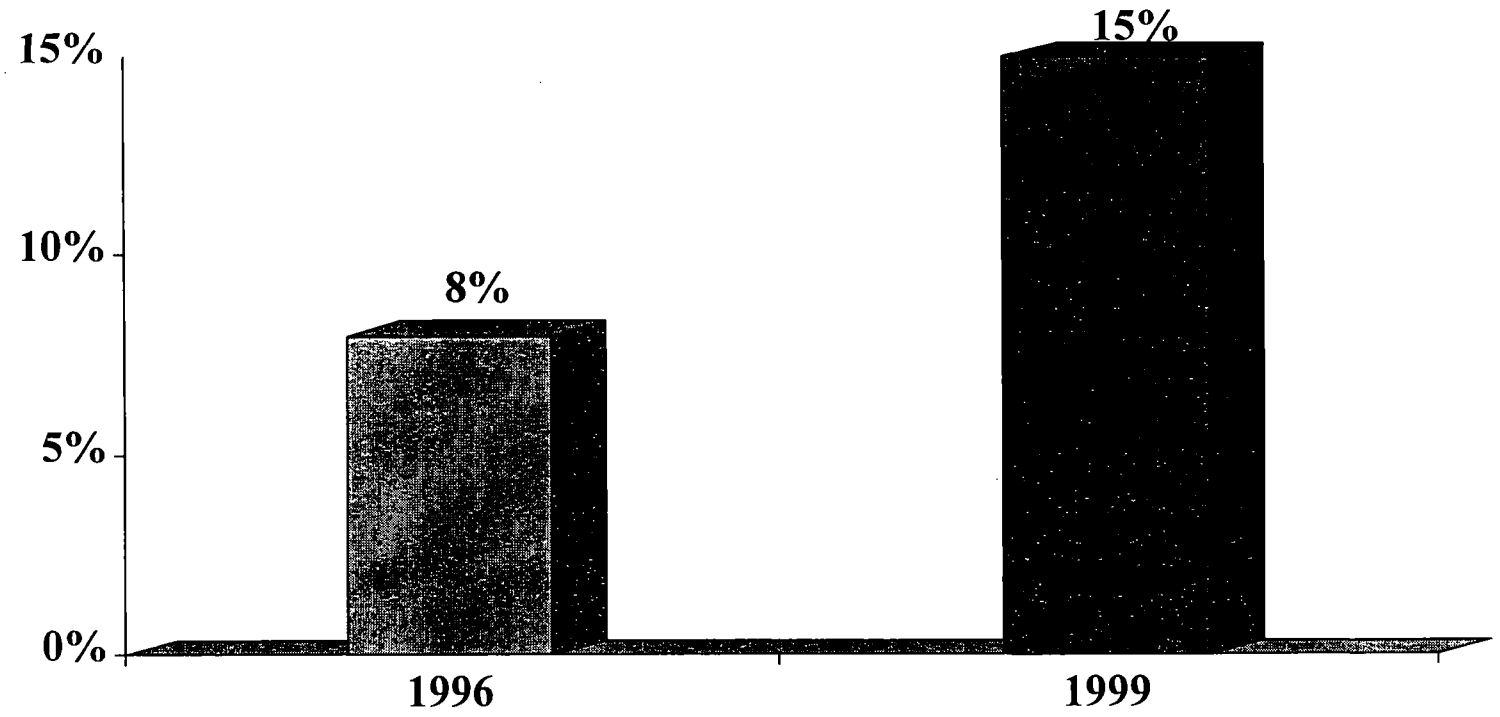

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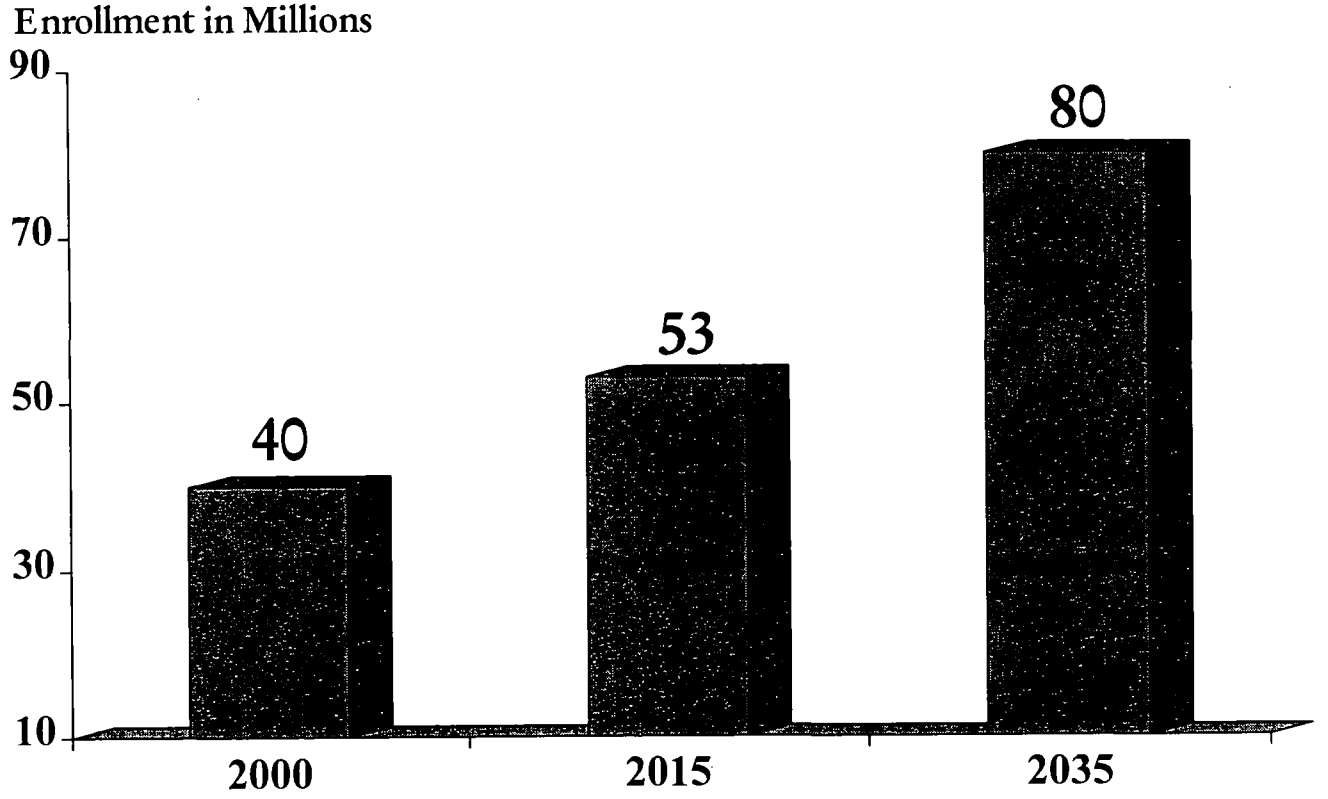

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Adding Private Purchasing Tools to Traditional Medicare

- Allows Medicare to adopt innovate private-sector practices to improve efficiency and quality, like:
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- Eliminates copayments and deductibles for all preventive services covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, and mammographies
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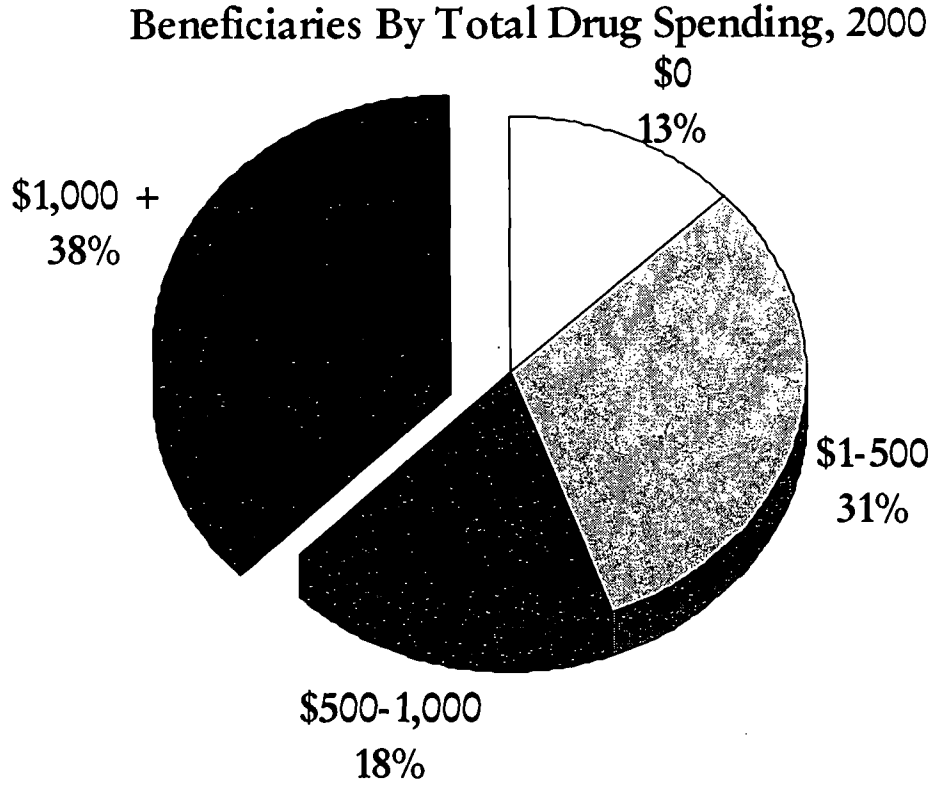

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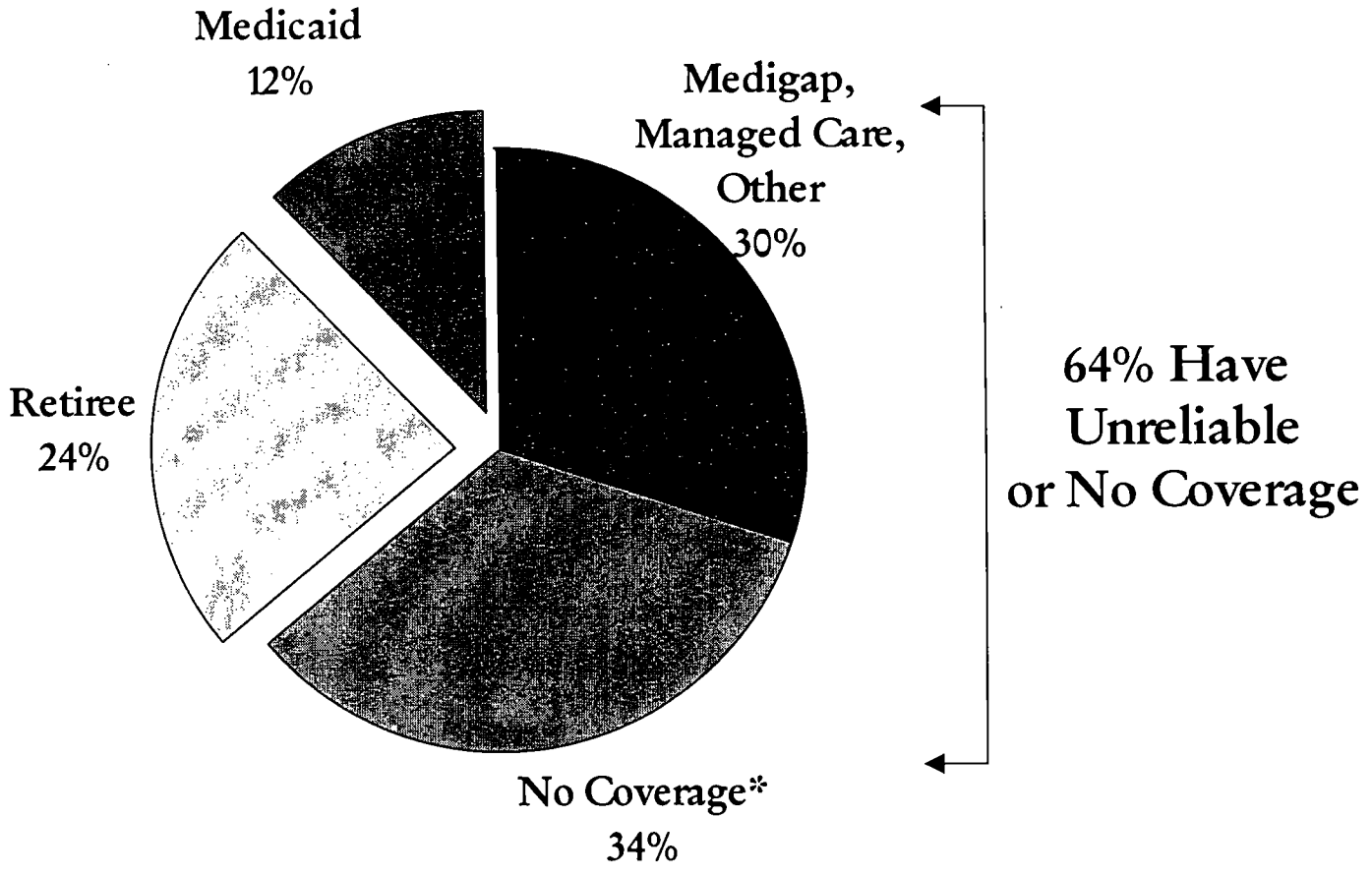

