

Congress of the United States

Washington, DC 20515

Prescription Drug Task Force

November 17, 1998

Senator John Breaux
Statutory Chairman
Bipartisan Commission on the Future of Medicare
Adams Building, Library of Congress
101 Independence Ave., S.E.
Washington, D.C. 20540-1998

Congressman Bill Thomas
Administrative Chairman
Bipartisan Commission on the Future of Medicare
Adams Building, Library of Congress
101 Independence Ave. S.E.
Washington, D.C. 20540-1998

Dear Chairmen Breaux and Thomas:

As members of the House Prescription Drug Task Force, we are writing to you to express our strong support for the consideration of the inclusion of prescription drug coverage in the Medicare program.

As the National Bipartisan Commission on the Future of Medicare continues the important task of considering ways to preserve the Medicare program, we hope that the Commission will not only consider the solvency of the program but will also consider the coverage our national health insurance program should provide for our senior citizens.

We believe that prescription drug coverage is of utmost importance to America's seniors. The rising costs of prescription drugs is particularly difficult for seniors, who use one-third of all prescriptions. Although prescription drugs are frequently used to treat common acute and chronic diseases, many Americans, especially the elderly and other vulnerable populations, are unable to afford necessary medications because of excessive and persistent prescription drug price inflation. Because Medicare does not cover outpatient drugs and Medicaid is only available in extreme circumstances, many seniors do not have prescription drug coverage and must incur these expenditures out-of-pocket. Few seniors can afford the limited protection offered by some Medigap plans. Furthermore, we are learning that Medicare managed care plans may not be providing the answers that we may have hoped for.

Not only do seniors require more medications than the rest of the population, they are forced to pay more for medications. Several members of Congress recently asked the Government Reform and Oversight Committee to investigate whether pharmaceutical companies are taking advantage of older Americans through price discrimination, and if so, whether this is part of the explanation for the high drug prices being paid by older Americans. This study compared the prices paid by pharmaceutical companies' most favored customers to the prices paid by seniors without any prescription drug coverage for the ten brand name drugs most commonly used by seniors.

The study showed that older Americans and others who pay for their own drugs are charged far more for their prescription drugs than are the drug companies' most favored customers, such as large insurance companies and health maintenance organizations. For example, a senior pays for prescription drugs, on average, almost twice as much as the drug companies' favored customers. This price differential is approximately four times greater than the average price differential for other consumer goods.

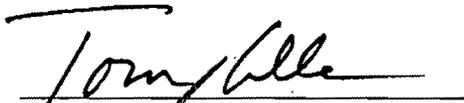
Other drugs commonly used by seniors that are not among the top ten have even higher price differentials. For example, an equivalent dose of Synthroid, a commonly used hormone treatment, would cost the favored customers only \$1.78 but would cost the average senior almost \$30.00. This is a price differential of over 1,600%.

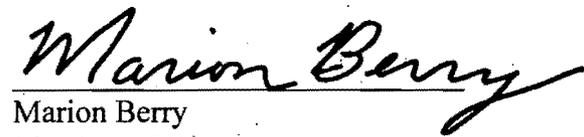
Prescription drug coverage is necessary to health improvement and health maintenance. We understand that cost is an important consideration as you deliberate this issue. We believe that there are fiscally responsible approaches to ensuring that Medicare beneficiaries get the prescription drugs they need. Furthermore, we believe that the inclusion of a Medicare prescription drug benefit will ultimately save money in other acute care costs.

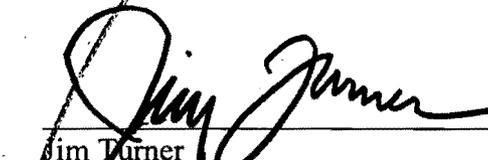
We are enclosing a copy of the Government Reform and Oversight Minority Staff Report: *Prescription Drug Pricing in the United States: Drug Companies Profit at the Expense of Older Americans* for your review.

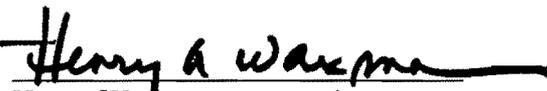
Thank you in advance for your consideration of these matters.

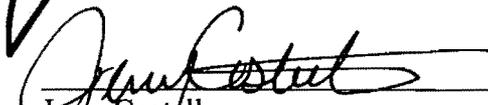
Sincerely,

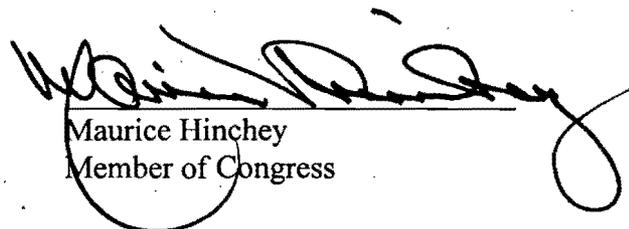

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Member of Congress


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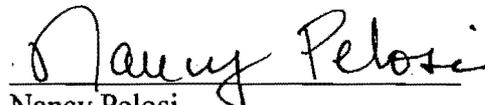

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Sherrod Brown

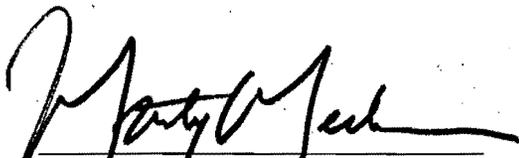
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Member of Congress

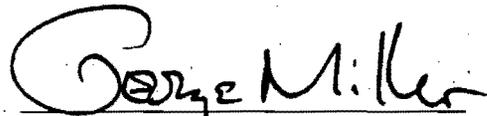
Robert Weygand

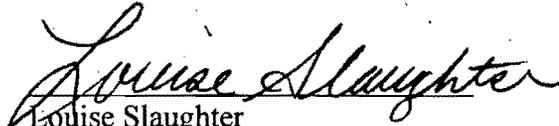
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Member of Congress

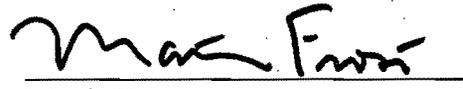
Ted Strickland

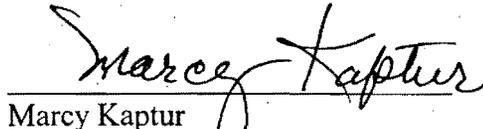
Ted Strickland
Member of Congress

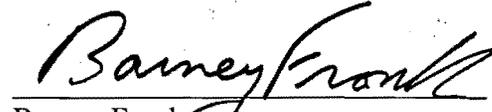

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Member of Congress

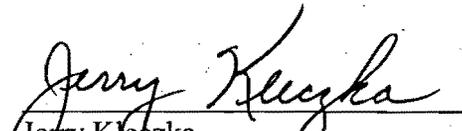

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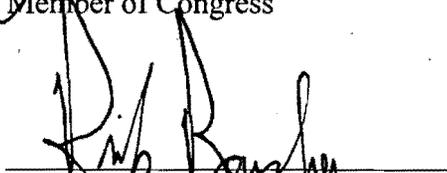

Martin Frost
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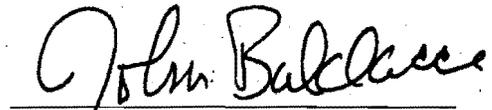

Marcy Kaptur
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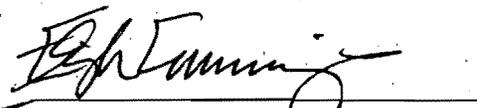

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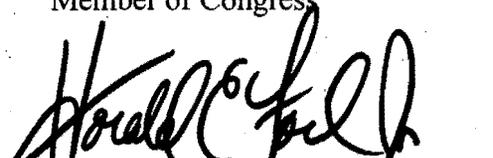

Rick Baucher
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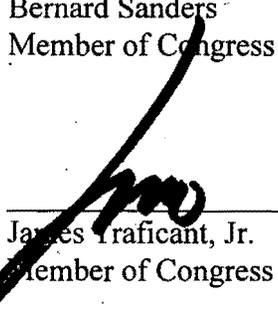

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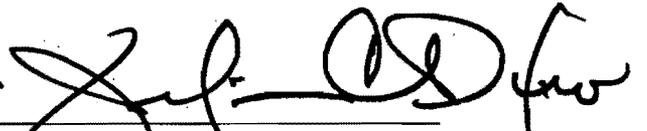

Bernard Sanders
Member of Congress

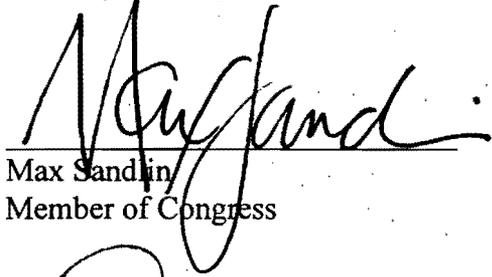

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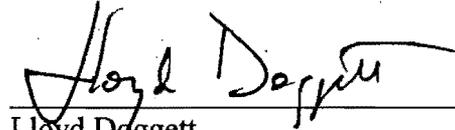

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Member of Congress

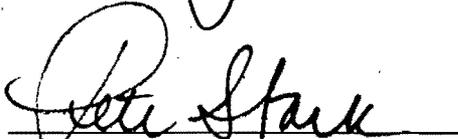

Earl Pomeroy
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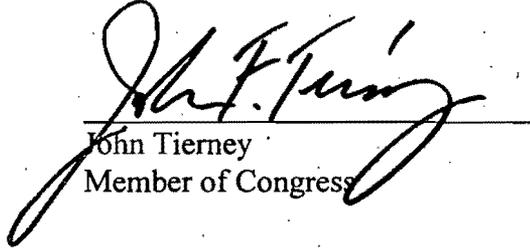

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Julian Dixon
Member of Congress

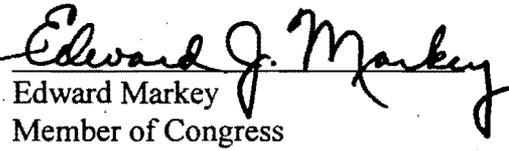

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WASHINGTON, DC 20510-6300

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DATE:

12/21/98

TO:

Chris Jennings

FAX NUMBER:

456-5557

FROM:

David Nexon

(202) 224-7675 phone

(202) 224-3533 fax

NUMBER OF PAGES:

3

(including cover)

MESSAGE:

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If you have trouble receiving this fax, please call (202) 224-7675

United States Senate

WASHINGTON, DC 20510-2101

Options to Fit Prescription Drug Coverage within the FY2000 Budget December 21, 1998

Costs of Prescription Drug Options

Option	Cost
Comprehensive Coverage under Medicare Part B	\$18 billion/year ¹
Catastrophic Coverage under Medicare Part B <i>\$1000 deductible, 20% cost-sharing, and \$4000 limit on out-of-pocket spending</i>	\$10 billion/year ¹
Basic Coverage under Medicare Part B <i>\$1200/year with 20% cost-sharing</i>	\$8 billion/year ²

Options to Reduce or Finance Medicare Prescription Drug Costs

1. Year 2000 and subsequent year costs can be reduced by phasing in the program in a way that allows the use of tobacco tax financing to support the Medicare drug benefit without as great a negative impact on the rest of the budget. By starting the new program after the beginning of FY2000, costs in that year can be reduced to any desired level, depending on the date in which the benefit becomes available. In addition, the actual value of the benefit can be phased in over a more extended period of time, e.g., start with a \$500 basic benefit in 2001 that does not phase up to a \$1,200 per year benefit until 2003.
2. The federal budget impact of the program can be reduced by raising the beneficiary premium share. Currently, beneficiaries pay 25% of the costs of Part B benefits. For this new benefit, beneficiaries could be asked to pay 50% of the cost. This change would reduce the cost of partial coverage to \$5-\$6 billion per year. Making a comparable adjustment to the catastrophic benefit premium and increasing the deductible could reduce this cost to the \$5-\$6 billion range as well.
3. Another approach to reducing the federal cost would be to provide less generous Medicare coverage, but supplement it with a federal-state program to assist low-income seniors or those with exceptionally high drug costs. States choosing to participate could

¹Based on preliminary CBO estimates, adjusted to reflect discounts achieved by bulk purchases.

