

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

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

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EXECUTIVE SUMMARY

In congressional districts around the country, older Americans are increasingly concerned about the high prices that they pay for prescription drugs. Numerous members of Congress have requested that the minority staff of the Committee on Government Reform and Oversight investigate this issue. This report summarizes investigations of prescription drug pricing conducted by the minority staff in 20 congressional districts.

Numerous studies have concluded that many older Americans pay high prices for prescription drugs and have a difficult time paying for the drugs they need. This study presents new and disturbing evidence about the cause of these high prices. The findings indicate that older Americans and others who pay for their own drugs are charged far more for their prescription drugs than are the drug companies' most favored customers, such as large insurance companies and health maintenance organizations. The findings show that the average senior citizen paying for his or her own prescription drugs must pay twice as much for the drugs as the drug companies' favored customers. The study found that this is an unusually large price differential -- more than four times greater than the average price differential for other consumer goods.

It appears that drug companies are engaged in a form of "discriminatory" pricing that victimizes those who are least able to afford it. Large corporate and institutional customers with market power are able to buy their drugs at discounted prices. Drug companies then raise prices for sales to seniors and others who pay for drugs themselves to compensate for these discounts to the favored customers.

Older Americans are having an increasingly difficult time affording prescription drugs. By one estimate, more than one in eight older Americans has been forced to choose between buying food and buying medicine. Case studies conducted in several states and included in this analysis illustrate these hardships. Legislation that protects older Americans from the pharmaceutical industry's discriminatory pricing would reduce the cost of prescription drugs for seniors and improve the health and financial well-being of millions of Americans.

A. Methodology

This study investigates the pricing of the five brand name prescription drugs with the highest sales to the elderly. It estimates the differential between the price charged to the drug companies' most favored customers, such as large insurance companies and HMOs, and the price charged to seniors. The results are based on a survey of retail prescription drug prices in chain and independently owned drug stores in 20 congressional districts across the nation. These prices are compared to the prices paid by the drug companies' most favored customers. For comparison purposes, the study also estimates the differential between prices for favored customers and retail prices for other consumer items.

B. Findings

The study finds that:

- **Older Americans pay inflated prices for commonly used drugs.** For the five drugs investigated in this study, the average price differential was 99% (Table 1). This means that senior citizens and other individuals who pay for their own drugs pay twice as much for these drugs than do the drug companies' most favored customers.

Table 1: Average Retail Prices for the Best-Selling Drugs for Older Americans Are Twice as High as the Prices That Drug Companies Charge Their Most Favored Customers.

Prescription Drug	Manufacturer	Use	Prices for Favored Customers	Retail Prices for Senior Citizens	Price Differential for Senior Citizens
Zocor	Merck	High Cholesterol	\$42.95	\$104.80	144%
Prilosec	Astra/Merck	Ulcers	\$56.38	\$111.94	99%
Norvasc	Pfizer Inc.	High Blood Pressure	\$58.83	\$113.77	93%
Procardia XL	Pfizer Inc.	Heart Problems	\$67.35	\$126.86	88%
Zoloft	Pfizer, Inc.	Depression	\$123.88	\$213.72	73%
Average Price Differential					99%

- **For other popular drugs, the price differential is even higher.** This study also analyzed a number of other popular drugs used by older Americans, and in some cases found even higher price differentials (Table 2). The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the price differential for senior citizens was 1,446%. An equivalent dose of this drug would cost the manufacturers' favored customers only \$1.75, but would cost the average senior citizen more than \$27.00. For Micronase, a diabetes treatment manufactured by Upjohn, an equivalent dose would cost the favored customers \$10.05, while seniors are charged an average of \$46.50. The price differential was 363%.

Table 2: Price Differentials for Some Drugs Are Over 1,400%.

Prescription Drug	Manufacturer	Use	Prices for Favored Customers	Retail Prices for Senior Citizens	Price Differential for Senior Citizens
Synthroid	Knoll Pharmaceuticals	Hormone Treatment	\$1.75	\$27.05	1446%
Micronase	Upjohn	Diabetes	\$10.05	\$46.50	363%

- **Price differentials are far higher for drugs than they are for other goods.** This study compared drug prices at the retail level to the prices that the pharmaceutical industry gives its most favored customers, such as large insurance companies and HMOs. Because these customers typically buy in bulk, some difference between retail prices and “favored customer” prices would be expected. The study found, however, that the differential was much higher for prescription drugs than it was for other consumer items. The study compared the price differential for prescription drugs to the price differentials on a selection of other consumer items. The average price differential for the five prescription drugs was 99%, while the price differential for other items was only 22%. Compared to manufacturers of other retail items, pharmaceutical manufacturers appear to be engaging in significant price discrimination against older Americans and other individual consumers.
- **Pharmaceutical manufacturers, not drug stores, appear to be responsible for the discriminatory prices that older Americans pay for prescription drugs.** In order to determine whether drug companies or retail pharmacies were responsible for the high prescription drug prices being paid by older Americans, the study compared average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that pharmacies appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. Retail prices were actually below the published national Average Wholesale Price, and the differential between retail prices and a second indicator of the amount pharmacies pay for prescription drugs, prices from one major wholesaler, is only 22%. This indicates that it is drug company pricing policies that appear to account for the inflated prices charged to older Americans and other customers.
- **Discriminatory prescription drug pricing is a national problem.** This study looked at prescription drug pricing in 20 congressional districts in different parts of the United States. Significant price differentials were found in all congressional districts. The highest average price differential was 123% in California, while the lowest price differential was 85% in Wisconsin. Price differentials for the five drugs were above 100% in six of the 20 districts, and were 90% or higher in 19 of the 20 districts. These results indicate that, while there is a small variation in prices in different regions of the country, high prescription drug costs and large price differentials caused by discriminatory pricing are a nationwide problem.

I. THE VULNERABILITY OF OLDER AMERICANS TO HIGH DRUG PRICES

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

According to the National Institute on Aging, "as a group, older people tend to have more long-term illnesses -- such as arthritis, diabetes, high blood pressure, and heart disease -- than do younger people."¹ Other chronic diseases which disproportionately affect older Americans include depression and neurodegenerative diseases such as Alzheimer's disease, Lou Gehrig's disease, and Parkinson's disease.

According to the American Association of Retired Persons, older Americans spend almost three times as much of their income (21%) on health care as do those under the age of 65 (8%), and more than three-quarters of Americans aged 65 and over are taking prescription drugs.²

The average older American takes 2.4 prescription drugs.³ More importantly, older Americans take significantly more drugs on average than the under-65 population.⁴ It is estimated that the elderly in the United States, who make up 12% of the population, use one-third of all prescription drugs.⁵

Although the elderly have the greatest need for prescription drugs, they often have the most inadequate insurance coverage for the cost of these drugs. A 1996 AARP survey indicated

¹ National Institute on Aging (NIA), NIA Age Page (www.nih.gov/nia/health/pub/medicine.htm).

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

³ AUS/ICR for the American Association of Retired Persons, National Pharmaceutical Council, and Pharmaceutical Executive Magazine, *Survey on Prescription Drug Issues and Usage Among Americans Aged 50 and Older, I* (May 1996).

⁴ Senate Special Committee on Aging, *Developments In Aging: 1996*, 1 S. Rep. 36, 105th Cong., 1st Sess. 121 (1997).

⁵ Senate Special Committee On Aging, *Developments in Aging: 1993*, 1 S. Rep. 403, 103d Cong., 2d Sess. 35 (1994).

that 37% of older Americans do not have insurance coverage for prescription drugs.⁶ As a result, many older Americans -- a large percentage of whom live on a limited, fixed income -- are forced to pay the full, out-of-pocket expense of prescription drugs.

The primary reason for this burden is that, with the exception of drugs administered during in-patient hospital stays, Medicare generally does not cover prescription drugs. While Medicare managed care plans may offer optional prescription drug coverage, they are available only as an option subject to the discretion and fiscal priorities of the health plans. Moreover, these Medicare managed plans currently serve only a small portion of the Medicare population.

Although Medicare beneficiaries can purchase supplemental "Medigap" insurance privately, these policies are often prohibitively expensive or inadequate. For example, one of the standardized Medigap policies available provides only a \$3,000 drug benefit, while still leaving beneficiaries vulnerable to a high deductible and to paying at least half of their total drug costs.⁷

Medicare beneficiaries without public or private prescription drug coverage are the group most at risk of high out-of-pocket prescription drug costs. According to the Senate Special Committee on Aging, this group includes those "who are not poor enough to receive Medicaid, do not have employer-based retiree prescription drug coverage, and cannot afford any other private prescription drug insurance plans."⁸

The high costs of prescription drugs, and the lack of insurance coverage, directly affect the health and welfare of older Americans. In 1993, 13% of older Americans surveyed reported that they were forced to choose between buying food and buying medicine.⁹ By another estimate, five million older Americans are forced to make this difficult choice.¹⁰

⁶ AARP Public Policy Institute and the Lewin Group, *supra* note 2.

⁷ Families USA Foundation, *Worthless Promises: Drug Companies Keep Boosting Prices*, 6 (March 1995).

⁸ Senate Report, *supra* note 4, at 122.

⁹ Families USA Foundation, *supra* note 7, at 6.

¹⁰ Senate Special Committee on Aging, *A Status Report -- Accessibility and Affordability of Prescription Drugs For Older Americans*, S. Rep. 100, 102d Cong., 2d Sess. 2 (1992).

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

The minority staff of the Committee on Government Reform and Oversight has conducted drug pricing investigations in 20 congressional districts at the request of the members that represent these districts. The goal of these investigations was to determine whether pharmaceutical manufacturers are taking advantage of older Americans through price discrimination, and if so, whether this is part of the explanation for the high drug prices being paid by older Americans. This report presents a summary of the findings from these investigations.

Industry analysts have recognized that price discrimination occurs in the prescription drug market. According to a recent *Standard & Poor's* report on the pharmaceutical industry, “[d]rugmakers have historically raised prices to private customers to compensate for the discounts they grant to managed care customers. This practice is known as ‘cost shifting.’”¹¹ Under this practice, “drugs sold to wholesale distributors and pharmacy chains for the individual physician/patient are marked at the higher end of the scale.”¹²

Although industry analyses acknowledge that price discrimination occurs, they have not estimated its degree or impact. This report is the first national effort to quantify the extent of price discrimination and its impact on senior citizens in the United States.

The study design and methodology used to test whether drug companies are discriminating against older Americans in their pricing are described in part III. The results of the study are described in part IV. These results show that drug manufacturers appear to be engaged in substantial price discrimination against older Americans and other individuals who must pay for their own prescription drugs. The consequences of the manufacturers' pricing policies are discussed in part V.