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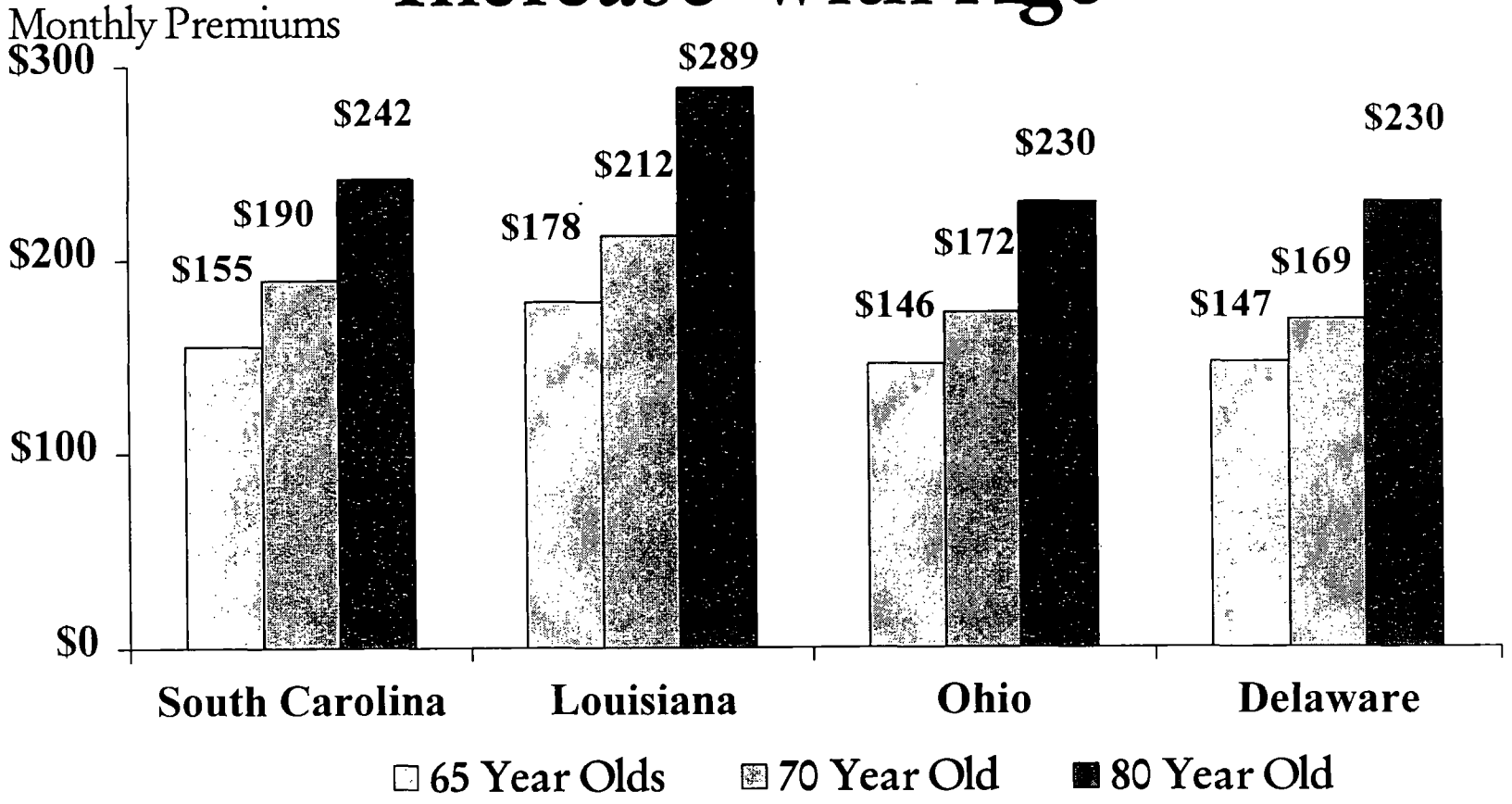

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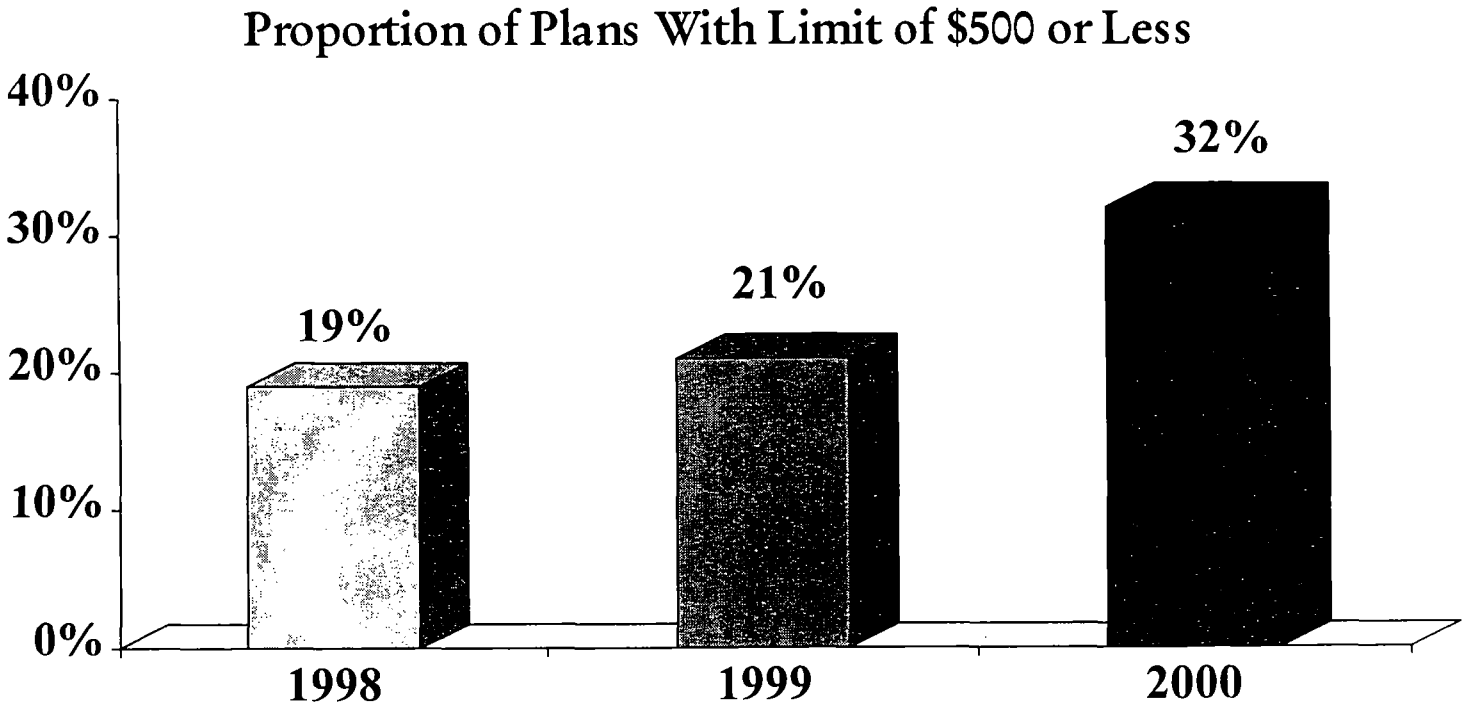

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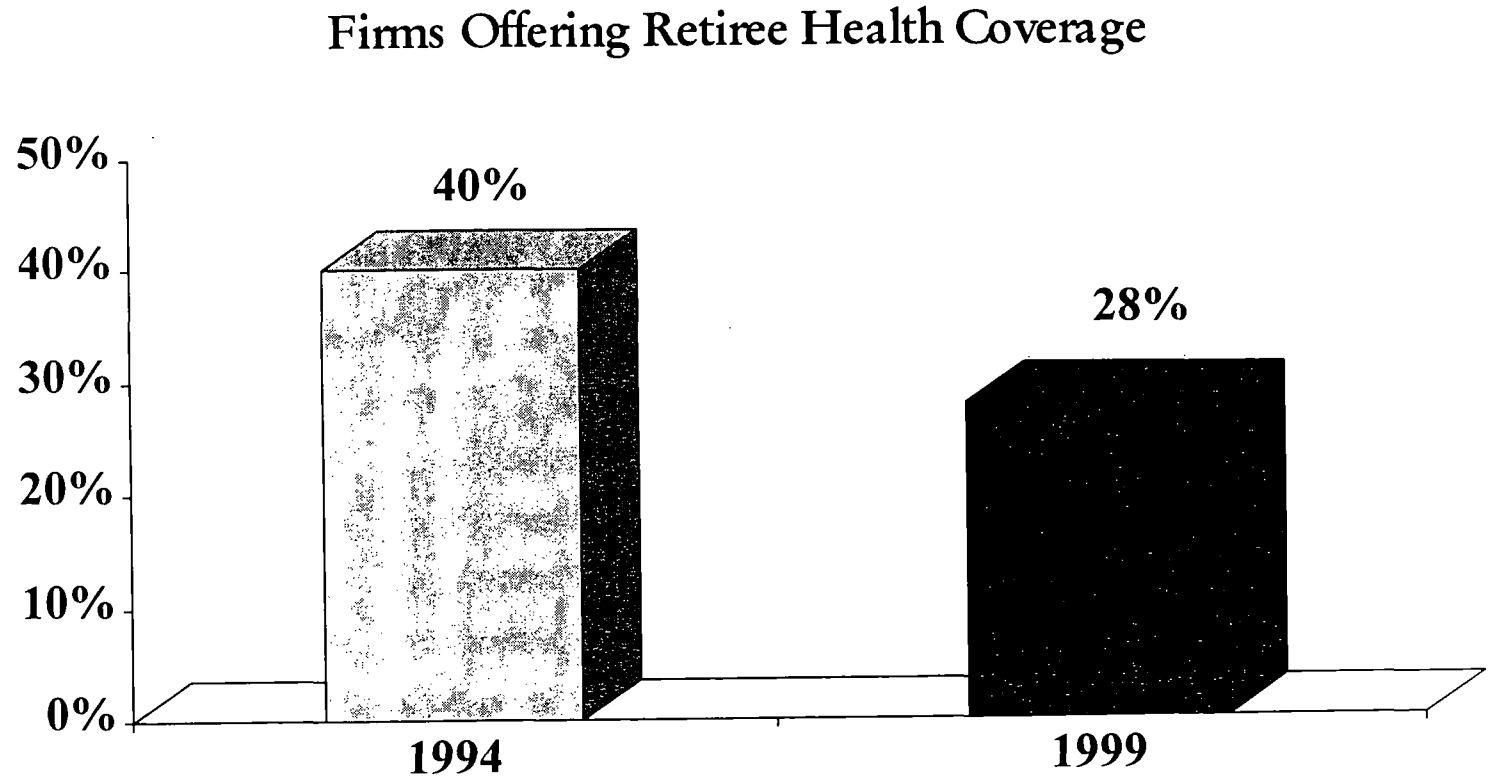

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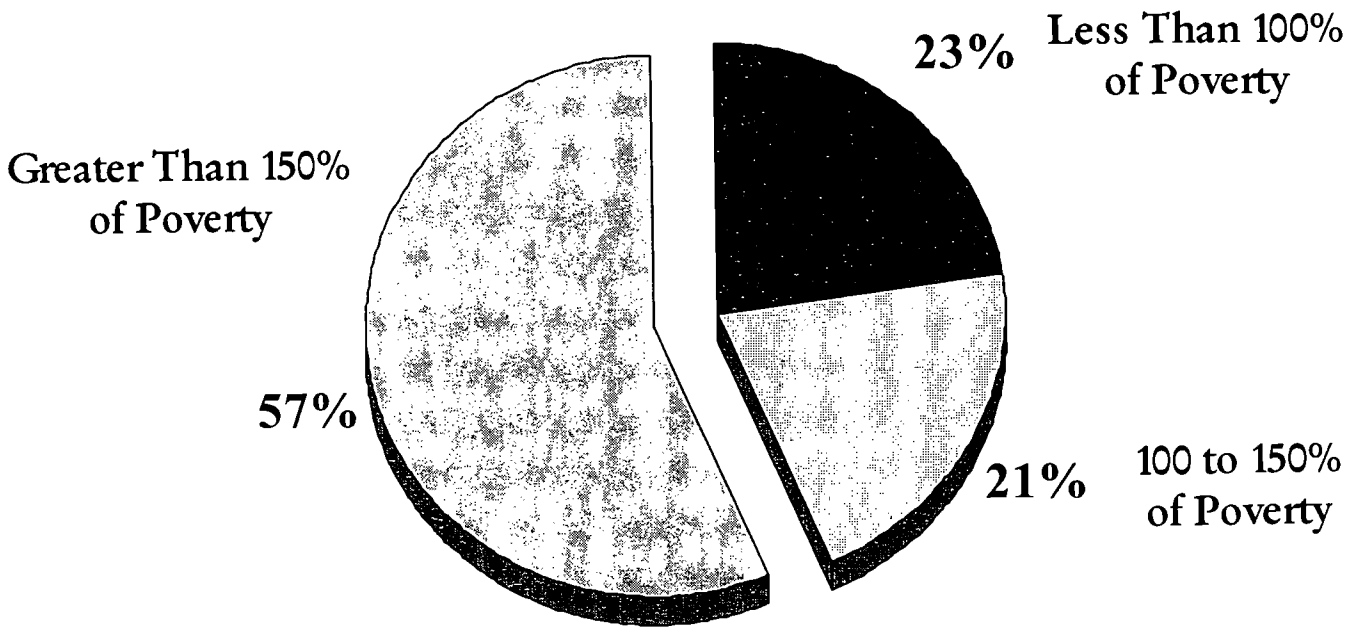

