

QUESTIONS AND ANSWERS ON PRESCRIPTION DRUGS

Q: 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 address it.

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 Republican budget committee chairmen are dedicating as little as half of the \$40 billion they previously committed to improving the Medicare program to 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 they're relying on the private insurers to voluntarily offer a drug-only benefit (that the industry itself has said they cannot support), this policy cannot be guaranteed to be available to all seniors in need of a drug benefit.

Not affordable for most seniors, even if it is available. Furthermore, because they only provide direct premium assistance to seniors with annual incomes of under \$12,600, their benefit will not 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 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.

More work needs to be done. It is our hope that just as the Republicans' interest in this issue has evolved from nothing to good principles but bad 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.

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

A: I'm not going to entertain hypothetical questions. I will say this: Since over half of the elderly 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.

We just don't think it's right to deny access to a Medicare prescription drug benefit to a widow who earns \$25,000 a year in income. We don't think that income is or should be viewed as wealthy and therefore somehow not deserving of an affordable prescription drug option.

Q: Would the President support an income related premium for a drug benefit or 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. However, last year, it became clear that many Republicans and Democrats had major concerns with such approaches, and that we would not be able to achieve bipartisan consensus for it.

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.

Q: What is your position on the Graham-Conrad proposal for a Medicare prescription drugs benefit that includes an income related premium? Does this mean that the Administration supports the income related provisions that would have higher income beneficiaries pay more for a prescription drug option?

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. Since the beginning of the Administration, the President has indicated his openness to an income related approach for the Medicare program. 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, it needs to be workable, administratable, and designed to attract bipartisan support. In the context of a prescription drug benefit, we also 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. Having said this, we remain open to this type of approach, and will fully evaluate it when the details of the proposal become available.

Q: 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, better able 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.

Q: 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 in its strongest solvency position in 25 years? 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 not only protects surplus revenue from being spent on excessive and ill-advised tax cuts, it also 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 much 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. The President's proposal is in actuality an economically 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.

Q: 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 scored the President's Medicare reform proposal on the new baseline. ^{Certainly} ~~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.

Q: 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 the success of our efforts to make the program more efficient and free from fraud and abuse, the program has become stronger and better able to be modernized to include the provision of a new, voluntary, prescription drug benefit. We now know that the program is not only stronger, but so too is the economy. 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.~~

Q: 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, but it should not be done outside of this context. Moreover, we do not believe it is likely that this Congress, and particularly the Senate Finance Committee, will pass any prescription drug benefit without also passing some important reforms that make Medicare more competitive and successful in combating wasteful spending in the program.

Q: 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've always stated that we would like to receive any information that validates concerns about payment adequacy. 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 that time.

Q: What about other provider payment shortcomings? What about [pick your provider]?

A: Once again, we are actively seeking reliable information on appropriate payment rates for all providers that participate in the Medicare program. We have yet to complete a review of any such information, and in fact, are still awaiting additional analytical materials regarding provider payment rates in this area.

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

A: We have found that election years are frequently the time that much of our work gets done, because Members of Congress need to be much more responsive to the desires of their constituents. This, together with meeting the unmet needs of seniors through Medicare reform, makes us believe there is a real chance for action this year. We believe that the members will not want to return to their districts without addressing this issue.

Q: / 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 block grant approach; and now, although it is still severely flawed, they are suggesting some type of benefit for Medicare beneficiaries. We hope and believe this evolution will continue, and as we continue to inform the public and the Congress about the best policy approaches to dealing with this overwhelming health care challenge so that realistic and workable policies can emerge from the Congress.

QUESTIONS AND ANSWERS ON THE VICE PRESIDENT'S DRUG PROPOSAL

Q: Does the Vice President's prescription drug proposal reflect the Administration's policy for catastrophic drug coverage?

A: The Vice President's proposal is his own initiative. I have made no final decision about the structure or design of the policy he would like to see included in any final Medicare reform initiative. As we indicated at the time I unveiled the budget, I want to work in a bipartisan fashion with the Congress, consumers, and other interested parties to develop the best approach and that review process has not been completed.

Q: Well, what do you think of the Vice President's proposal? Could you support it? Is it a policy worth considering?

A: It certainly is a thoughtful proposal worthy of consideration. We are evaluating a series of options in regards to their impact on consumers, the pharmaceutical industry, the Medicare program, and the overall budget.

Q: Do the cost of this benefit that he is proposing seem to be consistent with your estimates?

A: From everything we know, the cost estimates are within the ballpark – but again, we haven't completed our evaluation of options or costs of any particular policy.

DRAFT: 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.

- M 4/15/00*
- ***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.
- Fallon
Dr
SPM*

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.

QUESTIONS AND ANSWERS ON MEDICARE PRESCRIPTION DRUGS

Q: 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 of all, I do believe it is encouraging that the Republican leadership has finally talked about working 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 address it.

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 likely to be unaffordable to millions of seniors and people with disabilities, even if it is available in some places.

Just this week, we learned that the Republican budget committee chairmen are dedicating as little as half of the \$40 billion they previously committed to improving the Medicare program to a prescription drug benefit. Moreover, they are refusing to release 10 year numbers on their proposal because they know their exploding tax policy will eat up virtually all revenue necessary to adequately fund a drug benefit after 5 years.

And because they're relying on the private insurers to voluntarily offer a drug-only benefit (that the industry itself has said they cannot support), this policy cannot be guaranteed to be available to all seniors in need of a drug benefit.

Furthermore, because they only provide direct subsidies to seniors with annual incomes of under \$12,600, their benefit will not 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 premium assistance to the benefits we provide to all beneficiaries, and I believe it would completely 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 health care treatment will become more and more dependant on the use of life-saving medications.

It is my hope that just as the Republicans' interest in this issue has evolved from nothing to good principles but bad policy, that it can further evolve into good policy and good principles.

A Prescription Drug Plan for a Stronger Medicare

✓ **Lowers Drug Prices and Expands Access to Prescription Drugs for All Beneficiaries Without Threatening the Patient-Doctor Relationship.**

For the first time, seniors and the disabled won't have to pay full price for prescription drugs. Equally important, patients will have access to the specific drug -- brand or generic -- that their doctor prescribes. The plan addresses this problem by giving Medicare beneficiaries real bargaining power through private health plans to purchase drugs at discount rates. Studies show, including the White House study released April 10th, that insurance-based plans offer policyholders discounts of at least 15 percent on drug prices. Health plans are able to do this through flexibility on cost-sharing, tier pricing, benefit design, formularies, etc.

✓ **Protects Against Higher Drug Prices and Runaway Out-of-Pocket Costs.**

The plan provides coverage and security against escalating out-of-pocket drug costs for every Medicare beneficiary by setting a monetary ceiling beyond which Medicare would pay 100% of beneficiaries' drug costs. By contrast, the President's plan leaves beneficiaries vulnerable to pay full and unlimited drug costs above \$2,000.

✓ **Expands Seniors' Right to Choose the Coverage that Best Suits Their Needs Through a Voluntary and Universally-Offered Benefit.**

Under the plan, beneficiaries may choose from several competing prescription drug plans. The new drug benefit would be 100% voluntary while preserving current coverage for seniors who want to keep what they have. If a senior is pleased with his/her current policy, they can choose to stay with their original plan. Instead of limiting the types of drugs health plans can cover, the proposal allows beneficiaries to choose coverage that fits their health needs.

Market-Based Approach. Unlike a one-size-fits-all plan, the proposal adopts a market-oriented benefit that gives seniors real insurance coverage. Because Medicare represents a pool of 40 million potential purchasers, private health plans will design several option packages to best serve individual needs instead of simply one government-defined benefit.

✓ **Rejects Big Government Approach With A Public-Private Partnership That Lowers Premiums.**

The plan targets those seniors and disabled who lack prescription drug coverage by providing 100% federal assistance for low-income seniors who face the greatest obstacles in obtaining drug coverage today -- including 100% full reimbursement for premiums. Like the President, the plan also includes reimbursement phase-outs exceeding the poverty line.

Managing Risk and Lowering Premiums. Studies show that a small proportion of seniors consume a majority of prescription drugs, making that segment difficult to insure and driving up costs for everyone. The plan calls for Government to share in insuring the sickest seniors, thereby making risk more manageable for private insurers. By Government sharing in the coverage of high risk seniors, premiums would be lowered for every beneficiary.

No Cherry-Picking. Government and private insurers would share in covering the high cost seniors, creating incentives in the private market to control costs and prevent adverse selection of only the healthiest beneficiaries.

Other Plans Could Participate. Private employers would be given the option to buy-in to enhance their current plans or begin offering prescription drug coverage to their employees. States that currently offer prescription drug coverage could choose to enhance their plans with the new federal coverage and not jeopardize the existing coverage their residents currently have. States would also maintain their current assistance for non-drug related premiums and cost-sharing.