III. METHODOLOGY

A. Selection of Drugs for this Survey

This survey is based primarily on a selection of the five patented, nongeneric drugs with the highest annual sales to older Americans in 1997. The list was obtained from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE). The PACE program

¹¹ Herman Saftlas, *Standard & Poor's, Healthcare: Pharmaceuticals, Industry Surveys*, 19-20 (December 18, 1997).

¹² *Id.* at 19.

is the largest out-patient prescription drug program for older Americans in the United States for which claims data is available and is used in this study, as well as by several other analysts, as a proxy database for prescription drug usage by all older Americans. In 1997, over 250,000 persons were enrolled in the program, which provided over \$100 million of assistance in filling over 2.8 million prescriptions.¹³

B. Determination of Average Retail Drug Prices for Older Americans

In order to determine the prices that senior citizens are paying for prescription drugs, the minority staff conducted a survey of pharmacies in 20 congressional districts in fifteen states. The twenty districts where the survey was conducted were the 5th District in Alabama (Rep. Robert E. (Bud) Cramer, Jr), the 1st District in Arkansas (Rep Marion Berry), the 22nd District in California (Rep. Lois Capps), the 29th District in California (Rep. Henry A. Waxman), the 3rd District in Connecticut (Rep. Rosa L. DeLauro), the 5th District in Connecticut (Rep. James H. Maloney), the 3rd District in Iowa (Rep. Leonard L. Boswell), the 1st District in Maine (Rep. Thomas H. Allen), the 6th District in Massachusetts (Rep. John F. Tierney), the 1st District in Michigan (Rep. Bart Stupak), the 26th District in New York (Rep. Maurice Hinchey), the At Large District in North Dakota (Rep. Earl Pomeroy), the 13th District in Ohio (Rep. Sherrod Brown), the 9th District in Tennessee (Rep. Harold E. Ford, Jr.), the 1st District in Texas (Rep. Max Sandlin), the 2nd District in Texas (Rep. Jim Turner), the 24th District in Texas (Rep. Martin Frost), the At Large District in Vermont (Rep. Bernard Sanders), the 5th District in Wisconsin (Rep. Thomas M. Barrett), and the 8th District in Wisconsin (Rep. Jay W. Johnson). The locations of the districts where pharmacies were surveyed for this study are shown in Appendix D.

C. Determination of Prices for Drug Companies' Most Favored Customers

Drug pricing is complicated and drug companies closely guard their pricing strategies. The best publicly available indicator of the prices companies charge their most favored customers, such as large insurance companies and HMOs, is the Federal Supply Schedule (FSS).

The FSS is a price catalog containing goods available for purchase by federal agencies. Drug prices on the FSS are negotiated by the Department of Veterans Affairs. The prices on the FSS closely approximate the prices that the drug companies charge their most favored nonfederal customers. According to the U.S. General Accounting Office (GAO), "[u]nder [General Services Administration] procurement regulations, VA contract officers are required to seek an FSS price that represents the same discount off a drug's list price that the manufacturer offers its most-

¹³ Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly* (January 1 - December 31, 1997).

favored nonfederal customer under comparable terms and conditions.”¹⁴ Thus, in this study, FSS prices are used to represent the prices drug companies charge their most favored customers.

This update includes FSS prices as of October 8, 1998. These prices represent changes in the FSS prices from the initial staff report. This update also corrects a technical error and includes information on surveys conducted in twelve congressional districts since the publication of the initial report.

D. Determination of Prices Paid by Pharmacies

The survey also looked at two other pricing indicators: (1) the Average Wholesale Price (AWP) and (2) the prices charged pharmacies by a large drug wholesaler. These two prices provide an indicator of the extent of markups that are attributable to the pharmacy (in contrast to those that are due to the drug manufacturer). The AWP is an average of prices charged by the drug wholesalers to retail pharmacies. The AWP prices were obtained from the *1997 Drug Topics Red Book*.¹⁵ As another measure of wholesale prices, the study used the wholesale prices charged pharmacies by McKesson, the world’s largest wholesaler.

E. Determination of Drug Dosages

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

F. Comparison of Price Differentials for Other Retail Items

In order to determine whether the differential between FSS prices and retail prices for drugs commonly used by older Americans is unusually large, the study compared the prescription drug price differentials to price differentials on other consumer products. To make this comparison, a list of consumer items other than drugs available through the FSS was assembled. FSS prices were then compared with the retail prices at which the items could be bought at a large national chain.¹⁶

¹⁴ U.S. General Accounting Office, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain*. (June 1997) (emphasis added).

¹⁵ Medical Economics Company, Inc., *1997 Drug Topics Red Book*.

¹⁶ The items used were binder clips, rubber bands, toilet paper, Rolodex, tape dispensers, wastebaskets, scissors, pencils, paper towels, post-it notes, envelopes, and correction fluid.

IV. DRUG COMPANIES CHARGE OLDER AMERICANS DISCRIMINATORY PRICES

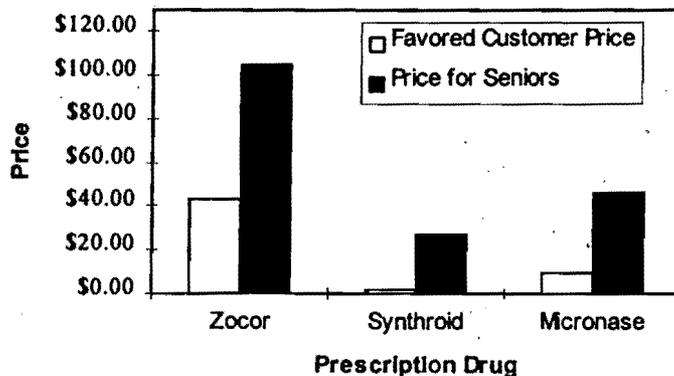
A. Discrimination in Drug Pricing

For the five patented, nongeneric drugs most commonly used by seniors, the average differential between the price that would be paid by a senior citizen and the price that would be paid by the drug companies' most favored customers was 99% (Table 1). The study thus showed that the average price that older Americans and other individual consumers pay for these drugs is double the price paid by the drug companies' favored customers, such as large insurance companies and HMOs.

For individual drugs, the price differential was even higher. Among the five best selling drugs, the highest price differential was 144% for Zocor, a cholesterol treatment manufactured by Merck. For other popular drugs, the study found even greater price differentials.

The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the price differential for senior citizens was 1,446%. An equivalent dose of this drug would cost the most favored customers only \$1.75 but would cost the average senior citizen in the United States \$27.05. For Micronase, a diabetes treatment manufactured by Upjohn, the price differential was 363% (Figure 1) Every drug looked at in this study had a large price differential. Four of the five best selling drugs (Zocor, Norvasc, Prilosec, and Procardia XL) had price differentials of over 85%.

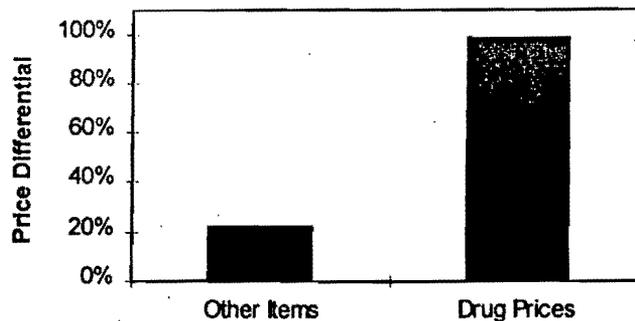
Figure 1: Older Americans Pay Inflated Prices for Prescription Drugs.



B. Comparison With Other Consumer Goods

The study also analyzed whether the large differentials in prescription drug pricing could be attributed to a volume effect. The drug companies' most favored customers, such as large insurance companies and HMOs, typically buy large volumes of drugs. Thus, it could be expected that there would be differences between the prices charged the most favored customers and retail prices. The study found, however, that the differentials in prescription drug prices were much greater than the differentials in prices for other consumer goods. The study found that, in the case of other consumer goods, the average differential between retail prices and the prices charged most favored customers, such as large corporations and institutions, was only 22%. The average price differential in the case of prescription drugs was more than four times larger than the average price differential for other consumer goods (Figure 2). This indicates that a volume effect is unlikely to explain the large differential in prescription drug pricing.

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



C. Drug Company Versus Pharmacy Responsibility

The study also sought to determine whether drug companies or retail pharmacies were responsible for the high prices being paid by older Americans. To do this, the study compared the average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that pharmacies appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. The study found that the average retail price for the five most common drugs was actually lower than the published national Average Wholesale Price, and only 22% higher than the price available directly from one large wholesaler (Figure 3).

This finding indicates that it is drug company pricing policies, not retail markups, that account for the inflated prices charged to older Americans and other individual customers.¹⁷ These findings are consistent with other experts who have concluded that because of the competitive nature of the pharmacy business at the retail level, there is a relatively small profit margin for retail pharmacists.¹⁸

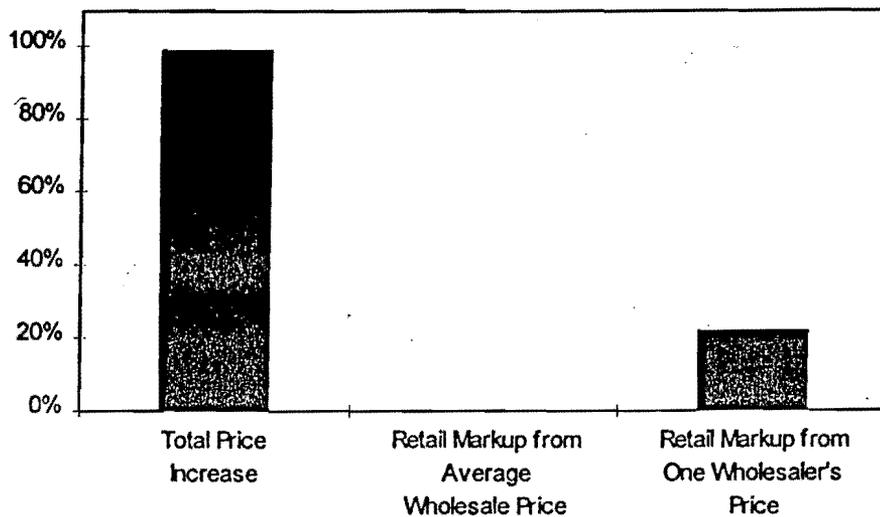
¹⁷ National Association of Chain Drug Stores, *Did You Know . . .* (pamphlet) [citing financial data assembled by Keller Bruner & Company, P.C., Certified Public Accountants (1995)].