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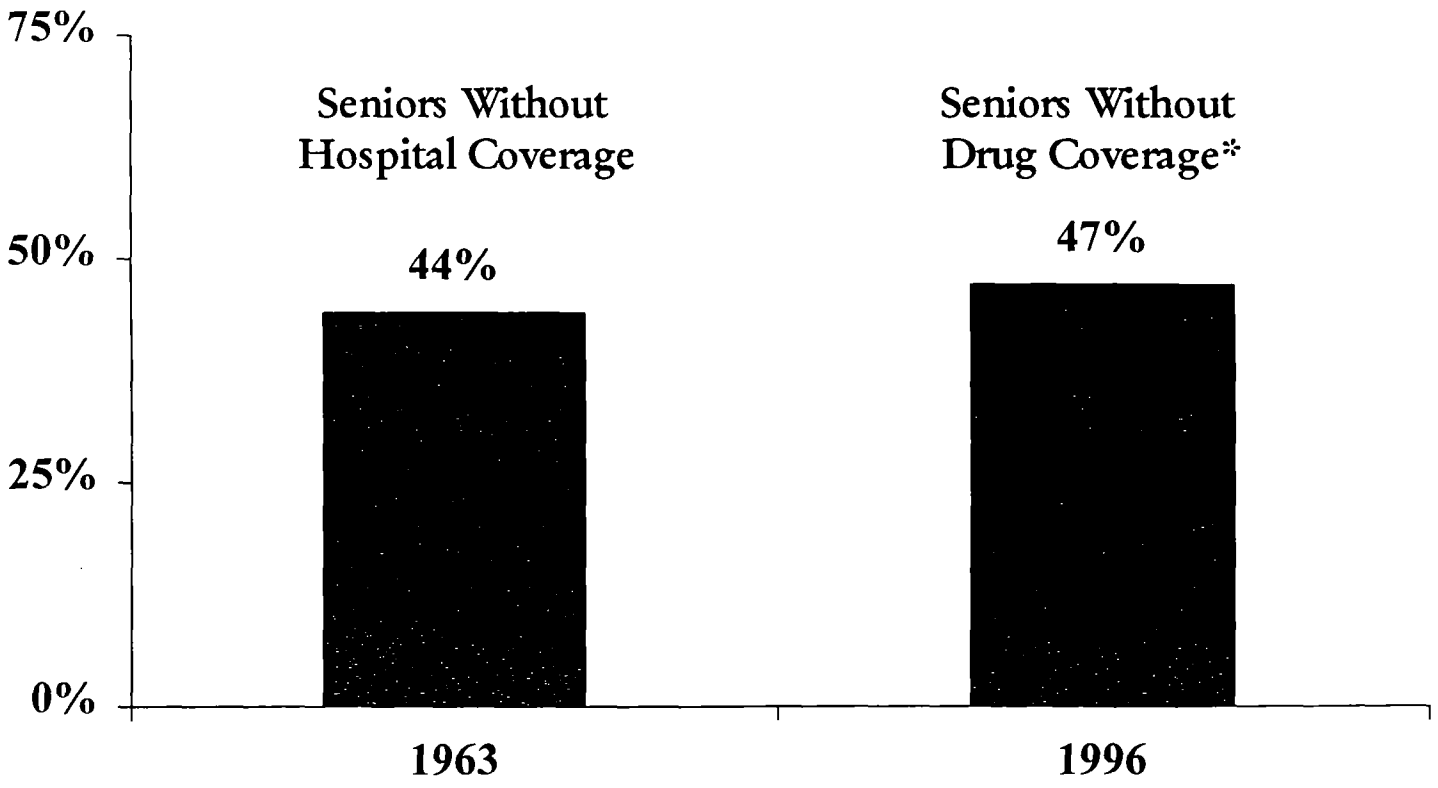

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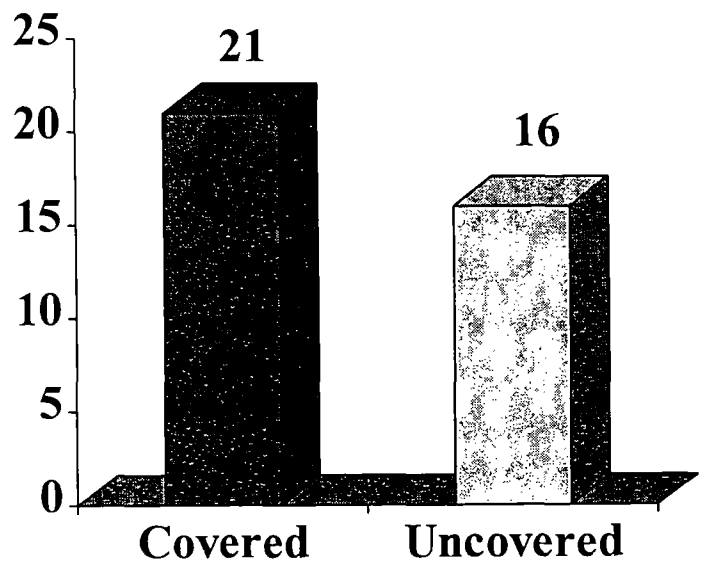

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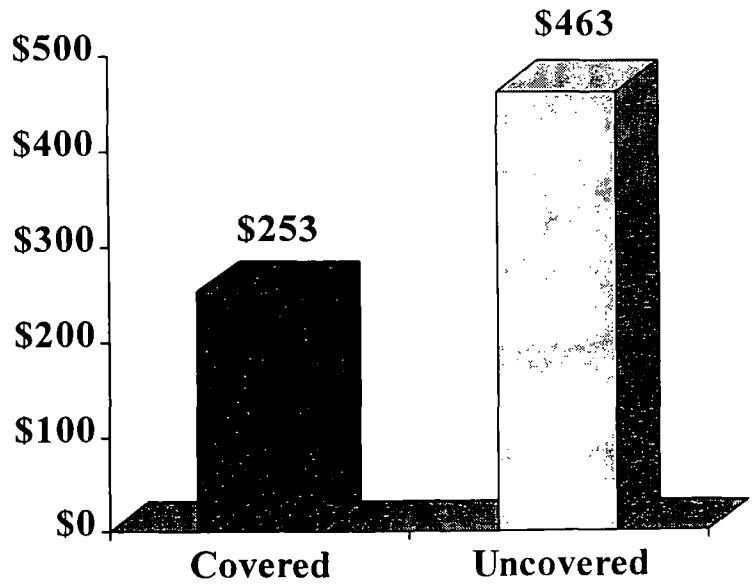

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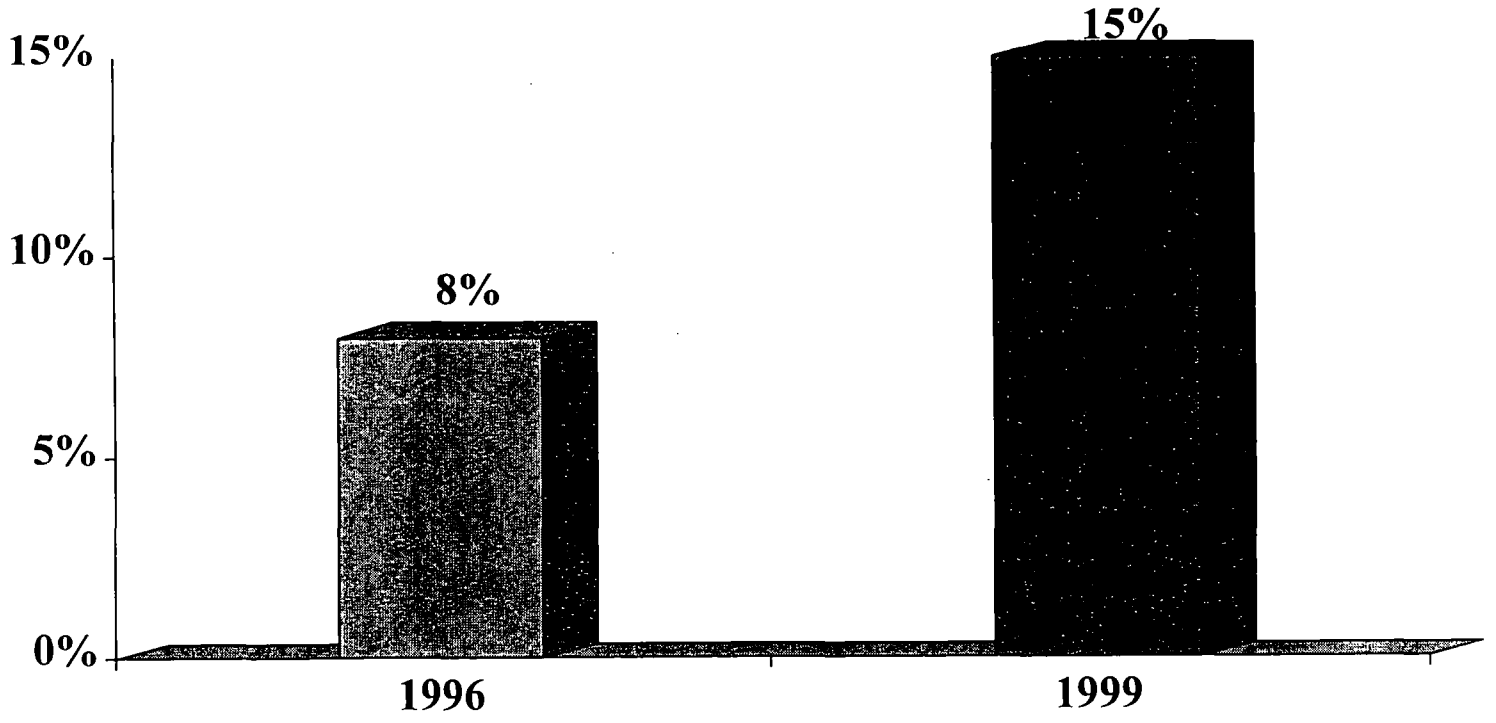

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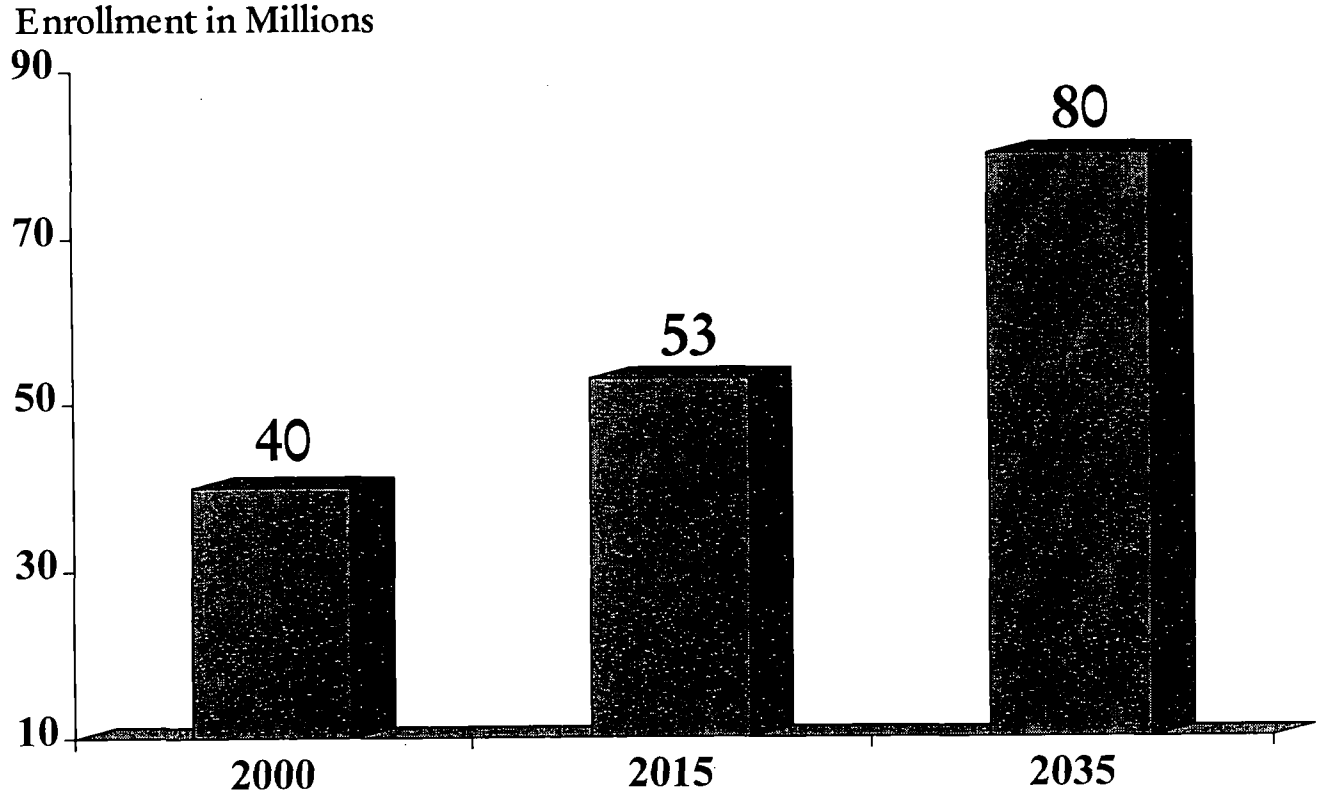

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QUESTIONS AND ANSWERS ON PRESCRIPTION DRUGS

Q: If you are serious about trying to pass a drug benefit this year, why are you criticizing Republicans instead of reaching out to them and trying to build a consensus?

A: The President praised the Republicans for their commitment to goals which he shares – but feels that it is necessary to ensure that the policy actually achieves the goals. He believes it's important that we clarify where the policy comes up short. This will help, not hurt, the possibility of achieving a compromise on this issue because it will improve the chances that these policies can be modified in time for the Congress to pass them in a form that is acceptable to the President and the beneficiaries they are designed to help.

Q: Are you in the position to confirm that the numbers in the Families USA study are correct? Can you vouch for their accuracy?

A: The report produced by Families USA seems to largely mirror many of the findings that HHS and other independent experts have produced. Moreover, the researcher who has done the work on these numbers (Dr. Steve Shondlemeyer) is an extremely well respected analyst who has been cited for years by the Congress and others for his independent analyses.

QUESTIONS AND ANSWERS ON PRESCRIPTION DRUGS
April 20, 2000

Q1: The White House is strongly criticizing the Republican prescription drug benefit. What are your concerns about this proposal, and does this mean that any possibility of a compromise on prescription drugs this year is dead?

A: **First, it is encouraging that the Republican leadership has finally begun to work on proposals to provide prescription drug coverage to Medicare beneficiaries.** Last year, the Republicans were unwilling to even discuss this issue, and this year, they are saying that they want to help make prescription drugs more affordable to all Medicare beneficiaries.

The policy doesn't live up to the rhetoric. While this is an encouraging development, the major problem is that their policies don't match their rhetoric. Their approach is underfunded, unlikely to be available to all beneficiaries, and would inevitably be unaffordable to millions of seniors and people with disabilities, even if it is available in some places.

- ***Reneges on funding commitment for a meaningful prescription drug benefit.*** Just recently, we learned that the Republicans proposed a budget resolution that dedicated as little as $20 billion to improving the Medicare program to include a prescription drug benefit. Moreover, because they are refusing to release 10-year numbers on their proposal, we fear they are attempting to conceal the fact that their exploding tax policy will eat up virtually all revenue necessary to adequately fund a drug benefit into the future.

- ***Does not assure availability of prescription drug coverage.*** And because the Republican plan relies on private insurers to voluntarily offer a drug-only benefit, this policy cannot be guaranteed to be available to all seniors in need of a drug benefit. The insurance industry itself has expressed skepticism on the Republican approach. Chip Kahn, president of the Health Insurance Association of America, said recently, "I don't know of an insurance company that would offer a drug-only policy like that, or even consider it...The idea of marketing a plan with just drugs has all kinds of problems."