Better Quality. Because the proposal is market-oriented, plans will evolve in order to adopt new cutting-edge drug therapies, thereby preventing the need for expensive hospital stays or surgery. The package also fully utilizes innovations of private health plans to ensure seniors are taking the right medications in the right doses.

✓ **Invests \$40 Billion to Modernize and Strengthen Medicare.**

The proposal invests \$40 billion of the non-Social Security surplus to strengthen Medicare and offer prescription drug coverage to every beneficiary. The five-year investment sets aside \$5.2 billion more than the President's plan. Only because of efforts to strengthen Medicare in 1997, Congress is now able to offer this new benefit.

Structural Improvements. The proposal creates an Entity to bring flexibility to the administration of a pharmaceutical benefit, medical and hospital care and increase choices for seniors.

✓ **Preserves and Protects Medicare to Keep Program Solvent for Future Generations.**

According to the recently released Medicare Trustee Report, Medicare will be completely broke by 2023, but the program will begin to run deficits in less than 10 years, by 2010. The plan recognizes the need to modernize Medicare with a prescription drug benefit, but also includes structural improvements to ensure the program's long-term solvency.

✓ **Ensures that Today's Scientific Research and Medical Innovation will Continue to Find Tomorrow's Cures.**

By rejecting Washington-mandated price controls and a big-government approach, the plan will ensure continued innovation and development of life-saving drug therapies. In recent years, scientific and medical research resulted in 400 medications to treat the top 3 killers of seniors – heart disease, cancer and stroke.

Prescription Drugs & Stronger Medicare Without Big Government Intrusion

OVERVIEW:

- *House Republicans support a fair and responsible prescription drug plan that's affordable, available, and voluntary to all senior citizens and disabled Americans.*

AFFORDABLE:

- *Senior citizens and disabled Americans should never be forced to choose between food and medicine.*
- *We will help more people get prescription drug coverage at lower costs by creating group-buying power without price-fixing or government controls.*
- *Our plan also strengthens Medicare so we can protect you against high out-of-pocket drug costs that threaten both your health security and financial security.*

AVAILABLE:

- *We will reduce the runaway costs of medicine, but not with an expensive Washington-based, one-size-fits-all program that kills the research and innovation of life-saving cures.*
- *Our Public-Private Partnership ensures that drug coverage is available to all who need it by managing risk and lowering premiums.*
- *We protect our most vulnerable citizens who face the greatest obstacles in obtaining drug coverage today – including full reimbursement for premiums.*
- *We create an Entity to bring flexibility to the administration of a pharmaceutical benefit, medical and hospital care and increase choices for seniors.*

VOLUNTARY:

- *We promote the right to choose the coverage that best suits your needs from several competing prescription drug plans.*
- *Because our new drug benefit is 100% voluntary, it preserves your right to keep the coverage you already have.*
- *Our successful structural improvements of the past and on-going efforts to root-out waste, fraud and abuse have allowed us to provide prescription drug coverage as well as strengthen Medicare overall so it's there when you need it.*

To: Chris



J. Dennis Hastert
Fourteenth District
Illinois

<http://www.speaker.gov>

Speaker's Press Office

United States House of Representatives
Washington, DC 20515

FOR IMMEDIATE RELEASE:
April 12, 2000

CONTACT: 202-225-2800
John Feehery

Statement by House Speaker J. Dennis Hastert (R-IL) Regarding the Prescription Drug Plan and a Stronger Medicare

Washington, DC – House Speaker J. Dennis Hastert (R-IL) made the following statement today:

"Today, we unveil a balanced plan to modernize Medicare by providing a voluntary prescription drug benefit to the American people.

"I want to commend Chairman Bliley, Chairman Archer, Chairman Bilirakis and Chairman Thomas, and all the members of the Commerce and Ways and Means Committees who have worked so hard for the last month on the issue of Prescription Drugs.

"This is a serious, responsible proposal, which will help American seniors get better access to prescription drug coverage. I believe that this plan will help lower the costs of prescription drugs for many senior citizens. No American should be forced to choose between putting food on the table and taking life-saving prescription drugs.

"This legislation is necessary because prescription drugs are becoming a more important part of our nation's health care needs. Those Medicare beneficiaries who choose this voluntary plan will never have to pay retail prices for their prescription drugs again.

"This plan gives our senior citizens flexibility to pick the plan that best fits their needs. It provides protection against high out-of-pocket and unexpected costs. This plan uses the market place, not government regulations, to control the cost of drugs. It protects innovation so we can continue to develop life-saving drugs to battle such diseases as cancer, heart disease and Alzheimer's Disease.

"I pledge to work with the President to modernize our Medicare system with a common-sense prescription drug plan.

"Now, it is my pleasure to introduce Lillie Miller from Alexandria, Virginia. I believe she will benefit under our plan."

###

Prescription Drugs & Stronger Medicare Without Big Government Intrusion

OVERVIEW:

- *House Republicans support a fair and responsible prescription drug plan that's affordable, available, and voluntary to all senior citizens and disabled Americans.*

AFFORDABLE:

- *Senior citizens and disabled Americans should never be forced to choose between food and medicine.*
- *We will help more people get prescription drug coverage at lower costs by creating group-buying power without price-fixing or government controls.*
- *Our plan also strengthens Medicare so we can protect you against high out-of-pocket drug costs that threaten both your health security and financial security.*

AVAILABLE:

- *We will reduce the runaway costs of medicine, but not with an expensive Washington-based, one-size-fits-all program that kills the research and innovation of life-saving cures.*
- *Our Public-Private Partnership ensures that drug coverage is available to all who need it by managing risk and lowering premiums.*
- *We protect our most vulnerable citizens who face the greatest obstacles in obtaining drug coverage today – including full reimbursement for premiums.*
- *We create an Entity to bring flexibility to the administration of a pharmaceutical benefit, medical and hospital care and increase choices for seniors.*

VOLUNTARY:

- *We promote the right to choose the coverage that best suits your needs from several competing prescription drug plans.*
- *Because our new drug benefit is 100% voluntary, it preserves your right to keep the coverage you already have.*
- *Our successful structural improvements of the past and on-going efforts to root-out waste, fraud and abuse have allowed us to provide prescription drug coverage as well as strengthen Medicare overall so it's there when you need it.*

A Prescription Drug Plan for a Stronger Medicare

- ✓ **Lowers Drug Prices and Expands Access to Prescription Drugs for All Beneficiaries Without Threatening the Patient-Doctor Relationship.**

For the first time, seniors and the disabled won't have to pay full price for prescription drugs.

Equally important, patients will have access to the specific drug -- brand or generic -- that their doctor prescribes. The plan addresses this problem by giving Medicare beneficiaries real bargaining power through private health plans to purchase drugs at discount rates.

Studies show, including the White House study released April 10th, that insurance-based plans offer policyholders discounts of at least 15 percent on drug prices. Health plans are able to do this through flexibility on cost-sharing, tier pricing, benefit design, formularies, etc.

- ✓ **Protects Against Higher Drug Prices and Runaway Out-of-Pocket Costs.**

The plan provides coverage and security against escalating out-of-pocket drug costs for every Medicare beneficiary by setting a monetary ceiling beyond which Medicare would pay 100% of beneficiaries' drug costs. By contrast, the President's plan leaves beneficiaries vulnerable to pay full and unlimited drug costs above \$2,000.

- ✓ **Expands Seniors' Right to Choose the Coverage that Best Suits Their Needs Through a Voluntary and Universally-Offered Benefit.**

Under the plan, beneficiaries may choose from several competing prescription drug plans.

The new drug benefit would be 100% voluntary while preserving current coverage for seniors who want to keep what they have. If a senior is pleased with his/her current policy, they can choose to stay with their original plan. Instead of limiting the types of drugs health plans can cover, the proposal allows beneficiaries to choose coverage that fits their health needs.

Market-Based Approach. Unlike a one-size-fits-all plan, the proposal adopts a market-oriented benefit that gives seniors real insurance coverage. Because Medicare represents a pool of 40 million potential purchasers, private health plans will design several option packages to best serve individual needs instead of simply one government-defined benefit.

- ✓ **Rejects Big Government Approach With A Public-Private Partnership That Lowers Premiums.**

The plan targets those seniors and disabled who lack prescription drug coverage by providing 100% federal assistance for low-income seniors who face the greatest obstacles in obtaining drug coverage today -- including 100% full reimbursement for premiums. Like the President, the plan also includes reimbursement phase-outs exceeding the poverty line.

Managing Risk and Lowering Premiums. Studies show that a small proportion of seniors consume a majority of prescription drugs, making that segment difficult to insure and driving up costs for everyone. The plan calls for Government to share in insuring the sickest seniors, thereby making risk more manageable for private insurers. By Government sharing in the coverage of high risk seniors, premiums would be lowered for every beneficiary.