²Based on preliminary CBO estimates, adjusted to reflect discounts achieved by bulk purchases and providing 20% cost-sharing.

be asked to finance 50% of the costs. (Fourteen states already have such programs in place funded exclusively by state funds.)

4. A further alternative would be to use corporate welfare reforms to fill the budget shortfall created by dedicating all or most of the tobacco tax revenue to Medicare drug coverage. The tobacco tax is unlikely to be enacted without a popular use of the revenue, such as Medicare drug coverage, to pull it along. An approach that filled the hole with defensible corporate welfare reforms would free up the tobacco tax for Medicare, even if these proposals might not be likely to be enacted.

ARRIVED
from John's ofc
1/10/99



RITE AID Corporation

WILLIAM A.K. TITELMAN
Executive Vice President
Managed Care & Public Affairs

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Camp Hill, PA 17011
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- wtitelman@riteaid.com

MEMORANDUM

~~cc: Chris Jennings~~

To: John Podesta

From: Bill Titelman

Re: Medicare Coverage of Prescription Drugs: Rite Aid/PCS Health Systems Recommendations

Date: June 11, 1999

As you may know, Rite Aid Corporation is one of the nation's leading community pharmacies and we recently acquired PCS Health Systems, the nation's largest pharmaceutical benefit manager (PBM). Senior executives from Rite Aid and PCS will be meeting at 11:00 AM on Tuesday, June 15th with Chris Jennings to discuss their recommendations with respect to the coverage of prescription drugs by Medicare. At the meeting will be Tim Noonan, Rite Aid's President and COO; Elizabeth Dichter, PCS's Executive Vice President, Strategic Marketing; and me, Rite Aid's Executive Vice President for Managed Care and Public Affairs. Given this group's experience and expertise concerning the design of prescription drug benefit packages, we thought it would be valuable for you to review our recommendations (which I have enclosed) prior to finalizing the President's package.

We would be happy to meet with you either on Tuesday or at your earliest convenience to further discuss these issues with you.

Please feel free to call me with any questions.

WAKT:gr

Enclosure

PHOTOCOPY
PRESERVATION

Chris
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MEDICARE DRUG BENEFIT PLAN DESIGN SUGGESTIONS

In order to provide a meaningful and effective drug benefit for the elderly, it is critical that the plan (a) works for seniors, i.e. is simple, convenient, and does not impose barriers on access, but instead encourages seniors to seek out, use and remain compliant with appropriate drug therapy; and (b) allows the flexibility necessary to manage utilization and costs while preserving and enhancing the quality of care. The following suggestions are offered with these goals in mind:

- **Private sector delivery mechanism should be utilized.** Private entities, such as pharmacy benefit management and other companies with similar capabilities, which have the expertise, operational capacity and sophistication and, most important, experience in managing pharmacy benefits on a large scale, should be utilized to provide the benefit. These entities already have in place the mechanisms necessary to deliver of a cost effective drug benefit, and have proven themselves able to manage utilization through innovative programs which do not sacrifice clinical quality or consumer choice. Successful mechanisms include online claims adjudication, formulary management, pharmacy network contracting, rebate negotiation, generic substitution and therapeutic interchange, physician drug utilization review, utilization management (including drug limits, prior authorization, step therapy) and disease management.
- **Standard basic benefit package with ability to offer variations.** To ensure adequacy of the benefit and a basic level of uniformity, there should be a standard core benefit package. This core package should cover all FDA-approved drugs determined to meet essential clinical needs, but should not mandate coverage of every FDA-approved drug. Discretionary or lifestyle drugs excluded from the basic benefit package could be covered in supplemental benefit packages and options, which should be permitted to be offered so as to increase consumer choice and encourage competition.
- **Use Flexible Methods to Control Costs Without Discouraging Appropriate Utilization.** There are several ways in which this can be achieved:
 - **Separate plan design for low-income beneficiaries.** While every senior paying into the Medicare system should be eligible for a drug benefit, the benefit's costs should be lower for low-income beneficiaries. This is critical to ensure that those most in need have affordable access to the benefit. In addition to lower premiums, low-income beneficiaries could pay a minimal deductible with a lower, or even zero, copayment. This system would promote accessibility and better manage program costs.

- **Minimize deductible and utilize fixed copayments rather than percentage coinsurance.** The willingness and ability of the elderly to access and utilize the drug benefit will depend upon its affordability and simplicity. A high deductible (which requires that the initial drug costs up to a fixed dollar limit be borne by the consumer) and percentage coinsurance (where a fixed percentage of the cost of every prescription is borne by the consumer) act as barriers to appropriate drug use. Fixed copayments (where a set dollar of the cost of the prescription is paid by the consumer), indexed as necessary to drug cost increases, are preferred by the elderly because they are predictable, simpler to budget for, and easier to remember. Copayments could also vary based on a clinical classification of different prescriptions, with those meeting core clinical needs requiring the lowest, or even a zero, copayment. In addition, as mentioned above, the plan for low-income beneficiaries could be designed with no deductible or copayment required for the core benefit package.
- **Beneficiary drug purchases for covered drugs up to any deductible or beyond any dollar cap should be at contract price.** If a deductible or dollar cap is imposed, beneficiaries should be entitled to the same contract price as the government for covered drugs they are required to purchase to meet the deductible or that exceed the cap. This will ensure that there is no cost shifting to the elderly to the extent they bear their own basic drug costs.
- **Use flexible drug utilization management techniques instead of arbitrary dollar benefit caps.** Dollar caps, which limit the total annual reimbursement per patient, impose arbitrary and inflexible ceilings on drug use. Historically, caps have distorted utilization patterns and/or increased noncompliance (e.g. pill-splitting, skipping year-end refills). Today there exist many more sophisticated, flexible and clinically-based formulary and drug utilization management tools that contain drug costs without sacrificing the quality of care afforded to the elderly, such as:
 - a clinical-needs based formulary that excludes certain discretionary or lifestyle drugs;
 - three-tiered copayments (generic, preferred, non-preferred);

- mandatory generic substitution and voluntary therapeutic interchange;
 - prior authorization, managed drug limits and step-therapy;
 - drug utilization review;
 - disease management;
 - case management for high-cost beneficiaries.
- **Require pharmacy networks to meet minimum accessibility standards, and permit the development of performance-based networks.** At a minimum, a national pharmacy network which meets Medicaid accessibility standards should be required. Subject to these standards, plans should have the flexibility to develop performance-based networks, i.e. networks of pharmacies which undertake, and are proven, to meet higher service and cost containment standards such as higher generic dispensing rates.
 - **Allow beneficiaries equal choice of their local community pharmacist or mail order.** Plans offering incentives to use mail should be required to offer a retail maintenance option to beneficiaries. This option would allow the elderly to obtain drugs at their community pharmacies on the same terms and in the same quantities as they would obtain these drugs through the mail. This would allow the elderly, who more than any other group, need, seek out and benefit from the personal contact and counseling available from community pharmacists, the flexibility to choose the delivery channel most convenient and appropriate for them. Internet pharmacies should also be permitted as an additional delivery channel option for the elderly.
 - **Employers must receive incentives to maintain retiree drug benefits.** Currently, a significant portion of the elderly population receives good, often generous, drug coverage through employers. However, increasing drug costs are causing many employers to reduce or eliminate these benefits. Employers should be encouraged, through economic incentives such as tax credits or other tax preferences, to continue to offer these benefits. Preserving existing employer plans in this way will reduce the government outlay for a Medicare drug benefit without imposing an economic penalty on those employers who have chosen to provide this benefit to their retirees.
 - **Preemption from conflicting state laws.** In order to provide the benefit in a consistent and efficient manner, it is essential that the program be allowed to operate free from the myriad of often conflicting and inconsistent

state laws regulating every aspect of pharmacy practice and benefit management, from provider networks to formularies to the details of plan design.

- **Mandatory beneficiary education and information.** Educating and advising beneficiaries about their drug benefit, and about drug use and compliance in general, is an integral part of any benefit, and is especially critical for the elderly. Some elements of an appropriate education program might include:
 - information to help beneficiaries evaluate their drug benefit choices;
 - an explanation of how to use the drug benefit, from what to ask the doctor, going to the pharmacy, differences between brands and generics;
 - compliance and drug usage information, such as directions for use, dosage and administration, drug interactions and precautions, and disposal of old medications.
- **A mechanism to evaluate the impact of the program on the healthcare system.** The program should establish funding to research the impact of improved drug usage and compliance on the healthcare system, including any reductions in medical costs and improvements in the quality of life of beneficiaries.

Still Rising:

**Drug Price
Increases for
Seniors
1999 - 2000**



*Support for this report was generously provided by
The Retirement Research Foundation*

Families USA
Publication 00-103

April 2000
\$5.00



INTRODUCTION

For older Americans, the affordability of prescription drugs has long been a pressing concern. Outpatient prescription drug coverage is one of the last major benefits still excluded from Medicare, and the elderly are the last major *insured* consumer group without access to prescription drugs as a standard benefit. Although many Medicare beneficiaries have access to supplemental prescription drug coverage, too often that coverage is very expensive and very limited in scope. What is more, such coverage is on the decline.

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

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

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

FINDINGS

- The prices of the 50 prescription drugs² most frequently used by the elderly rose by nearly two times the rate of inflation during calendar year 1999.* On average, the prices of these top 50 drugs increased by 3.9 percent from January 1999 to January 2000, though the general rate of inflation in that period was 2.2 percent. (See Table 1.)
- From January 1999 to January 2000, of the 50 drugs most commonly used by the elderly:
 - Fewer than one-quarter of these drugs (12 out of 50) rose less than the rate of inflation. For nine of these drugs, there was no increase in price.
 - Two-thirds of these drugs (33 out of 50) rose 1.5 or more times the rate of inflation.
 - Half of these drugs (25 out of 50) rose two or more times the rate of inflation.
 - Nearly one-third of these drugs (15 out of 50) rose at more than three times the rate of inflation.
 - One-fifth of these drugs (11 out of 50) rose at more than four times the rate of inflation.
- Among the 50 drugs most frequently used by seniors, the following drugs rose most significantly in price from January 1999 to January 2000:
 - furosemide (a diuretic manufactured by Watson that is used to treat conditions such as hypertension and congestive heart failure), which rose by 50.0 percent (approximately 23 times the rate of inflation);
 - Klor-Con 10 (manufactured by Usher-Smith and used as a potassium replacement) rose 43.8 percent (approximately 20 times the rate of inflation);

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

DRUG PRICES FOR SENIORS

- metoprolol (manufactured by Mylan and used as a beta blocker) rose 15.8 percent (more than 7 seven times the rate of inflation);
 - APAP/propoxyphene (manufactured by Mylan and used as a pain reliever) rose 15.4 percent (7 times the rate of inflation); and
 - Premarin (manufactured by Wyeth-Ayerst and used for estrogen replacement) rose 12.1 percent (5.5 times the rate of inflation).
- Over the six years from January 1994 to January 2000, the prices of the prescription drugs most frequently used by older Americans rose, on average, 30.5 percent. This increase was twice the rate of inflation, which was 15.4 percent over that period. (See Table 2.)
- Of the 50 drugs most frequently used by older Americans, 39 have been on the market for the six-year period from January 1994 to January 2000.
- The prices of 37 of those 39 drugs increased faster than the rate of inflation over the six-year period.
 - More than three-quarters of those drugs (30 out of 39) rose at least 1.5 times as fast as the rate of inflation over the six-year period.
 - Half of those drugs (22 out of 39) rose at least two times the rate of inflation over the six-year period.
 - More than one-fourth of those drugs (11 out of 39) rose at least three times the rate of inflation over the six-year period.
 - The prices of 6 of the 39 drugs increased at least five times faster than the rate of inflation over the six-year period.
- Of the 39 drugs that were used most frequently by seniors and that were on the market from January 1994 to January 2000, the drugs that rose most significantly in price were:
- lorazepam (manufactured by Mylan and used to treat conditions such as anxiety, convulsions, and Parkinson's disease), which rose by 409 percent (almost 27 times the rate of inflation);

STILL RISING

- furosemide, which rose by 210 percent (almost 14 times the rate of inflation);
 - Klor-Con 10 (manufactured by Upsher-Smith and used as a potassium replacement), which rose by 164 percent (almost 11 times the rate of inflation);
 - Imdur (manufactured by Schering and used to treat angina), which rose by 122 percent (eight times the rate of inflation); and
 - Lanoxin (manufactured by Glaxo Wellcome and used to treat congestive heart failure), which rose by 90 percent (almost six times the rate of inflation).
- Of the 39 drugs that were used most frequently by seniors and that were on the market for the period from January 1994 to January 2000, 31 increased in price on at least six occasions during those six years. During those years, the following drugs increased in price at least nine times:
- Imdur, which increased 11 times;
 - Premarin, which increased 10 times;
 - Atrovent (manufactured by Boehringer Ingelheim and used as a respiratory agent in the treatment of asthma, bronchitis, and emphysema), which increased 10 times;
 - Synthroid (manufactured by Knoll and used as a synthetic thyroid agent), which increased 9 times; and
 - K-Dur 20 (manufactured by Schering and used as a potassium replacement), which increased 9 times.