¹⁸ In 1993, independent pharmacies sued 19 drug manufacturers, alleging that the differential between the prices charged most favored customers and the prices charged pharmacies violated antitrust laws. In 1996, 11 of these drug manufacturers agreed to settle with the pharmacies. Under this agreement, these pharmaceutical companies promised to offer pharmacies the same price discounts as favored customers like large HMOs if the pharmacies could show the same ability to move market share as the favored customers. On July 13, 1998, four additional drug manufacturers agreed to a settlement under similar terms.

Unfortunately, the results of this study cast doubt on whether these agreements are likely to end the price discrimination practices of the large pharmaceutical companies. All five of the most popular prescription drugs in this survey are covered by the agreement reached in 1996, and there is still large price discrimination for all of these drugs. Synthroid is also covered under the agreement, and this drug has a price differential of more than 1,400%.

The reason for the continued high price differentials may be that, unlike hospitals or HMOs, pharmacies cannot control decisions made by doctors about what drugs to prescribe, and thus are unable to demonstrate to the drug manufacturers that they can influence market share. The doubts raised by this study are consistent with the observations of other industry analysts, who note that "there is already intense skepticism among retail buying groups for independent drugstores about whether the smaller independents will have the ability to qualify for the potential windfall and pass the savings on to customers." *Drug Makers Agree To Offer Discounts For Pharmacies*, Wall Street Journal (July 15, 1998).

Figure 3: Drug Companies, Not Retail Pharmacists, Are Responsible for High Drug Costs Paid by Older Americans.



D. Discriminatory Prescription Drug Pricing Is a National Problem

This study looked at prescription drug pricing in 20 congressional districts in different parts of the United States. Significant price differentials were found in all congressional districts. The highest average price differential was 123% in the 22nd District in California, represented by Rep. Lois Capps. The lowest price differential was 85% in the 8th District in Wisconsin, represented by Rep. Jay Johnson. Price differentials were above 100% in six of the 20 districts: the 22nd District in California, the 29th District in California, the 6th District in Massachusetts, the 9th District in Tennessee, the 1st District in Texas, and the At Large District in Vermont. Price differentials were 90% or higher in 19 of the 20 districts.¹⁹ These results indicate that, while there is a small variation in prices in different regions of the country, high prescription drug costs and large price differentials caused by discriminatory pricing are a nationwide problem.

V. THE CONSEQUENCES OF DRUG COMPANIES' DISCRIMINATORY PRICING

There are two conflicting consequences of the current drug industry pricing practices. Although these pricing practices have allowed the drug industry to grow and amass large profits,

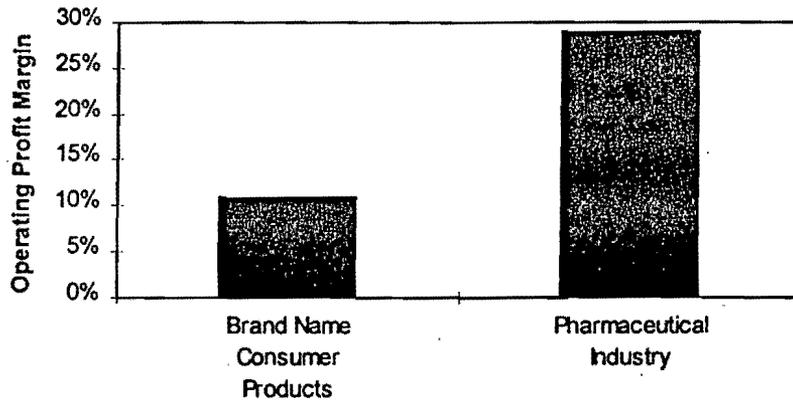
¹⁹ The price differentials in each of the 20 districts are shown in Appendix A.

they have also imposed severe financial hardships on older Americans and others who buy their own drugs.

A. Drug Company Profits

Drug industry pricing strategies have boosted the industry's profitability to extraordinary levels. The annual profits of the top ten drug companies are nearly \$20 billion.²⁰ Moreover, the drug companies make unusually high profits compared to other companies. The average manufacturer of branded consumer goods, such as Proctor & Gamble or Colgate-Palmolive, has an operating profit margin of 10.5%. Drug manufacturers, however, have an operating profit margin of 28.7% -- nearly three times greater (Figure 4).²¹

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



These high profits appear to be directly linked to the pricing strategies observed in this study. For instance, Merck, the country's largest pharmaceutical manufacturer, had an increase in profits of 15% to 18% in the second quarter of 1998. According to industry analysts, Merck's

²⁰ See 1998 Fortune 500 Industry List (www.pathfinder.com/fortune500/indlist.html).

²¹ Paul J. Much, Houlihan Lokey Howard & Zukin, *Expert Analysis of Profitability* (February 1988).

increased profits were due in large part to sales of Zocor,²² which is sold at a price differential of 144%. Zocor itself accounts for 6% of Merck's revenues.²³

Overall, profits for the major drug manufacturers are expected to grow by about 20% in 1998, compared to 5% to 10% for other companies on the Standard & Poors Index. The drug manufacturers' profits are expected to grow by up to an additional 25% in 1999.²⁴ According to one analyst, "the prospects for the pharmaceutical industry are as bright as they've ever been."²⁵

B. What High Drug Prices Mean for Older Americans

While drug companies are thriving under their current pricing strategies, older Americans are not. Surveys indicate that high prescription drug prices impose financial hardships on millions of older Americans. To assess the extent of these difficulties, senior citizens were interviewed in the congressional districts investigated in this study. These case studies illustrate the financial hardships faced by seniors.

Geneva and Percy Kief. Geneva Kief and her husband, Percy, live in a complex for the elderly in Old Orchard Beach, in the 1st Congressional District in Maine. Mrs. Kief is 77 years old and has lived in Maine for the past 40 years. Mr. Kief is 76 years old and has lived in Maine all of his life. Their prescription drug expenses are so high that Mr. Kief has been forced into the Medicaid program and Mrs. Kief often cannot afford to take the medications her doctor has prescribed.

The Kief's only income is from Social Security. After Mr. Kief underwent surgery for a broken hip in September 1997, their monthly bill for prescription drugs rose to \$600, half of their combined monthly income. They could no longer afford to pay for Mr. Kief's prescription drugs, so he was forced to enroll in Medicaid.

Mrs. Kief has not enrolled in Medicaid. Mrs. Kief's monthly bill for prescription drugs is \$230, more than half of her monthly Social Security check of \$411. She suffers from high blood pressure, asthma, two broken disks in her back, and edema. Her doctor has prescribed eight prescription drugs for these ailments, but she cannot afford to take all of her medications. Two of her medications, Ventolin and Slobid, make her hands and body tremble. Mrs. Kief said, "It's very embarrassing when you have to write or even get out and do things and you're shaking all over." To prevent this, her doctor has prescribed Tranxene. But she cannot afford the full

²² *Drugmakers Have Healthy Outlook*, USA Today (July 20, 1998).

²³ *Top 200 Drugs of 1997*, IMS America (1998).

²⁴ USA Today, *supra* note 22.

²⁵ *Id.*, D1.

dosage. Mrs. Kief said, "Most of the time, I only take part of my medicine. Sometimes I don't take them at all because I just can't afford it."

Mrs. Kief became so worried about her husband's health and how she would afford the prescribed drugs that her doctor told her that she should take two antidepressants, Welbutin and Noratriptyline. Ironically, she rarely takes these drugs because she simply cannot afford to pay for the prescriptions.

Frances Staley. Frances Staley, is blind and a resident of Orange, in the 2nd Congressional District in Texas. She has serious problems paying for the prescription drugs that she needs. Ms. Staley takes nine different medications: Miacalcin for osteoporosis, Avapro for blood pressure, Alprazolam for anxiety, Tambocar for heart rate control, Plavix for stroke prevention, Furosemide for fluid retention, Buspar for tension, Propulsid for acid reflux, and Prilosec for stomach acid. Although she has Medicare for most health-related expenses, she has no coverage for the cost of prescription drugs.

Ms. Staley spends an average of \$540 per month on the costs of her prescriptions. Because her only source of income, Social Security, provides approximately \$650 per month, she is left with only a little over \$100 a month for other expenses.

Ms. Staley must constantly worry about being able to even afford food, and at times, she has simply been unable to afford her prescriptions. Like many senior citizens in similar situations, she "never mentions that too much to anyone."

James and Pat Alexander. James and Pat Alexander live in Mountain View, in the 1st Congressional District in Arkansas. Both are disabled. Doctors have prescribed seven medications (Procardia, Nitrostat, Nitrobid, Cardene, Proventil, Intaloral, and Albuterol) for Mrs. Alexander, in addition to the Albuterol and oxygen required by Mr. Alexander. Since the Alexanders started having medical problems, they have lost their home and car due to lost wages, health care costs, and the high price of prescription medicine. The Alexanders do not have supplemental health insurance, and despite severe financial difficulties, the couple's income disqualifies them from receiving prescription drug coverage under Medicaid.

The Alexanders have a total income of \$1,317 a month, all from Social Security. They face prescription drug bills of \$300 to \$400 monthly, up to 30% of their total income.

Unfortunately, they are frequently able to afford only half of these costs, and as a result of the high cost of prescription drugs, they are often forced to skip medications. For example, Mrs. Alexander frequently does not take Nitrostat, prescribed for the chest pains caused by her heart condition. This causes terrible discomfort and fear. "You just have to suffer the discomfort and the pain that you have . . . I have to worry about whether or not [skipping the medication] will throw me into a heart attack," Mrs. Alexander said.

Marian Miller. Marian Miller lives in senior subsidized housing in Milwaukee, in the 5th Congressional District in Wisconsin. Ms. Miller pays 30% of her income towards her rent. Her monthly income from Social Security and pension is \$1,100. Ms. Miller, who suffers from hardening of the arteries, blood clots, high blood pressure, and heart disease, takes eight prescription medications each month. The medications are Procardia, Imdur, Coumadin, Furosemide, Prilosec, two types of Nitroglycerin, and FE-tinic for iron.

None of her medications are covered by health insurance, and Ms. Miller spends over \$300 a month for these medications, almost 40% of her remaining income after her rent. Sometimes, Ms. Miller goes without buying her medication so she can pay her bills. Because of the expense, she is often forced to reduce her dosages, putting her health at risk. According to Ms. Miller, "I know that my health problems are not being handled well because sometimes I take medicine every other day instead of every day to make it last longer."

Wilma Gagnon. Wilma Gagnon is a resident of Alpena, in the 1st congressional district in Michigan. Ms. Gagnon, a 75-year-old widow, suffers from high blood pressure, heart problems, asthma, acid reflux, depression, and anxiety, and takes nine prescription drugs (Lorazepam, Dyazide, Amitriptyline, Procardia, Prilosec, Albuterol, and two different asthma medications).

Her monthly prescription bills are approximately \$350, one third of her total monthly income of \$1,057. Although Ms. Gagnon says she will not skip any medications because of the health risk, she is sometimes forced to go without food.