No Cherry-Picking. Government and private insurers would share in covering the high cost seniors, creating incentives in the private market to control costs and prevent adverse selection of only the healthiest beneficiaries.

Other Plans Could Participate. Private employers would be given the option to buy-in to enhance their current plans or begin offering prescription drug coverage to their employees. States that currently offer prescription drug coverage could choose to enhance their plans with the new federal coverage and not jeopardize the existing coverage their residents currently have. States would also maintain their current assistance for non-drug related premiums and cost-sharing.

Better Quality. Because the proposal is market-oriented, plans will evolve in order to adopt new cutting-edge drug therapies, thereby preventing the need for expensive hospital stays or surgery. The package also fully utilizes innovations of private health plans to ensure seniors are taking the right medications in the right doses.

✓ **Invests \$40 Billion to Modernize and Strengthen Medicare.**

The proposal invests \$40 billion of the non-Social Security surplus to strengthen Medicare and offer prescription drug coverage to every beneficiary. The five-year investment sets aside \$5.2 billion more than the President's plan. Only because of efforts to strengthen Medicare in 1997, Congress is now able to offer this new benefit.

Structural Improvements. The proposal creates an Entity to bring flexibility to the administration of a pharmaceutical benefit, medical and hospital care and increase choices for seniors.

✓ **Preserves and Protects Medicare to Keep Program Solvent for Future Generations.**

According to the recently released Medicare Trustee Report, Medicare will be completely broke by 2023, but the program will begin to run deficits in less than 10 years, by 2010. The plan recognizes the need to modernize Medicare with a prescription drug benefit, but also includes structural improvements to ensure the program's long-term solvency.

✓ **Ensures that Today's Scientific Research and Medical Innovation will Continue to Find Tomorrow's Cures.**

By rejecting Washington-mandated price controls and a big-government approach, the plan will ensure continued innovation and development of life-saving drug therapies. In recent years, scientific and medical research resulted in 400 medications to treat the top 3 killers of seniors – heart disease, cancer and stroke.

NAPWA Applauds Efforts to Establish Meaningful Medicare Drug Coverage

Benefit should build on Medicare to be affordable, accessible and available to all



1413 K Street, NW
Washington, DC
20005-1442
202-898-0414
FAX 202-898-0435
www.napwa.org

FOR IMMEDIATE RELEASE

Contact: Jeff Crowley, 202.898.0414, ext. 102

April 12, 2000—Washington, DC: The House Republican Leadership released today a new Medicare prescription drug proposal. The National Association of People with AIDS (NAPWA) is encouraged that, following earlier pronouncements by the President and the Democratic Leadership in the Congress in support of their own prescription drug proposal, that a clear consensus exists to address this urgent problem. We remained concerned, however, that a large gap must be bridged between the competing Republican and Democratic proposals.

For people living with HIV and AIDS, Medicare is the second largest source of health care in the United States. One in five people living with HIV in the United States who are receiving on-going health care are now covered by Medicare.

In recent years, HIV/AIDS has fallen from the leading cause of death of people aged 25-44 years to the eleventh leading cause of death for people in this age group due, in part, to the availability of effective prescription drug therapies. The availability of these medications has alleviated death and suffering for literally thousands of people all across the nation. Despite this fact, many Medicare beneficiaries living with HIV are provided a broad range of benefits, but not the single benefit most critical to keeping them alive.

Too little is known about the adequacy of the Republican proposal announced today. Based on the outlined released, however, we are troubled that this plan may expose individuals to a private health care market whose track record, absent government regulations, on meeting the needs of people living with HIV and other disabilities, is deplorable.

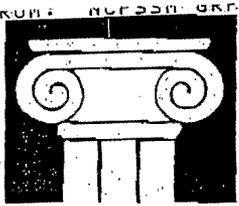
NAPWA believes that any new plan should:

- Build on the success of the existing Medicare program. This includes retaining the social insurance nature of the program. While it may seem politically attractive to start with a benefit for people with low-incomes, this would set a dangerous precedent toward establishing a two-tiered system that is not based on the medical needs of the individual.
- Provide for all medically necessary and appropriate prescription drug needs of beneficiaries, including off label medication uses.
- Ensure against inequities created by regional variation in health care costs and protect against discrimination on the basis of health status.
- Be affordable to people with low incomes and extensive health-related needs.

“Given support across the political spectrum for a Medicare prescription drug benefit, people living with HIV and millions of Medicare beneficiaries are counting on the continued leadership of the President and the Congressional Leadership to come together to establish a benefit that serves the medical needs of all Medicare beneficiaries,” said Terje Anderson, Executive Director of NAPWA.

###

The National Association of People with AIDS (NAPWA) advocates on behalf of the nearly one million people living with HIV in the United States in order to end the pandemic and the human suffering caused by HIV and AIDS.



National Committee to
Preserve Social Security
and Medicare

10 G Street, NE, Suite 800
Washington, D.C. 20002 4215 202 216-0420
Contact: Kris Geddings 703 709-6680

FHA NO.: 2022160446

04-13-00 03:59P P.02

NEWS

FOR IMMEDIATE RELEASE:
Wednesday -- April 12, 2000

For More Information:
Dave Roach 202/216-8378

Republican Prescription Drug Plan Falls Short Of the Needs of America's Seniors

WASHINGTON, D.C. -- The newly unveiled prescription drug plan by Congress's Republican leadership is a step toward a solution, but it falls seriously short of the needs of millions of America's senior citizens, according to one of the nation's leading health and retirement advocacy groups.

"We're gratified that the Republican leaders have made a serious effort to fashion a remedy," said Max Richtman, executive vice president of the National Committee to Preserve Social Security and Medicare, "but we are very disappointed that their proposal will not establish a drug benefit as part of the Medicare program for all seniors." ✱

✱ "By focusing its assistance only on low-income seniors, the GOP plan will leave millions of modest- and middle-income seniors without affordable and dependable drug coverage," Richtman said.

"The GOP plan offers no assistance for middle-income seniors or any assurances that they will be able to obtain or afford private insurance," Richtman said. "The private insurance marketplace has not provided adequate pharmaceutical coverage to date, and the Republican plan provides no reason to expect that it will any time soon in the future." ✱

Richtman said the National Committee will continue to try to persuade Republican and Democratic members of Congress alike that the most effective solution is to establish a voluntary and affordable prescription drug benefit for all seniors as part of Medicare.

With about five million members and supporters, the non-profit National Committee is a leading citizens education and advocacy group for health and retirement concerns.

represents 100 national groups

CONSORTIUM FOR CITIZENS WITH DISABILITIES HEALTH TASK FORCE

Republican Drug Plan is an Incremental Approach to Eliminating Medicare Entitlement

Persons with disabilities are very concerned about lack of drug coverage in Medicare

- 14% of Medicare beneficiaries (over 5 million persons) are under 65;
- they use drugs regularly more than seniors (83% vs. 76%)
- they have lower incomes
- they have limited access to Medigap policies

* [Republican plan for prescription drugs is an incremental approach to eliminating the entitlement to Medicare one benefit at a time (starting with prescription drugs)

A separate private insurance plan didn't work for Medicare beneficiaries 35 years ago, and it won't work for prescription drugs for Medicare beneficiaries now

Private health plans achieve price discounts while making profits by rationing care on the basis of price (e.g. discriminating against high users, tier pricing that charges more for brand-name drugs even when they are medically necessary, imposing different cost-sharing requirements, formulary design based on price, etc.) not by providing prescription drugs or other health care services on the basis of medical need

Republican plan does not specify drug benefit; it sets up an independent board that takes authority away from HCFA

* [Republican plan does not ensure affordability
public subsidy for those under 150% of poverty does not help those with incomes over \$13,000 who are not eligible for Medicaid

catastrophic benefit for persons at all levels of income is not clear in the Republican plan

* [Republican plan does not ensure that drug prices are reasonable
unless drug benefit is universal, adverse selection will drive prices up to ensure that private insurers can cover their costs and make a profit

Choice of different drug plans is a guarantee that only wealthy can get what they need

CCD Health Task Force is pleased that both Democrats and Republicans are finally talking about the importance of a drug benefit for Medicare beneficiaries; but we believe this can only be achieved through maintenance of the social insurance nature of Medicare, through a universal drug benefit that protects low users as well as high users, and that eliminates the inequities in drug prices that affect all prescription drug users

CCD Health Task Force Co-chairs:

Bob Griss Center on Disability and Health (202) 842-4408

Shelley McLane, National Association of Protection and Advocacy Systems (202) 408-9514

Kathy McGinley, The Arc (202) 785-3388

Jeff Crowley, National Association for People with AIDS: (202) 898-0414

LEADERSHIP COUNCIL
of
AGING ORGANIZATIONS

**STATEMENT BY LEADERSHIP COUNCIL OF AGING ORGANIZATIONS
RESPONSE TO REPUBLICAN LEADERSHIP PRESCRIPTION DRUG PLAN**

**PRESS CONTACT: BRIAN LINDBERG
202-789-3606**

**FOR IMMEDIATE RELEASE
APRIL 12, 2000**

Today, the Republican Leadership of the House released the conceptual framework for its Medicare prescription drug benefit that it plans to consider this year. Upon the initial reports of the proposed legislation, it is apparent that the Republican Leadership proposal fails to meet critical criteria identified by the LCAO for a successful prescription drug benefit.