DRUG PRICES FOR SENIORS

Table 1
Annual Percent Change in Price of the Top 50 Drugs (by Number of Claims) Used by the Elderly*

Rank by # of Claims	Brand Name Drug	Strength	Dose Form	94-95 % Price Change	95-96 % Price Change	96-97 % Price Change	97-98 % Price Change	98-99 % Price Change	99-00 % Price Change	94-95 Multiple % of CPI	95-96 Multiple % of CPI	96-97 Multiple % of CPI	97-98 Multiple % of CPI	98-99 Multiple % of CPI	99-00 Multiple % of CPI
1	Lanoxin	b 0.13 mg	tab	4.1%	4.9%	18.8%	25.4%	15.4%	1.0%	1.6	1.7	6.4	11.1	9.9	0.5
2	Prilosec	20 mg	cap cr	-2.1%	0.0%	0.0%	3.8%	2.7%	3.0%	[0.8]	0.0	0.0	1.7	1.7	1.4
3	Norvasc	5 mg	tab	4.0%	3.5%	3.0%	2.7%	2.6%	3.1%	1.6	1.2	1.0	1.2	1.7	1.4
4	K-Dur 20	20 meq	tab cr	5.5%	7.5%	10.0%	4.9%	6.2%	4.0%	2.1	2.7	3.4	2.1	4.0	1.8
5	Pepcid	20 mg	tab	3.4%	3.8%	3.7%	3.5%	3.1%	3.9%	1.3	1.3	1.2	1.5	2.0	1.8
6	Lanoxin	b 0.25 mg	tab	4.1%	4.9%	18.8%	25.4%	15.4%	1.0%	1.6	1.7	6.4	11.1	9.9	0.5
7	Imdur	b 60 mg	tab er	23.1%	29.7%	10.0%	9.6%	9.6%	5.0%	9.0	10.5	3.4	4.2	6.2	2.3
8	Synthroid	b 0.1 mg	tab	4.8%	5.8%	3.5%	9.3%	9.8%	9.4%	1.9	2.1	1.2	4.0	6.3	4.2
9	Vasotec	5 mg	tab	3.4%	4.2%	3.2%	3.9%	3.2%	3.8%	1.3	1.5	1.1	1.7	2.0	1.7
10	Procardia XL	30 mg	tab cr	4.0%	3.5%	3.0%	2.7%	2.6%	3.1%	1.6	1.2	1.0	1.2	1.7	1.4
11	Glucophage	500 mg	tab	nm	nm	8.2%	7.4%	12.3%	7.0%	nm	nm	2.8	3.2	7.9	3.2
12	Lipitor	10 mg	tab	nm	nm	nm	nm	3.0%	0.0%	nm	nm	nm	nm	1.9	0.0
13	Fosamax	10 mg	tab	nm	nm	3.7%	3.2%	6.8%	6.5%	nm	nm	1.3	1.4	4.4	2.9
14	Synthroid	b 0.05 mg	tab	4.7%	6.1%	3.8%	9.3%	9.8%	9.4%	1.8	2.2	1.3	4.1	6.3	4.3
15	Zolof	50 mg	tab	8.3%	3.5%	3.0%	2.7%	2.6%	3.1%	3.3	1.2	1.0	1.2	1.7	1.4
16	Vasotec	10 mg	tab	3.4%	4.2%	3.2%	3.9%	3.2%	3.8%	1.3	1.5	1.1	1.7	2.0	1.7
17	Xalatan	0.01 %	sol	nm	nm	nm	4.0%	14.5%	0.0%	nm	nm	nm	1.8	9.3	0.0
18	Premarin	0.63 mg	tab	6.4%	6.4%	7.4%	4.4%	8.0%	12.1%	2.5	2.3	2.5	1.9	5.1	5.5
19	Cardizem CD	b 240 mg/24 hr	cap	4.4%	0.0%	4.9%	4.0%	4.0%	10.3%	1.7	0.0	1.7	1.8	2.5	4.6
20	Humulin N	b 100 IU	inj	3.5%	3.5%	10.0%	4.9%	5.0%	5.0%	1.4	1.2	3.4	2.1	3.2	2.3
21	APAP/propoxyphene	b 650 mg	tab	22.6%	0.0%	0.0%	0.0%	0.0%	15.4%	8.8	0.0	0.0	0.0	0.0	7.0
22	Cozaar	50 mg	tab	nm	nm	3.7%	6.0%	3.5%	0.0%	nm	nm	1.2	2.6	2.2	0.0
23	Cardizem CD	b 180 mg/24 hr	cap	4.4%	0.0%	4.9%	4.0%	4.0%	10.2%	1.7	0.0	1.7	1.7	2.5	4.6
24	Norvasc	10 mg	tab	4.0%	3.5%	3.0%	0.0%	0.0%	0.0%	1.6	1.2	1.0	0.0	0.0	0.0
25	albuterol	b 90 mcg	aerosol	nm	nm	0.0%	0.0%	0.0%	0.0%	nm	nm	0.0	0.0	0.0	0.0
26	Coumadin	b 5 mg	tab	3.5%	4.3%	4.0%	3.8%	4.9%	5.0%	1.4	1.5	1.4	1.7	3.1	2.3
27	Zocor	10 mg	tab	4.4%	3.9%	3.9%	3.5%	3.9%	0.0%	1.7	1.4	1.3	1.5	2.5	0.0
28	Zocor	20 mg	tab	4.4%	3.9%	0.0%	3.5%	3.9%	0.0%	1.7	1.4	0.0	1.5	2.5	0.0
29	Synthroid	b 0.08 mg	tab	4.6%	6.0%	3.8%	9.0%	9.8%	9.4%	1.8	2.1	1.3	3.9	6.3	4.2
30	Imdur	b 30 mg	tab er	nm	nm	10.0%	9.6%	9.6%	5.0%	nm	nm	3.4	4.2	6.2	2.3
31	Atrovent	0.02 mg/ac	inh aer	7.7%	3.5%	3.0%	4.9%	14.1%	8.2%	3.0	1.2	1.0	2.2	9.1	3.7
32	Procardia X	10 mg	tab cr	4.0%	3.5%	3.0%	2.7%	2.6%	3.1%	1.6	1.2	1.0	1.2	1.7	1.4
33	Miacalcin	200 IU/ac	spray	nm	nm	nm	8.7%	4.2%	8.2%	nm	nm	nm	3.8	2.7	3.7
34	ranitidine HCl	b 150 mg	tab	nm	nm	nm	nm	0.0%	0.0%	nm	nm	nm	nm	0.0	0.0
35	Zestril	b 10 mg	tab	0.0%	4.2%	4.0%	4.0%	3.8%	1.6%	0.0	1.5	1.4	1.7	2.4	0.7
36	Toprol XL	50 mg	tab	0.0%	9.8%	8.1%	5.0%	5.0%	4.5%	0.0	3.5	2.8	2.2	3.2	2.0
37	Pravachol	20 mg	tab	5.0%	4.0%	4.0%	4.9%	10.2%	6.9%	2.0	1.4	1.4	2.1	6.6	3.1
38	Coumadin	b 2 mg	tab	3.6%	4.0%	4.1%	3.8%	4.9%	5.0%	1.4	1.4	1.4	1.7	3.1	2.3
39	Klor-Con 10	b 10 meq	tab er	31.9%	4.0%	25.3%	7.0%	0.0%	43.8%	12.5	1.4	8.6	3.1	0.0	19.8
40	Ultram	50 mg	tab	nm	nm	3.9%	9.0%	9.6%	4.0%	nm	nm	1.3	3.9	6.2	1.8
41	Mevacor	20 mg	tab	4.4%	3.9%	3.9%	3.5%	0.0%	3.8%	1.7	1.4	1.3	1.5	0.0	1.7
42	Paxil	20 mg	tab	4.0%	8.6%	4.5%	3.9%	3.9%	4.5%	1.6	3.0	1.5	1.7	2.5	2.0
43	furosemide	b 40 mg	tab	0.0%	0.0%	0.0%	0.0%	106.6%	50.0%	0.0	0.0	0.0	0.0	68.4	22.7
44	Propulsid	10 mg	tab	4.9%	3.9%	3.9%	4.9%	9.0%	4.0%	1.9	1.4	1.3	2.1	5.8	1.8
45	Relafen	500 mg	tab	4.0%	8.7%	4.5%	3.9%	4.9%	0.0%	1.6	3.1	1.5	1.7	3.1	0.0
46	Cardizem CD	b 120 mg/24 hr	cap	4.4%	0.0%	5.0%	4.0%	4.0%	10.3%	1.7	0.0	1.7	1.7	2.6	4.7
47	metoprolol	b 50 mg	tab	2.5%	10.7%	1.9%	0.0%	0.0%	15.8%	1.0	3.8	[0.7]	0.0	0.0	7.2
48	Nitrostat	b 0.4 mg	sub	4.6%	9.4%	4.6%	8.9%	4.0%	4.1%	1.8	3.3	1.6	3.9	2.6	1.9
49	lorazepam	b 0.5 mg	tab	9.4%	13.8%	2.7%	0.0%	279.4%	5.0%	3.7	4.9	0.9	0.0	179.4	2.2
50	Demadex	20 mg	tab	nm	9.8%	11.8%	3.5%	0.0%	4.8%	nm	3.4	4.0	1.5	0.0	2.2
Average Weighted by Sales:				4.0%	3.7%	3.5%	4.0%	6.6%	3.9%	1.6	1.3	1.2	1.7	4.2	1.8
CPI - All Items, Annual Percent Change				2.6%	2.8%	3.0%	2.3%	1.6%	2.2%						

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

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

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

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

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

STILL RISING

Table 2
Cumulative Price Change of the Top 50 Drugs (by Number of Claims) Used by the Elderly*

