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THE NATION'S ELDERLY

Some prescriptions are entirely too expensive

● Rep. Tom Allen is taking on the pharmaceutical industry to help the uninsured elderly.

Back when he was Maine's senior senator, Secretary of Defense William Cohen was noted for his efforts to ensure that older Americans had access to the prescription drugs many of them vitally need. His departure left the nation's elderly without an able, knowledgeable champion in Congress.

The void, however, has been filled by another Mainer. U.S. Rep. Tom Allen, a Democrat, has taken up the cause that the Republican senator defended so well.

This month, Allen released a report showing that older Americans and others with no insurance pay significantly more for prescription drugs as do the government, insurance companies and other preferred buyers.

According to the report, prepared by the House Committee on Government Reform and Oversight at Allen's direct-

ion, drug companies are engaged in a form of "discriminatory pricing that victimizes those who are least able to afford it." It explained that "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 to compensate for these discounts to their favored customers."

The numbers are important because 37 percent of the elderly do not have insurance to cover prescription drugs.

The report — the first of its kind — showed that Maine senior citizens pay \$117.96 for Ticlid, a stroke medicine made by Hoffman-LaRoche. Favored customers like insurance companies pay \$33.75 for the same drug — a 251 percent difference.

Allen plans to introduce legislation to address the situation. He wants to provide seniors with the same sort of buying power that preferred customers get. Seniors, after all, are a large share of the market and deserve a group rate.

With Allen's help, they'll get it.

Study: Uninsured elderly pay double for medicines

● Rep. Tom Allen wants to stop drug makers from earning huge profits on people without insurance.

By DIETER BRADBURY
Staff Writer

Elderly people with no insurance are paying twice as much for prescription drugs as the government, insurance companies and other preferred buyers, according to a report released Wednesday by U.S. Rep. Tom Allen.

The Portland Democrat accused drug manufacturers of building huge profit margins on the backs of the uninsured elderly.

He said drug prices were forcing some low-income elderly people to

choose between buying food and medicine.

"Our nation's seniors should not have to bear the burden of paying for pharmaceutical-company profits," he said.

Allen said he would introduce legislation in Congress to address the situation. One option, he said, would be to expand the Medicare program to cover prescription drugs.

The Pharmaceutical Research and Manufacturers Association, a trade group for drug companies, said Wednesday it was unaware of the report. "It's premature for us to comment," said Jeff Trehitt, an association spokesman.

The report was prepared by staff

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DRUGS

Continued from Page 1A

of the House Committee on Government Reform and Oversight. They surveyed nine drugstores in southern Maine for retail prices on the 10 drugs most often sold to the elderly.

Included were such medications as Ticlid, Relafen and Prilosec, prescribed for stroke, arthritis and ulcers, respectively. Other drugs on the list are used to treat heart disease and regulate blood pressure and cholesterol.

The retail prices in Maine were compared with what major insurance companies, health-maintenance organizations and other favored customers would pay.

Those costs are private information, but the researchers estimated them by using the price the Department of Veterans Affairs pays for the drugs. By law, companies are supposed to give the department a price comparable to what they would charge their best private customers.

On average, the retail price for the 10 drugs was more than twice as high as the price charged to the stores' favored customers, the report found.

Relafen, for example, a heart medication made by Smithkline Beecham, is sold to insurers and the government for \$62.58. The price at retail, \$116.39. Ticlid, a stroke medicine made by Hoffman-LaRoche, sold to insurers for \$33.57 and to retail customers for \$117.96.

The study found that the differential between the price charged to favored customers and the retail price was five times higher for drugs than for other types of consumer goods.

Allen said the study also found that pharmacies charged comparable retail prices and took "relatively small" markups of 3 percent to 22 percent.

"Large pharmaceutical companies drive up the prices," he said. "Drug manufacturers make six times more profit on prescriptions than retail pharmacies."

COMPARING PRICES

Retail prices for drugs commonly used by the elderly are much higher than the prices drug companies charge to insurance companies and other preferred buyers. This chart shows the 10 drugs most commonly prescribed to elderly people, their

manufacturers and uses, and comparative prices. Retail costs are based on a survey of nine chain and independent drug stores in southern Maine.

Drug	Maker	Use	Prices For Favored Customers	Retail For Maine Senior Citizens	Price Different
Ticlid	Hoffman-LaRoche	Stroke	\$ 33.75	\$117.96	251%
Zocor	Merck	Cholesterol	\$ 42.95	\$103.92	142%
Fosamax	Merck	Osteoporosis	\$ 31.86	\$ 61.66	94%
Prilosec	Astra/Merck	Ulcers	\$ 58.38	\$111.89	92%
Norvasc	Pfizer Inc.	Blood Pressure	\$ 58.83	\$111.71	90%
Relafen	Smithkline Beecham	Arthritis	\$ 62.58	\$116.39	86%
Procardia XL	Pfizer Inc.	Heart	\$ 67.35	\$118.85	76%
Cardizem CD	Hoechst Marion Roussel	Angina/Hypertension	\$ 99.36	\$174.99	76%
Zolof	Zöloft	Depression	\$123.88	\$213.28	72%
Vasotec	Merck	Blood Pressure	\$ 56.08	\$ 96.49	72%

Source: Minority Staff Report, House Committee on Government Reform and Oversight

Staff

Allen said drug prices are important because studies have shown that 37 percent of the elderly have no insurance for prescription medications.