She says that because of the high costs of prescription drugs, she feels that she cannot afford nutritious food, which adds to her depression. According to Ms. Gagnon, if drug prices were lower, she would be able to "go to the grocery store and buy what I need without worrying."

Berdie Hopewell. Berdie Hopewell is a 67-year-old resident of Elyria, Ohio, in the 13th Congressional District in Ohio. Ms. Hopewell suffers from eye trouble, a scalp condition, high blood pressure, asthma, and pain and swelling of her legs, and takes 13 prescription medications (Proventil, Asthmacort, Neurontin, Furosemide, Clonazepam, Cortisone, Singulair, Volmax, Prilosec, Cardizem, K-Dur, Fluocinonide, and Nizoral) for these conditions.

Ms. Hopewell's sole source of income is Social Security. Her monthly income is only \$800. While Ms. Hopewell does have some insurance coverage, her monthly bills for her prescription drugs are still \$325 -- 40% of her monthly income. According to Ms. Hopewell, "After I pay my bills, I have \$20 to buy groceries for the whole month... I've got a light bill, a gas bill, a car payment. By the time I pay everything, I have nothing."

As a result of these high costs, Ms. Hopewell has trouble affording her medications and has had to reduce her dosage or skip her medications altogether. She also reports that she has

been forced to choose between paying for basic items like food and electricity and paying for her prescription medications. She says that “we go without food and medication to pay bills.” She concludes, “It’s a tough struggle.”

Appendix A
Results By Congressional District

Congressional District	Member of Congress	Average Price Differential For Top Five Drugs
Alabama (5th)	Rep. Robert E. (Bud) Cramer, Jr.	90%
Arkansas (1st)	Rep. Marion Berry	97%
California (22nd)	Rep. Lois Capps	123%
California (29nd)	Rep. Henry A. Waxman	120%
Connecticut (3rd)	Rep. Rosa L. DeLauro	93%
Connecticut (5th)	Rep. James H. Maloney	92%
Iowa (3rd)	Rep. Leonard L. Boswell	96%
Maine (1st)	Rep. Thomas H. Allen	96%
Massachusetts (6th)	Rep. John F. Tierney	102%
Michigan (1st)	Rep. Bart Stupak	90%
New York (26th)	Rep. Maurice Hinchey	95%
North Dakota (At Large)	Rep. Earl Pomeroy	99%
Ohio (13th)	Rep. Sherrod Brown	90%
Tennessee (9th)	Rep. Harold E. Ford, Jr.	109%
Texas (1st)	Rep. Max Sandlin	101%
Texas (24th)	Rep. Martin Frost	95%
Texas (2nd)	Rep. Jim Turner	95%
Vermont (At Large)	Rep. Bernard Sanders	109%
Wisconsin (5th)	Rep. Thomas M. Barrett	98%
Wisconsin (8th)	Rep. Jay W. Johnson	85%
Average Price Differential		99%

Appendix B

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

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

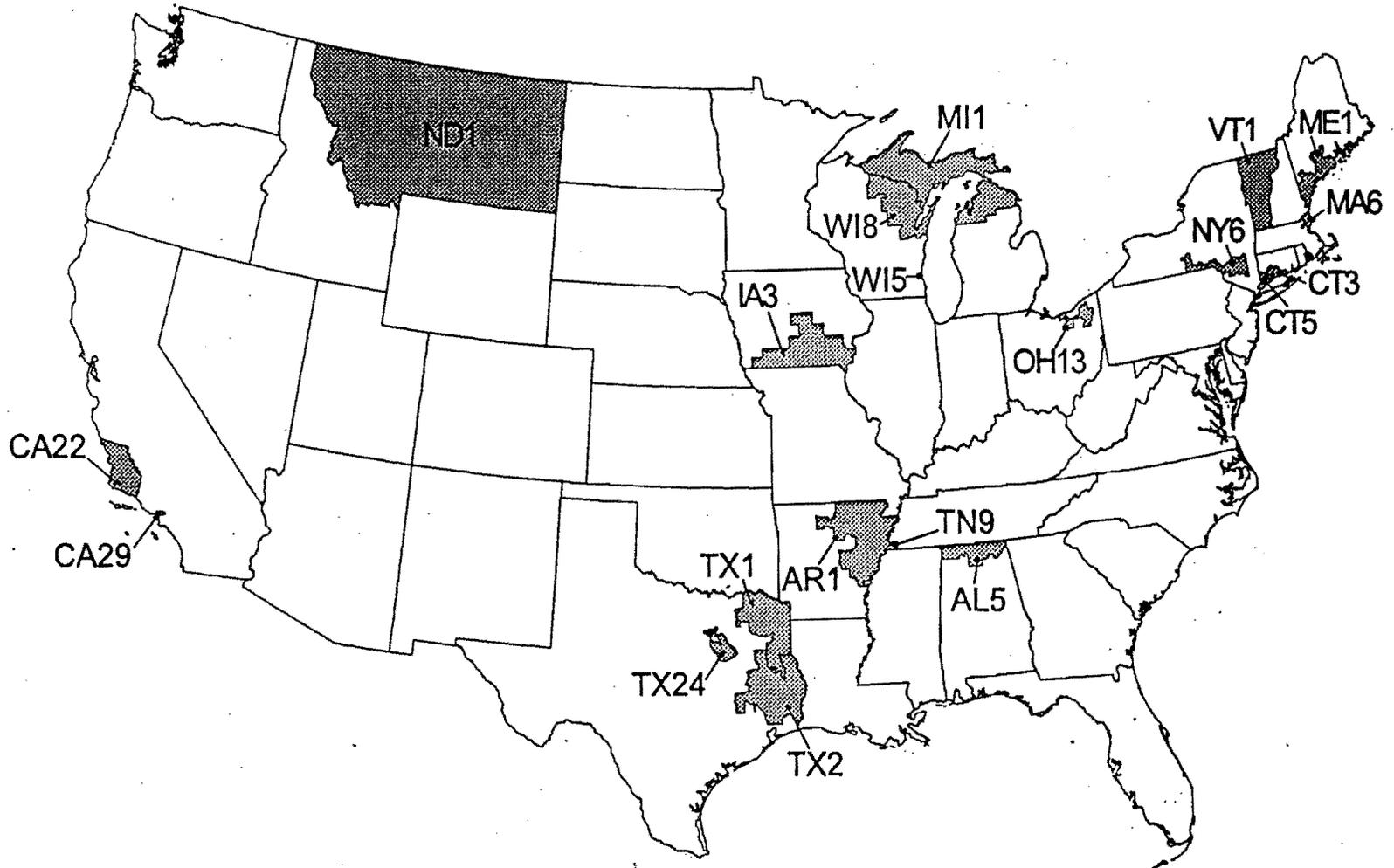
Source: Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly* (January 1 - December 31, 1997).

Appendix C

Price Comparisons for Non-Prescription Drug Items

Item	FSS Price	Retail Price	Differential
Binder Clip, small, 1 box	\$0.49	\$0.49	0%
Rubber Bands, 1 lb.	\$2.57	\$2.67	4%
Toilet Paper, 96 Rolls	\$44.74	\$47.98	7%
Rolodex, 500 cards	\$13.24	\$14.29	8%
Tape Dispenser	\$1.44	\$1.69	17%
Wastebasket, Plastic, 13 qt.	\$2.95	\$3.49	18%
Scissors	\$10.88	\$12.99	19%
Pencils, #2, 20-pack	\$1.03	\$1.26	22%
Paper Towels	\$22.94	\$29.98	31%
Post-It Notes	\$2.08	\$2.89	39%
Envelopes, 500, White, 20 lb. weight	\$6.45	\$9.49	47%
Correction Fluid, 18 ml., dozen.	\$6.66	\$9.99	50%
Average Price Differential			22%

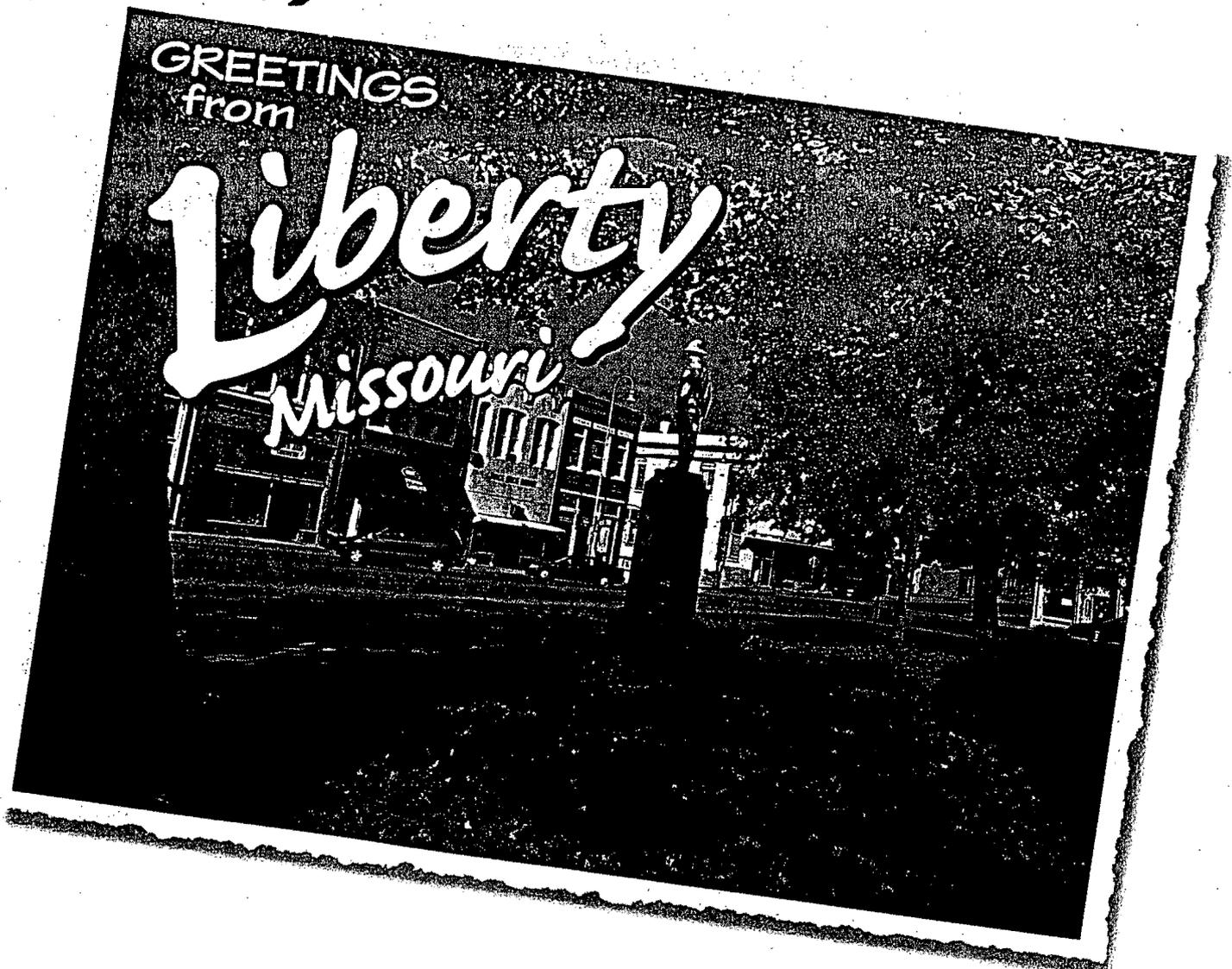
Appendix D
Congressional Districts Where Drug Pricing Survey Was Conducted



OCTOBER 31, 1998 NUMBER 44

National Journal

THE WEEKLY
ON POLITICS AND
GOVERNMENT



...where the weather is lovely, the economy is sound, the politics are local,
and almost nobody really gives a darn about Bill and Monica and Ken.