- ***Not affordable for most seniors, even if it is available.*** Furthermore, because they only provide direct premium assistance to beneficiaries with annual incomes of under $12,600, the Republican benefit will almost inevitably fail to be an affordable option even if it's available. This would be the first time in the program's history that we did not provide universal premium assistance for benefits, and it would undermine the social insurance concept of the program.

Older Americans are not interested in placebos – they are interested in a real drug benefit. It is simply untenable for us not to act on this issue when we know the whole future of medicine will become increasingly dependant on the use of life-saving medications.

Policy must change to be meaningful to beneficiaries and acceptable to the President. It is our hope that just as the Republicans' interest in this issue has evolved from nothing to good principles but flawed policy, that it can further evolve into good policy as well as good principles. We stand ready to work with Republicans and Democrats – in the context of broader reform – to further strengthen and modernize Medicare.

Q2: Would the President veto a prescription drug plan that was limited to low income beneficiaries?

A: It is in no one's interest to entertain hypothetical questions. It is important to note, however, that the President believes that middle-income beneficiaries such as a widow who has a $25,000 pension, should have access to an affordable prescription drug option. Over half of Medicare beneficiaries without drug coverage have incomes above 150 percent of the poverty level and millions more have inadequate, expensive, and undependable coverage. It is hard to imagine why anyone in Congress would advocate a low-income only approach.

Q3: Would the President support an income-related premium for a drug benefit, like in the Graham-Conrad (Robb-Bryan) bill, for the program as a whole?

A: He has not ruled out any such approach. In fact, in previous years the President has supported this concept. This approach is completely different from a means tested benefit that would allow only low-income beneficiaries to access any voluntary benefit at all. However, we need to determine whether it would create an adverse selection problem, in which only the less healthy populations might opt for this benefit if it became too expensive. It also needs to be workable, administratable, and designed to attract bipartisan support. Last year, it became clear that many Republicans and Democrats had major concerns with such approaches. We all know that a necessary precondition for any successful health reform initiative is achieving bipartisan support. If it becomes clear that members in both parties are willing to entertain an income related approach, we certainly will work with them to see if a consensus position can be developed.

Q4: What is your position on the Graham-Conrad proposal for a Medicare prescription drugs benefit?

A: We are encouraged that it appears to meet the principles that we and the Senate Democratic leadership recently laid out, including being voluntary, affordable, accessible, meaningful, competitively managed, and consistent with overall structural reform. We look forward to seeing the final bill and will assess our position on it then.

Q5: Doesn't the revised Trustees' Report released today reduce the pressure for reform?

A: The Trustees' Report does not change the fact that the Medicare population will double from 40 to 80 million beneficiaries over the next 35 years. The longer we wait to reform the program, the harder it will become to address the challenges it faces. In particular, the baby boomers recognize the importance of starting now to make the program more efficient, prepare it to meet the challenges of the 21st century, and ensure they will not be a burden on their children. They also understand that avoiding this problem will not make it go away.

Q6: How can you justify a revenue transfer of $300 billion to the Medicare program to extend solvency at a time when the Medicare program is more solvent than ever? Doesn't this effectively kill the President's proposal to use surplus dollars in this way?

A: Dedicating a portion of the surplus to extend the solvency of the Medicare program helps buy down the nation's debt, freeing up resources which can be used to deal with the inevitable demographic challenges facing the program. Most Americans would prefer that we take care of first things first and address the undeniable fiscal and demographic burdens that will be imposed upon our health care system and our economy rather than squander the entire surplus on an exploding tax cut. The President's proposal represents a conservative mechanism to strengthen not only Medicare, but the economy as a whole. Once the Congress fully recognizes this, we have some confidence that they will move to protect these dollars and preserve them for the inevitable demographic challenges facing the Medicare program. Additional revenue is required to make the program financially sound for the next generation of beneficiaries.

Q7: If the Trust Fund is already solvent until 2025, how many additional years of solvency are gained under the President's plan?

A: We have not estimated the effect of the President's Medicare reform proposal on the new baseline. Certainly, while it would extend the life of the Trust Fund beyond 2030, it would be premature to speculate until the official estimate has been completed.

Q8: Why do you believe today's announcement from the Medicare actuary enhances the likelihood that the Congress will pass a prescription drug benefit this year?

A: Because of our successful efforts to make the program more efficient and reduce fraud and abuse, the program has become stronger and better prepared for a new, voluntary, prescription drug benefit. Moreover, the economy has never been stronger. As a consequence, we have the resources to help finance this drug benefit within the context of broader reforms that modernize and strengthen the program. To fail to take advantage of this opportunity is to suggest that excessive, unnecessary, and economically damaging tax cuts are more important than providing prescription drug coverage for our nation's seniors.

Q9: If Democrats and Republicans are so far apart, is compromise even possible?

A: The Republican party has moved a long way in just the last year. Last year, they wouldn't even mention the drug issue; then they suggested a low-income block grant approach; and now, although it is still severely flawed, they are suggesting some type of benefit for all Medicare beneficiaries. We hope and believe this evolution will continue, especially as we continue to inform the public and the Congress about the extent of this overwhelming health care challenge and realistic and workable policy options emerge from the Congress.

Q10: Why do you believe it is possible to pass a prescription drug benefit with so few days left before the elections?

A: The President has repeatedly stated that election years are times that we can get more accomplished than normal. In the last Presidential election year – 1996 – we passed and enacted the Kennedy-Kassenbaum, welfare reform initiatives, and an increase in the minimum wage. Elections have a way of bringing politicians closer to the people they represent, and because the public strongly supports the addition of a long overdue voluntary prescription drug benefit to Medicare, the President believes that it is very possible to see a bipartisan consensus emerge on this issue in the context of broader reforms for the program.

Q11: Aren't both the Democrats and the Republicans dedicating significant resources to a drug benefit? Is there really a difference between the two proposals?

A: Unfortunately, there is a large difference between the President's proposal and the House Republican outline. Although it's difficult to say for certain, since the Republican announcement raises more questions than it answers, it is clear that their approach could not assure access to an affordable, voluntary, prescription drug benefit for all Medicare beneficiaries. As the President has stated repeatedly, we need to have an adequately financed voluntary prescription drug benefit that all Medicare beneficiaries in need of coverage can access. The design of this policy, no matter how many dollars are dedicated to it, will make a difference in its accessibility and affordability to both beneficiaries and the program as a whole.

Having said this, it is also clear that the Republican leadership has not even agreed to dedicate the same level of resources that the President has.

Q12: Are you abandoning your proposal to structurally reform the program? Why are you focusing almost exclusively on the prescription drug benefit?

A: The President has never made a statement about the need for a new prescription drug benefit without underscoring his strong belief that it should be provided within the context of broader reform within the program as a whole. Clearly, the prescription drug benefit is viewed by many – and likely is – the engine for this necessary reform. Moreover, we have been informed by Members of the Senate Finance Committee that they agree that we should not pass any prescription drug benefit without also passing some important reforms that make Medicare more competitive and efficient.

Q13: Does the Vice President's prescription drug proposal reflect the Administration's policy for catastrophic drug coverage? Do you support it?

A: The Vice President has designed a very thoughtful proposal to provide protection against catastrophic drug costs. The President indicated that he wanted us to work with the Congress to evaluate and develop a joint approach to dealing with this issue as we collaborate with the Congress on the design and structure of a voluntary prescription drug benefit. In our discussions with the Congress, we continue to evaluate options for developing a stop-loss insurance benefit. We are confident that we will be able to achieve consensus on the best way to provide protections for beneficiaries who are burdened by catastrophic drug costs.

Q14: Would the Administration support the use of multiple pharmacy benefit managers (PBMs) within a region as a means of increasing Congressional and pharmaceutical industry support for a Medicare drug benefit? What's wrong with having multiple PBMs?

A: As the current MedPAC co-chair, Joe Newhouse, has recently stated, using multiple PBMs to provide a drug benefit to Medicare beneficiaries would reduce the discounts available for seniors purchasing prescription drugs and increase the cost of the program providing coverage for them. Moreover, doing so would be at odds with current private sector practices, which, virtually without exception, only contract out with one PBM per insurer. Finally, it is important to note that under the President's plan, many beneficiaries would have access to not only the fee for service program, but managed care and retiree health options as well. As a consequence, there would not be excessive market consolidation, and in fact, the purchasing model would mirror what is occurring in the private sector today. It would take place in an environment in which many private insurers in the under 65 population represent much larger purchasers for many fee for service plans. We don't believe it makes sense to make a policy change that will increase prices and add a new layer of administrative complexity for beneficiaries, as well as increase costs for workers supporting the program.

Q15: The Medicare Payment Assessment Commission just recommended that hospital payment rates be increased. Does the Administration agree with this recommendation and reject its own budget proposal to cut Medicare provider payments?

A: We are always looking for any information that helps us best evaluate and ensure adequate payment to providers. As the President has made clear in the past, he wants to make certain that access to high-quality services is assured in the Medicare program. We are reviewing the MedPAC recommendation closely to determine whether any modification to our previous positions on provider payment is warranted. We have not finalized that review as of this time.

Q16: Won't the introduction of any Medicare prescription drug benefit give employers who are struggling to afford prescription drug coverage today an excuse to drop it?

A: A well-designed Medicare prescription drug option should not result in further erosion of retiree coverage – and could, in fact, increase coverage. Employers who offer prescription drug coverage to retirees today do so because they think it is an important part of their employee compensation package. While rising costs have resulted in a number of employers dropping this coverage, the President's proposal, which allows them to offer the same coverage for less, should stop – if not reverse – this trend. The proposal would make a special premium assistance payment for (1) employers that offer meaningful prescription drug coverage or (2) for beneficiaries whose employers buy them into the Medicare benefit. This is a voluntary incentive for employers and, in a recent survey, four out of five who now offer coverage said that they would take it. The Congressional Budget Office reports that 75 percent of retirees with coverage would elect to keep that coverage.

Q17: Isn't the President's employer incentive proposal just paying employers more for what they are already doing?

A: It is important to put this incentive program in context. While the incentive payment is more than today's tax subsidy, it is less than what retirees would get if they were directly enrolled in the new Medicare option. In other words, if the lack of an incentive program resulted in employers dropping their coverage, then Medicare would pay more for the retirees than it would pay if the retiree stayed in the retiree plan with the incentive program. By pooling lower employer contributions with lower Medicare premium assistance, everyone wins under this option.

Q18: Why not include a "maintenance of effort" provision to ensure that employers do not drop drug coverage when the Medicare prescription drug benefit begins?

A: The President's plan uses incentives rather than mandates to encourage employers to continue their retiree coverage. This not only ensures that the employers who voluntarily offer retiree coverage are not penalized, but encourages employers who do not now offer retiree drug coverage to do so.

Q19: The Congressional Budget Office (CBO), in its April analysis of the President's budget, assumes that "only 25 percent of employers would accept the premium subsidy and keep their current drug coverage for Medicare-eligible retirees." Aren't they suggesting that the President's proposal does not work?

A: CBO staff have indicated that they did not include in their estimates the incentive payment for those employers buying retirees into Medicare Part D. If they estimated the complete policy and relied on the same study they cite, then 80 percent of employers would participate in the incentive plan.

Q20: Merck-Medco recently announced that they will provide uninsured Americans over the age of 18 with price discounts on prescription drugs. Doesn't this indicate that the pharmaceutical companies are moving in the right direction without Federal intervention?

A: We welcome this recognition of and response to the fact that uninsured Americans are paying the highest prices in the world for prescription drugs. We are still reviewing the specific details of the policy and commend Merck-Medco for its initiative, but, as the company acknowledges, having access to a discount in no way replaces the need for prescription drug coverage for Medicare beneficiaries.

50 TOP-SELLING DRUGS FOR SENIORS

6 years (1994 - 2000)

39 of the 50 were marketed all 6 years

37 of 39 rose *faster than* inflation

30 of 39 rose *at least* 1.5 x inflation

22 of 39 rose *at least* 2 x inflation

11 of 39 rose *at least* 3 x inflation

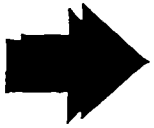
6 of 39 rose *at least* 5 x inflation

FamiliesUSA

The Voice for Health Care Consumers

50 TOP-SELLING DRUGS FOR SENIORS

1 year (1999 - 2000)



12 rose less than inflation

BUT . . .

33 rose *at least* 1.5 x inflation

25 rose *at least* 2 x inflation

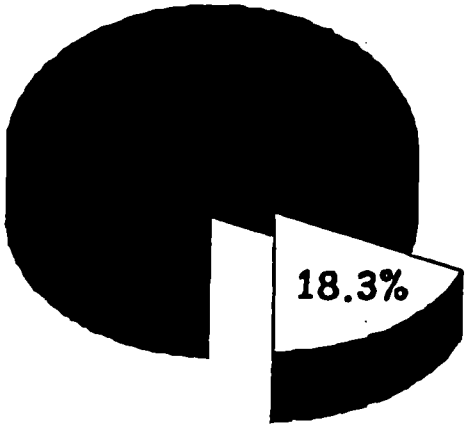
16 rose *at least* 3 x inflation

11 rose *at least* 4 x inflation

FamiliesUSA
The Voice for Health Care Consumers

Widow living on $12,525 a year (150% of poverty)

Diabetes, hypertension, & high cholesterol



Drug costs consume up to 18.3% of income

		Annual Cost:
Glucophage 500mg (diabetes)		$ 708
Procardia XL 30/60mg (hypertension)		$ 521/901
Lipitor 10mg (cholesterol)		$ 686
	Total:	**$1,915/2,295**

Acid reflux disease

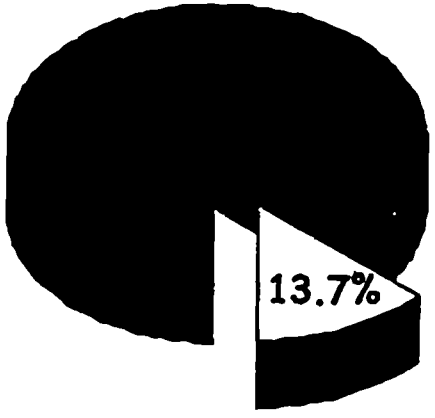
Drug costs consume up to 11.6% of income

Prilosec 20 mg *Annual Cost:* $1,455

FamiliesUSA
The Voice for Health Care Consumers

Widow living on $16,700 a year (200% of poverty)

Diabetes, hypertension, & high cholesterol



Drug costs consume up to 13.7% of income

		Annual Cost:
Glucophage 500mg (diabetes)		$ 708
Procardia XL 30/60mg (hypertension)		$ 521/901
Lipitor 10mg (cholesterol)		$ 686
	Total:	**$1,915/2,295**

Acid reflux disease

Drug costs consume up to 8.7% of income

Prilosec 20 mg *Annual Cost:* $1,455

FamiliesUSA
The Voice for Health Care Consumers

Still Rising:

Drug Price Increases for Seniors 1999 - 2000

FamiliesUSA
The Voice for Health Care Consumers

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DRUG PRICES FOR SENIORS

INTRODUCTION

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 much larger share of drug costs out of their own pockets than do those who are under 65. The elderly are also least likely to receive the benefit of price discounts for prescription drugs—discounts that are provided to bulk purchasers of drugs, including health plans covering younger populations. This means the prices of prescription drugs have a greater impact on older Americans than on younger persons.