Rank by # of Claims	Brand Name Drug	Strength	Dose Form	Therapeutic Category	Number of Price Changes 1994-2000	Cumulative Changes 1994-2000	Multiple of CPI 1994-2000	
1	Lanoxin	b	0.13 mg	tab	Cardiac Glycoside	8	89.6%	5.9
2	Prilosec		20 mg	cap cr	Gastrointestinal Agents	5	7.5%	0.5
3	Norvasc		5 mg	tab	Calcium Channel Blocker	6	20.4%	1.3
4	K-Dur 20		20 meq	tab cr	Potassium Replacement	9	44.6%	2.9
5	Pepcid		20 mg	tab	Gastrointestinal Agents	6	23.3%	1.5
6	Lanoxin	b	0.25 mg	tab	Cardiac Glycoside	8	89.6%	5.9
7	Imdur	b	60 mg	tab er	Vasodilator	11	121.8%	8.0
8	Synthroid	b	0.1 mg	tab	Synthetic Thyroid Agent	9	50.7%	3.3
9	Vasotec		5 mg	tab	ACE Inhibitor	6	23.7%	1.6
10	Procardia XL		30 mg	tab cr	Calcium Channel Blocker	6	20.4%	1.3
11	Glucophage		500 mg	tab	Oral Antidiabetic Agent	6	nm	nm
12	Lipitor		10 mg	tab	Lipid-Lowering Agent	1	nm	nm
13	Fosamax		10 mg	tab	Osteoporosis Treatment	6	nm	nm
14	Synthroid	b	0.05 mg	tab	Synthetic Thyroid Agent	9	51.3%	3.4
15	Zoloft		50 mg	tab	Antidepressant	6	25.5%	1.7
16	Vasotec		10 mg	tab	ACE Inhibitor	6	23.7%	1.5
17	Xalatan		0.0 %	sol	Glaucoma Treatment	3	nm	nm
18	Premarin		0.63 mg	tab	Estrogen Replacement	10	53.7%	3.5
19	Cardizem CD	b	240 mg/24 hr	cap	Calcium Channel Blocker	6	30.6%	2.0
20	Humulin N	b	100 IU	inj	Insulin Anti-Diabetic Agent	7	36.3%	2.4
21	APAP/propoxyphene	b	650 mg	tab	Opiate Agonist	2	41.4%	2.7
22	Cozaar		50 mg	tab	Angiotensin II Inhibitor	4	nm	nm
23	Cardizem CD	b	180mg/24 hr	cap	Calcium Channel Blocker	6	30.5%	2.0
24	Norvasc		10 mg	tab	Calcium Channel Blocker	4	10.9%	0.7
25	albuterol	b	90 mcg	aerosol	Respiratory Agent	0	nm	nm
26	Coumadin	b	5 mg	tab	Anticoagulant	6	28.3%	1.9
27	Zocor		10 mg	tab	Lipid-Lowering Agent	5	21.2%	1.4
28	Zocor		20 mg	tab	Lipid-Lowering Agent	4	16.6%	1.1
29	Synthroid	b	0.08 mg	tab	Synthetic Thyroid Agent	9	50.8%	3.3
30	Imdur	b	30 mg	tab er	Vasodilator	7	nm	nm
31	Atrovent		0.02 mg/ac	inh aer	Respiratory Agent	10	48.7%	3.2
32	Procardia XL		60 mg	tab cr	Calcium Channel Blocker	6	20.4%	1.3
33	Miacalcin		200 IU/ac	spray	Calcitonin Replacement	4	nm	nm
34	ranitidine HCl	b	150 mg	tab	Gastrointestinal Agents	0	nm	nm
35	Zestril	b	10 mg	tab	ACE Inhibitor	4	18.9%	1.2
36	Toprol XL		50 mg	tab	Beta Blocker	7	36.9%	2.4
37	Pravachol		20mg	tab	Lipid-Lowering Agent	8	40.4%	2.6
38	Coumadin	b	2 mg	tab	Anticoagulant	6	28.1%	1.8
39	Klor-Con 10	b	10 meq	tab er	Potassium Replacement	6	164.4%	10.7
40	Ultram		50 mg	tab	Anti-inflammatory/Analgesic	6	nm	nm
41	Mevacor		20 mg	tab	Lipid-Lowering Agent	5	21.0%	1.4
42	Paxil		20 mg	tab	Antidepressant	6	33.1%	2.2
43	furosemide	b	40 mg	tab	Loop Diuretic	2	210.0%	13.7
44	Propulsid		10 mg	tab	Gastrointestinal Agents	7	34.7%	2.3
45	Relafen		500 mg	tab	Anti-inflammatory/Analgesic	6	28.8%	1.9
46	Cardizem CD	b	120mg/24 hr	cap	Calcium Channel Blocker	6	30.8%	2.0
47	metoprolol	b	50 mg	tab	Beta Blocker	7	28.9%	1.9
48	Nitrostat	b	0.4 mg	sub	Vasodilator	6	41.1%	2.7
49	lorazepam	b	0.5 mg	tab	Benzodiazepine Anxiolytic	5	409.4%	26.8
50	Demadex		20 mg	tab	Loop Diuretic	7	nm	nm
Top 50 Drugs, Average Weighted by Sales					5.9	30.5%	2.0	
CPI - All Items, Annual Percent Change						15.4%		

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

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

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

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

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

DRUG PRICES FOR SENIORS

Table 3

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

Rank by # of Claims	Brand Name Drug	Strength	Dose Form	1994 Cost/Year	1995 Cost/Year	1996 Cost/Year	1997 Cost/Year	1998 Cost/Year	1999 Cost/Year	2000 Cost/Year
1	Lanoxin	b	0.13 mg tab	\$ 39	\$ 41	\$ 43	\$ 51	\$ 64	\$ 74	\$ 75
2	Prilosec		20 mg cap cr	\$ 1,353	\$ 1,325	\$ 1,325	\$ 1,325	\$ 1,375	\$ 1,412	\$ 1,455
3	Norvasc		5 mg tab	\$ 414	\$ 430	\$ 445	\$ 459	\$ 471	\$ 483	\$ 498
4	K-Dur 20		20 meq tab.cr	\$ 252	\$ 266	\$ 286	\$ 315	\$ 330	\$ 351	\$ 365
5	Pepcid		20 mg tab	\$ 524	\$ 542	\$ 562	\$ 583	\$ 603	\$ 622	\$ 646
6	Lanoxin	b	0.25 mg tab	\$ 39	\$ 41	\$ 43	\$ 51	\$ 64	\$ 74	\$ 75
7	Imdur	b	60 mg tab er	\$ 237	\$ 291	\$ 378	\$ 416	\$ 456	\$ 500	\$ 525
8	Synthroid	b	0.1 mg tab	\$ 75	\$ 78	\$ 83	\$ 86	\$ 94	\$ 103	\$ 113
9	Vasotec		5 mg tab	\$ 322	\$ 333	\$ 347	\$ 358	\$ 372	\$ 384	\$ 398
10	Procardia XL		30 mg tab.cr	\$ 432	\$ 450	\$ 465	\$ 479	\$ 492	\$ 505	\$ 521
11	Glucophage		500 mg tab	nm	nm	\$ 507	\$ 548	\$ 589	\$ 661	\$ 708
12	Lipitor		10 mg tab	nm	nm	nm	nm	\$ 666	\$ 686	\$ 686
13	Fosamax		10 mg tab	nm	nm	\$ 609	\$ 631	\$ 651	\$ 696	\$ 741
14	Synthroid	b	0.05 mg tab	\$ 66	\$ 69	\$ 73	\$ 76	\$ 83	\$ 91	\$ 99
15	Zolof		50 mg tab	\$ 681	\$ 738	\$ 764	\$ 787	\$ 808	\$ 829	\$ 855
16	Vasotec		10 mg tab	\$ 338	\$ 349	\$ 364	\$ 376	\$ 390	\$ 403	\$ 418
17	Xalatan		0.01 % sol	nm	nm	nm	\$ 331	\$ 345	\$ 394	\$ 394
18	Premarin		0.63 mg cap	\$ 135	\$ 144	\$ 153	\$ 165	\$ 172	\$ 186	\$ 208
19	Cardizem CD	b	240 mg/24 hr cap	\$ 204	\$ 213	\$ 213	\$ 224	\$ 233	\$ 242	\$ 267
20	Humulin N	b	100 IU inj	\$ 307	\$ 318	\$ 329	\$ 362	\$ 380	\$ 399	\$ 419
21	APAP/propoxyphene	b	650 mg tab	\$ 314	\$ 385	\$ 385	\$ 385	\$ 385	\$ 385	\$ 444
22	Cozaar		50 mg tab	nm	nm	\$ 402	\$ 416	\$ 441	\$ 457	\$ 457
23	Cardizem CD	b	180 mg/24 hr cap	\$ 151	\$ 157	\$ 157	\$ 165	\$ 172	\$ 179	\$ 197
24	Norvasc		10 mg tab	\$ 716	\$ 745	\$ 771	\$ 794	\$ 794	\$ 794	\$ 794
25	albuterol	b	90 mcg aerosol	nm	nm	\$ 313	\$ 313	\$ 313	\$ 313	\$ 313
26	Coumadin	b	5 mg tab	\$ 193	\$ 200	\$ 208	\$ 217	\$ 225	\$ 236	\$ 248
27	Zocor		10 mg tab	\$ 657	\$ 686	\$ 713	\$ 741	\$ 766	\$ 796	\$ 796
28	Zocor		20 mg tab	\$ 1,191	\$ 1,243	\$ 1,292	\$ 1,292	\$ 1,337	\$ 1,389	\$ 1,389
29	Synthroid	b	0.08 mg tab	\$ 73	\$ 76	\$ 81	\$ 84	\$ 92	\$ 101	\$ 110
30	Imdur	b	30 mg tab er	nm	nm	\$ 359	\$ 395	\$ 433	\$ 475	\$ 498
31	Airovent		0.02 mg/ac inh aer	\$ 382	\$ 411	\$ 425	\$ 438	\$ 460	\$ 525	\$ 568
32	Procardia XL		60 mg tab.cr	\$ 748	\$ 778	\$ 805	\$ 829	\$ 852	\$ 874	\$ 901
33	Miacalcin		200 IU/ac spray	nm	nm	nm	\$ 411	\$ 447	\$ 466	\$ 504
34	rانيتidine HCl	b	150 mg tab	nm	nm	nm	nm	\$ 540	\$ 540	\$ 540
35	Zestril	b	10 mg tab	\$ 285	\$ 285	\$ 297	\$ 309	\$ 321	\$ 333	\$ 339
36	Toprol XL		50 mg tab	\$ 155	\$ 155	\$ 171	\$ 185	\$ 194	\$ 204	\$ 213
37	Pravachol		20 mg tab	\$ 632	\$ 663	\$ 690	\$ 717	\$ 753	\$ 830	\$ 887
38	Coumadin	b	2 mg tab	\$ 185	\$ 192	\$ 199	\$ 207	\$ 215	\$ 226	\$ 237
39	Klor-Con 10	b	10 meq tab er	\$ 108	\$ 143	\$ 148	\$ 186	\$ 199	\$ 199	\$ 286
40	Ulram		50 mg tab	nm	nm	\$ 876	\$ 910	\$ 992	\$ 1,088	\$ 1,131
41	Mevacor		20 mg tab	\$ 729	\$ 761	\$ 790	\$ 821	\$ 850	\$ 850	\$ 882
42	Paxil		20 mg tab	\$ 638	\$ 664	\$ 721	\$ 753	\$ 783	\$ 813	\$ 850
43	furosemide	b	40 mg tab	\$ 18	\$ 18	\$ 18	\$ 18	\$ 18	\$ 38	\$ 57
44	Propulsid		10 mg tab	\$ 876	\$ 919	\$ 955	\$ 992	\$ 1,041	\$ 1,134	\$ 1,180
45	Relafen		500 mg tab	\$ 687	\$ 714	\$ 776	\$ 811	\$ 843	\$ 884	\$ 884
46	Cardizem CD	b	120 mg/24 hr cap	\$ 122	\$ 127	\$ 127	\$ 133	\$ 139	\$ 144	\$ 159
47	metoprolol	b	50 mg tab	\$ 314	\$ 322	\$ 357	\$ 350	\$ 350	\$ 350	\$ 405
48	Nitrostat	b	0.4 mg sub	\$ 12	\$ 13	\$ 14	\$ 14	\$ 16	\$ 16	\$ 17
49	lorazepam	b	0.5 mg tab	\$ 97	\$ 106	\$ 120	\$ 124	\$ 124	\$ 469	\$ 493
50	Demadox		20 mg tab	nm	\$ 187	\$ 205	\$ 229	\$ 237	\$ 237	\$ 249

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

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

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

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

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

NOTES TO TABLES**Tables 1-3:**

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

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

- mg - milligram, which is 1/1,000th of a gram
- mg/ac - milligrams per actuation (spray)
- mcg - microgram, which is 1/1-millionth of a gram
- meq - milliequivalent, an alternate form of measurement
- iu - International Unit, a measurement of biological activity
- iu/ac - International Units per actuation (spray)
- sol - solution
- inj - injection
- tab - tablet
- tab cr - controlled release tablet
- tab er - extended release tablet
- cap - capsule
- cap cr - controlled release capsule
- inh aer - inhalant aerosol
- sub - sublingual, or under the tongue

DISCUSSION

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

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

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

As a result of the public's growing concern about the affordability of prescriptions for seniors, a number of proposals are being considered to extend drug coverage for the elderly. Conceptually, these proposals fall mainly into two categories. One approach would add prescription drugs on a voluntary basis *for all Medicare beneficiaries*, with special protections for the poor. Another approach would provide public subsidies only *to low-income seniors* for the purchase of private sector drug coverage. Under this latter approach, subsidies typically taper off at 133 per-

STILL RISING

cent of the federal poverty line and end completely at 150 percent of poverty.