A Campaign Dispatch by Burt Solomon

Bitter Pills

HALF OF THE ELDERLY
PAY FAR MORE FOR
MEDICINES THAN
BULK BUYERS DO.
LOOK FOR THIS TO
BECOME A HOT—AND
HIGHLY PARTISAN—
ISSUE EARLY
NEXT YEAR.

BY MARILYN WERBER SERAFINI ■

If you have private health insurance, filling a prescription isn't generally a problem. You pop into the corner drugstore or supermarket, pull out a prescription card, pay a \$5 to \$15 co-payment and let the healing begin.

But for 81-year-old Dorothy Paddock of Columbia Heights, Minn., a trip to the pharmacy is a painful experience. Out of a monthly income of about \$1,000, Paddock sometimes pays as much as \$300 for medicine for

her heart and high blood pressure. The health maintenance organization that Paddock uses for Medicare covers 10 percent of the cost as an extra benefit, but this isn't much help. "There are different things I would like to have done [in my retirement], but I can't afford it because, to me, medication and food are number one," Paddock said. "I used to buy clothes, but I cut down completely now, practically."

To some, Paddock seems to be lucky. Only about half of all Medicare beneficiaries get some help with the cost of prescriptions, whether it's through their supplemental insurance (known as Medigap), Medicaid, retiree health plans or Medicare HMOs. Medicare itself doesn't offer a drug benefit.

To make matters worse, there's new evidence that seniors who buy their own medicine are paying higher prices—double, on



CHERYL A. MEYER

DOROTHY PADDOCK:

Living on a fixed retirement income, she can't afford to buy clothes because she sometimes pays \$300 a month for medicines.

average—than HMOs, insurance companies, Medicaid, federal health programs, and other bulk buyers pay.

A patient may obtain medicines directly from, say, a hospital or an HMO that buys its drugs directly from the manufacturer at a discounted rate. Or a patient who has insurance coverage for prescriptions can buy from the corner drugstore at a discounted rate (the co-payment plus whatever the health plan forks over) that the insurer has negotiated with the pharmacy; the pharmacy, in turn, may—or may not—get a discount from the manufacturer. But pity the poor consumer who has no coverage for prescriptions and who has no discounts available. The pharmaceutical company that must make up the revenues it has lost from buyers with greater leverage has nowhere else to turn.

Over the summer, the Democratic staff of the House Government Reform and Oversight Committee conducted 20 studies to monitor the prices of best-selling drugs for older Americans. For Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals Co., the monthly retail cost to seniors was \$27.05—an astonishing 1,446 percent more than the \$1.75 that favored-group purchasers paid.

Drug companies will sell at much lower prices “to the federal government or someone else like an HMO or large mail-order operation than they will to a retail pharmacy,” said Rep. Marion Berry, D-Ark., a registered pharmacist. “There’s abundant evidence that seniors are the ones who are getting really whacked.”

In the pharmaceutical companies’ defense, it must be acknowledged that the industry is feeling pressure from cost-conscious health care plans to sell them drugs at cheaper prices. Moreover, today’s higher drug prices reflect the growing cost of research and development. The cost of bringing a single new medicine to market is about \$500 million, compared with \$125 million (in today’s dollars) just 20 years ago. “Out of every 15,000 compounds synthesized, only three ever get to market,” said Alan F. Holmer, president of the Pharmaceutical Research and Manufacturers of America. “Only one is able to get sufficient return in sales to meet the R&D cost to get that product to patients in the first place.” Holmer declined to talk about Democratic allegations of discriminatory pricing, because of a court battle in progress over the issue.

In the meantime, drug company profits have increased dramatically, which Holmer says is justified. “The pharmaceutical industry is one of America’s most competitive industries,” he explained. “The industry needs to be profitable to attract investment and sustain innovation.” And there are plenty of new drugs on the horizon for dreaded afflictions such as osteoporosis, Parkinson’s disease and Alzheimer’s. Moreover, Holmer argues, the drug industry is sensitive to the needs of low-income seniors. Pharmaceutical companies, for instance, annually provide financial assistance—on a case-by-case basis—to 1 million Americans.

Rep. Henry A. Waxman of California, the Government Reform Committee’s ranking Democrat, is unimpressed. What’s going on, he says, is a blatant case of price discrimination in order to bolster manufacturers’ profits. “Their case is so much weakened when you look at the high prices the elderly pay to keep [companies’] profits high,” he said in an interview. “This will become a big issue when [members of Congress] wake up to the fact that this is a very difficult problem for many of their elderly constituents. When people realize the problem, they become outraged, but many people don’t realize they’re paying the highest possible price and that they’re cross-subsidizing the pharmaceutical industry for price breaks the industry is giving to others.”

The rising cost of medication is a growing problem for millions of the elderly, who make up only 14 percent of the country’s population but consume 30 percent of the prescription drugs. It’s especially tough for people like Paddock, who live on fixed incomes. Each year, the average senior pays \$350 out-of-pocket, compared with \$69 for the average person under 65.

Even seniors who get some help with these costs face significant limits. (Just ask Paddock.) The best Medigap policy that older Americans can buy pays for only half the cost of pre-

ACROSS THE BORDER:
Groups of elderly Minnesotans have traveled to Winnipeg, Canada, to buy medicines more cheaply than they could at home.



COURTESY OF THE SENIOR FEDERATION

scriptions and imposes a \$250 deductible. “Medigap provides awful coverage,” said Howard Bedlin, vice president for public policy for the National Council on the Aging. Of seniors who get a drug benefit, about 59 percent get relatively good coverage from an employer retirement program, 13 percent get some help from Medicaid, 14 percent from purchasing Medigap and 14 percent—including Paddock—from Medicare HMOs.

Indeed, the cost of drugs to the elderly may be a hot political issue in the making. Waxman and other Democrats believe it will burst into the political arena sometime next year, when they’ll aggressively promote the conclusions of their findings and the National Bipartisan Commission on

the future of Medicare makes its recommendations about how to restructure the health care program for the elderly.

PRICES AND PROFITS

Discriminatory pricing has evolved, critics say, as a way for pharmaceutical companies to respond to changes in the health care marketplace. With the sharp growth of cost-conscious managed care, large insurance companies and health plans have the leverage—and the incentive—to negotiate discounted prices with everyone from doctors and hospitals to pharmaceutical manufacturers and pharmacies. The federal government also receives preferred prices for veterans' programs and other federal health ventures because its price schedule is fixed by government edict. Drug-makers even sell pharmaceuticals to Canada and Mexico at discount prices, a study by the committee's Democratic staff found on Oct. 27. In the congressional district of Rep. Tom Allen, D-Maine, for instance, the elderly paid 72 percent more than Canadians did and 102 percent more than Mexicans.

To recoup what's lost by these discounts, drug companies sell their wares to pharmacies at higher prices for retail customers. "This illustrates pretty drastic cost-shifting in the marketplace, and the ones hit the hardest are the ones least able to pay," said John C. Rother, director of legislation at the American Association of Retired Persons. "Low-income seniors are subsidizing others," Rother lamented.

The situation has become so dire that "a substantial number" of seniors can't afford to take the drugs their doctors prescribe, Allen said. "The market has changed over time, and with some consequences that are severe for the elderly."

Jeffrey Hausfeld, an ear, nose and throat specialist in Washington, estimates that about 15 percent of his Medicare patients just don't take the medications he prescribes—or don't take them correctly—for financial reasons. "They do something to stretch it out," he said. "Some skip days or break pills in half, and some just don't fill the

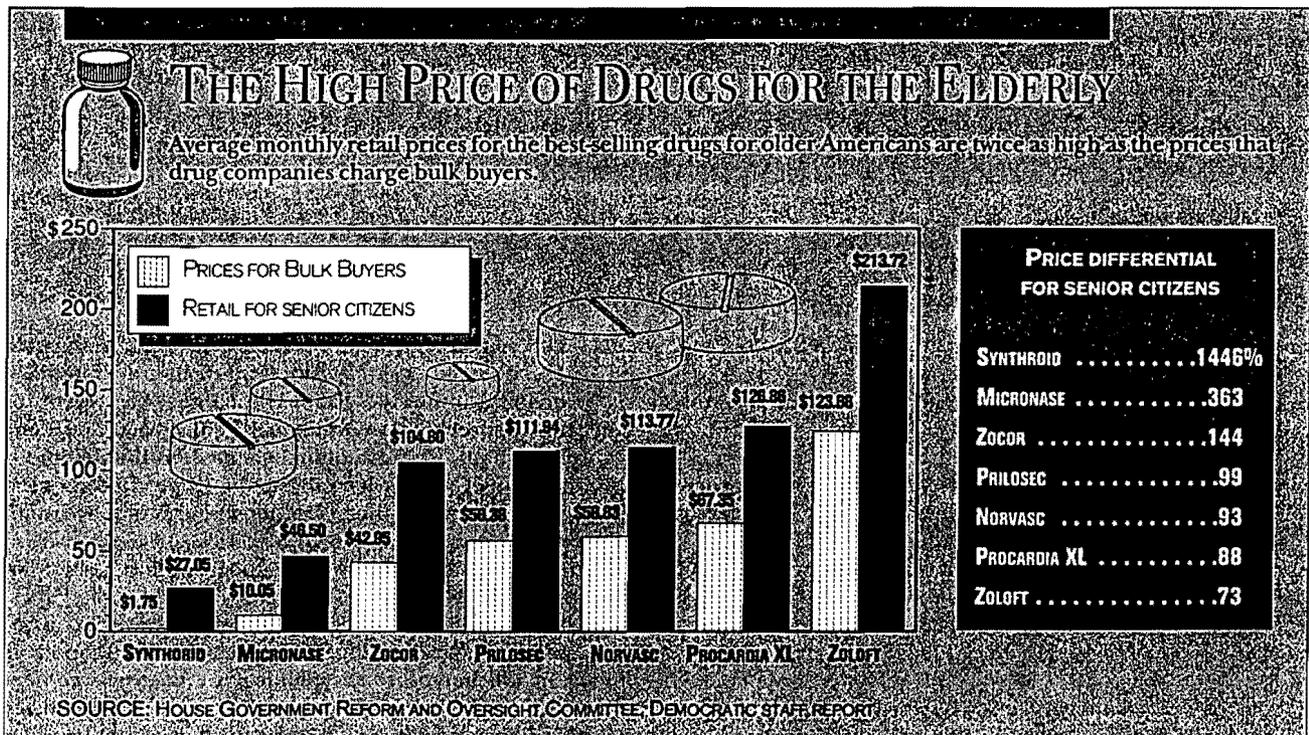
prescriptions." Hausfeld says he welcomes drug company representatives in his office so he can get samples to save for elderly patients in rough financial shape.