* According to Brian Lindberg, Chair of the LCAO Health and Long-Term Care Committee, "The Republican proposal appears to fail Medicare beneficiaries in two specific ways: access and affordability. Under the Republican proposal, Medicare beneficiaries would not have access to a voluntary prescription drug benefit as part of Medicare's defined benefit package. Further, it falls short of our expectation and commitment that all Medicare beneficiaries will have such a benefit regardless of income. By means-testing the benefit and subsidies, this proposal moves Medicare away from its universal approach and toward a welfare approach."

The proposal relies on the private insurance industry to offer benefits to low-income beneficiaries subsidized by the government. There is no indication that health insurers will offer an affordable insurance product to the majority of older Americans. In fact, the insurance industry had opposed the creation of such drug policies in the past because they would be too expensive. There is no guarantee that those using the traditional Medicare program will have an opportunity to buy an affordable drug coverage policy.

The LCAO principles for a prescription drug benefit explicitly state that the financing of a new benefit should protect all older Americans and disabled beneficiaries from burdensome out-of-pocket expenses, particularly low-income beneficiaries. Without a guarantee of affordable coverage for all Medicare beneficiaries, the Republican proposal ignores this crucial point.

* Martha A. McSteen, President of the National Committee to Preserve Social Security and Medicare, said, "The National Committee is committed to a program that will serve all Medicare eligible older adults and individuals with disabilities with an affordable, voluntary benefit. The proposal fails to meet this standard."

* Steve McConnell, Vice President for Public Policy and Program Services for the Alzheimer's Association, questioned the level of commitment to the benefit, stating "It appears that only \$20 billion of the \$40 billion originally discussed will be reserved in the Republican budget for the drug benefit."

Finally, the LCAO looks forward to working with President Clinton and Congress to provide an affordable prescription drug benefit to all Medicare beneficiaries.

In February 33 members of the LCAO sent a letter to each member of the House and Senate outlining the critical issues that must be addressed in any Medicare prescription drug benefit that will gain their support. The LCAO clearly stated that the principles set forth in that communication were essential elements that must be incorporated into the bills that were being drafted. The following are some of the LCAO principles:

Benefits

- Medicare should guarantee access to a voluntary prescription drug benefit as apart of its defined benefit package.
- Medicare's contribution toward the cost of the prescription drug benefit must keep pace with the increase in prescription drug costs and not be tied to budgetary caps.

Coverage

- The Medicare prescription drug benefit should be available to all Medicare eligible older Americans and persons with disabilities, regardless of income or health status.
- The Medicare prescription drug benefit must be voluntary and provide safeguards against erosion of current prescription drug coverage provided by others.

Affordability

- The financing of a new Medicare prescription drug benefit should protect all beneficiaries from burdensome out-of-pocket expenses and unaffordable cost sharing, particularly low-income beneficiaries.
- The government subsidy must be sufficient to guard against risk selection and to provide an attractive benefit design.

AARP NEWS



For further inquiry, contact AARP Communications
601 E Street, NW • Washington, DC 20049
(202) 434-2560 • Fax: (202) 434-2588 • www.aarp.org

File

FOR IMMEDIATE RELEASE:
April 12, 2000

CONTACT: Steve Hahn
(202) 434-2560

STATEMENT BY AARP EXECUTIVE DIRECTOR HORACE B. DEETS ON HOUSE REPUBLICAN MEDICARE PRESCRIPTION DRUG PROPOSAL

House Republican leaders today outlined a new proposal to help Medicare beneficiaries purchase prescription drug coverage. Many details of this plan are yet to be spelled out, but we are pleased that this proposal moves beyond the prescription drug benefit developed by the Medicare Commission – a proposal that would have provided prescription drug coverage only to low-income older Americans – to providing prescription drug coverage to all older and disabled Americans in Medicare.

As we understand it, the proposal would provide a full subsidy for low-income beneficiaries without jeopardizing Medicare's social insurance foundation. In addition, it has the potential for reducing the premiums that all older Americans would pay for their Medicare prescription drug coverage by providing a government subsidy for those people in Medicare who have extraordinarily high drug costs.

AARP supports a prescription drug benefit in Medicare that would be available to and affordable for all beneficiaries. Many questions must be answered about this proposal before we can judge whether it meets these criteria. Among these questions: Would the level of federal subsidy, which is the same as in the President's proposal, prove adequate to attract the broad risk pool that is needed to make the coverage affordable for the vast majority of beneficiaries? Would this public-private partnership, with its many implementation details, prove workable?

At this early stage, we believe this proposal has merit and should be explored carefully and fully. AARP is prepared to work with the proponents of this idea, as well as with other Members of Congress and the President on a bipartisan basis, to help shape a Medicare prescription drug benefit that will meet the needs of older Americans today and in the future.

####

**REPUBLICANS' PRESCRIPTION DRUG PROPOSAL:
DESIGNED FOR THOSE WHO SELL DRUGS, NOT THOSE WHO NEED THEM**

April 12, 2000

The House Republican Leadership recently released a broad outline of a proposal on prescription drugs for Medicare beneficiaries. It appears that the Republicans' proposal was developed more for those who sell drugs than those who need them. It provides no details of the premium for the policy, what the basic benefit would cover, or how much it would cost the Medicare program. The details that are in the Republican leadership's outline, which is consistent with proposals supported by the pharmaceutical industry, raise serious concerns, including (1) covering prescription drugs through drug-only private insurance plans rather than Medicare, even though insurers have raised doubts about their willingness to offer such policies; (2) limiting premium assistance for its basic benefit to beneficiaries with income up to 150 percent of poverty (\$12,600 for a single and \$17,000 for couples), leaving out millions of uninsured and underinsured seniors; and (3) encouraging private plans to participate by having the government bear most of the risk of covering sick beneficiaries.

RENEGES ON FUNDING COMMITMENT FOR MEANINGFUL PRESCRIPTION DRUG BENEFIT

- **The Republicans' budget chairmen have acknowledged that their budget resolution uses only half -- \$20 billion -- of its Medicare reserve for prescription drugs.** This is insufficient to finance a meaningful, affordable, accessible drug benefit for all beneficiaries. The Republicans have also refused to spell out their 10-year funding commitment for prescription drugs, raising the prospect that it is significantly underfunded, primarily due to their tax cut whose costs will explode after 2005.

DOES NOT ASSURE AVAILABILITY OF PRESCRIPTION DRUG COVERAGE

- **Private plans not required, and likely will not offer, coverage in all areas.** Relying solely on private insurers rather than providing plan choices through Medicare is likely to be an empty promise. Today, Medigap covers prescription drugs for only about 10 percent of Medicare beneficiaries. Although the proposal aims to encourage more private plans to participate by protecting them against high costs, it would not ensure that even a single private plan will offer coverage in all areas of the country. Moreover, major representatives of the insurance industries have stated that they have no desire to participate in this program. Thus, even those seniors qualifying for means-tested, direct premium assistance are not assured access to a private plan to provide them affordable coverage.

NOT AFFORDABLE FOR MOST SENIORS, EVEN IF IT IS AVAILABLE

- **Premiums much higher than the President's voluntary plan.** Its drug only, private insurance policy design assures that the premium will be significantly higher than the President's plan and will expose seniors and people with disabilities to significant out-of-pocket costs before the benefit begins. Moreover, direct premium assistance is limited to those with incomes below \$13,000 to \$17,000. This leaves out half of Medicare beneficiaries lacking drug coverage today, including a widow with income of \$15,000 and a woman with Alzheimer's disease whose husband has income of \$25,000.

NO SPECIFIED BENEFIT

- **Lack of a specific benefit asks the Congress and the public to buy a "pig in a poke".** Republicans would ask that Congress vote for a plan without a design, instead allowing a private plans and independent "entity" to make the critical decision about what type of prescription drug coverage seniors would get. Despite this flexibility, its design almost inevitably would result in plans with a high deductible, high premium, or both which would result in millions of beneficiaries continuing to have high out-of-pocket costs.

REPUBLICAN PRESCRIPTION DRUG PLAN: RHETORIC DOES NOT MATCH REALITY

Rhetoric: *"Expands seniors' right to choose the coverage that best suits their needs through a voluntary and universally-offered benefit."*

Reality: Unless the plan includes a mandate on private insurance to participate, there is no guarantee that prescription drug coverage will be "universally offered." Seniors in rural or high-risk communities may have a hard time finding a prescription drug plan, even if they qualify for the means-tested assistance.