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

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

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

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

The second example is a senior with no drug coverage who has diabetes, hypertension, and high cholesterol—three conditions that often occur in conjunction with one another. A widow or widower with these three conditions is likely to be treated with Glucophage, Procardia XL, and Lipitor. Annual costs for Glucophage (500 milligram tablets) will be \$708. Annual costs for Procardia XL will either be

DRUG PRICES FOR SENIORS

\$521 or \$901, depending on whether 30 milligram tablets or 60 milligram tablets are prescribed. The annual costs for Lipitor (10 milligram tablets) will be \$686.

Thus, the total annual spending for a senior with diabetes, hypertension, and high cholesterol—for these three drugs alone—will range from \$1,915 to \$2,295. For a widow or widower subsisting at 150 percent of poverty, this expenditure will constitute from 15.3 to 18.3 percent of that senior's total income. Even at twice the poverty level, these costs will consume from 11.5 to 13.7 percent of total annual income. These costs, therefore, are likely to cause significant economic hardships.

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

CONCLUSION

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

APPENDIX: METHODOLOGY

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

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

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

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

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

ENDNOTES

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

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

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

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

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

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

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

CREDITS

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for developing the data used in this report

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Drugs Pricier for Seniors, Government Study Shows

Medicine: Problem is worsening as cost of prescriptions continues to skyrocket, report finds.

By ALISSA J. RUBIN, Times Staff Writer

WASHINGTON--Nearly half of all older Americans have no coverage for prescription drugs and they pay at least 15% more for the medications they do buy, according to a government study to be released today by President Clinton.

And many of the senior citizens may pay significantly more than that, according to the study, the government's first detailed drug-pricing study in a decade.

Although it has long been clear that those without insurance pay more for their prescriptions than those who have coverage, the study highlights that coverage also carries with it the benefit of significant drug company discounts and rebates, as much as an additional 35%.

The majority of older Americans without drug coverage have incomes below \$17,000 a year, but even among those with higher incomes--as much as \$45,000 a year for a couple--nearly 25% lack coverage.

The problem is worsening as more companies drop their retiree drug plans and the cost of drugs continues to skyrocket, the study found. Drug prices rose more than twice as rapidly as other health care costs from 1993 to 1998--12% annually compared to other medical expenditures, which had an average annual growth rate of 5%.

The new information, while hardly surprising, is likely to sharpen the debate on Capitol Hill and on the campaign trail over how to design a prescription drug benefit for seniors.

The issue has become increasingly high profile in Congress as lawmakers complete their work on the 2001 budget and House Republicans expect to offer a drug-coverage plan for seniors, perhaps as early as this week. Their plan is likely to focus on subsidizing coverage for lower-income seniors and encouraging the insurance industry to provide more drug coverage for other seniors.

Clinton, who requested the study, plans to use the data to underscore the need for the speedy passage of his plan, which, when fully phased in, would pay up

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his plan, which, when fully phased in, would pay up to 50% of the first \$5,000 in drug bills for all seniors, regardless of income, and includes additional coverage for those whose drug costs are extremely high.

"The study furthers our case for a voluntary prescription drug benefit that is available to all beneficiaries," said a senior White House official, adding that Clinton plans to keep hammering on the drug coverage issue for the remainder of his term in office.

Clinton also will call today for a conference this summer on drug pricing to continue efforts to broaden understanding of how drugs are priced and specifically of rebate arrangements.

Representatives of the insurance industry and drug manufacturers said the study appeared thorough, and they agreed generally with the problems it highlights. However, they differ deeply with the White House on how to provide coverage for seniors who lack it.

"Clearly the study shows that the area is complex and that many elderly need some kind of assistance to buy their drugs by anybody's definition," said Chip Kahn, president of the Health Insurance Industry Assn. of America.

"The problem Congress has is that this isn't the best political environment to settle an issue like this, and Republicans and Democrats aren't going to agree about how to make that happen . . . and so it will be taken to the polls in November."

Alan Holmer, president of the Pharmaceutical Manufacturers of America, took a harder line because the drug industry is inalterably opposed to any government regulation of drug prices.

"Expanded drug coverage is the answer, but the president's plan is the wrong solution," said Holmer. "Seniors need to be able to choose the private insurance plan that's best for them--not a big-government, one-size-fits-all scheme," Holmer said.

The study, which is more than 200 pages long, outlines the enormous complexities in how prescription drugs are priced. Cost depends on the buyer, the volume of the drug bought and on the arrangement between the drug company and the pharmacy benefit manager--the companies that coordinate the transaction between the drug company, the insurer and the pharmacy where the consumer buys the drug.

Rebates given by drug manufacturers reduce the total amount paid by the insurer or the pharmacy benefit manager. However, it remains unclear whether those savings are passed on to the consumer directly through lower drug prices or indirectly, through a more inclusive insurance benefit. Alternatively, the savings may go to improve the profit margins of the insurer, HMO or pharmacy



benefit manager.

The effort to investigate drug pricing started more than a year ago when Rep. Henry A. Waxman (D-Los Angeles) began surveying pharmacies on behalf of other members of Congress to provide data on the price differentials for insured and uninsured seniors.

"The pricing system for drugs is broken. Seniors who can pay the least but need drugs the most pay the highest prices. Congress must act now," said Waxman.

The studies have been wildly popular with Democrats, 115 of whom have asked Waxman's staff to do such surveys for their congressional districts.

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FAX

To: Barbara Washington

From: Steve Calfo, ASA
Health Care Financing Administration

Fax #: 202-690-8168

Phone: 410-786-7907

Subject: Prescription Drug Estimates for 6 Proposals

Date: 4/6/00

Pages: Cover + 12

I created estimates for the most recent prescription drug benefit requests. 6 estimates were created. There are two sheets for each estimate. The first 5 estimates do not include an employer subsidy option. The last estimate includes an employer subsidy and is Option 5. Option 5 has the highest cost. The order of the estimates are as follows:

- Option 1
- Option 2
- Option 3
- Option 4
- Option 5
- Option 5 * includes employer subsidy since this option is the highest cost

If you have any questions please contact me at (410) 786-7907.

Steve Calfo

OPTION01

Model run 04/06/2000

04/07/2000 8:32

250 DEDUCT, 50 PCT COINS TO 2000 OOP, 25 PCT COINS TO 3500 OOP —
 (Start date 1/1/2003.) — PBM administration — \$3,500 OOP protection starting in
 2003 with 0% coinsurance— Low Income Premium Subsidy Option — 0% new
 SLMB's — 0% new QI's — 5% new QMB's — 100% Induction — MSP —
 Institutionalized expenses included

DRUGCPI Update index

50% Premium Rate (total)

1.02 Effect of Income Related Premium

Fiscal Year	Medicare Cash Outlays			Employer Subsidy	Monthly Premium Rate	Medicare Premiums	Net Medicare Impact	Federal Medicaid	Low Income Subsidy	Net Budget Impact
	Total Cost	FFS Cost	M+C Cost							
2001	\$0	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2002	\$0	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2003	\$22,805	\$18,970	\$3,835	\$0	\$43.54	\$15,100	\$7,705	\$1,104	\$177	\$8,985
2004	\$41,671	\$34,438	\$7,233	\$0	\$47.51	\$22,111	\$19,560	\$1,428	\$254	\$21,242
2005	\$46,005	\$37,694	\$8,311	\$0	\$51.97	\$24,402	\$21,602	\$1,544	\$281	\$23,427
2006	\$50,936	\$41,416	\$9,521	\$0	\$56.66	\$26,992	\$23,944	\$1,669	\$311	\$25,924
2007	\$56,368	\$45,531	\$10,837	\$0	\$61.53	\$29,805	\$26,563	\$1,807	\$345	\$28,715
2008	\$62,325	\$50,052	\$12,272	\$0	\$66.61	\$32,917	\$29,407	\$1,941	\$382	\$31,730
2009	\$68,964	\$55,059	\$13,905	\$0	\$72.14	\$36,366	\$32,598	\$2,083	\$422	\$35,103
2010	\$76,441	\$60,617	\$15,823	\$0	\$78.19	\$40,141	\$36,300	\$2,242	\$468	\$39,010
2001-2004	\$64,476	\$53,408	\$11,068	\$0		\$37,211	\$27,264	\$2,532	\$431	\$30,227
2005-2009	\$284,597	\$229,752	\$54,845	\$0		\$150,483	\$134,114	\$9,044	\$1,741	\$144,899
2001-2009	\$349,072	\$283,159	\$65,913	\$0		\$187,694	\$161,378	\$11,576	\$2,172	\$175,126
2001-2005	\$110,480	\$91,101	\$19,379	\$0		\$61,614	\$48,866	\$4,076	\$712	\$53,654
2006-2010	\$315,033	\$252,675	\$62,358	\$0		\$166,221	\$148,812	\$9,742	\$1,928	\$160,482
2001-2010	\$425,513	\$343,777	\$81,737	\$0		\$227,835	\$197,678	\$13,818	\$2,640	\$214,136

(\$ millions)

OLP P.03

OPTION01

Model run 03/22/2000

04/07/2000 8:38

250 DEDUCT, 50 PCT COINS TO 2000 OOP, 25 PCT COINS TO 3500 OOP — (Start date 1/1/2003.) — PBM administration
 — \$3,500 OOP protection starting in 2003 with 0% coinsurance — Low Income Premium Subsidy Option — 0% new SLMB's
 — 0% new QI's — 5% new QMB's — 100% Induction — MSP — Institutionalized expenses included

Benefit structure

Year	Breakpoints (set 1)			Breakpoints (set 2)			Breakpoints (set 3)			Breakpoints (set 4)		
	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP
2003	\$250	100.00%	\$250	\$3,750	50.00%	\$2,000	\$9,750	25.00%	\$3,500	\$∞	0.00%	\$3,500
2004	\$264	100.00%	\$264	\$3,956	50.00%	\$2,110	\$10,286	25.00%	\$3,693	\$∞	0.00%	\$3,693
2005	\$278	100.00%	\$278	\$4,174	50.00%	\$2,226	\$10,852	25.00%	\$3,896	\$∞	0.00%	\$3,896
2006	\$294	100.00%	\$294	\$4,403	50.00%	\$2,348	\$11,449	25.00%	\$4,110	\$∞	0.00%	\$4,110
2007	\$310	100.00%	\$310	\$4,646	50.00%	\$2,478	\$12,079	25.00%	\$4,336	\$∞	0.00%	\$4,336
2008	\$327	100.00%	\$327	\$4,901	50.00%	\$2,614	\$12,743	25.00%	\$4,574	\$∞	0.00%	\$4,574
2009	\$345	100.00%	\$345	\$5,171	50.00%	\$2,758	\$13,444	25.00%	\$4,826	\$∞	0.00%	\$4,826
2010	\$364	100.00%	\$364	\$5,455	50.00%	\$2,909	\$14,183	25.00%	\$5,091	\$∞	0.00%	\$5,091