In 1999, Families USA found that the prices of the 50 prescription drugs most commonly used by older Americans rose much faster than the rate of inflation for each of the previous five years.[1] To determine if this trend of steadily increasing prices for prescription drugs has improved, remained the same, or worsened from 1999 to 2000, Families USA gathered updated information on the prices of the prescription drugs most commonly used by older Americans.

Our analysis shows that, in each of the past six 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 six years and nearly two times the rate of inflation in the last year.

FINDINGS

- The prices of the 50 prescription drugs[2] most frequently used by the elderly rose by nearly two times the rate of inflation during calendar year 1999.* On average, the prices of these top 50 drugs increased by 3.9 percent from January 1999 to January 2000, though the general rate of inflation in that period was 2.2 percent. (See Table 1.)

- From January 1999 to January 2000, of the 50 drugs most commonly used by the elderly:
  - Fewer than one-quarter of these drugs (12 out of 50) rose less than the rate of inflation. For nine of these drugs, there was no increase in price.
  - Two-thirds of these drugs (33 out of 50) rose 1.5 or more times the rate of inflation.
  - Half of these drugs (25 out of 50) rose two or more times the rate of inflation.
  - Nearly one-third of these drugs (15 out of 50) rose at more than three times the rate of inflation.
  - One-fifth of these drugs (11 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 1999 to January 2000:
  - furosemide (a diuretic manufactured by Watson that is used to treat conditions such as hypertension and congestive heart failure), which rose by 50.0 percent (approximately 23 times the rate of inflation);
  - Klor-Con 10 (manufactured by Usher-Smith and used as a potassium replacement) rose 43.8 percent (approximately 20 times the rate of inflation);

* The data on average drug price increases used in this report weight drug price increases by sales. This means that the average drug price increases reported take into account the market share of each of the 50 top-selling drugs. This is the methodology often used by industry sources.

DRUG PRICES FOR SENIORS

- metoprolol (manufactured by Mylan and used as a beta blocker) rose 15.8 percent (more than 7 seven times the rate of inflation);
- APAP/propoxyphene (manufactured by Mylan and used as a pain reliever) rose 15.4 percent (7 times the rate of inflation); and
- Premarin (manufactured by Wyeth-Ayerst and used for estrogen replacement) rose 12.1 percent (5.5 times the rate of inflation).

■ Over the six years from January 1994 to January 2000, the prices of the prescription drugs most frequently used by older Americans rose, on average, 30.5 percent. This increase was twice the rate of inflation, which was 15.4 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 six-year period from January 1994 to January 2000.
- The prices of 37 of those 39 drugs increased faster than the rate of inflation over the six-year period.
- More than three-quarters of those drugs (30 out of 39) rose at least 1.5 times as fast as the rate of inflation over the six-year period.
- Half of those drugs (22 out of 39) rose at least two times the rate of inflation over the six-year period.
- More than one-fourth of those drugs (11 out of 39) rose at least three times the rate of inflation over the six-year period.
- The prices of 6 of the 39 drugs increased at least five times faster than the rate of inflation over the six-year period.

■ Of the 39 drugs that were used most frequently by seniors and that were on the market from January 1994 to January 2000, the drugs that rose most significantly in price were:
- lorazepam (manufactured by Mylan and used to treat conditions such as anxiety, convulsions, and Parkinson's disease), which rose by 409 percent (almost 27 times the rate of inflation);

- furosemide, which rose by 210 percent (almost 14 times the rate of inflation);
- Klor-Con 10 (manufactured by Upsher-Smith and used as a potassium replacement), which rose by 164 percent (almost 11 times the rate of inflation);
- Imdur (manufactured by Schering and used to treat angina), which rose by 122 percent (eight times the rate of inflation); and
- Lanoxin (manufactured by Glaxo Wellcome and used to treat congestive heart failure), which rose by 90 percent (almost 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 2000, 31 increased in price on at least six occasions during those six years. During those years, the following drugs increased in price at least nine times:

- Imdur, which increased 11 times;
- Premarin, which increased 10 times;
- Atrovent (manufactured by Boehringer Ingelheim and used as a respiratory agent in the treatment of asthma, bronchitis, and emphysema), which increased 10 times;
- Synthroid (manufactured by Knoll and used as a synthetic thyroid agent), which increased 9 times; and
- K-Dur 20 (manufactured by Schering and used as a potassium replacement), which increased 9 times.

STILL RISING

Table 2

Cumulative Price Change of the Top 50 Drugs (by Number of Claims) Used by the Elderly[a]

Rank by # of Claims	Brand Name Drug		Strength	Dose Form	Therapeutic Category	Number of Price Changes 1994-200	Cumulative Changes 1994-2000	Multiple of CPI 1994-2000
1	Lanoxin	b	0.13 mg	tab	Cardiac Glycoside	8	89.6%	5.9
2	Prilosec		20 mg	cap cr	Gastrointestinal Agents	5	7.5%	0.5
3	Norvasc		5 mg	tab	Calcium Channel Blocker	6	20.4%	1.3
4	Ogen 0.625		0.625 mg	tab	Estrogen Replacement	6	44.4%	2.9
5	Pepcid		20 mg	tab	Gastrointestinal Agents	6	23.3%	1.5
6	Lanoxin	b	0.25 mg	tab	Cardiac Glycoside	8	89.6%	5.9
7	Imdur	b	60 mg	tab sr	Vasodilator	1	101.4%	6.6
8	Synthroid	b	0.1 mg	tab	Synthetic Thyroid Agent	2	50.7%	3.3
9	Vasotec		5 mg	tab	ACE Inhibitor	6	23.7%	1.6
10	Procardia XL		30 mg	tab cr	Calcium Channel Blocker	6	20.4%	1.3
11	Glucophage		500 mg	tab	Oral Antidiabetic Agent	6	nm	nm
12	Lipitor		10 mg	tab	Lipid-Lowering Agent	5	nm	nm
13	Fosamax		10 mg	tab	Osteoporosis Treatment	6	nm	nm
14	Synthroid	b	0.05 mg	tab	Synthetic Thyroid Agent	9	51.3%	3.4
15	Zestril		20 mg	tab	Antihypertensive	6	23.5%	1.5
16	Vasotec		10 mg	tab	ACE Inhibitor	6	23.7%	1.6
17	Xalatan		0.0 %	sol	Glaucoma Treatment	3	nm	nm
18	Premarin		0.63 mg	tab	Estrogen Replacement	10	53.7%	3.5
19	Cardizem CD		240mg/24hr	cap	Calcium Channel Blocker	6	30.8%	2.0
20	Humulin N		100 IU	vial	Insulin/Antidiabetic Agent	7	32.3%	2.1
21	APAP/propoxyphene	b	650 mg	tab	Opiate Agonist	2	41.4%	2.7
22	Cozaar		50 mg	tab	Angiotensin II Inhibitor	4	nm	nm
23	Norvasc CD		360mg/24hr	cap	Calcium Channel Blocker	6	30.8%	2.0
24	Norvasc		10 mg	tab	Calcium Channel Blocker	6	16.2%	1.0
25	albuterol	b	90 mcg	aerosol	Respiratory Agent	0	nm	nm
26	Coumadin	b	5 mg	tab	Anticoagulant	6	28.3%	1.9
27	Zocor		10 mg	tab	Lipid-Lowering Agent	5	21.0%	1.4
28	Zestril		20 mg	tab	Antihypertensive	6	23.5%	1.5
29	Synthroid	b	0.08 mg	tab	Synthetic Thyroid Agent	9	50.8%	3.3
30	Imdur	b	30 mg	tab er	Vasodilator	7	nm	nm
31	Aerobid		0.02 mg	inhaler	Respiratory Agent	0	48.6%	3.2
32	Procardia XL		60 mg	tab sr	Calcium Channel Blocker	6	20.4%	1.3
33	Miacalcin		200 IU/ac	spray	Calcitonin Replacement	4	nm	nm
34	ranitidine HCl	b	150 mg	tab	Gastrointestinal Agents	0	nm	nm
35	Lasix		40 mg	tab	Loop Diuretic	7	16.9%	1.1
36	Norvasc		5 mg	tab	Calcium Channel Blocker	6	16.2%	1.0
37	Pravachol		20mg	tab	Lipid-Lowering Agent	8	40.4%	2.6
38	Coumadin	b	2 mg	tab	Anticoagulant	6	28.1%	1.8
39	Diovan		80 mg	tab	Angiotensin II Inhibitor	5	17.0%	1.0
40	Diovan		160 mg	tab	Angiotensin II Inhibitor	5	17.0%	1.0
41	Mevacor		20 mg	tab	Lipid-Lowering Agent	5	21.0%	1.4
42	Paxil		20 mg	tab	Antidepressant	6	33.1%	2.2
43	Procanbid		1000 mg	tab	Antiarrhythmic	2	21.0%	1.4
44	Prevacid		30 mg	cap	Gastrointestinal Agent	1	34.2%	2.2
45	Relafen		500 mg	tab	Anti-inflammatory/Analgesic	6	28.8%	1.9
46	Cardizem CD	b	120mg/24hr	cap	Calcium Channel Blocker	6	30.8%	2.0
47	Metoprolol		50 mg	tab	Beta Blocker	2	28.9%	1.9
48	Nitrostat		0.4 mg	tab	Vasodilator	6	41.1%	2.7
49	lorazepam	b	0.5 mg	tab	Benzodiazepine Anxiolytic	5	409.4%	26.8
50	Demadex		20 mg	tab	Loop Diuretic	7	nm	nm
	Top 50 Drugs Average Weighted by Sales[c]					5.9	30.5%	2.0
	CPI All Items, Annual Percent Change						15.4%	

nm Not marketed during part or all of the period indicated.

[a] Based on price as of January 31 for each year reported. Drugs are listed in descending order of expenditures.

[b] Generic or co-marketed versions of this drug product are available.

[c] The weighted average was calculated based on 1998 expenditures for each drug in the Pennsylvania PACE program.

SOURCE: Compiled by PRIME Institute, University of Minnesota for Families USA. Based on data published by the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) and data found in PriceChek PC, published by MediSpan (First Databank, Indianapolis), April 2000.

DRUG PRICES FOR SENIORS

Table 3

Wholesale Cost Per Year of Therapy for Top 50 Drugs (by Number of Claims) Used by the Elderly[a]

Rank by # of Claims	Brand Name Drug		Strength	Dose Form	1994 Cost/Year	1995 Cost/Year	1996 Cost/Year	1997 Cost/Year	1998 Cost/Year	1999 Cost/Year	2000
1	Lanoxin	b	0.13 mg	tab	$ 39	$ 41	$ 43	$ 51	$ 64	$ 74	$ 75
2	Prilosec		20 mg	cap cr	$ 1,353	$ 1,325	$ 1,325	$ 1,325	$ 1,375	$ 1,412	$ 1,455
3	Norvasc		5 mg	tab	$ 414	$ 430	$ 445	$ 459	$ 471	$ 483	$ 498
4	K-Dur 20		20 meq	tab cr	$ 252	$ 266	$ 286	$ 315	$ [illegible]	$ 351	$ 365
5	Pepcid		20 mg	tab	$ 524	$ 542	$ 562	$ 583	$ 603	$ 622	$ 646
6	Lanoxin	b	0.25 mg	tab	$ 39	$ 41	$ 43	$ 51	$ 64	$ 74	$ 75
7	Imdur	b	60 mg	tab er	$ 237	$ 291	$ 378	$ 416	$ 456	$ 500	$ 525
8	Synthroid	b	0.1 mg	tab	$ 75	$ 78	$ 83	$ 86	$ 94	$ 103	$ 113
9	Vasotec		5 mg	tab	$ 322	$ 333	$ 347	$ 358	$ 372	$ 384	$ 398
10	Procardia XL		30 mg	tab cr	$ 432	$ 450	$ 465	$ 479	$ 492	$ 505	$ 521
11	Glucophage		500 mg	tab	[illegible]	[illegible]	$ 507	$ 548	$ [illegible]	$ 661	$ 708
12	[illegible]		10 mg	tab	nm	nm	nm	nm	$ 666	$ 686	$ 686
13	Fosamax		10 mg	tab	nm	nm	$ 609	$ 631	$ 651	$ 696	$ 741
14	Synthroid	b	0.05 mg	tab	$ 66	$ 69	$ 73	$ 76	$ 83	$ 91	$ 99
15	Zoloft		50 mg	tab	$ [illegible]	$ [illegible]	$ 764	$ 787	$ [illegible]	$ [illegible]	$ [illegible]
16	Vasotec		10 mg	tab	$ 338	$ [illegible]	$ 364	$ 376	$ [illegible]	$ [illegible]	$ 418
17	Xalatan		0.01 %	sol	nm	nm	nm	$ 331	$ 345	$ 394	$ 394
18	Premarin		0.63 mg	cap	$ 135	$ 144	$ 153	$ 165	$ 172	$ 186	$ 208
19	Cardizem CD	b	240 mg/24 hr	cap	$ 204	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]
20	Humulin N	b	100 IU	inj	$ 307	$ 318	$ 329	$ 362	$ 380	$ [illegible]	$ 419
21	APAP/propoxyphene	b	650 mg	tab	$ 314	$ 385	$ 385	$ 385	$ 385	$ 385	$ 444
22	Cozaar		50 mg	tab	nm	nm	$ 402	$ 416	$ 441	$ 457	$ 457
23	Cardizem CD	b	180 mg/24 hr	cap	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]
24	Norvasc		10 mg	tab	$ [illegible]	$ [illegible]	$ 771	$ 794	$ 794	$ 794	$ 794
25	albuterol	b	90 mcg	aerosol	nm	nm	$ 313	$ 313	$ 313	$ 313	$ 313
26	Coumadin	b	5 mg	tab	$ 193	$ 200	$ 208	$ 217	$ 225	$ 236	$ 248
27	Zocor		10 mg	tab	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]
28	Zocor		20 mg	tab	$ [illegible]	$ [illegible]	$ 1,292	$ 1,294	$ [illegible]	$ 1,389	$ [illegible]
29	Synthroid	b	0.08 mg	tab	$ 73	$ 76	$ 81	$ 84	$ 92	$ 101	$ 110
30	Imdur	b	30 mg	tab er	nm	nm	$ 359	$ 395	$ 433	$ 475	$ 498
31	Atrovent		0.02 mg/act	inhaler	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]
32	Procardia XL		60 mg	tab cr	$ [illegible]	$ [illegible]	$ 805	$ 829	$ 852	$ 874	$ 901
33	Miacalcin		200 IU/ac	spray	nm	nm	nm	$ 411	$ 447	$ 466	$ 504
34	ranitidine HCl	b	150 mg	tab	nm	nm	nm	nm	$ 540	$ 540	$ 540
35	Zestril	b	10 mg	tab	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]
36	Toprol XL		50 mg	tab	$ [illegible]	$ [illegible]	$ [illegible]	$ 185	$ [illegible]	$ 204	$ [illegible]
37	Pravachol		20 mg	tab	$ 632	$ 663	$ 690	$ 717	$ 753	$ 830	$ 887
38	Coumadin	b	2 mg	tab	$ 185	$ 192	$ 199	$ 207	$ 215	$ 226	$ 237
39	Klor-Con 10	b	10 meq	tab	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]
40	Ultram		50 mg	tab	nm	nm	$ 876	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]
41	Mevacor		20 mg	tab	$ 729	$ 761	$ 790	$ 821	$ 850	$ 850	$ 882
42	Paxil		20 mg	tab	$ 638	$ 664	$ 721	$ 753	$ 783	$ 813	$ 850
43	[illegible]	b	40 mg	tab	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]
44	Propulsid		10 mg	tab	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]
45	Relafen		500 mg	tab	$ 687	$ 714	$ 776	$ 811	$ 843	$ 884	$ 884
46	Cardizem CD	b	120 mg/24 hr	cap	$ 122	$ 127	$ 127	$ 133	$ 139	$ 144	$ 159
47	metoprolol	b	50 mg	tab	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]
48	Nitrostat	b	0.4 mg	tab	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]
49	lorazepam	b	0.5 mg	tab	$ 97	$ 106	$ 120	$ 124	$ 124	$ 469	$ 493
50	Demadex		20 mg	tab	nm	$ 187	$ 205	$ 229	$ 237	$ 237	$ 249