Rhetoric: *"Lowers drug prices and expands access to prescription drugs for all beneficiaries...."*

Reality: This proposal will not lower prices for all beneficiaries since all beneficiaries will not be able to afford it – assuming that they even have an option at all. The Republicans have means tested their premium assistance to those with income below is \$12,600 for a single and \$17,000 for couples. Thus, a widow with income of \$20,000 will face a premium that could easily be more than twice the current Part B premium of \$45.50.

Rhetoric: *"The plan provides coverage and security against escalating out-of-pocket drug costs for every Medicare beneficiary by setting a monetary ceiling beyond which Medicare would pay 100% of beneficiaries' costs. By contrast, the President's plan leaves beneficiaries vulnerable to pay full and unlimited drug costs above \$2,000."*

Reality: The outline of the Republican plan does not include a specific policy for stop-loss protection. While the President also has not yet specified his stop-loss limit, he has explicitly dedicated \$35 billion in surplus to assure that Medicare beneficiaries have meaningful protection against excessive out-of-pocket spending on medications.

Rhetoric: *"Those Medicare beneficiaries who choose this voluntary plan will never have to pay retail prices for their prescription drugs again."*

Reality: Private Medigap insurers today rarely negotiate for discounts, instead paying for half of the retail price for prescription drugs. The only way that the Republicans can assure that beneficiaries will "never" again pay retail prices is to mandate that private insurers negotiate for price discounts, which seems unlikely.

Rhetoric: *"The proposal invests \$40 billion of the non-Social Security surplus to strengthen Medicare and offer prescription drug coverage to every beneficiary. The five-year investment sets aside \$5.2 billion more than the President's plan."*

Reality: The Republican chairmen of the budget committees stated that only \$20 billion of the \$40 billion would be dedicated to prescription drugs – much less than what the Republican plan claims. Moreover, the Republican budget does not commit to any funding after 5 years, probably because the surplus will be used for a large and irresponsible tax cut – not a meaningful Medicare prescription drug benefit.

Rhetoric: *"Preserves and protects Medicare to keep program solvent for future generations."*

Reality: The Republican outline released today does not include a single specific policy that affects solvency or protects the program. In contrast, the President's plan, according to the Medicare actuary and Congressional Budget Office, not only adds a meaningful prescription drug benefit but slows Medicare growth, dedicates \$299 billion of the non-Social Security surplus and extends the life of the Medicare trust fund to at least 2030.

RHETORIC DOES NOT MATCH REALITY

Rhetoric: *"Expands seniors' right to choose the coverage that best suits their needs through a voluntary and universally-offered benefit."*

Reality: Unless the plan includes a mandate on private insurance to participate, there is no guarantee that prescription drug coverage will be "universally offered." Seniors in rural or high-risk communities may have a hard time finding a prescription drug plan, even if they qualify for the means-tested assistance.

Rhetoric: *"Lowers drug prices and expands access to prescription drugs for all beneficiaries without threatening the patient-doctor relationship."*

Reality: This proposal will not lower prices for all beneficiaries since not all beneficiaries will be able to afford it – assuming that they have an option. The Republicans have means tested their premium assistance to those with income below is \$12,600 for a single and \$17,000 for couples. Thus, a widow with income of \$17,000 will face a premium without explicit government assistance that could easily exceed \$100 per month – more than twice the current Part B premium.

Rhetoric: *"The plan provides coverage and security against escalating out-of-pocket drug costs for every Medicare beneficiary by setting a monetary ceiling beyond which Medicare would pay 100% of beneficiaries' costs. By contrast, the President's plan leaves beneficiaries vulnerable to pay full and unlimited drug costs above \$2,000."*

Reality: The outline of the Republican plan does not include a specific policy for stop-loss protection. While the President also has not yet specified his stop-loss limit, he has explicitly dedicated \$35 billion in surplus to assure that Medicare beneficiaries have meaningful protection against excessive out-of-pocket spending on medications.

Rhetoric: *"Those Medicare beneficiaries who choose this voluntary plan will never have to pay retail prices for their prescription drugs again."*

Reality: Private Medigap insurers today rarely negotiate for discounts, instead paying for half of the retail price for prescription drugs. The only way that the Republicans can assure that beneficiaries will "never" again pay retail prices is to mandate that private insurers negotiate for price discounts, which seems unlikely.

Rhetoric: *"The proposal invests \$40 billion of the non-Social Security surplus to strengthen Medicare and offer prescription drug coverage to every beneficiary. The five-year investment sets aside \$5.2 billion more than the President's plan."*

Reality: Just two days ago, the Republican chairmen of the budget committees stated that only \$20 billion of the \$40 billion would be dedicated to prescription drugs – much less than what the Republican plan claims. Moreover, the Republican budget does not commit to any funding after 5 years, probably because what surplus is available is being used for a large and irresponsible tax cut – not a meaningful Medicare prescription drug benefit.

Rhetoric: *"Preserves and protects Medicare to keep program solvent for future generations."*

Reality: The Republican outline released today does not include a single specific policy that affects solvency or protects the program. In contrast, the President's plan, according to the Medicare actuary and Congressional Budget Office, not only adds a meaningful prescription drug benefit but slows Medicare growth and extends the life of the Medicare trust fund to at least 2030.

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 i
 - A. Methodology i
 - B. Findings i
- I. The Vulnerability Of Older Americans to High Drug Prices 1
- II. Are Drug Companies Exploiting the Vulnerability of Older Americans? 3
- III. Methodology 4
 - A. Selection of Drugs 4
 - B. Determination of Drug Prices for Seniors 4
 - C. Determination of Drug Prices for Favored Customers 5
 - D. Determination of Drug Prices for Pharmacies 6
 - E. Determination of Drug Dosages 6
 - F. Price Differentials for Other Consumer Goods 6
- IV. Drug Companies Charge Older Americans Discriminatory Prices 7
 - A. Discrimination in Drug Pricing 7
 - B. Comparison with Other Consumer Goods 8
 - C. Drug Company Versus Pharmacy Responsibility 9
- V. Drug Manufacturer Profitability 10
- VI. Appendices 12

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 as 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. Mechan (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

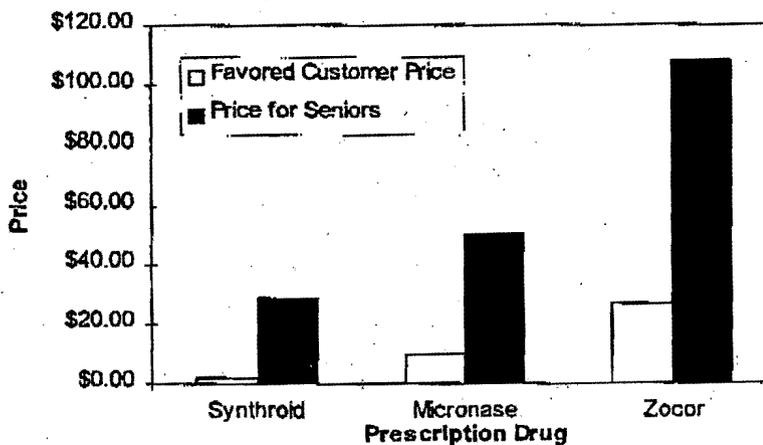
A. Discrimination in Drug Pricing

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.



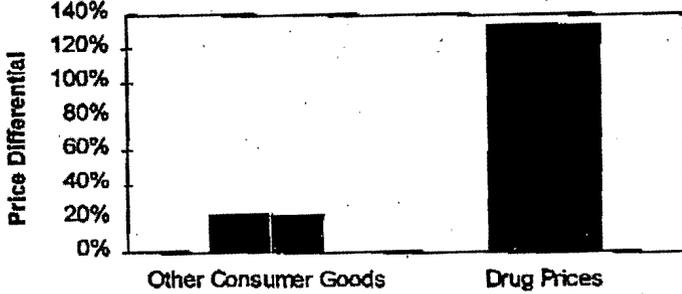
Every drug looked at in this study had a large price differential. Among the five highest selling drugs, four (Zocor, Norvasc, Prilosec, and Procardia XL) had price differentials that exceeded 90%. The lowest price difference was still high -- 78%, for Zoloft.

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.