Pharmaceutical companies must also offset higher R&D costs and greater competition, as more and more drugs flood the market. While drug companies once directed their marketing to doctors and other health care providers, their new strategy is to advertise directly to the public. Once or twice a day, Hausfeld says, a patient asks for a specific drug because he's seen an ad on television. This advertising costs money, of course, and critics complain that it's putting even greater financial pressure on drug-makers to jack up prices when it comes to retail customers.

A stirring battle between brand-name and generic drug manufacturers is making matters worse. The generic drug companies complain that their brand-name rivals are making it hard for them to keep prices down, by filing frivolous lawsuits for the sole purpose of delaying the expiration of patents. The generic companies, slowed in bringing their cheaper alternatives to market, claim they've been forced to decide between raising prices or ceasing production altogether.

While brand-name manufacturers have been profitable in recent years, half of the 24 companies that make generic drugs are losing money. As of December 1997, Mylan Laboratories Inc. was losing money on 41 of its 97 generic products, according to the Pittsburgh company. Mylan decided to raise prices on seven drugs instead of stopping their production. The company, though, says the prices are still 45 percent to 55 percent lower than the prices of the brand-name versions.

Brand-name drugs generally receive 20-year patents to help manufacturers recoup the costs of research and development. But it often takes five to six years of the patent period before the drug receives approval from the Food and Drug Administration and arrives on the market. That, plus the growing expense of R&D, Holmer said, makes it



tricky for a company to make money.

Berry, for one, blames both sides. Mylan, he says, increased prices by at least 230 percent on one drug—"and the highest one was 4,000 per cent." But, he added, "the brand-name folks are even worse. The only people that make more money than this are the people who sell illegal drugs."

A NATIONAL PROBLEM

Discriminatory pricing, the new congressional studies conclude, is a problem coast to coast. Indeed, the findings were relatively consistent in 20 congressional districts around the country. The elderly faced the highest price disparity in California, where they paid an average of 123 percent more than group purchasers. The lowest price differential—85 percent—was in Wisconsin. Price differentials exceeded 100 percent in six districts, and at least 90 percent in 19 of them. At the behest of other members of Congress, a half-dozen additional studies are now under way in their districts.

Allen, a House freshman, asked for the first study in June, after he got desperate letters from constituents. He'd also found high drug prices to be a particularly sensitive subject at meetings with elderly constituents in his district. "If you go to a meeting of seniors and the issue comes up," he recounted, "people stand up and tell stories, and you can hear the frustration and anxieties about their financial situations."

Although big buyers of anything might expect to exert the leverage for volume discounts, the price differentials for drugs commonly used by older Americans, the report found, are far higher than for other consumer goods. For the latter, the disparity between what retail customers and bulk buyers pay is only 22 percent.

Moreover, the studies found that pharmacies were marking up the prices very little. On average, the retail price for the 10 most common drugs was only 4 percent higher than the published national wholesale price.

Drug company profits, meanwhile, are enormous. The annual profits of the 10 leading drug companies were nearly \$20 billion last year, according to *Fortune* magazine. Drug manufacturers showed an operating profit margin of 28.7 percent, nearly three times greater than the average at brand-name consumer companies such as Procter & Gamble Co. or Colgate-Palmolive Co., which boast profit margins of 10.5 percent.

The congressional studies link these large profits directly to the pricing strategies for drugs widely used by the elderly. For example, Merck & Co. Inc., the country's largest drug manufacturer, showed increases of 15 percent in both the second and third quarters of 1998. Industry analysts attribute the increased profits in large part to sales of Zocor, a cholesterol medicine, which sells for 144 percent more to retail customers than to bulk buyers. Zocor accounts for 6 percent of Merck's revenues.

Overall, profits for the major drug companies are expect-



HENRY WAXMAN:
The elderly are "cross-subsidizing the pharmaceutical industry for price breaks the industry is giving to others."

ed to grow by 20 percent this year, compared with 5 percent to 10 percent for other companies on the Standard & Poor's index.

THE SHREWD ELDERLY

Frustrated seniors have been resourceful when it comes to finding medicine they can afford. Still, they've had only limited success.

Paddock was one of hundreds of Minnesotans who took bus trips to Winnipeg, Canada, in 1995 and 1996 to buy prescription drugs. The trips were sponsored by the Senior Federation, a St. Paul-based advocacy group affiliated with the National Council of Senior Citizens in Washington, to arrange for regular mail orders of medication for elderly Americans. Paddock says she and her husband, who has since died, took prescriptions with them, set up credit card accounts with a Winnipeg pharmacy and called in prescription numbers when they needed refills. "It worked fine for close to a year," said Paddock, who estimates that she and her husband saved \$800 as a result.

Then, a large order just didn't come. After several weeks, it was delivered along with a letter from the U.S. Food and Drug Administration telling the Paddocks that importing prescription drugs was illegal and that—next time—their package would be confiscated. Others got the same letter, which scared seniors into severing their relationships with pharmacies in Canada.

Advocacy groups for seniors report that many older Americans who live near the Canadian or Mexican border cross it frequently to buy their medicines more cheaply. But it may not be safe to carry drugs back, FDA spokeswoman Ivy Kupec explained. "We approve drugs in the United States for safety and effectiveness, and to assure that the manufacturing process is good," she said. "We can't always be guaranteed [good quality] when they get products from other places. It may have the same name on the label. You may think you're getting [the antacid] Zantac, but that might or might not be Zantac, or it may be super-potent Zantac."

Nonetheless, U.S. customs officials still exercise a certain amount of discretion, said Kupec, acknowledging some confusion about what the rules are. "We tend not to be too heavy-handed on this issue."

Buddy Robinson, staff director of the Minnesota Senior Federation in Duluth, said that the elderly haven't had much trouble personally carrying drugs back over the border. The problem came when they tried to establish the longer-term direct-mail arrangements. "The FDA actions are protecting prices for the companies," he said. "They don't seem to have any big problem with people who can physically cross the border, but it's a problem for people to do it through the mail, because it has the potential to become widespread and erode high prices and profits of the drug companies."

Joan Winn, a 65-year-old retired nurse-anesthetist, also went on the trips. Winn, who has arthritis, high blood pressure, asthma and a deformed spine, said she saved plenty of money by buying Canadian drugs. She called the FDA and asked why the agency was stopping shipments of medicine

that saved the elderly money. "I was told that the cost is not a factor as far as the FDA was concerned. I said, 'You made Dr. Kevorkian look like a piker, because you cause people to die a slow death because they can't afford the medications.'

"We have selective free trade," she charged. "It depends on whose pocket is going to get full."

At the request of Sen. Paul Wellstone, D-Minn., and Rep. Gil Gutknecht, R-Minn., FDA officials came to a Minneapolis suburb on Oct. 27 to hear suggestions from nearly 250 seniors. The officials seemed resistant to allowing the elderly to import drugs, but they promised to work on reaching an accord with Canada so that each country accepts the other's drug approvals and lets its businesses import drugs. But both steps may take legislation.

POLITICIANS TO THE RESCUE

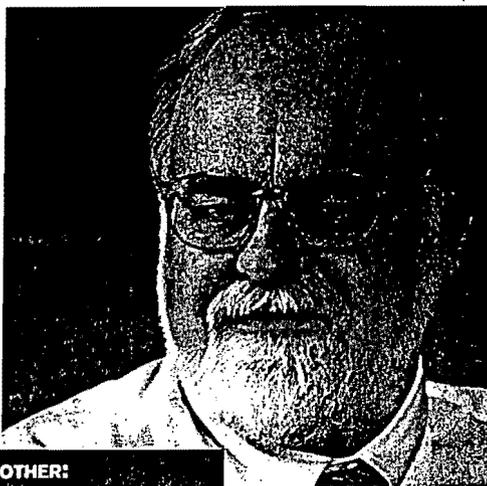
But congressional Democrats say it will take much more than changing FDA rules to fix this mess. Since June, the issue has become a popular one for Democratic politicians, who have introduced two bills to allow the elderly who buy their own medicine to get the same prices at retail pharmacies that bulk buyers pay. In response, the politicians figure, drug manufacturers would either raise prices a little for everyone else—or cut profits.

In addition, Reps. Allen and Berry created the Prescription Drug Task Force, which held its first meeting in September, to start looking at the problem. Next year, the bills' sponsors and task force members intend to seek support from Republicans and to secure the attention of the Medicare commission. But it may be an uphill battle on both fronts. The commission is expected to recommend changes to Medicare that would restructure the huge program as well as save money. While some people say the best solution is to simply add prescription drugs to the list of core Medicare benefits, it would clearly cost the government a lot of money—by some estimates, \$40 billion a year. What's more, convincing Republicans to support legislation that could clearly be viewed as government regulation of a successful, competitive industry might prove ideologically daunting.

Holmer of the pharmaceutical trade group argues that the legislation could potentially harm all patients, including the elderly. "All it does is promise lower prices to pharmacies, and not lower prices to seniors," he said. "It's the pharmacy owners who will be able to buy at the federal supply schedule prices. There's no requirement that they'll have to pass the savings along to seniors."

The bill, he added, is bad policy based on unsound economics. "It would result in price controls in more than 40 percent of the market. Price controls don't work, and they would undermine research on cures."

Holmer said that the issue would be best addressed by the Medicare commission so that it might be studied in the context of the entire program. "It's enormously important,"



JOHN ROTHER:

For seniors who buy their own medications, "the ones hit the hardest are the ones least able to pay."

he said, "that we don't attempt to solve one problem by creating an even greater one."