nm Not marketed during part or all of the period indicated.

[a] Based on price as of January 31 for each year and usual dose as reported in PriceChek PC. Drugs are listed in descending order of expenditures.

[b] Generic or co-marketed versions of this drug product are available.

[c] The weighted average was calculated based on 1998 expenditures for each drug in the Pennsylvania PACE program.

SOURCE: Compiled by PRIME Institute, University of Minnesota for Families USA. Based on data published by the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) and data found in PriceChek PC, published by MediSpan (First Databank, Indianapolis), April 2000.

NOTES ON TABLES

Tables 1-3

Drug names that are capitalized are brand names. The drugs that are not capitalized are generic.

The following are abbreviations used in the tables and the explanations of each:

mg = milligram, which is 1/1000th of a gram

mg/ac = milligrams per actuation (or puff)

mcg = microgram, which is 1/1000th of a mg or 1/1000,000th of a gram

meq = milliequivalent, an alternative form of measurement

IU = International Unit, a measurement of biological activity

IU/ac = International Units per actuation (or puff)

sol = solution

inj = injection

tab = tablet

tab cr = controlled release tablet

tab er = extended release tablet

cap = capsule

cap cr = controlled release capsule

inh ac = inhalant actuation

sub = sublingual, or under the tongue

DISCUSSION

The prices of prescription drugs used by older Americans continue to rise faster than the rate of inflation. Over the past year, prices for the 50 drugs most commonly used by the elderly rose nearly two times the rate of inflation. This continues the trend experienced in the prior five years. From January 1994 through January 2000, the prices of the drugs most widely prescribed for seniors also increased by twice the rate of inflation.

For seniors—many of whom live on fixed incomes—prescription drugs become increasingly unaffordable as prices continue to rise at double the rate of inflation. Mounting drug prices are especially burdensome for the one-third (34 percent) of seniors who have no insurance coverage for prescription drugs throughout the year as well as for the nearly half (47 percent) of seniors who lack coverage for at least part of the year.[3] Moreover, three other trends are exacerbating the drug affordability problem for the aged.

First, new (and, often, considerably more expensive) drugs to treat conditions that afflict many of the elderly are being brought to market. While the introduction of these drugs provide new hope for ameliorating various health conditions and *may* result in fewer hospitalizations, they increase the portion of seniors' incomes devoted to drug purchases.[4] Second, partially as a result of increased direct-to-consumer advertising by the major pharmaceutical companies, the volume of drug purchases is increasing significantly.[5] Third, as drug prices escalate, the demand for discounts by institutional purchasers of drugs (such as hospitals and HMOs) is increasing—thereby intensifying price pressures on those individuals who are unable to secure such discounts, especially seniors without insurance coverage. From 1996 to 1999, for example, the drug price differential for seniors with and without insurance coverage increased from 8 percent to 15 percent.[6]

As a result of the public's growing concern about the affordability of prescriptions for seniors, a number of proposals are being considered to extend drug coverage for the elderly. Conceptually, these proposals fall mainly into two categories. One approach would add prescription drugs on a voluntary basis *for all Medicare beneficiaries,* with special protections for the poor. Another approach would provide public subsidies only *to low-income seniors* for the purchase of

private sector drug coverage. Under this latter approach, subsidies typically taper off at 133 percent of the federal poverty line and end completely at 150 percent of poverty.

With prescription drug prices rising at twice the rate of inflation, limiting drug subsidization on a means-tested basis could be severely burdensome to moderate-income seniors. For example, a widow or widower with income at 150 percent of the federal poverty line only has $12,525 in annual income. Similarly, 150 percent of poverty for an aged couple is only $16,870 in annual income.

Seniors with incomes at 150 percent, or even 200 percent, of poverty often cannot afford the prescriptions they need. Two examples are illustrative—the first for a person with a gastrointestinal condition, the second for a senior afflicted with diabetes, hypertension, and high cholesterol.

For a widow or widower with a gastrointestinal problem, the drug most likely to be prescribed is Prilosec. Based on 1998 data from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program (the largest outpatient prescription drug program for older Americans in the United States), Prilosec is the second highest of all the top-selling drugs prescribed for seniors. The annual cost for a senior with no drug coverage taking Prilosec (20 milligram, controlled release capsules) is $1,455. For a widow or widower subsisting at 150 percent of poverty ($12,525 of income per year), the annual cost of Prilosec alone will consume more than one out of nine dollars (11.6 percent) of that senior's total budget. Even at twice the poverty level ($16,700 per year), Prilosec will consume almost one out of eleven dollars (8.7 percent) of that widow or widower's total income.

Drug Name	Therapeutic Category	Annual Cost	Percent of Annual Income	
			150% of Poverty ($12,525/year)	200% of Poverty ($16,700/year)
Prilosec	Treatment for Acid Reflux	$1,455	11.6%	8.7%

The second example is a senior with no drug coverage who has diabetes, hypertension, and high cholesterol—three conditions that often occur in conjunction with one another. A widow or widower with these three conditions is

likely to be treated with Glucophage, Procardia XL, and Lipitor. Annual costs for Glucophage (500 milligram tablets) will be $708. Annual costs for Procardia XL will either be $521 or $901, depending on whether 30 milligram tablets or 60 milligram tablets are prescribed. The annual costs for Lipitor (10 milligram tablets) will be $686.

Thus, the total annual spending for a senior with diabetes, hypertension, and high cholesterol—for these three drugs alone—will range from $1,915 to $2,295. For a widow or widower subsisting at 150 percent of poverty, this expenditure will constitute from 15.3 to18.3 percent of that senior's total income. Even at twice the poverty level, these costs will consume from 11.5 to 13.7 percent of total annual income. These costs, therefore, are likely to cause significant economic hardships.

Drug Name	Therapeutic Category	Annual Cost	Percent of Annual Income	
			150% of Poverty ($12,525/year)	200% of Poverty ($16,700/year)
Glucophage	Treatment of Diabetes	$ 708		
Procardia XL 30mg/60mg	Treatment for Hypertension	$ 521 - 901		
Lipitor	Treatment for High Cholesterol	$ 686		
Total		$1,915 - $2,295	15.3% - 18.3%	11.5% - 13.7%

CONCLUSION

The cost of prescription drugs already places a heavy burden on older Americans. The steady escalation in these costs puts many seniors at risk of being unable to obtain the prescription drugs they need to maintain their health. Even for individuals with incomes significantly above the federal poverty line, the affordability of prescription drugs is a significant and growing concern. These older persons often fall through the cracks: They generally have too much income to quality for means-tested assistance, yet they can easily be impoverished just paying for their prescription drugs. Unless seniors gain access to prescription drug coverage in Medicare, increasing numbers of elderly Americans will find prescription drugs to be unaffordable.

APPENDIX: METHODOLOGY

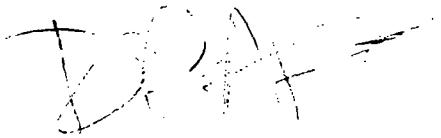
This report updates the findings of our earlier report, *Hard to Swallow*. That report used data from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program. PACE is the largest outpatient prescription drug program for older Americans in the United States. In 1998, 241,496 persons were enrolled in the PACE program, and the program filled 9,406,499 prescriptions. Because of its large size and abundance of claims data, the PACE database is commonly used to proxy the elderly's prescription drug use and expenditures.

Using PACE claims data for 1998 (the latest claims data available when we published *Hard to Swallow)*, we developed a list of the 50 top-selling prescription drugs used by older Americans and ranked them by number of prescriptions issued.[3] Price histories for the 50 top-selling drugs in the PACE program were obtained from Price-Chek PC, a database published by Medispan/First DataBank. The price indicator used in *Hard to Swallow* and this update is the average wholesale price (AWP), the price that drug manufacturers suggest that drug wholesalers charge pharmacies.

It is sometimes suggested that the AWP is not an accurate measure of drug prices paid by consumers because so many of those consumers enjoy discounts that have been negotiated by managed care organizations or other bulk purchasers of pharmaceuticals. Most older Americans, however, cannot negotiate such discounts. In fact, because most older Americans must pay retail prices at pharmacies, they pay *more* than the AWP, not less.

Another commonly used measure of drug prices is the wholesale acquisition cost (WAC), the price that wholesalers pay manufacturers. Although data given in *Hard to Swallow* and this update were calculated using the AWP, calculations using the WAC showed similar trends.

Hard to Swallow and this update both use weighted averages in calculating annual price increases for the entire list of top-selling drugs. That is, before averaging, the price of each drug is multiplied by a factor that represents the drug's percentage of total sales of all drugs on the list for a given year. This adjustment is made to ensure that the price trends reported accurately reflect the cost of drugs older people use most often.



ENDNOTES

[1] Families USA, *Hard to Swallow: Rising Drug Prices for America's Seniors* (Washington, DC: Families USA, November 1999); see also, Families USA, *Worthless Promises: Drug Companies Keep Boosting Prices* (Washington, DC: Families USA, March 1995).

[2] In this report, the term "drugs" refers to drug products packaged and distributed by the manufacturer. Two items that have the same chemical make-up and bear the same name are listed as separate drugs (drug products) if they are made in different dose forms and/or packaged in different quantities.

[3] Bruce Stuart, Dennis Shea and Becky Briesacher, *Prescription Dugs for Medicare Beneficiaries: Coverage and Health Status Matter* (New York, NY: The Commonwealth Fund, January 2000).

[4] Peter J. Neumann, Eileen A. Sandberg, Chaim M. Bell, Patricia W. Stone, and Richard H. Chapman, "Are Pharmaceuticals Cost Effective? A Review of the Evidence," *Health Affairs* 19, no. 2 (March/April 2000): 92-109.

[5] Michael S. Wilkes, Robert A. Bell, and Richard L. Kravitz, "Direct-to-Consumer Prescription Drug Advertising: Trends, Impact, and Implications," *Health Affairs* 19, no. 2 (March/April 2000): 110-128.

[6] Department of Health & Human Services, *Prescription Drug Coverage, Spending Utilization and Prices* (Washington, DC: Department of Health & Human Services, April 2000).

[7] A second list of the 50 top-selling PACE drugs was developed using both expenditures and volume of claims. The blended list produced most, but not all, of the same drugs. Both lists, however, produce the same overall trends in drug price increases.

50 TOP-SELLING DRUGS FOR SENIORS

6 years (1994 - 2000)

39 of the 50 were marketed all 6 years

37 of 39 rose *faster than* inflation

30 of 39 rose *at least* 1.5 x inflation

22 of 39 rose *at least* 2 x inflation

11 of 39 rose *at least* 3 x inflation

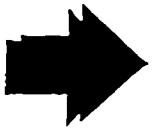
6 of 39 rose *at least* 5 x inflation

FamiliesUSA

The Voice for Health Care Consumers

50 TOP-SELLING DRUGS FOR SENIORS

1 year (1999 - 2000)



12 rose less than inflation

BUT . . .