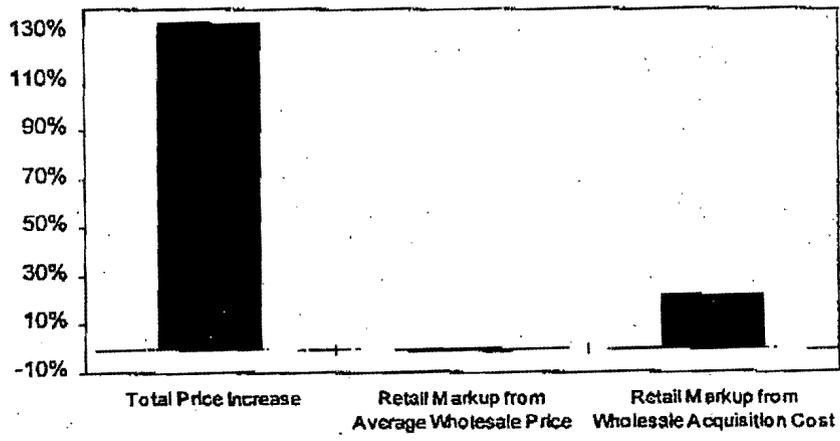
Figure 2: Price Differentials on Drugs Commonly Used by Older Americans Are Far Higher Than Differentials for Other Consumer Goods.



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

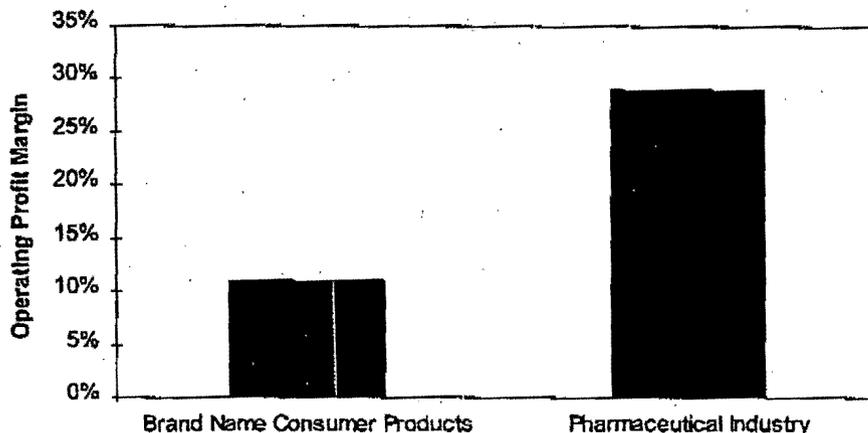


²⁵ National Association of Chain Drug Stores, *Did You Know . . .* (pamphlet) (citing financial data assembled by Keller Bruner & Company, P.C., Certified Public Accountants 1995).

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

Brand Name Drug	Dosage and Form	Indication	Prices (Dollars)				Price Differential (Average Retail Price vs. Favored Customer Price)
			Favored Customer Price	Wholesale Acquisition Cost	Average Wholesale Price	Average Retail 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	\$118.06	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%
Micronasc	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%

DISTRICT OFFICE:
8438 WEST 30 STREET
SUITE 800
LOS ANGELES, CA 90048-4143
(213) 851-1040

Congress of the United States

House of Representatives

Washington, DC 20515-0529

HENRY A. WAXMAN
29TH DISTRICT, CALIFORNIA

Medicare Reform:
Prescription Drug Plan

TELEFAX COVER SHEET

TO: CHRIS JENNINGS

FROM: KAREN NELSON

Number of pages including cover sheet: 1

FAX 456-7431

If you have any problems reading this material, please call
(202) 225-3976.

DAN BURTON, INDIANA,
CHAIRMAN

BENJAMIN A. GILMAN, NEW YORK
 CONSTANCE A. MORELLA, MARYLAND
 CHRISTOPHER SHAYS, CONNECTICUT
 ILEANA ROS-LEHTINEN, FLORIDA
 JOHN M. McHUGH, NEW YORK
 STEPHEN HORN, CALIFORNIA
 JOHN L. MICA, FLORIDA
 THOMAS M. DAVIS III, VIRGINIA
 DAVID M. MCINTOSH, INDIANA
 MARK E. SOUDER, INDIANA
 JOE SCARBOROUGH, FLORIDA
 STEVEN C. LATOURETTE, OHIO
 MARSHALL "MARK" SANFORD, SOUTH CAROLINA
 BOB BARR, GEORGIA
 DAN MILLER, FLORIDA
 ASA HUTCHINSON, ARKANSAS
 LEE TERRY, NEBRASKA
 JUDY BIGGERT, ILLINOIS
 GREG WALDEN, OREGON
 DOUG OSE, CALIFORNIA
 PAUL RYAN, WISCONSIN
 HELEN CHENOWETH, IDAHO
 DAVID VITTER, LOUISIANA

ONE HUNDRED SIXTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515-6143

MAJORITY (202) 225-5074
 MINORITY (202) 225-5051
 TTY (202) 225-6852

RANKING MINORITY MEMBER

TOM LANTOS, CALIFORNIA
 ROBERT E. WISE, JR., WEST VIRGINIA
 MAJOR R. OWENS, NEW YORK
 EDOLPHUS TOWNS, NEW YORK
 PAUL E. KANJORBKI, PENNSYLVANIA
 PATSY T. MINK, HAWAII
 CAROLYN B. MALONEY, NEW YORK
 ELEANOR HOLMES NORTON,
 DISTRICT OF COLUMBIA
 CHAKA FATTAH, PENNSYLVANIA
 ELIJAH E. CUMMINGS, MARYLAND
 DENNIS J. KUCINICH, OHIO
 ROD R. BLAGOJEVICH, ILLINOIS
 DANNY K. DAVIS, ILLINOIS
 JOHN F. TIERNEY, MASSACHUSETTS
 JIM TURNER, TEXAS
 THOMAS H. ALLEN, MAINE
 HAROLD E. FORD, JR., TENNESSEE
 JANICE D. SCHAKOWSKY, ILLINOIS

BERNARD SANDERS, VERMONT,
 INDEPENDENT

January 21, 2000

Dear Colleague:

Earlier this month, it appeared that the efforts of many members of Congress to provide prescription drug coverage for seniors and end price discrimination could be succeeding. Although the drug industry has long fought our efforts, Gordon Binder, the chairman of Amgen, said in an interview with the *New York Times* that the industry has had a change of heart.

According to Mr. Binder, "That was then, and this is now. We sense that all sides are moving in more of a positive direction to get something done. We want to be part of that."¹ A recent ad by PhRMA, the industry trade association, proclaimed: "It's time for a breakthrough in the Medicare debate."

Unfortunately, however, internal industry documents from a January 19 meeting of PhRMA's "Public Affairs Section" raise questions about the industry's new commitment to helping seniors obtain affordable medications.

One document distributed at the meeting is a calendar of activities planned by PhRMA in January and February. Many of these activities seem designed to reduce -- not build -- support for prescription drug coverage. For example, they include:

- A state media tour that seeks to justify the industry practice of charging higher prices to U.S. seniors than to Canadian citizens;
- The release of reports by surrogates who are on record as opposing plans to provide meaningful drug benefits to seniors;
- An "anti-Allen bill mailing"; and
- Paid advertisements, phone banking, direct mail drops, and "grass tops" letters.

I have enclosed a copy of this calendar because I thought it would be helpful for you to have an opportunity to review the activities PhRMA is planning -- especially if you will be a target of PhRMA's manufactured grass roots campaign.

¹*Drug Makers Drop their Opposition to Medicare Plan*, *New York Times* (Jan. 14, 2000).

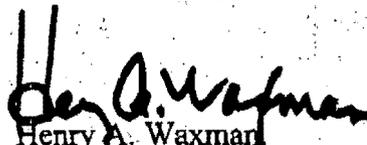
Dear Colleague
January 21, 2000
Page 2

The documents also show that some of our most vociferous critics are candidates for drug industry funding. Robert Goldberg, who represents the "Ethics and Public Policy Center," wrote letters and op-eds in many members' districts last year attacking our efforts to focus attention on the plight of seniors who cannot afford their medications. Now he's sent a memo to Alixe Mattingly, PhRMA's senior vice president for public affairs, saying "Let's keep this going" and asking for financial support from drug companies.

The documents also indicate that Alan Holmer, PhRMA's president, had a meeting scheduled with Betsy McCaughey Ross to discuss funding her efforts, which include publishing op-eds in national newspapers on "how President Clinton's Medicare plan would limit [seniors'] access to ... medications and tie their doctor's hands." Ironically, this meeting was scheduled in the same week that Mr. Holmer was quoted in the *Washington Post* talking about the industry's "strong desire" for "expanded coverage for seniors."²

I continue to hope that the drug industry will decide to work with us in a genuine effort to bring relief to millions of seniors across the nation. Regrettably, these internal documents seem to indicate that PhRMA's cynical campaign to mislead and scare seniors will continue.

Sincerely,



Henry A. Waxman
Ranking Minority Member

Attachments (4)

²*Prospects for Medicare Prescription Benefit Grow*, *Washington Post* (Jan. 15, 2000).