TD

APR-07-2000 10:25 FROM HCFA DRACT

250 DEDUCT, 50 PCT COINS TO 2000 OOP, 25 PCT COINS TO 4000 OOP —
 (Start date 1/1/2003.) — PBM administration — \$4,000 OOP protection starting in
 2003 with 0% coinsurance— Low Income Premium Subsidy Option — 0% new
 SLMB's — 0% new QI's — 5% new QMB's — 100% Induction — MSP —
 Institutionalized expenses included

DRUGCPI Update index

50% Premium Rate (total)

1.02 Effect of Income Related Premium

Fiscal Year	Medicare Cash Outlays			Employer Subsidy	Monthly Premium Rate	Medicare Premiums	Net Medicare Impact	Federal Medicaid	Low Income Subsidy	Net Budget Impact
	Total Cost	FFS Cost	M+C Cost							
2001	\$0	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2002	\$0	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2003	\$22,686	\$18,871	\$3,815	\$0	\$43.31	\$15,022	\$7,664	\$1,114	\$176	\$8,955
2004	\$41,438	\$34,245	\$7,192	\$0	\$47.23	\$21,986	\$19,452	\$1,450	\$253	\$21,154
2005	\$45,720	\$37,460	\$8,259	\$0	\$51.63	\$24,249	\$21,471	\$1,569	\$280	\$23,319
2006	\$50,591	\$41,135	\$9,456	\$0	\$56.27	\$26,808	\$23,784	\$1,699	\$309	\$25,792
2007	\$55,960	\$45,202	\$10,758	\$0	\$61.08	\$29,588	\$26,373	\$1,841	\$342	\$28,556
2008	\$61,849	\$49,671	\$12,179	\$0	\$66.09	\$32,664	\$29,185	\$1,980	\$379	\$31,544
2009	\$68,410	\$54,616	\$13,793	\$0	\$71.55	\$36,071	\$32,338	\$2,129	\$419	\$34,886
2010	\$75,790	\$60,101	\$15,689	\$0	\$77.51	\$39,796	\$35,994	\$2,296	\$464	\$38,753
2001-2004	\$64,124	\$53,116	\$11,007	\$0		\$37,008	\$27,116	\$2,564	\$428	\$30,109
2005-2009	\$282,531	\$228,085	\$54,446	\$0		\$149,380	\$133,151	\$9,217	\$1,729	\$144,096
2001-2009	\$346,655	\$281,202	\$65,453	\$0		\$186,388	\$160,267	\$11,781	\$2,157	\$174,205
2001-2005	\$109,843	\$90,577	\$19,267	\$0		\$61,257	\$48,587	\$4,133	\$708	\$53,427
2006-2010	\$312,601	\$250,726	\$61,875	\$0		\$164,927	\$147,674	\$9,944	\$1,913	\$159,531
2001-2010	\$422,444	\$341,303	\$81,141	\$0		\$226,184	\$196,260	\$14,077	\$2,620	\$212,958

(\$ millions)

P.04
 OLP
 TO
 HCFA DACT
 FROM
 10:26
 04-07-2000

OPTION02

Model run 03/22/2000

04/07/2000 8:38

250 DEDUCT, 50 PCT COINS TO 2000 OOP, 25 PCT COINS TO 4000 OOP — (Start date 1/1/2003.) — PBM administration
 — \$4,000 OOP protection starting in 2003 with 0% coinsurance — Low Income Premium Subsidy Option — 0% new SLMB's
 — 0% new QI's — 5% new QMB's — 100% Induction — MSP — Institutionalized expenses included

Benefit structure

Year	Breakpoints (set 1)			Breakpoints (set 2)			Breakpoints (set 3)			Breakpoints (set 4)		
	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP
2003	\$250	100.00%	\$250	\$3,750	50.00%	\$2,000	\$11,750	25.00%	\$4,000	\$0	0.00%	\$4,000
2004	\$264	100.00%	\$264	\$3,956	50.00%	\$2,110	\$12,396	25.00%	\$4,220	\$0	0.00%	\$4,220
2005	\$278	100.00%	\$278	\$4,174	50.00%	\$2,226	\$13,078	25.00%	\$4,452	\$0	0.00%	\$4,452
2006	\$294	100.00%	\$294	\$4,403	50.00%	\$2,348	\$13,797	25.00%	\$4,697	\$0	0.00%	\$4,697
2007	\$310	100.00%	\$310	\$4,646	50.00%	\$2,478	\$14,556	25.00%	\$4,955	\$0	0.00%	\$4,955
2008	\$327	100.00%	\$327	\$4,901	50.00%	\$2,614	\$15,357	25.00%	\$5,228	\$0	0.00%	\$5,228
2009	\$345	100.00%	\$345	\$5,171	50.00%	\$2,758	\$16,201	25.00%	\$5,515	\$0	0.00%	\$5,515
2010	\$364	100.00%	\$364	\$5,455	50.00%	\$2,909	\$17,092	25.00%	\$5,819	\$0	0.00%	\$5,819

OPTION03

Model run 04/06/2000

04/07/2000 8:35

2006²

250 DEDUCT, 50 PCT COINS TO 1500 OOP, 25 PCT COINS TO 3500 OOP —
 (Start date 1/1/2003.) — PBM administration — \$3,000 OOP protection starting in
 2003 with 0% coinsurance — Low Income Premium Subsidy Option — 0% new
 SLMB's — 0% new QI's — 5% new QMB's — 100% Induction — MSP —
 Institutionalized expenses included

DRUGCPI Update index
 50% Premium Rate (total)
 1.02 Effect of Income Related Premium

Fiscal Year	Medicare Cash Outlays			Employer Subsidy	Monthly Premium Rate	Medicare Premiums	Net Medicare Impact	Federal Medicaid	Low Income Subsidy	Net Budget Impact
	Total Cost	FFS Cost	M+C Cost							
2001	\$0	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2002	\$0	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2003	\$23,873	\$19,859	\$4,015	\$0	\$45.58	\$15,808	\$8,066	\$1,078	\$185	\$9,329
2004	\$43,644	\$36,069	\$7,575	\$0	\$49.77	\$23,160	\$20,484	\$1,358	\$266	\$22,108
2005	\$48,217	\$39,506	\$8,711	\$0	\$54.48	\$25,578	\$22,638	\$1,466	\$295	\$24,399
2006	\$54,307	\$44,155	\$10,153	\$0	\$60.95	\$28,861	\$25,446	\$1,527	\$333	\$27,306
2007	\$60,657	\$48,996	\$11,662	\$0	\$66.32	\$32,107	\$28,550	\$1,608	\$372	\$30,530
2008	\$67,234	\$53,995	\$13,239	\$0	\$71.90	\$35,519	\$31,716	\$1,711	\$412	\$33,838
2009	\$74,503	\$59,481	\$15,022	\$0	\$77.98	\$39,294	\$35,208	\$1,825	\$456	\$37,490
2010	\$82,693	\$65,575	\$17,118	\$0	\$84.63	\$43,432	\$39,261	\$1,951	\$506	\$41,718
2001-2004	\$67,518	\$55,928	\$11,590	\$0		\$38,968	\$28,550	\$2,436	\$451	\$31,436
2005-2009	\$304,919	\$246,132	\$58,786	\$0		\$161,360	\$143,558	\$8,137	\$1,867	\$153,563
2001-2009	\$372,436	\$302,060	\$70,376	\$0		\$200,328	\$172,108	\$10,573	\$2,318	\$184,999
2001-2005	\$115,735	\$95,434	\$20,301	\$0		\$64,547	\$51,188	\$3,901	\$746	\$55,835
2006-2010	\$339,395	\$272,201	\$67,194	\$0		\$179,214	\$160,181	\$8,622	\$2,078	\$170,882
2001-2010	\$455,130	\$367,635	\$87,494	\$0		\$243,761	\$211,369	\$12,524	\$2,824	\$226,717

(\$ millions)

OPTION03 Model run 03/22/2000

04/07/2000 8:38

250 DEDUCT, 50 PCT COINS TO 1500 OOP, 25 PCT COINS TO 3500 OOP — (Start date 1/1/2003.) — PBM administration
 — \$3,000 OOP protection starting in 2003 with 0% coinsurance— Low Income Premium Subsidy Option — 0% new SLMB's
 — 0% new QI's — 5% new QMB's — 100% Induction — MSP — Institutionalized expenses included

Benefit structure

Year	Breakpoints (set 1)			Breakpoints (set 2)			Breakpoints (set 3)			Breakpoints (set 4)		
	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP
2003	\$250	100.00%	\$250	\$2,750	50.00%	\$1,500	\$10,750	25.00%	\$3,500	\$∞	0.00%	\$3,500
2004	\$264	100.00%	\$264	\$2,901	50.00%	\$1,583	\$11,343	25.00%	\$3,693	\$∞	0.00%	\$3,693
2005	\$278	100.00%	\$278	\$3,061	50.00%	\$1,670	\$11,967	25.00%	\$3,896	\$∞	0.00%	\$3,896
2006	\$294	100.00%	\$294	\$3,229	50.00%	\$1,761	\$8,184	25.00%	\$3,000	\$∞	0.00%	\$3,000
2007	\$310	100.00%	\$310	\$3,407	50.00%	\$1,858	\$8,634	25.00%	\$3,165	\$∞	0.00%	\$3,165
2008	\$327	100.00%	\$327	\$3,594	50.00%	\$1,960	\$9,109	25.00%	\$3,339	\$∞	0.00%	\$3,339
2009	\$345	100.00%	\$345	\$3,792	50.00%	\$2,068	\$9,610	25.00%	\$3,523	\$∞	0.00%	\$3,523
2010	\$364	100.00%	\$364	\$4,000	50.00%	\$2,182	\$10,138	25.00%	\$3,716	\$∞	0.00%	\$3,716

OPTION04

Model run 04/06/2000

04/07/2000 8:34

250 DEDUCT, 75 PCT COINS TO 1000 OOP, 50 PCT COINS TO 3000 OOP, 25 PCT COINS TO 4000 OOP — (Start date 1/1/2003.) — PBM administration — \$3,000 OOP protection starting in 2003 with 0% coinsurance— Low Income Premium Subsidy Option — 0% new SLMB's — 0% new QI's — 5% new QMB's — 100% Induction — MSP — Institutionalized expenses included

DRUGCPI Update index

50% Premium Rate (total)