The political dangers of this issue, though, are already becoming evident in a congressional campaign in east Texas. Brian Babin, a Republican challenging Rep. Jim Turner, D-Texas, a leading supporter of the Democratic bill, recently released a statement lambasting the legislation. "This plan by my opponent is simply another attempt by Mr. Turner and Bill and Hillary Clinton to socialize our health care industry," Babin said.

Still, there's general agreement between both parties, that the problem of drug coverage for

seniors must be dealt with soon. President Clinton raised the issue in the 1992 presidential campaign, and he proposed a Medicare drug coverage benefit in 1993. "It's been a great frustration to the president that we haven't been able to adequately address the problem," said Christopher C. Jennings, special assistant to Clinton for health care policy. "It is a major shortcoming of Medicare, and any serious restructuring of the program needs to at least take steps to address it. The great challenge, of course, has been—and will continue to be—how to do it affordably. There are no easy answers."

The issue of how to make drugs cheaper for seniors has arisen repeatedly at Medicare commission meetings, and Deborah Steelman, a Washington attorney and Republican-appointed commissioner, said it will be a "huge part of the conversation" as the commission gears up again after the election.

Rep. William M. Thomas, R-Calif., administrative chairman of the commission, agreed. The problem is broad, he said in an interview, and must be addressed in the larger context of Medicare reform. "The reason you've got a problem with seniors is that the Medicare system is basically a fee-for-service system," he said. "Those in fee-for-service get a prescription from a doctor and they become retail purchasers." Thomas said that Medicare needs to be adjusted so it reflects how people younger than 65 get their health care, which is mainly through managed care.

One way would be to reform the Medigap system so that seniors would pay more of their out-of-pocket costs up front in deductibles and co-payments. That might make it easier, Thomas said, for Medigap plans to offer needed benefits such as prescription drugs without charging much more.

Steelman and Thomas asserted, however, that Republicans will indeed have trouble embracing the Democratic approach. "The idea that seniors are discriminated against because they're retail customers is ludicrous," Thomas said. Steelman added, "I'm a free-market Republican, and I can't see that as the answer to anything." She said she isn't convinced that there's discrimination involved. "Any [individual] who pays out-of-pocket has volume and scale working against them," she said.

Democrats, though, claim that their legislation is the best kind of solution. It wouldn't cost the government a dime, and it would help ordinary people—such as Paddock—who are having the hardest time affording the prescription drugs they so badly need. ■



HEALTH CARE FINANCING ADMINISTRATION



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*Devorah Adler
Bob Donnelly*

PHONE: _____

FROM:

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395-7848*

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11/10/98

REMARKS:

Massachusetts Issue



DEPARTMENT OF HEALTH & HUMAN SERVICES

HEALTH CARE FINANCING
ADMINISTRATION

November 10, 1998

Office of the
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Government Center
Boston, MA 02203

Ms. Margaret McKenna and Mr. Jay Egan
Acting Interim Co-Executive Directors
Fallon Community Health Plan, Inc.
Senior Plan
10 Chestnut Street
Worcester, Massachusetts 01608

Dear Ms. McKenna and Mr. Egan:

Many managed care companies offer Medicare beneficiaries a number of supplemental benefits -- such as prescription drug coverage -- in addition to those normally provided under fee-for-service Medicare. Like you, I think that these additional benefits are valuable to the many beneficiaries who choose managed care plans, and on behalf of the Health Care Financing Administration (HCFA), I encourage plans to offer them. Several issues have caused uncertainty this year in Massachusetts regarding the prescription benefits that would be available to beneficiaries.

On October 30th, a federal judge ruled that federal law prevents Massachusetts, or any other state, from requiring Medicare plans to provide unlimited drug coverage. Senator Edward Kennedy proposed that this year's federal budget bill grandfather in the Massachusetts requirement. The Clinton Administration, several members of the House and Senate, and Governor Paul Cellucci supported the bipartisan effort, but the proposal was not enacted.

HCFA will allow health maintenance organizations (HMOs) in Massachusetts that have currently approved Adjusted Community Rates (ACRs) for 1999 a brief, time-limited opportunity to resubmit the prescription drug portion of the previously approved 1999 ACR. This proposal applies to coverage and premiums related to prescription drugs only. Plans will not be allowed to change their service areas or any of the other benefits for enrollees. The attachment to this letter provides specific details as to what is allowed under this proposal. As always, plans have the option to improve the benefits in their packages, including the submission of an unlimited prescription drug benefit.

Page 2 - Ms. Margaret McKenna/Mr. Jay Egan

Massachusetts health plans participating in Medicare will have until November 17, 1998 to submit new prescription benefit packages, if they so choose.

This decision reflects factors that created a unique situation in Massachusetts:

- A conflict between federal and state laws created confusion over the drug-coverage requirements. As a result, when plans prepared their Medicare benefit packages this spring, Massachusetts officials warned that the state's requirement for unlimited drug coverage would be enforced.
- Before the Medicare+Choice regulation was published, HCFA let one plan submit a contingent benefit package that otherwise would not have been allowed. While this should not have happened, the intent was to protect the choices available to beneficiaries.

HCFA wants to do everything possible to work with your plan to minimize any confusion that may result from even this limited benefit change. Therefore, we will act quickly on these submissions so that beneficiaries will have enough time to consider their Medicare options before the new packages take effect on January 1. HCFA will contact beneficiary groups to help them better understand our policy. As I am sure you are aware, under law, HMOs will need to notify their beneficiaries of any changes in the benefit package 30 days prior to when those changes take effect. Also, as required by law, HCFA must review all marketing material that will be used with beneficiaries.

Beneficiaries also will be able to obtain assistance in understanding their options through the Massachusetts State Health Insurance Assistance Program at 1-800-882-2003, or their local area agency on aging. They can call the U.S. Administration on Aging at 1-800-677-1116 for a referral to their local agency.

Medicare+Choice is a new program, created last year and implemented this year. In the wake of this situation, we intend to issue new guidelines to clarify our policies in order to avoid similar situations in the future and prevent late changes in the coverage available to beneficiaries.

Page 3 - Ms. Margaret McKenna/Mr. Jay Egan

Thank you for your time and attention to this matter. I look forward to continuing to work with you and organizations in the future. If you have any further questions, please contact Phil Doerr in the Central Office at (410) 786-1059.

Sincerely,

Robert A. Berenson M.D.

Robert A. Berenson, M.D.

Director

Center for Health Plans and Providers

Attachments

Attachment 1

Adjusted Community Rating Proposal

The Health Care Financing Administration (HCFA) will allow health maintenance organizations (HMOs) in Massachusetts that have currently approved Adjusted Community Rates (ACRs) for 1999 a brief, time-limited opportunity to resubmit the prescription drug portion of the previously approved 1999 ACR. This applies to coverage and costs related to prescription drugs. For example, changes may include increases or decreases in the prescription drug benefits that are included as additional benefits, mandatory supplemental benefits, or optional supplemental benefits. We will also accept changes in beneficiary cost-sharing related to prescription drugs (premiums, deductibles, coinsurance or copayments), consistent with the actuarial analysis assumptions contained in your previous filing. As HCFA has previously stated, nothing in the federal law prohibits a plan from voluntarily complying with state law by offering unlimited prescription drugs to all Medicare beneficiaries.

On the other hand, HCFA will not accept changes in the ACR that are unrelated to the prescription drug benefit (unless the prescription drug change affects the calculation of "additional benefits.") We will also not accept proposals to change the service area for the plan. Please note that premiums for previously approved prescription drug benefit packages can only be increased if the prescription drug benefit package will be improved. To the extent that a plan changes the prescription drug benefit, the premium for that revised benefit must use the actuarial assumptions in your existing filing.

All changes must be submitted in the form of a revised 1999 ACR proposal that is received by HCFA no later than 5:00 p.m. on Tuesday, November 17, 1998.

If you intend to make any changes in your ACR, please forward the appropriate material to:

Center for Health Plans and Providers
Health Plan Purchasing Administration
ATTN: Phil Doerr, Room C-4-18-27
Health Care Financing Administration
7500 Security Boulevard
Baltimore MD 21244-1850
FAX: (410) 786-8933

Possible impact on the ACR that may result from a re-filing:

The objective of the Adjusted Community Rate Proposal (ACRP) is to:

- Determine if the ACR is reasonable,
- Compare the rate to the payment and determine savings,
- Distribute any savings, in the form of benefits, to the beneficiary, and
- Ensure the beneficiary is not overcharged.

HCFA uses an automated ACRP to expedite the preparation and review of the ACRP. The primary parts of the ACRP as follows:

- Exhibit 1: States the contract period and gives the geographic area covered by the contract.
- Exhibit 11: Outlines the basic benefits and copayments provided to enrollees.
- Exhibit 111: Lists the optional supplemental benefits and copayments.
- The ACRP spreadsheet (outlined below).

In addition to the ACRP, the organization must submit a Beneficiary Information Form (BIF) that sets forth the covered benefits as well as the additional benefits.

Primary line items in the ACRP are as follows:

Lines 1-25 is a calculation to compare the average payment rate (APR) to the adjusted community rate (ACR) to determine savings. This comparison requires the pricing of all Medicare required benefits and the anticipated payment rate the HMO expects to receive. Line 25 displays the amount by which the APR exceeds the ACR. Any savings shown on line 25 must be returned to the beneficiary in the form of additional benefits or contributed to a rate stabilization fund. In nearly all cases the savings are eliminated through the offering of additional benefits. *These lines should not change from the HMO's original ACR submission.*

Lines 26-36 prices these additional benefits, adds the annual Medicare deductibles and coinsurance, deducts the savings from line 25 and arrives at the maximum amount that can be charged to the beneficiary prior to the subtraction of any copayments. *These lines could change, but plans may not change their actuarial assumptions from their previous filing.*

Lines 37-38 computes the value of any copayments charged by the HMO. This amount reduces the maximum premium to be charged, and shown on line 36. Line 39 then illustrates the final maximum premium that can be charged following the copayment calculation. *These lines could change.*

Line 40 indicates the amount of premium waiver that the HMO will offer. *This line could change.*

Lines 45-46 calculates any optional supplemental benefits, including copayments, that the HMO is offering. *These lines could change.*

Internal Questions and Answers for Massachusetts health plan situation
November 9, 8:00 p.m.

Q: Why are you forcing beneficiaries to pay higher drug prices by letting plans drop their unlimited prescription drug coverage now?

A: Obviously, we want beneficiaries to get the broadest range of extra benefits at an affordable cost from their Medicare+Choice plan. But under federal law, the state can't force plans to offer unlimited prescription coverage.

Most plans decided to drop the unlimited drug benefit in May when they submitted their benefit package for the 1999 year. At the time, some plans maintained the unlimited benefit in a good faith belief that state law required it.

The Clinton Administration also supported Senator Ted Kennedy's legislation, which would have allowed the Massachusetts' requirement to prevail. Despite the support of several senators and Gov. Paul Cellucci, it was not enacted.