Agenda



PUBLIC AFFAIRS SECTION MEETING

January 19, 2000

9:30 AM to 1:30 PM

*The Madison Hotel
15th & M Streets, NW
2nd Floor, Executive Chambers 1 & 2
Washington, DC 20005*

Opening Remarks and Introductions	Alixé Mattingly
Medicare Update	Alixé Mattingly
Ally Development/Grassroots Mobilization Update	Wes Metheny
Researcher Fly-In Event/Innovation Day Proposal	Wes Metheny
Media Relations Update	Jackie Cottrell
Advertising Update	Alexandra Bickel
Citizens for Better Medicare Update	Timothy Ryan
Member Company Activities "Best Practices"	Open Discussion
<u>Other</u>	
Privacy Regulations	Valerie Volpe
Y2K Summary	Mark Grayson

Lunch Will Be Served

Pharmaceutical Research and Manufacturers of America

1100 Fifteenth Street, N.W. Washington, D.C. 20005 (202) 835-3400

January

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3 Grass tops letters cont.	4	5 Employer/Health/Think Tank Ally Meeting.	6 AD Sec Call on Educ. Allies on SOTU Fed Sec Mtg	7 Heinbold mtg. (NYC)	8
9	10 Pre-SOTU Polling; Goldberg study; Canada access; HIAA Hill briefing; drug costs	11 Atlantic Monthly briefing CEO edit call - Gilmartin	12 AD Call on Educ. Emp. SOTU; AIM Hill Medi. Briefing (Private Sec Qual); Sperling, Summers mtgs.	13 PhRMA Executive Committee	14 CSE Paper (T)	15 Polling on Breauz-Frist (T)
16 NCPA Papers: MA Proposal, Drug Store Mark-up, Myths about Profits	17 PhRMA ads begin; CBM ads begin; Direct mail drop; CBM phone banks.	18 RNC Health LA Briefing; PhRMA annual press briefing; Release HHS/Clinton studies	19 PA Section mtg. CEO edit call-Taurel; PhRMA release of polling data	20 Hispanic BRT Survey; Hill Briefing; Holmer HMC Council speech	21 Canada day release (Fraser, Lewin) and Hill Briefing Calgary Herald ad	22 State media tours on Canada begin (MN, WA, VT, MA, ME, MI, MT, OR)
23 Two Heritage Papers: Canada & Clinton Plan BIO-DC ads and studies; CBM ad	24 Ads continue; Hill Leg staff briefing	25 SOTU Ally Organizing meeting	26 Tape Holmer response to SOU; CAHI press conf. In Orlando	27 SOTU; feed Holmer response Ind. Institute ad	28 AEI Price Control Overview Book Released; Develop post-SOTU messages & polling	29
30	31 Primer ready(T); Ads continue; Release price control study (T)					

2000

February

<i>Sun</i>	<i>Mon</i>	<i>Tue</i>	<i>Wed</i>	<i>Thu</i>	<i>Fri</i>	<i>Sat</i>
		1 CEO edit call - (Zenner) State Media tours on price controls begin	2 NTJ study release Holmer - AARP	3 Release of CAHI study on uninsured	4 NCPA Briefing on Cost Analysis of Breux/Frist	5
6 Goldberg study briefing: impact on cancer patients (T)	7 Greenberger release on Canada/women (possible Hill briefing)	8	9 Release of CAGW study on MoC plan vs. Clinton	10	11	12
13	14 PhRMA Release of premium increase study	15 Anti-Allen bill mailing (F)	16 Release of 3 rd Millennium study on Clinton plan PhRMA-AMA Dinner	17 PhRMA Board Meeting CEO edit call (Binder)	18	19
20	21 Small Biz Survival Committee roll-out begins	22 Activist KIT II mailing (T)	23 Release of Economic Impact of Rx industry study (national & states)	24	25	26
27 IIMA Studies: Value of Tech; Re- imbursements	28 Tazzi Study (F)	29				

2000

E AND • 1015 Fifteenth Street N.W.
PUBLIC Washington, D.C. 20005
POLICY telephone (202) 682-1200
CENTER fax (202) 408-0632

January 17, 2000

To: Alixe

From: Bob Goldberg

Subject: Support in The Gathering Storm

As you know, last year I put out a steady stream of articles (see attached samples), did dozens of radio interviews and participated in a number of live and televised forums on the issue of prescription drug coverage. I plan to renew this effort. Additionally, I have been asked by several organizations to do papers, articles, editorials on various issues ranging from responses to the charge that the pharmaceutical industry is not paying its 'fair share' in taxes to the impact of a government run drug plan on the future of biomedical research to the canard that somehow 'we' (meaning government and insurance companies) can't afford the future stream of new drugs. I also want to work with other policy types and editorial writers to bring them into the fray. Needless to say, I am also help in getting organized in the months ahead.

Ironically I have been so busy that I have not had time to reach out to the right people for such additional funding. So now I am asking your help to help me contact the appropriate individuals in various companies to support my research and writing.

You know that I have made an impact and regard what I do as a mission, not just a academic pursuit. Let's keep this going. Thanks.



Mr. Alan Holmer, President and CEO
Pharmaceutical Research and Manufacturers of America
1100 Fifteenth Street NW
Washington, D.C. 20005

Dear Mr. Holmer,

January 7, 2000

1015 18TH
STREET, N.W.
SUITE 300
WASHINGTON,
DC
20036
202-223-7770
202-223-8537
(FAX)
www.hudson.org

INDIANAPOLIS
WASHINGTON
MONTREAL

I am looking forward to meeting with you on Tuesday. To be helpful to you, I have assembled some materials for you, including a list of my recent publications and my resume. As you can see, I publish regularly in *The New York Times*, *The Wall Street Journal*, *USA Today*, *U.S. News & World Report*, *The New Republic*, *The Los Angeles Times*, *The Daily News* and many other newspapers and magazines. My skill is not only as a scholar but also as a highly effective, popular communicator. I appear frequently on television talk shows on CNN and other networks.

Also enclosed are two recent newspaper pieces on how pharmaceutical innovation will help control health care costs and a piece, directed at seniors, on how President Clinton's Medicare drug plan would limit their access to the newest, most effective medications and tie their doctor's hands.

Finally, you will see enclosed an article "No Exit" that I wrote in 1994, warning of the dangers of the Clinton health plan. The article had an enormous impact, and helped turn the political tide. It was reprinted in *Readers Digest*, as well as newspapers across the nation, and it won the National Magazine Award for the best article in the nation on public policy, and the H.L. Mencken Award.

I am asking Pharma to support my work at the Hudson Institute, because my writings on health care policy can make a substantial difference in public opinion and in the nation's capitol. My track record proves it.

Again, I look forward to meeting with you on Tuesday at 11:30. Thank you for taking the time.

Sincerely,

Handwritten signature of Betsy McCaughey Ross in cursive script.
Betsy McCaughey Ross

NATIONAL
Politics

The New York Times
ON THE WEB

- Home
- Site Index
- Site Search
- Forums
- Archives
- Marketplace

103-2255

January 14, 2000

Herke H...
J. A. C...
Concord

**Drug Company Executives Drop
Opposition to Medicare Coverage of
Prescription Drugs**

Related Articles

- Issue in Depth: Health Care

Forum

- Join a Discussion on Health Care Reform

NH
NSC Film

By **ROBERT PEAR**

WASHINGTON, Jan. 13 — Drug company executives asked the White House today for a cease-fire in their war over drug prices and said unequivocally that they wanted to work with President Clinton and Congress to establish Medicare coverage of prescription drugs this year.

In the past, the industry had said it could accept Medicare coverage of prescription drugs only as part of a comprehensive plan to redesign the entire Medicare program. Companies feared that government-subsidized coverage of drugs would lead to government efforts to set drug prices, an idea the industry firmly opposes.

But now spokesmen for the industry -- Gordon M. Binder, chairman of Amgen, and Raymond V. Gilmartin, chairman of Merck -- say they could accept legislation to provide Medicare drug benefits this year, as a step toward comprehensive changes in the program, which finances health care for 39 million people who are elderly or disabled.

"If comprehensive reform does not occur this year," Mr. Gilmartin said, "we would support federal legislation to provide all seniors with access to pharmaceutical insurance coverage." If properly designed, he said, such legislation could get medicines to people who need them without controlling drug prices.

With Congress scheduled to reconvene later this month, the issue of Medicare coverage for prescription drugs is very much alive. Democrats see the issue as a winner and promise to keep up a drumbeat for coverage on Capitol Hill and in election campaigns



across the country.

Drugs have become an indispensable part of modern health care. Medicare's failure to cover drugs for people outside the hospital is widely seen as the biggest gap in the 35-year-old program. But plugging the hole is an immense challenge. Even well-run health insurance plans report that spending on drugs is rising more than 15 percent a year.