1.02 Effect of Income Related Premium

Fiscal Year	Medicare Cash Outlays			Employer Subsidy	Monthly Premium Rate	Medicare Premiums (\$ millions)	Net Medicare Impact	Federal Medicaid	Low Income Subsidy	Net Budget Impact
	Total Cost	FFS Cost	M+C Cost							
2001	\$0	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2002	\$0	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2003	\$17,833	\$14,834	\$2,999	\$0	\$34.05	\$11,808	\$6,025	\$1,215	\$138	\$7,378
2004	\$32,650	\$26,983	\$5,667	\$0	\$37.26	\$17,330	\$15,320	\$1,730	\$199	\$17,248
2005	\$36,178	\$29,642	\$6,536	\$0	\$40.93	\$19,201	\$16,977	\$1,865	\$221	\$19,063
2006	\$50,367	\$40,930	\$9,438	\$0	\$62.15	\$27,617	\$22,751	\$1,702	\$319	\$24,772
2007	\$61,287	\$49,499	\$11,788	\$0	\$67.62	\$32,726	\$28,560	\$1,568	\$379	\$30,507
2008	\$68,552	\$55,054	\$13,498	\$0	\$73.31	\$36,214	\$32,338	\$1,617	\$420	\$34,375
2009	\$75,960	\$60,644	\$15,316	\$0	\$79.50	\$40,063	\$35,897	\$1,722	\$465	\$38,084
2010	\$84,300	\$66,850	\$17,451	\$0	\$86.27	\$44,276	\$40,025	\$1,839	\$516	\$42,380
2001-2004	\$50,483	\$41,817	\$8,666	\$0		\$29,139	\$21,344	\$2,944	\$337	\$24,626
2005-2009	\$292,344	\$235,768	\$56,576	\$0		\$155,821	\$136,523	\$8,474	\$1,804	\$146,801
2001-2009	\$342,827	\$277,585	\$65,242	\$0		\$184,960	\$157,867	\$11,418	\$2,142	\$171,427
2001-2005	\$86,661	\$71,459	\$15,202	\$0		\$48,340	\$38,322	\$4,809	\$559	\$43,689
2006-2010	\$340,466	\$272,976	\$67,491	\$0		\$180,896	\$159,571	\$8,449	\$2,099	\$170,118
2001-2010	\$427,128	\$344,435	\$82,693	\$0		\$229,236	\$197,892	\$13,257	\$2,657	\$213,807

TO FROM HCFA DACT 10:27 APR-07-2000 P.08

DLP P.09

OPTION04 Model run 03/22/2000 04/07/2000 8:34

250 DEDUCT, 75 PCT COINS TO 1000 OOP, 50 PCT COINS TO 3000 OOP, 25 PCT COINS TO 4000 OOP — (Start date 1/1/2003.) — PUM administration — \$3,000 OOP protection starting in 2003 with 0% coinsurance — Low Income Premium Subsidy Option — 0% new SLMB's — 0% new Q1's — 5% new QMB's — 100% Induction — MSP — Institutionalized expenses included

Benefit structure

Year	Breakpoints (set 1)			Breakpoints (set 2)			Breakpoints (set 3)			Breakpoints (set 4)			Breakpoints (set 5)		
	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP
2003	\$250	100.00%	\$250	\$1,250	75.00%	\$1,000	\$5,250	50.00%	\$3,000	\$9,250	25.00%	\$4,000	\$0	0.00%	\$4,000
2004	\$264	100.00%	\$264	\$1,319	75.00%	\$1,055	\$5,539	50.00%	\$3,165	\$9,759	25.00%	\$4,220	\$0	0.00%	\$4,220
2005	\$278	100.00%	\$278	\$1,391	75.00%	\$1,113	\$5,843	50.00%	\$3,339	\$10,295	25.00%	\$4,452	\$0	0.00%	\$4,452
2006	\$294	100.00%	\$294	\$2,706	50.00%	\$1,500	\$8,706	25.00%	\$3,000	\$0	0.00%	\$3,000	\$0	0.00%	\$3,000
2007	\$310	100.00%	\$310	\$2,855	50.00%	\$1,583	\$9,185	25.00%	\$3,165	\$0	0.00%	\$3,165	\$0	0.00%	\$3,165
2008	\$327	100.00%	\$327	\$3,012	50.00%	\$1,670	\$9,690	25.00%	\$3,339	\$0	0.00%	\$3,339	\$0	0.00%	\$3,339
2009	\$345	100.00%	\$345	\$3,178	50.00%	\$1,761	\$10,223	25.00%	\$3,523	\$0	0.00%	\$3,523	\$0	0.00%	\$3,523
2010	\$364	100.00%	\$364	\$3,353	50.00%	\$1,858	\$10,786	25.00%	\$3,716	\$0	0.00%	\$3,716	\$0	0.00%	\$3,716

TO

APR-07-2000 10:27 FROM HCFA DACT

OPTION05

Model run 03/22/2000

04/07/2000 8:38

250 DEDUCT, 50 PCT COINS TO 3000 OOP — (Start date 1/1/2003.) — PBM adm inistration — \$3,000 OOP protection starting in 2003 with 0% coinsurance — Low Income Premium Subsidy Option — 0% new SLMB's — 0% new QI's — 5% new QMB's — 100% Induction -- MSP — Institutionalized expenses included

Benefit structure

Year	Breakpoints (set 1)			Breakpoints (set 2)			Breakpoints (set 3)			Breakpoints (set 4)		
	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP
2003	\$250	100.00%	\$250	\$5,750	50.00%	\$3,000	\$∞	0.00%	\$3,000	\$∞	0.00%	\$3,000
2004	\$264	100.00%	\$264	\$6,066	50.00%	\$3,165	\$∞	0.00%	\$3,165	\$∞	0.00%	\$3,165
2005	\$278	100.00%	\$278	\$6,400	50.00%	\$3,339	\$∞	0.00%	\$3,339	\$∞	0.00%	\$3,339
2006	\$294	100.00%	\$294	\$1,706	50.00%	\$1,000	\$11,798	25.00%	\$3,523	\$∞	0.00%	\$3,523
2007	\$310	100.00%	\$310	\$1,800	50.00%	\$1,055	\$12,447	25.00%	\$3,717	\$∞	0.00%	\$3,717
2008	\$327	100.00%	\$327	\$1,899	50.00%	\$1,113	\$13,132	25.00%	\$3,921	\$∞	0.00%	\$3,921
2009	\$345	100.00%	\$345	\$2,004	50.00%	\$1,174	\$13,854	25.00%	\$4,137	\$∞	0.00%	\$4,137
2010	\$364	100.00%	\$364	\$2,114	50.00%	\$1,239	\$14,616	25.00%	\$4,364	\$∞	0.00%	\$4,364

OPTION05

Model run 04/06/2000

04/07/2000 8:36

250 DEDUCT, 50 PCT COINS TO 3000 OOP — (Start date 1/1/2003.) — PBM administration — \$3,000 OOP protection starting in 2003 with 0% coinsurance—33% employer subsidy. —18.50% FFS persons with employer plan. — Low Income Premium Subsidy Option — 0% new SLMB's — 0% new QI's — 5% new QMB's — 100% Induction — MSP — Institutionalized expenses included

DRUGCPI Update index

50% Premium Rate (total)

1.02 Effect of Income Related Premium

Fiscal Year	Medicare Cash Outlays			Employer Subsidy	Monthly Premium Rate	Medicare Premiums	Net Medicare Impact	Federal Medicaid	Low Income Subsidy	Net Budget Impact
	Total Cost	FFS Cost	M+C Cost							
2001	\$0	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2002	\$0	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2003	\$18,918	\$15,158	\$3,760	\$1,410	\$42.69	\$12,655	\$7,673	\$1,101	\$173	\$8,948
2004	\$34,614	\$27,521	\$7,092	\$2,084	\$46.59	\$18,453	\$18,245	\$1,430	\$249	\$19,924
2005	\$38,287	\$30,135	\$8,153	\$2,292	\$50.99	\$20,400	\$20,179	\$1,541	\$276	\$21,996
2006	\$47,959	\$37,393	\$10,565	\$2,902	\$66.65	\$26,018	\$24,843	\$1,506	\$352	\$26,702
2007	\$56,084	\$43,404	\$12,680	\$3,320	\$72.41	\$29,937	\$29,467	\$1,475	\$406	\$31,347
2008	\$62,455	\$48,011	\$14,444	\$3,651	\$78.40	\$33,106	\$33,000	\$1,538	\$449	\$34,987
2009	\$69,181	\$52,815	\$16,366	\$4,016	\$84.91	\$36,599	\$36,598	\$1,636	\$497	\$38,730
2010	\$76,761	\$58,139	\$18,622	\$4,422	\$92.01	\$40,409	\$40,773	\$1,744	\$550	\$43,068
2001-2004	\$53,532	\$42,679	\$10,852	\$3,494		\$31,108	\$25,918	\$2,531	\$422	\$28,871
2005-2009	\$273,966	\$211,758	\$62,207	\$16,181		\$146,060	\$144,087	\$7,696	\$1,980	\$153,763
2001-2009	\$327,497	\$254,438	\$73,060	\$19,675		\$177,168	\$170,004	\$10,227	\$2,402	\$182,634
2001-2005	\$91,819	\$72,814	\$19,005	\$5,786		\$51,508	\$46,097	\$4,072	\$698	\$50,867
2006-2010	\$312,439	\$239,763	\$72,676	\$18,311		\$166,069	\$164,680	\$7,899	\$2,254	\$174,834
2001-2010	\$404,258	\$312,577	\$91,681	\$24,097		\$217,577	\$210,777	\$11,971	\$2,953	\$225,701

OPTION05

Model run 03/22/2000

04/07/2000 8:38

250 DEDUCT, 50 PCT COINS TO 3000 OOP — (Start date 1/1/2003.) — PBM adm inistration — \$3,000 OOP protection starting in 2003 with 0% coinsurance—33% employer subsidy. — 18.50% FFS persons with employer plan. — Low Income Premium Subsidy Option — 0% new SLMB's — 0% new QI's — 5% new QMB's — 100% Induction — MSP — Institutionalized expenses included

Benefit structure

Year	Breakpoints (set 1)			Breakpoints (set 2)			Breakpoints (set 3)			Breakpoints (set 4)		
	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP
2003	\$250	100.00%	\$250	\$5,750	50.00%	\$3,000	\$∞	0.00%	\$3,000	\$∞	0.00%	\$3,000
2004	\$264	100.00%	\$264	\$6,066	50.00%	\$3,165	\$∞	0.00%	\$3,165	\$∞	0.00%	\$3,165
2005	\$278	100.00%	\$278	\$6,400	50.00%	\$3,339	\$∞	0.00%	\$3,339	\$∞	0.00%	\$3,339
2006	\$294	100.00%	\$294	\$1,706	50.00%	\$1,000	\$11,798	25.00%	\$3,523	\$∞	0.00%	\$3,523
2007	\$310	100.00%	\$310	\$1,800	50.00%	\$1,055	\$12,447	25.00%	\$3,717	\$∞	0.00%	\$3,717
2008	\$327	100.00%	\$327	\$1,899	50.00%	\$1,113	\$13,132	25.00%	\$3,921	\$∞	0.00%	\$3,921
2009	\$345	100.00%	\$345	\$2,004	50.00%	\$1,174	\$13,854	25.00%	\$4,137	\$∞	0.00%	\$4,137
2010	\$364	100.00%	\$364	\$2,114	50.00%	\$1,239	\$14,616	25.00%	\$4,364	\$∞	0.00%	\$4,364

TO

Medicare Patients Pay 15% More for Drugs

HHS Study Finds Growing Gap in Prescription Costs for the Insured and Others

By JULIET EILPERIN
Washington Post Staff Writer

The Clinton administration is releasing a study today documenting that Medicare recipients pay an average of 15 percent more for prescription drugs than patients whose insurers have negotiated discounts, in an effort to pressure Congress to enact a universal drug benefit for senior citizens this year.

President Clinton, who ordered the Department of Health and Human Services last fall to conduct the survey, is scheduled to announce today that the White House will hold a conference on drug pricing this summer that will include representatives from the pharmaceutical industry.

The move comes as lawmakers debate whether to provide prescription drug coverage for the elderly before Congress adjourns this fall.

Seniors are a key swing vote in the November elections, and Democrats are seeking to make drug benefits a pivotal question, with Senate candidates from Michigan to Montana transporting seniors across the border to Canada so they can fill their prescriptions for less money.

Even Republican Sen. Slade Gorton, who is seeking reelection from Washington state this year, is proposing that drug companies be prohibited from charging more for drugs in the United States than they do in Mexico and Canada. As many as 50 House Democrats are planning to hold prescription drug-related events in their districts during this month's spring recess.