We don't expect every plan to make changes now. It's also possible that some plans, which had a no-drug option, now will offer some drug coverage. And any plan is free to offer unlimited drug benefits as part of this revision process. In fact, they can use the opportunity to adjust the premiums so they can offer that coverage to beneficiaries.

Q: How will beneficiaries know what their drug coverage is, or will be?

A: Health plans will have until November 16 to submit any changes in their prescription benefit packages, if they so choose. We will finalize the benefits quickly so that beneficiaries will have enough time to consider their Medicare options before the new packages take effect on January 1.

The health plans must notify beneficiaries at least 30 days in advance of any changes to their benefits package, so all current managed-care enrollees will be told about any changes in time to consider all their available Medicare options. **In addition, we are asking the plans to tell beneficiaries about their other options in those notices.**

Beneficiaries also will be able to obtain assistance through the Massachusetts State Health Insurance Assistance Program at 1-800-882-2003, or their local area agency on aging. They can call the U.S. Administration on Aging at 1-800-677-1116 for a referral.

In addition, updated comparative information about the options available in each Massachusetts county will be posted at WWW.MEDICARE.GOV -- our consumer site on

the World Wide Web. Many libraries and senior centers can help beneficiaries obtain information from this site.

Q: How will beneficiaries pay for their drugs now?

A: Beneficiaries will still have all the benefits covered by Medicare, and those in managed-care plans will have many additional benefits, including some drug coverage in most cases. And Massachusetts health plans could use this opportunity to provide beneficiaries with an unlimited drug benefit through narrow changes to their prescription coverage plans.

Also, beneficiaries who choose to switch out of their managed-care plan and return to original Medicare can get unlimited drug coverage through Medigap supplemental insurance. Two companies offer the unlimited drug benefit in Massachusetts.

Under current state policy, beneficiaries can sign up in February and March next year with coverage effective June 1, 1999. The premiums for unlimited drug benefits under these Medigap plans are more expensive than the premiums charged by the HMOs. For more details, beneficiaries should contact the Massachusetts Division of Insurance at 617-521-7777 or the Massachusetts State Health Insurance Assistance Program at 1-800-882-2003.

In addition, Massachusetts has a state program that covers the costs of some prescription drug coverage that could help some beneficiaries. The Senior Pharmacy Program will cover up to \$750 of therapeutic classes of prescription drugs for seniors who have annual incomes under \$12,084. Beneficiaries should call 1-800-953-3305 for more details.

We obviously want our beneficiaries to get as many extra benefits as possible, including drug coverage. However, federal law is clear on this point: Neither Medicare nor the states can force plans to offer unlimited drug coverage.

Q: Why did HCFA allow Tufts to drop the unlimited prescription drug benefit?

A: Uncertain about the state requirement for unlimited drug benefits, Tufts asked for permission earlier this year to submit more than one proposal and then withdraw options later. At the time, HCFA approved the request, although in retrospect we probably shouldn't have.

The decision was made in an attempt to preserve as many options as possible for beneficiaries. However, the result is that Tufts received an unfair advantage vis-a-vis its competitors.

beneficiaries. In fact, HCFA would encourage all the HMO's to voluntarily offer the unlimited drug benefit. This would clearly be the best solution for beneficiaries. However, under the law, we cannot require plans to do that.

Q: Aetna/U.S. Healthcare this fall decided to pull out of Massachusetts altogether. Now, will you allow them to revise their prescription benefits package and return?

A: No. This opportunity is limited to those plans which already made the commitment to continue to serve Medicare beneficiaries in Massachusetts. We are not allowing any of the plans to expand or shrink their service area as part of this narrow, restricted opportunity.

Q: Why won't you let plans in other states change their benefits packages so they won't have to abandon beneficiaries in those markets?

A: First of all, the Massachusetts situation is unlike any other in the country: A conflict between federal and state laws created confusion over the drug-coverage requirements, and state officials warned plans in the spring that they would enforce the state law.

In addition, HCFA provided one plan with an unusual opportunity to submit contingent benefit packages that otherwise would not be allowed. While this probably should not have happened, the intent was to protect the choices available to beneficiaries.

As a result of this, we are allowing plans a brief-and-limited opportunity to revise their drug benefits. Plans will not be allowed to change their service areas or any of the other additional benefits for enrollees.

This fall, the American Association of Health Plans had asked us to allow all plans around the country to change all their benefits and premium packages. We rejected that proposal, which could result in higher premiums and fewer benefits for virtually all of the more than 6 million Medicare beneficiaries now enrolled in managed care plans.

Of those more than 6 million Medicare beneficiaries, about 50,000 are losing their only managed-care option. We have put new applications from managed-care plans to serve their communities on a fast track, as President Clinton ordered. But we don't think it would be in the best interest of beneficiaries to allow all plans to raise rates and cut benefits now.

Q: In Florida, Humana recently said that it would re-enter certain markets, if they could change their ACR, but you won't let them. Now, beneficiaries in at least one

county will remain without a HMO. Why are you letting plans change their ACRs to cut benefits in Massachusetts but you aren't letting Humana do it to preserve access in Florida?

A: The circumstances are completely different. In Massachusetts, we have a unique situation, where a conflict between state and federal law created broad confusion about what drug benefits HMOs had to provide. In addition, one plan was given a special opportunity to submit contingent benefit packages that otherwise would not be allowed. While this probably should not have happened, the intent was to protect the choices available to beneficiaries.

In Florida, you didn't have any of the circumstances, which taken together, created a unique situation in Massachusetts. In addition, Humana already decided to abandon the beneficiaries that it had served in that area. Nearly all those beneficiaries have access to other Medicare health plans, which chose to stay there.

Now, Humana promises to return if it can drastically cut benefits and raise premiums for Medicare beneficiaries. That just doesn't make sense, and we won't allow that to happen there or anywhere else.

However, we would move quickly to approve Humana's application if it chose to honor its commitments in the benefits package that it previously submitted.

In addition, as President Clinton ordered, we will move quickly to expedite approval of any new health plans applying to enter counties like the one in Florida, in which Medicare beneficiaries lost their only Medicare+Choice option. That situation affects about 50,000 Medicare beneficiaries out of the more than 6 million in managed-care plans nationwide.

Q: HCFA Administrator Nancy-Ann DeParle recently said that she couldn't reopen the ACR process because "The law is the law." But now, HCFA is allowing Massachusetts plans to reopen their ACRs. Does the law not apply there?

A: In Massachusetts, we're dealing with a unique set of circumstances created by a conflict between federal and state laws created confusion over the drug-coverage requirements. As a result, when plans prepared their Medicare benefit packages this spring, Massachusetts officials warned that the state's requirement for unlimited drug coverage would be enforced. The quote in question dealt with a request to enable Medicare plans around the country to drastically raise their premiums and cut benefits on virtually all of the 6 million beneficiaries in managed-care plans. We rejected that proposal, which would have involved much broader and more ominous changes than the limited, narrow ones we are now allowing in Massachusetts.

Moreover, it is clear from other answers in the same interview that the Administrator

did not intend to suggest that HCFA was legally precluded from allowing an HMO to revise its ACR proposal. For example, in a later statement, the Administrator defended HCFA's decision on the grounds that it is not "in our beneficiaries' best interests or the Medicare program's best interests to allow them to come in at this late date and increase premiums and lower the benefits, and change this program around for beneficiaries who have relied on it." The reporter noted that the Administrator made the point that "[a]llowing some HMOs to revise their rates...would have opened the door to identical requests from all the health plans covering six and a half million Medicare beneficiaries in managed care."

The complete reference to the law was that "the law is the law, and there's only so much that I can do to be flexible around that." This was a reference to the fact that the law limited HCFA's flexibility in permitting ACRs to be reopened in that the statute requires that information on benefits be provided to beneficiaries in time for an open enrollment period in November. It would not have been possible to permit every HMO to make changes to ACRs and still comply with the law's deadlines. This does not mean that it is not legally permissible for HCFA to permit targeted revisions under the exceptional circumstances presented in Massachusetts, for the reasons set forth above.

Internal Talking Points for Massachusetts health plan situation
November 9, 3:00 p.m.

- The Health Care Financing Administration (HCFA) encourages health plans that serve Medicare beneficiaries to offer additional benefits, including prescription drug coverage.
- Several issues have caused uncertainty this year in Massachusetts regarding the prescription benefits that would be available to beneficiaries.
- On October 30th, a federal judge ruled that Federal law prevents Massachusetts or any other state from requiring Medicare plans to provide unlimited drug coverage.
- Senator Ted Kennedy tried to insert language into this year's federal budget act that would have grandfathered in the Massachusetts requirement. The Clinton Administration, several senators, and Governor Paul Cellucci supported the bipartisan effort, but the proposal was not enacted.
- Because of the confusion that has existed and because HCFA did not respond clearly to the situation, we are now giving health maintenance organizations (HMOs) in Massachusetts that have currently approved Adjusted Community Rates (ACRs) for 1999 a brief, time-limited opportunity to resubmit the prescription drug portion of the previously approved 1999 ACR.
- This change applies to coverage and premiums related to prescription drugs only. Plans will not be allowed to change their service areas or any of the other benefits for enrollees.
- Massachusetts health plans participating in Medicare will have until November 17, 1998 to submit new prescription benefit packages, if they so choose.
- This decision reflects factors that created a unique situation in Massachusetts:
 - A conflict between federal and state laws created confusion over the drug-coverage requirements. As a result, when plans prepared their Medicare benefit packages this spring, Massachusetts officials warned that the state's requirement for unlimited drug coverage would be enforced.
 - Before the Medicare+Choice regulation was published, HCFA let one plan submit a contingent benefit package that otherwise would not have been allowed. While this should not have happened, the intent was to protect the choices available to beneficiaries.
- HCFA wants to do everything possible to work with your plans to minimize any confusion that may result from even this limited benefit change. Therefore, we will act quickly on these submissions so that beneficiaries will have enough time to consider their Medicare options before the new packages take effect on January 1. Beneficiary groups will be contacted by

HCFA to help them better understand our policy.

- Under law, HMOs will need to notify their beneficiaries of any changes in the benefit package 30 days prior to when those changes take effect. As also required by law, HCFA must review all marketing material that will be used with beneficiaries.
- Medicare+Choice is a new program, created last year and implemented this year. In the wake of this situation, we intend to issue new guidelines to clarify our policies in order to avoid similar situations in the future and prevent late changes in the coverage available to beneficiaries.
- Beneficiaries who need assistance in understanding any changes can contact their State Health Insurance Assistance Program at **1-800-882-2003**, or their local area agency on aging. They can call the U.S. Administration on Aging at 1-800-677-1116 for a referral to a local agency.