Mr. Binder and Mr. Gilmartin said they were tired of being excoriated by the White House and wanted to set a constructive, pragmatic and positive tone for the coming debate on Medicare drug benefits.

In a joint interview, the two men seemed slightly nervous and said they worried that Mr. Clinton would attack their industry in his State of the Union Message on Jan. 27.

"If very important people in America say bad things about the industry, that's harmful to us," said Mr. Binder, who was speaking as chairman of the industry's main trade group, the Pharmaceutical Research and Manufacturers of America.

The drug executives said their statements reflected policies endorsed this week by the executive committee of their trade association.

The overtures could be a ploy to take heat off the industry, some Democrats said, but they could also be a catalyst for negotiations.

As for the harsh words exchanged with the White House in the past, Mr. Binder said: "That was then, and this is now. We sense that all sides are moving in more of a positive direction to get something done. We want to be part of that."

Whether or not the industry's position has really changed, top executives are trying to sound more conciliatory, and that could be almost as significant. It suggests that they see Medicare drug coverage as inevitable and want to make the best deal possible.

White House officials welcomed the overtures, but said the president would keep pushing his plan for Medicare coverage of drugs.

They refused to say whether Mr. Clinton would tone down his criticism of drug companies if the industry toned down its criticism of his proposal.

 Chris Jennings, the health policy coordinator at the White House, said: "The pharmaceutical executives explicitly told us that they would soften their rhetoric. That would certainly be a constructive step. But only time will tell."

Joel P. Johnson, a senior adviser to the president, said tonight, "We've heard some positive words and are looking forward to positive deeds."

Drug executives have just recently recovered from the drubbing they

took in 1993 and 1994, when the president and Hillary Rodham Clinton assailed drug companies as greedy price gougers. The industry wants to avoid a repetition of that fight, and drug executives conveyed that message to White House officials who designed the president's latest proposal.

In the past, drug companies said they saw only one way to provide drug benefits to Medicare beneficiaries: through health maintenance organizations and other private health plans that serve 16 percent of the people on Medicare.

Now the industry says it sees a need to provide drug coverage for the 84 percent of Medicare beneficiaries still in the original fee-for-service program.

Mr. Binder said the government could make money available to private entities -- insurance companies and pharmaceutical benefit managers -- who could buy drugs and negotiate discounts on behalf of people in the fee-for-service program.

This idea is somewhat similar to the president's proposal and to a bill introduced in August by Senators Olympia J. Snowe, Republican of Maine, and Ron Wyden, Democrat of Oregon.

Mr. Binder acknowledged that the government would need to set "some minimum standards" for such drug benefits. "Any company that wanted to provide services within those ground rules could apply to do so," he said.

Mr. Gilmartin said he could envision insurance companies offering prescription drug coverage to supplement the standard package of benefits now available to Medicare patients. "The important principle is that these insurance plans would compete for Medicare beneficiaries, not for a contract with the federal government," Mr. Gilmartin said. "That's a key distinction."

~~X~~ The new stance was prompted, in part, by the comments of Clinton administration officials who said last month that the industry would bring price controls on itself if it kept resisting public demands for Medicare drug coverage. After reading those remarks, the executives said, they were shaken, but also saw some hopeful signs, and they requested a White House meeting to search for common ground.

Drug company executives said they had begun asking the same question as Mr. Clinton: Why are they working frantically to develop great new medicines for the elderly if many of the intended beneficiaries cannot get or afford them?

Under the president's proposal, Medicare would pay half of a beneficiary's drug expenses, up to certain limits. The maximum federal payment would start at \$1,000 a year and would rise gradually to \$2,500 in 2008.

Drug companies infuriated the White House last year when they attacked Mr. Clinton's proposal in a series of television and newspaper advertisements featuring an arthritic Medicare

beneficiary named Flo. The advertisements suggested that the Clinton plan would put big government inside the family medicine chest and force all the elderly into a government-run insurance plan.

In October, Mr. Clinton complained that the industry had blocked Congressional action on prescription drugs by spending "millions of dollars on an all-out media campaign filled with flat-out falsehoods." He ordered "a sweeping study" to document the impact of high drug prices on the elderly. Democrats say the study will provide them with ammunition for daily denunciations of the drug industry.

Mr. Gilmartin said that if Flo reappeared on television, she would not just criticize Mr. Clinton's plan. "It's important now for Flo to also be for something positive," Mr. Gilmartin said.



[Home](#) | [Site Index](#) | [Site Search](#) | [Forums](#) | [Archives](#) | [Marketplace](#)

[Quick News](#) | [Page One Plus](#) | [International](#) | [National/N.Y.](#) | [Business](#) | [Technology](#) | [Science](#) | [Sports](#) | [Weather](#) | [Editorial](#) | [Op-Ed](#) | [Arts](#) | [Automobiles](#) | [Books](#) | [Diversions](#)
[Job Market](#) | [Real Estate](#) | [Travel](#)

[Help/Feedback](#) | [Classifieds](#) | [Services](#) | [New York Today](#)

[Copyright 2000 The New York Times Company](#)



January 28, 2000

The Honorable Pete Stark
239 Cannon House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Stark:

I am writing in response to your letter concerning the design of a Medicare prescription drug benefit. Your commitment to prescription drug coverage for Medicare beneficiaries and long-standing leadership on this issue continue to be deeply appreciated.

Like you, AARP is committed to creating a Medicare prescription drug benefit for all beneficiaries as a high priority in Medicare reform. We believe modernizing Medicare's benefit package to keep up with advances in medicine is a must. Because prescription drugs are central to the delivery of high quality health care, Medicare should be like most other health insurance plans and include prescription drugs as part of Medicare's defined benefit package offered by all participating plans as well as in traditional fee-for-service.

AARP is committed to pursuing the answers to the questions you have raised and to continuing to advance the debate over the best way to assure that a prescription drug benefit that is available and affordable to all Medicare beneficiaries becomes part of Medicare's defined benefit package. We have identified some fundamental principles to guide the development of a Medicare prescription drug benefit:

- A Medicare prescription drug benefit must be *available* to *all* Medicare beneficiaries.
- Prescription drugs should be part of Medicare's defined benefit package. It is critical that beneficiaries understand what is included in their benefit and that they have dependable and stable prescription drug coverage.

No assurance that private plans will be offered throughout nation.

It is not part of Medicare's defined benefit

What is benefit?

How can it be defined as dependable



- The benefit needs to be affordable to assure enough participation and thereby avoid the dangers of risk selection. To this end, the government contribution will need to be significant enough to yield a premium that is affordable and attractive and a benefit design that is responsive to beneficiaries' needs. Medicare Part B is a model in this regard. The Part B benefit is voluntary, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation. *Do not use Part B model. How does it assure it is affordable.*
- Beneficiaries should be able to keep the coverage that they currently have, if they choose to do so. A Medicare prescription drug benefit should not be an incentive for employers to drop or cut back on retiree health coverage. *What is premium?*
- The benefit must assure that beneficiaries have access to needed drug therapies.
- The benefit must include quality improvement components to reduce medical errors and mismedication and to help reduce overall health care costs.
- The benefit must include meaningful cost-containment for both beneficiaries and the Medicare program. This should include drug purchasing strategies that enable Medicare beneficiaries and the program to take advantage of the aggregate purchasing power of Medicare beneficiaries.
- The benefit must provide additional subsidies for low-income beneficiaries to protect them from unaffordable costs and assure that they have access to the benefit.
- The benefit must be financed in a fiscally responsible manner that is both adequate and stable. AARP believes that an appropriate amount of the Federal budget surplus should be used to help finance a prescription drug benefit.
- A new prescription drug benefit should be part of a strong Medicare program. Prescription drug coverage must be integrated into the program in a manner that preserves and strengthens Medicare.

We understand your interest in ranking the importance of the variables involved in designing a drug benefit. At this time, however, AARP is in the process of evaluating what would make sense from a policy perspective as well as the type of benefit that would best meet the needs of current and future beneficiaries. For example, there are strong indications that older Americans want stop-loss coverage, but there are also indications that they want some degree of first dollar protection. Yet, depending on the amount of the corresponding premium, beneficiaries may not be able to afford a comprehensive benefit. More importantly, we are not yet prepared to say what type of

drug benefit design the public will support because we do not know what other changes will occur as part of Medicare reform and what their impact will be on beneficiaries.

We believe these principles will help define a Medicare prescription drug benefit that our broad-based membership can support. The task of designing a drug benefit will not be easy, but we look forward to working with you in this effort to carefully explore the best options for a Medicare prescription drug benefit. Please do not hesitate to contact me or have your staff contact Tricia Smith or Mila Becker of our Federal Affairs Department at (202) 434-3770.

Sincerely,

A handwritten signature in cursive script, appearing to read "H. Deets".

Horace B. Deets