White House officials said the study, which also shows that the gap between drug prices for people with and without insurance doubled between 1996 and 1999, demonstrates why Congress should

adopt the president's plan to provide prescription coverage for all Medicare recipients. Clinton's plan would cover half of all drug costs up to \$5,000 a year per person once it was fully implemented in 2009 and includes \$35 billion for seniors with catastrophic drug costs during the last five years of the plan.

"The report underscores the need for a voluntary prescription drug-care benefit for all Medicare beneficiaries, not only because it would provide needed insurance coverage but because it would utilize private sector negotiating practices to achieve discounts and rebates that would accrue to the benefit of seniors," said a White House official who asked not to be identified. "The president believes it just provides more attention to the need for prompt action by the Congress to pass legislation in this area."

House Republicans are planning to unveil their own prescription drug proposal this week, though their plan differs markedly from the president's. GOP lawmakers are focusing on providing private drug coverage to low-income seniors, and they have put aside \$40 billion in the budget over the next five years to pay for a benefit and broader reforms in the Medicare program.

Rep. Bill Thomas (R-Calif.), who chairs the House Ways and Means health subcommittee and is helping to draft the GOP's plan, noted that in 2003 Clinton's plan applies to just \$2,000 in drug costs, forcing seniors to shoulder the rest of their expenses.

"The point is all of this data clearly indicates that what seniors need is a private drug insurance plan that protects seniors from high out-of-pocket costs," Thomas said in an in-

terview yesterday. "The president's plan doesn't do that, and we will present one that does."

Insurance industry representatives such as Health Insurance Association of America President Chip Kahn have objected to a stand-alone prescription drug benefit, saying they will be blamed once health insurance costs rise dramatically as a result. But Thomas said insurers were "just being typical naysayers" and added the GOP plan includes a proposal for "Medicare modernization" that would make it more affordable than the president's over the next decade. According to Congressional Budget Office estimates, Clinton's plan would cost \$149 billion over 10 years.

The HHS study takes direct aim at Republican assertions that the elderly poor are most in need of drug coverage, stating that one in four Medicare beneficiaries with annual income four times above the poverty level, or roughly \$45,000 for a couple, lack drug coverage each year.

The report emphasizes that because seniors and people with disa-

bilities cannot take advantage of the discounts and rebates that other insured Americans enjoy, they often fail to purchase the drugs they need. About 10 percent of Medicare recipients without drug coverage reported in the last 12 months they did not fill a prescription because they could not afford it, compared to 2 percent who had coverage.

Prescription drug spending is increasing at an annual rate of 12 percent, twice as fast as other health spending, according to the report.

But Pharmaceutical Research and Manufacturers of America President Alan F. Holmer said rising drug costs do not justify administering a new drug benefit through the Medicare program.

"Expanded drug coverage is the answer, but the president's plan is the wrong solution," Holmer said in a statement yesterday. "Seniors need to be able to choose the private insurance plan that's best for them, not a big government, one-size-fits-all scheme. Momentum is growing in the Congress for a private sector approach, and we hope the president joins in that initiative."

PHOTOCOPY
PRESERVATION

White House Challenges Drug Companies for Charging Higher Prices to the Uninsured

By ROBERT PEAR

WASHINGTON, April 9 — The White House attacked the pricing policies of the drug industry today, saying drug companies charged higher prices to uninsured customers than to people with insurance, and President Clinton announced plans to hold a conference this summer to investigate how pharmaceutical companies set their prices.

The actions came as Mr. Clinton tried to fire up public support for Medicare coverage of prescription drugs, one of his top goals in his last year in office.

A new study, to be unveiled by Mr. Clinton on Monday, found that elderly people without insurance for drug costs typically pay 15 percent more than people with insurance for the same medicines. Moreover, it said, this gap has more than doubled in the last four years.

"Individuals without drug coverage pay a higher price at the retail pharmacy than the total price paid on behalf of those with drug coverage," said the report, which Mr. Clinton requested last October. "Seniors without drug coverage not only lack insurance against high costs, but do

not have access to the discounts and rebates that insured people receive."

Medicare, the federal health insurance program for 39 million people who are elderly or disabled, generally does not cover prescription drugs for people outside the hospital. Many beneficiaries have some type of supplemental insurance to help pay drug

Seeking support for Medicare coverage of prescription drugs.

costs, but the White House said such coverage was shrinking and was unreliable.

In its new study, the White House said that Medicare beneficiaries without drug insurance spent twice as much of their own money on prescriptions, but bought one-third fewer drugs than people with coverage. Health maintenance organizations and other large health insurance plans can obtain discounts for their

members that are not generally available to individuals paying cash for prescription drugs, the report said.

Spokesmen for the drug industry said they agreed with the government's finding that insurance could help consumers get discounts on prescription drugs. And that, they said, was why they wanted the government to subsidize private insurance to cover such costs for Medicare beneficiaries.

"Expanded drug coverage is the answer," said Alan F. Holmer, president of the Pharmaceutical Research and Manufacturers of America, the trade group. "But the president's plan is the wrong solution. Seniors need to be able to choose the private insurance plan that's best for them, not a big government one-size-fits-all scheme."

Federal officials said drug prices were determined by a complex process that involved discounts, rebates and other financial arrangements among drug manufacturers, wholesalers, pharmacists and insurers.

The drug industry regards the details of those arrangements as proprietary information. But the White

House said the conference on "prescription drug pricing practices" would investigate such rebates and discounts.

Chris Jennings, the White House health policy coordinator, said the administration and Congress needed information about drug discounts and rebates to help them design prescription drug benefits for Medicare.

"There is a basic need for policy makers to understand how this works," Mr. Jennings said in an interview.

"Medicare should use the best techniques of the private sector and should extract similar discounts from the pharmaceutical industry."

The Clinton administration's efforts to obtain such data are sure to cause apprehension among drug companies, which already fear that the White House wants to regulate drug prices, despite its protests to the contrary.

The White House said, "Our analysis tends to understate the ultimate price differences for insured and uninsured customers," because the government could not get data on rebates. Drug makers pay such rebates to benefit management compa-

nies that enhance their "market share" by including their products on a list of recommended drugs.

In the last month, the House and the Senate have endorsed budget blueprints that would provide up to \$40 billion over five years for Medicare drug benefits. But President Clinton has not begun serious negotiations with Congress on how to design such a benefit.

These are some of the obvious questions: How much should the beneficiary pay in premiums, deductibles and co-payments? How much of each prescription should the government pay? Should Medicare provide special protection to people needing very expensive drugs? Should the government subsidize drug benefits even for high-income people?

The new report, "Prescription Drug Coverage, Spending, Utilization and Prices," makes these points:

¶ Spending for prescription drugs is growing more than twice as fast as other health spending. From 1993 to 1998, drug spending increased an average of 12 percent a year, compared with an increase of about 5 percent a year for all other types of health spending.

¶ Ten percent of Medicare beneficiaries without drug coverage reported that they needed a prescription medicine in the last year but did not get it because they could not afford it. Only 2 percent of beneficiaries with drug coverage reported having had such an experience.

¶ About one-third of Medicare beneficiaries have no insurance to help them buy prescription drugs. Forty-seven percent of beneficiaries are uninsured for at least one month of the year; 53 percent have drug coverage for the entire year.

¶ Nearly one-fourth of Medicare beneficiaries with incomes exceeding four times the poverty level — more than \$45,000 a year for a couple — have no insurance coverage for prescription drugs. "This contradicts the belief that lack of coverage is a problem only for those with low incomes."

In addition, the White House said, the oldest Medicare beneficiaries are most likely to lack drug coverage. About 37 percent of beneficiaries 85 and older lack coverage, compared with 28 percent of beneficiaries age 65 to 69.

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Independent No Longer Alone in Fight Over Drug Costs

By ROBIN TONER

WASHINGTON

THE pharmaceutical industry has a lot of problems in Washington these days, its prices and profits proving an irresistible target for politicians with hard-pressed elderly constituents and an election on the horizon.

But there are few more persistent irritants than Representative Bernard Sanders, the democratic socialist from Vermont who is one of two independents in the House. Mr. Sanders, a gruff-spoken 58-year-old native of Flatbush, Brooklyn, with a thatch of white hair and a rumpled 60's-academic style, has twice taken elderly constituents on well-publicized trips to Canada to buy prescription drugs, highlighting the lower prices across the border.

He has pushed legislation that he said would allow American pharmacists and distributors to "reimport" prescription drugs approved by the Food and Drug Administration from Canada and Mexico and sell them at lower costs.

When a lobbying alliance backed by the pharmaceutical industry set up a Web site to highlight the problems in the Canadian health care system (www.busfromcanada.org), Mr. Sanders quickly countered with a Web site about the inequities of American drug pricing and the legislative proposals to deal with them (bernie.house.gov/bustocanada).

In an interview on Thursday night, Mr. Sanders had the quiet glow of a man who believed that political lightning was finally striking his cause.

"You're dealing here not just with an economic issue or even a health care issue, you're dealing with a very profound moral issue," he said. "Time is long overdue for the Congress to stand up to these people and protect the American people."

Jackie Cottrell, a spokeswoman for the Pharmaceutical Research and Manufacturers of America, responded, "What's moral is to make sure medicines are available through insurance coverage, but also to make sure that Congressman Sanders and his allies don't stifle our



Susana Raab for The New York Times

Bernard Sanders says pharmaceutical companies are on the defensive.

the 1980's when he was the mayor of Burlington, Vt., and created a task force on health care. Medicare, the health program for the elderly, generally does not cover outpatient prescription drugs, and a third of its elderly beneficiaries have no drug coverage at all. "You can't walk down a main street in Vermont without someone coming up and saying, 'Bernie, you've got to do something about the high cost of prescription drugs,'" he said.

THESE days, of course, nearly everyone says he wants to do something to help the elderly with drug costs, but Mr. Sanders stands out. He believes not only in new prescription drug coverage for the elderly, and not only in finding a way to end what he considers price discrimination against American consumers, but in a publicly financed national health insurance program, a Canadian-style system administered by the states, for everyone.

He does not seem to worry much about the drug industry's arguments that its prices in the United States are necessary to cover the cost of research. He said he met with some industry lobbyists last year and remembers that they were wearing "fancy shoes." He spoke not with irony but — to use his word — with "contempt."

not to mention a razor's edge.

"I know what it's like to live a family without any money," he said, "the economic suffering that is totally unnecessary among the uninsured, the young poor and many of the elderly. His father, who immigrated from Poland at the age of 17, was a paint salesman. "He worked very hard. He never made a lot of money," Mr. Sanders said quickly staccato, his eyes focused on the floor. "Lack of money was a constant stress on my personal relationship and in our household."

Mr. Sanders' only sibling brother, became a social worker. Mr. Sanders himself, after a year at Brooklyn College, went to the University of Chicago for a combination of loans, grants and part-time jobs. He was a latter student, he wrote in his autobiography, but "learned a

more from my out-of-class activities" in groups like the Congress of Racial Equality and the Young People's Socialist League.

He moved to Vermont in the late 1970s working at a mixture of state government carpentry and writing jobs, and ultimately ended up in politics. Initially, he had little success but he was elected mayor of Burlington from 1981 to 1989, and in 1990 won Vermont's House seat, the first independent elected to Congress in 40 years. Mr. Sanders has three children, and his wife, Jane O'Meara Sanders, has been a key adviser in his political career.

While he tends to align with the Democrats he said he never considered becoming a Democrat. Why?

"Both major political parties are heavily influenced by big money," he said. He noted that in nine years in Congress, he has spent most of his weekend in Washington. He talked scornfully to the journalists and the politicians who spent their time talking to one another, with "no sense of what's going on in the real world."

Mr. Sanders clearly feels he has the pharmaceutical industry on the defensive. "What I try to do here is not to be an ideologue, but to raise issues," he said. "And when you talk issues people respond positively." Still, he acknowledges "I sometimes scratch my head

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