33 rose *at least* 1.5 x inflation

25 rose *at least* 2 x inflation

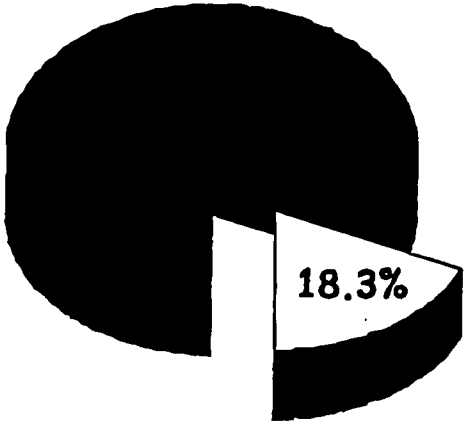
16 rose *at least* 3 x inflation

11 rose *at least* 4 x inflation

FamiliesUSA
The Voice for Health Care Consumers

Widow living on $12,525 a year (150% of poverty)

Diabetes, hypertension, & high cholesterol



Drug costs consume up to 18.3% of income

		Annual Cost:
Glucophage 500mg (diabetes)		$ 708
Procardia XL 30/60mg (hypertension)		$ 521/901
Lipitor 10mg (cholesterol)		$ 686
	Total:	**$1,915/2,295**

Acid reflux disease

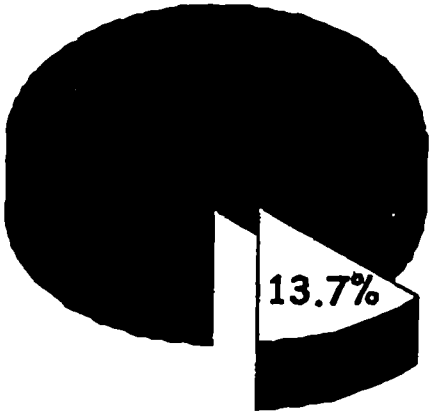
Drug costs consume up to 11.6% of income

Prilosec 20 mg *Annual Cost:* $1,455

FamiliesUSA
The Voice for Health Care Consumers

Wic'ow liv'ng on $. 6,700 a year (200% of poverty)

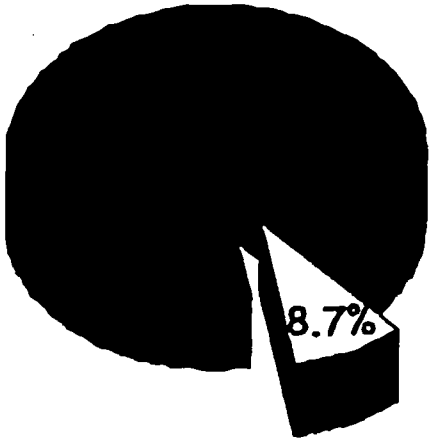
Diabetes, hypertension, & high cholesterol



Drug costs consume up to 13.7% of income

		Annual Cost:
Glucophage 500mg (diabetes)		$ 708
Procardia XL 30/60mg (hypertension)		$ 521/901
Lipitor 10mg (cholesterol)		$ 686
	Total:	**$1,915/2,295**

Acid reflux disease



Drug costs consume up to 8.7% of income

Prilosec 20 mg *Annual Cost:* $1,455

FamiliesUSA
The Voice for Health Care Consumers

Still Rising:

Drug Price Increases for Seniors 1999 - 2000

FamiliesUSA
The Voice for Health Care Consumers

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DRUG PRICES FOR SENIORS

INTRODUCTION

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 much larger share of drug costs out of their own pockets than do those who are under 65. The elderly are also least likely to receive the benefit of price discounts for prescription drugs—discounts that are provided to bulk purchasers of drugs, including health plans covering younger populations. This means the prices of prescription drugs have a greater impact on older Americans than on younger persons.

In 1999, Families USA found that the prices of the 50 prescription drugs most commonly used by older Americans rose much faster than the rate of inflation for each of the previous five years.[1] To determine if this trend of steadily increasing prices for prescription drugs has improved, remained the same, or worsened from 1999 to 2000, Families USA gathered updated information on the prices of the prescription drugs most commonly used by older Americans.

Our analysis shows that, in each of the past six 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 six years and nearly two times the rate of inflation in the last year.

FINDINGS

- The prices of the 50 prescription drugs[2] most frequently used by the elderly rose by nearly two times the rate of inflation during calendar year 1999.* On average, the prices of these top 50 drugs increased by 3.9 percent from January 1999 to January 2000, though the general rate of inflation in that period was 2.2 percent. (See Table 1.)

- From January 1999 to January 2000, of the 50 drugs most commonly used by the elderly:
  - Fewer than one-quarter of these drugs (12 out of 50) rose less than the rate of inflation. For nine of these drugs, there was no increase in price.
  - Two-thirds of these drugs (33 out of 50) rose 1.5 or more times the rate of inflation.
  - Half of these drugs (25 out of 50) rose two or more times the rate of inflation.
  - Nearly one-third of these drugs (15 out of 50) rose at more than three times the rate of inflation.
  - One-fifth of these drugs (11 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 1999 to January 2000:
  - furosemide (a diuretic manufactured by Watson that is used to treat conditions such as hypertension and congestive heart failure), which rose by 50.0 percent (approximately 23 times the rate of inflation);
  - Klor-Con 10 (manufactured by Usher-Smith and used as a potassium replacement) rose 43.8 percent (approximately 20 times the rate of inflation);

* The data on average drug price increases used in this report weight drug price increases by sales. This means that the average drug price increases reported take into account the market share of each of the 50 top-selling drugs. This is the methodology often used by industry sources.

DRUG PRICES FOR SENIORS

- metoprolol (manufactured by Mylan and used as a beta blocker) rose 15.8 percent (more than 7 seven times the rate of inflation);
- APAP/propoxyphene (manufactured by Mylan and used as a pain reliever) rose 15.4 percent (7 times the rate of inflation); and
- Premarin (manufactured by Wyeth-Ayerst and used for estrogen replacement) rose 12.1 percent (5.5 times the rate of inflation).

■ Over the six years from January 1994 to January 2000, the prices of the prescription drugs most frequently used by older Americans rose, on average, 30.5 percent. This increase was twice the rate of inflation, which was 15.4 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 six-year period from January 1994 to January 2000.
- The prices of 37 of those 39 drugs increased faster than the rate of inflation over the six-year period.
- More than three-quarters of those drugs (30 out of 39) rose at least 1.5 times as fast as the rate of inflation over the six-year period.
- Half of those drugs (22 out of 39) rose at least two times the rate of inflation over the six-year period.
- More than one-fourth of those drugs (11 out of 39) rose at least three times the rate of inflation over the six-year period.
- The prices of 6 of the 39 drugs increased at least five times faster than the rate of inflation over the six-year period.

■ Of the 39 drugs that were used most frequently by seniors and that were on the market from January 1994 to January 2000, the drugs that rose most significantly in price were:
- lorazepam (manufactured by Mylan and used to treat conditions such as anxiety, convulsions, and Parkinson's disease), which rose by 409 percent (almost 27 times the rate of inflation);

- furosemide, which rose by 210 percent (almost 14 times the rate of inflation);
- Klor-Con 10 (manufactured by Upsher-Smith and used as a potassium replacement), which rose by 164 percent (almost 11 times the rate of inflation);
- Imdur (manufactured by Schering and used to treat angina), which rose by 122 percent (eight times the rate of inflation); and
- Lanoxin (manufactured by Glaxo Wellcome and used to treat congestive heart failure), which rose by 90 percent (almost 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 2000, 31 increased in price on at least six occasions during those six years. During those years, the following drugs increased in price at least nine times:

- Imdur, which increased 11 times;
- Premarin, which increased 10 times;
- Atrovent (manufactured by Boehringer Ingelheim and used as a respiratory agent in the treatment of asthma, bronchitis, and emphysema), which increased 10 times;
- Synthroid (manufactured by Knoll and used as a synthetic thyroid agent), which increased 9 times; and
- K-Dur 20 (manufactured by Schering and used as a potassium replacement), which increased 9 times.

STILL RISING

Table 2

Cumulative Price Change of the Top 50 Drugs (by Number of Claims) Used by the Elderly[a]

Rank by # of Claims	Brand Name Drug		Strength	Dose Form	Therapeutic Category	Number of Price Changes 1994-200	Cumulative Changes 1994-2000	Multiple of CPI 1994-2000
1	Lanoxin	b	0.13 mg	tab	Cardiac Glycoside	8	89.6%	5.9
2	Prilosec		20 mg	cap cr	Gastrointestinal Agents	5	7.5%	0.5
3	Norvasc		5 mg	tab	Calcium Channel Blocker	6	20.4%	1.3
4	K-Dur 20		20meq	tab cr	Potassium Replacement	9	44.6%	2.9
5	Pepcid		20 mg	tab	Gastrointestinal Agents	6	23.3%	1.5
6	Lanoxin	b	0.25 mg	tab	Cardiac Glycoside	8	89.6%	5.9
7	Imdur		60 mg	tab er	Vasodilator	7	121.8%	8.0
8	Synthroid	b	0.1mg	tab	Synthetic Thyroid Agent	9	50.7%	3.3
9	Vasotec		5 mg	tab	ACE Inhibitor	6	23.7%	1.6
10	Procardia XL		30 mg	tab cr	Calcium Channel Blocker	6	20.4%	1.3
11	Glucophage		500 mg	tab	Oral Antihyperglycemic Agent	6	nm	nm
12	Lipitor		10 mg	tab	Lipid-Lowering Agent	5	nm	nm
13	Fosamax		10 mg	tab	Osteoporosis Treatment	6	nm	nm
14	Synthroid	b	0.05 mg	tab	Synthetic Thyroid Agent	9	51.3%	3.4
15	Zestril		10 mg	tab	ACE Inhibitor	6	23.5%	1.5
16	Vasotec		10 mg	tab	ACE Inhibitor	6	23.7%	1.6
17	Xalatan		0.0 %	sol	Glaucoma Treatment	3	nm	nm
18	Premarin		0.63 mg	tab	Estrogen Replacement	10	53.7%	3.5
19	Cardizem CD		240mg/24hr	cap	Calcium Channel Blocker	6	30.8%	2.0
20	Humulin N	b	100IU	vl	Insulin/Antidiabetic Agent	7	35.9%	2.4
21	APAP/propoxyphene	b	650 mg	tab	Opiate Agonist	2	41.4%	2.7
22	Cozaar		50 mg	tab	Angiotensin II Inhibitor	4	nm	nm
23	Adalat CC		30mg/24hr	tab	Calcium Channel Blocker	6	30.8%	2.0
24	Norvasc		10mg	tab	Calcium Channel Blocker	6	20.4%	1.3
25	albuterol	b	90 mcg	aerosol	Respiratory Agent	0	nm	nm
26	Coumadin	b	5 mg	tab	Anticoagulant	6	28.3%	1.9
27	Zocor		10mg	tab	Lipid-Lowering Agent	5	21.0%	1.4
28	Zocor		20mg	tab	Lipid-Lowering Agent	5	21.0%	1.4
29	Synthroid	b	0.08 mg	tab	Synthetic Thyroid Agent	9	50.8%	3.3
30	Imdur	b	30 mg	tab er	Vasodilator	7	nm	nm
31	Aerovent		0.02%	aerosol	Respiratory Agent	0	nm	nm
32	Procardia XL		60 mg	tab cr	Calcium Channel Blocker	6	20.4%	1.3
33	Miacalcin		200 IU/ac	spray	Calcitonin Replacement	4	nm	nm
34	ranitidine HCl	b	150 mg	tab	Gastrointestinal Agents	0	nm	nm
35	Zestril		20 mg	tab	ACE Inhibitor	6	23.5%	1.5
36	Lasix		40mg	tab	Loop Diuretic	7	35.9%	2.4
37	Pravachol		20mg	tab	Lipid-Lowering Agent	8	40.4%	2.6
38	Coumadin	b	2 mg	tab	Anticoagulant	6	28.1%	1.8
39	Motrin	b	10	tab	Anti-Inflammatory/Analgesic	5	18.4%	1.2
40	Lasix		20	tab	Loop Diuretic	7	35.9%	2.4
41	Mevacor		20 mg	tab	Lipid-Lowering Agent	5	21.0%	1.4
42	Paxil		20 mg	tab	Antidepressant	6	33.1%	2.2
43	Furosemide		40mg	tab	Loop Diuretic	7	35.9%	2.4
44	Prednisone		10mg	tab	Corticosteroid	7	34.2%	2.3
45	Relafen		500 mg	tab	Anti-Inflammatory/Analgesic	6	28.8%	1.9
46	Cardizem CD	b	120mg/24hr	cap	Calcium Channel Blocker	6	30.8%	2.0
47	Metamucil		50		Laxative/Bulk	6	28.8%	1.9
48	Nitrostat		0.4 mg	sub	Vasodilator	6	41.5%	2.7
49	lorazepam	b	0.5 mg	tab	Benzodiazepine Anxiolytic	5	409.4%	26.8
50	Demadex		20 mg	tab	Loop Diuretic	7	nm	nm
	Top 50 Drugs Average Weighted by Sales[c]					5.9	30.5%	2.0
	CPI - All Items, Annual Percent Change						15.4%	

nm Not marketed during part or all of the period indicated.

[a] Based on price as of January 31 for each year reported. Drugs are listed in descending order of expenditures.

[b] Generic or co-marketed versions of this drug product are available.

[c] The weighted average was calculated based on 1998 expenditures for each drug in the Pennsylvania PACE program.

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DRUG PRICES FOR SENIORS

Table 3
Wholesale Cost Per Year of Therapy for Top 50 Drugs (by Number of Claims) Used by the Elderly[a]

Rank by # of Claims	Brand Name Drug		Strength	Dose Form	1994 Cost/Year	1995 Cost/Year	1996 Cost/Year	1997 Cost/Year	1998 Cost/Year	1999 Cost/Year	2000
1	Lanoxin	b	0.13 mg	tab	$ 39	$ 41	$ 43	$ 51	$ 64	$ 74	$ 75
2	Prilosec		20 mg	cap cr	$ 1,353	$ 1,325	$ 1,325	$ 1,325	$ 1,375	$ 1,412	$ 1,455
3	Norvasc		5 mg	tab	$ 414	$ 430	$ 445	$ 459	$ 471	$ 483	$ 498
4	K-Dur 20		20 meq	tab cr	$ 252	$ 266	$ 286	$ 315	$ [illegible]	$ 351	$ 365
5	Pepcid		20 mg	tab	$ 524	$ 542	$ 562	$ 583	$ 603	$ 622	$ 646
6	Lanoxin	b	0.25 mg	tab	$ 39	$ 41	$ 43	$ 51	$ 64	$ 74	$ 75
7	Imdur	b	60 mg	tab er	$ 237	$ 291	$ 378	$ 416	$ 456	$ 500	$ 525
8	Synthroid	b	0.1 mg	tab	$ 75	$ 78	$ 83	$ 86	$ 94	$ 103	$ 113
9	Vasotec		5 mg	tab	$ 322	$ 333	$ 347	$ 358	$ 372	$ 384	$ 398
10	Procardia XL		30 mg	tab cr	$ 432	$ 450	$ 465	$ 479	$ 492	$ 505	$ 521
11	Glucophage		500 mg	tab	nm	nm	$ [illegible]	$ 548	$ [illegible]	$ 661	$ 708
12	Lipitor		10 mg	tab	nm	nm	nm	nm	$ 666	$ 686	$ 686
13	Fosamax		10 mg	tab	nm	nm	$ 609	$ 631	$ 651	$ 696	$ 741
14	Synthroid	b	0.05 mg	tab	$ 66	$ 69	$ 73	$ 76	$ 83	$ 91	$ 99
15	Zoloft		50 mg	tab	$ [illegible]	$ 718	$ 764	$ 787	$ 808	$ 829	$ 855
16	Vasotec		10 mg	tab	$ [illegible]	$ 329	$ [illegible]	$ 376	$ [illegible]	$ 400	$ [illegible]
17	Xalatan		0.01 %	sol	nm	nm	nm	$ 331	$ 345	$ 394	$ 394
18	Premarin		0.63 mg	cap	$ 135	$ 144	$ 153	$ 165	$ 172	$ 186	$ 208
19	Cardizem CD	b	240 mg/24 hr	cap	$ 204	$ [illegible]	$ [illegible]	$ 224	$ [illegible]	$ 242	$ 267
20	Humulin N	b	100 IU	[illegible]	$ 307	$ 318	$ 329	$ [illegible]	$ 380	$ 399	$ 419
21	APAP/propoxyphene	b	650 mg	tab	$ 314	$ 385	$ 385	$ 385	$ 385	$ 385	$ 444
22	Cozaar		50 mg	tab	nm	nm	$ 402	$ 416	$ 441	$ 457	$ 457
23	Cardizem CD	b	180 mg/24 hr	cap	$ 151	$ 157	$ 157	$ 165	$ [illegible]	$ 179	$ 197
24	Norvasc		10 mg	tab	$ [illegible]	$ 745	$ 771	$ 794	$ 794	$ 794	$ 794
25	albuterol	b	90 mcg	aerosol	nm	nm	$ 313	$ 313	$ 313	$ 313	$ 313
26	Coumadin	b	5 mg	tab	$ 193	$ 200	$ 208	$ 217	$ 225	$ 236	$ 248
27	Zocor		10 mg	tab	$ 657	$ 686	$ [illegible]	$ 741	$ 768	$ 796	$ 796
28	Zocor		20 mg	tab	$ [illegible]	$ [illegible]	$ 1,292	$ [illegible]	$ [illegible]	$ 1,389	$ 1,389
29	Synthroid	b	0.08 mg	tab	$ 73	$ 76	$ 81	$ 84	$ 92	$ 101	$ 110
30	Imdur	b	30 mg	tab er	nm	nm	$ 359	$ 395	$ 433	$ 475	$ 498
31	Atrovent		0.02 mg/ac	inhaler	$ [illegible]	$ [illegible]	$ 426	$ [illegible]	$ [illegible]	$ 525	$ [illegible]
32	Procardia XL		60 mg	tab cr	$ 748	$ 778	$ 805	$ 829	$ 852	$ 872	$ 901
33	Miacalcin		200 IU/ac	spray	nm	nm	nm	$ 411	$ 447	$ 466	$ 504
34	ranitidine HCl	b	150 mg	tab	nm	nm	nm	nm	$ 540	$ 540	$ 540
35	Zestril	b	10 mg	tab	$ 285	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ 338	$ [illegible]
36	Toprol XL		50 mg	tab	$ [illegible]	$ 153	$ 171	$ 185	$ 194	$ 204	$ [illegible]
37	Pravachol		20 mg	tab	$ 632	$ 663	$ 690	$ 717	$ 753	$ 830	$ 887
38	Coumadin	b	2 mg	tab	$ 185	$ 192	$ 199	$ 207	$ 215	$ 226	$ 237
39	Klor-Con 10	b	10 meq	tab	$ 208	$ [illegible]	$ 248	$ 186	$ [illegible]	$ [illegible]	$ 286
40	Ultram		50 mg	tab	nm	nm	$ 876	$ 910	$ [illegible]	$ 1,088	$ [illegible]
41	Mevacor		20 mg	tab	$ 729	$ 761	$ 790	$ 821	$ 850	$ 850	$ 882
42	Paxil		20 mg	tab	$ 638	$ 664	$ 721	$ 753	$ 783	$ 813	$ 850
43	Furosemide	b	40 mg	tab	$ 18	$ [illegible]	$ [illegible]	$ 18	$ 18	$ [illegible]	$ [illegible]
44	Propulsid		10 mg	tab	$ 876	$ 919	$ 955	$ 992	$ 1,041	$ 1,134	$ 1,180
45	Relafen		500 mg	tab	$ 687	$ 714	$ 776	$ 811	$ 843	$ 884	$ 884
46	Cardizem CD	b	120 mg/24 hr	cap	$ 122	$ 127	$ 127	$ 133	$ 139	$ 144	$ 159
47	metoprolol	b	50 mg	tab	$ [illegible]	$ [illegible]	$ [illegible]	$ 350	$ 350	$ 350	$ 405
48	Nitrostat	b	0.4 mg	sub	$ 12	$ [illegible]	$ 14	$ 14	$ 16	$ 16	$ 17
49	lorazepam	b	0.5 mg	tab	$ 97	$ 106	$ 120	$ 124	$ 124	$ 469	$ 493
50	Demadex		20 mg	tab	nm	$ 187	$ 205	$ 229	$ 237	$ 237	$ 249

nm Not marketed during part or all of the period indicated.

[a] Based on price as of January 31 for each year and usual dose as reported in PriceChek PC. Drugs are listed in descending order of expenditures.

[b] Generic or co-marketed versions of this drug product are available.

[c] The weighted average was calculated based on 1998 expenditures for each drug in the Pennsylvania PACE program.

SOURCE: Compiled by PRIME Institute, University of Minnesota for Families USA. Based on data published by the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) and data found in PriceChek PC, published by MediSpan (First Databank, Indianapolis), April 2000.

NOTES TO TABLES

Tables 1-3

Drug names that are capitalized are brand names. The drugs that are not capitalized are generic.

The following are abbreviations used in the tables and the explanations of each:

mg - milligram which is 1/1000th of a gram

mg/ac - milligrams per actuation (spray)

mcg - microgram which is 1/1000th of a gram

meq - milliequivalent, an alternate form of measurement

IU - International Units, a measurement of biological activity

IU/ac - International Units per actuation (spray)

sol - solution

inj - injection

tab - tablet

tab cr - controlled release tablet

tab er - extended release tablet

cap - capsule

cap cr - controlled release capsule

nas ac - inhalant or nasal

sub - sublingual, or under the tongue

DISCUSSION

The prices of prescription drugs used by older Americans continue to rise faster than the rate of inflation. Over the past year, prices for the 50 drugs most commonly used by the elderly rose nearly two times the rate of inflation. This continues the trend experienced in the prior five years. From January 1994 through January 2000, the prices of the drugs most widely prescribed for seniors also increased by twice the rate of inflation.

For seniors—many of whom live on fixed incomes—prescription drugs become increasingly unaffordable as prices continue to rise at double the rate of inflation. Mounting drug prices are especially burdensome for the one-third (34 percent) of seniors who have no insurance coverage for prescription drugs throughout the year as well as for the nearly half (47 percent) of seniors who lack coverage for at least part of the year.[3] Moreover, three other trends are exacerbating the drug affordability problem for the aged.

First, new (and, often, considerably more expensive) drugs to treat conditions that afflict many of the elderly are being brought to market. While the introduction of these drugs provide new hope for ameliorating various health conditions and *may* result in fewer hospitalizations, they increase the portion of seniors' incomes devoted to drug purchases.[4] Second, partially as a result of increased direct-to-consumer advertising by the major pharmaceutical companies, the volume of drug purchases is increasing significantly.[5] Third, as drug prices escalate, the demand for discounts by institutional purchasers of drugs (such as hospitals and HMOs) is increasing—thereby intensifying price pressures on those individuals who are unable to secure such discounts, especially seniors without insurance coverage. From 1996 to 1999, for example, the drug price differential for seniors with and without insurance coverage increased from 8 percent to 15 percent.[6]

As a result of the public's growing concern about the affordability of prescriptions for seniors, a number of proposals are being considered to extend drug coverage for the elderly. Conceptually, these proposals fall mainly into two categories. One approach would add prescription drugs on a voluntary basis *for all Medicare beneficiaries,* with special protections for the poor. Another approach would provide public subsidies only *to low-income seniors* for the purchase of

private sector drug coverage. Under this latter approach, subsidies typically taper off at 133 percent of the federal poverty line and end completely at 150 percent of poverty.

With prescription drug prices rising at twice the rate of inflation, limiting drug subsidization on a means-tested basis could be severely burdensome to moderate-income seniors. For example, a widow or widower with income at 150 percent of the federal poverty line only has $12,525 in annual income. Similarly, 150 percent of poverty for an aged couple is only $16,870 in annual income.

Seniors with incomes at 150 percent, or even 200 percent, of poverty often cannot afford the prescriptions they need. Two examples are illustrative—the first for a person with a gastrointestinal condition, the second for a senior afflicted with diabetes, hypertension, and high cholesterol.

For a widow or widower with a gastrointestinal problem, the drug most likely to be prescribed is Prilosec. Based on 1998 data from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program (the largest outpatient prescription drug program for older Americans in the United States), Prilosec is the second highest of all the top-selling drugs prescribed for seniors. The annual cost for a senior with no drug coverage taking Prilosec (20 milligram, controlled release capsules) is $1,455. For a widow or widower subsisting at 150 percent of poverty ($12,525 of income per year), the annual cost of Prilosec alone will consume more than one out of nine dollars (11.6 percent) of that senior's total budget. Even at twice the poverty level ($16,700 per year), Prilosec will consume almost one out of eleven dollars (8.7 percent) of that widow or widower's total income.

Drug Name	Therapeutic Category	Annual Cost	Percent of Annual Income	
			150% of Poverty ($12,525/year)	200% of Poverty ($16,700/year)
Prilosec	Treatment for Acid Reflux	$1,455	11.6%	8.7%

The second example is a senior with no drug coverage who has diabetes, hypertension, and high cholesterol—three conditions that often occur in conjunction with one another. A widow or widower with these three conditions is

likely to be treated with Glucophage, Procardia XL, and Lipitor. Annual costs for Glucophage (500 milligram tablets) will be $708. Annual costs for Procardia XL will either be $521 or $901, depending on whether 30 milligram tablets or 60 milligram tablets are prescribed. The annual costs for Lipitor (10 milligram tablets) will be $686.

Thus, the total annual spending for a senior with diabetes, hypertension, and high cholesterol—for these three drugs alone—will range from $1,915 to $2,295. For a widow or widower subsisting at 150 percent of poverty, this expenditure will constitute from 15.3 to18.3 percent of that senior's total income. Even at twice the poverty level, these costs will consume from 11.5 to 13.7 percent of total annual income. These costs, therefore, are likely to cause significant economic hardships.

Drug Name	Therapeutic Category	Annual Cost	Percent of Annual Income	
			150% of Poverty ($12,525/year)	200% of Poverty ($16,700/year)
Glucophage	Treatment of Diabetes	$ 708		
Procardia XL 30mg/60mg	Treatment for Hypertension	$ 521 - 901		
Lipitor	Treatment for High Cholesterol	$ 686		
Total		$1,915 - $2,295	15.3% - 18.3%	11.5% - 13.7%

CONCLUSION

The cost of prescription drugs already places a heavy burden on older Americans. The steady escalation in these costs puts many seniors at risk of being unable to obtain the prescription drugs they need to maintain their health. Even for individuals with incomes significantly above the federal poverty line, the affordability of prescription drugs is a significant and growing concern. These older persons often fall through the cracks: They generally have too much income to quality for means-tested assistance, yet they can easily be impoverished just paying for their prescription drugs. Unless seniors gain access to prescription drug coverage in Medicare, increasing numbers of elderly Americans will find prescription drugs to be unaffordable.

APPENDIX: METHODOLOGY

This report updates the findings of our earlier report, *Hard to Swallow*. That report used data from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program. PACE is the largest outpatient prescription drug program for older Americans in the United States. In 1998, 241,496 persons were enrolled in the PACE program, and the program filled 9,406,499 prescriptions. Because of its large size and abundance of claims data, the PACE database is commonly used to proxy the elderly's prescription drug use and expenditures.

Using PACE claims data for 1998 (the latest claims data available when we published *Hard to Swallow)*, we developed a list of the 50 top-selling prescription drugs used by older Americans and ranked them by number of prescriptions issued.[3] Price histories for the 50 top-selling drugs in the PACE program were obtained from Price-Chek PC, a database published by Medispan/First DataBank. The price indicator used in *Hard to Swallow* and this update is the average wholesale price (AWP), the price that drug manufacturers suggest that drug wholesalers charge pharmacies.

It is sometimes suggested that the AWP is not an accurate measure of drug prices paid by consumers because so many of those consumers enjoy discounts that have been negotiated by managed care organizations or other bulk purchasers of pharmaceuticals. Most older Americans, however, cannot negotiate such discounts. In fact, because most older Americans must pay retail prices at pharmacies, they pay *more* than the AWP, not less.

Another commonly used measure of drug prices is the wholesale acquisition cost (WAC), the price that wholesalers pay manufacturers. Although data given in *Hard to Swallow* and this update were calculated using the AWP, calculations using the WAC showed similar trends.

Hard to Swallow and this update both use weighted averages in calculating annual price increases for the entire list of top-selling drugs. That is, before averaging, the price of each drug is multiplied by a factor that represents the drug's percentage of total sales of all drugs on the list for a given year. This adjustment is made to ensure that the price trends reported accurately reflect the cost of drugs older people use most often.

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[1] Families USA, *Hard to Swallow: Rising Drug Prices for America's Seniors* (Washington, DC: Families USA, November 1999); see also, Families USA, *Worthless Promises: Drug Companies Keep Boosting Prices* (Washington, DC: Families USA, March 1995).

[2] In this report, the term "drugs" refers to drug products packaged and distributed by the manufacturer. Two items that have the same chemical make-up and bear the same name are listed as separate drugs (drug products) if they are made in different dose forms and/or packaged in different quantities.

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