He said he asked for the study because so many of his elderly constituents complain about rising drug costs.

Geneva Kief, 77, of Old Orchard Beach said Wednesday she and her husband, Percy, can't afford the medications their doctors have prescribed for their health problems, including a broken hip, asthma, high blood pressure, back pain and edema.

"Trying to make ends meet on what little bit of Social Security we get, it's rough, really rough," she said. "It's either eat or buy medicine. There you go."

Laurence Gross, executive director of the Southern Maine Agency on Aging, said he frequently hears about elderly people who walk out of drugstores empty-handed because they can't afford the cost of medicine.

Medicare, the government health program for the elderly, generally does not pay for drugs prescribed outside the hospital, Allen noted.

The state of Maine expanded its low-cost drug program this year to help low-income elderly residents



Staff photo by Gordon Child

Geneva Kief, 77, of Old Orchard Beach shows the many prescription medications she takes for a variety of health problems. Her husband, seen in the background, also needs expensive pills.

buy prescription medicine.

However, the program only covers certain types of conditions, such as heart disease, arthritis, high blood pressure and chronic lung disease.

Gross praised Allen for drawing

attention to drug costs, especially because drug companies have been raising drug prices faster than the rate of inflation.

"It's real important to hold the pharmaceutical industry's feet to the fire," Gross said.

Bangor Daily News

July 2, 1998

Elderly charged too much

Allen: Drug firms profit from senior citizens

The Associated Press

PORTLAND — Seniors in southern Maine pay more than double the rate of large insurers, managed care companies and even the government for prescription drugs, U.S. Rep. Tom Allen said Wednesday.

Allen said he hoped a study he commissioned would help focus attention on a nationwide trend of higher prices paid by the 37 percent of seniors who have no prescription coverage.

The cost-shifting helps pad the earnings of the pharmaceutical industry, which is already the most profitable business sector with earnings of more than \$20 billion last year, Allen said.

"Drug companies' profits are being earned on the backs of elderly patients who cannot afford it," he said.

The Pharmaceutical Research and Manufacturers of America had no comment Wednesday. Jeff Trehitt, a spokesman, said the organization was trying to obtain the report before discussing it.

The study, based on the 10 prescription drugs prescribed most often for seniors, was conducted at Allen's request by the staff of the House Government Reform and Oversight Committee.

It found that "favored" customers like large insurers paid \$33.57 for a standard prescription of Ticlid, which is used to prevent strokes, while senior citizens in southern Maine paid \$117.96.

At times, the difference was even greater.

Synthroid, a hormone replacement used by people with thyroid problems, was \$1.78 for favored customers, compared to \$30 for seniors, the study said. That amounts to an increase of 1,500 percent. Overall, seniors in southern Maine paid 105 percent more than the rate borne by "favored" customers, the study found.

See Prescriptions, B6, Col. 1

Allen plans efforts to level drug costs for elderly residents

Prescriptions, from B1

Although the study was based on findings in Maine's 1st Congressional District, the results would be similar across the country, Allen said at a news conference Wednesday.

Medicare does not pay for prescription drugs. Although so-called "Medigap" can be purchased to cover prescriptions, 37 percent of seniors pay for prescriptions out of their pockets.

Allen said he proposed to introduce legislation to help level the field for prescription drug costs.

One solution may be to link the

cost of prescription drugs for seniors to the federal rate schedule used by the Veterans Administration and other federal agencies, Allen said. Allen hastened to point out that pharmacists are not to blame because their average markup is only between 3 percent and 22 percent. Paul Levesque, a pharmacist from the Portland Professional Pharmacy, said he remembers the day his father, a pharmacist, had to break the news to someone that a prescription cost \$35.

Now prescription drugs can

reach into the hundreds of dollars apiece. And elderly residents often need eight or 10 pills a day.

Levesque said he has heard of seniors having to skip doses or cutting their pills in half. Allen said it sometimes boils down to a choice between food or prescription drugs.

"People should not have to choose between buying prescription drugs or groceries. Our nation's seniors should not have to bear the burden of paying for pharmaceutical company profits," Allen said.

Journal Tribune

July 2, 1998

Allen: Elderly pay more than fair share for prescriptions

By DAVID SHARP
Associated Press

PORTLAND — Seniors in southern Maine pay more than double the rate of large insurers, managed care companies and even the government for prescription drugs, U.S. Rep. Tom Allen says.

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Medicare does not pay for prescription drugs. Although so-called "Medigap" can be purchased to cover prescriptions, 37 percent of seniors pay for prescriptions out of their pockets.

Allen said one solution to the cost disparity would be legislation linking the cost of prescription drugs for seniors to the federal rate schedule used by the Veterans Administration and other federal agencies.

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Those expensive little pills Seniors paying too much for drugs

Political seasons aside — and when you're a member of Congress, it's nearly always political season — 1st District Rep. Tom Allen is onto something.

He announced this week that Maine seniors who don't have prescription coverage pay far too much for medicine, possibly to enable drug companies to give better deals to managed-care companies.

In many cases, according to a study ordered by Allen, seniors pay twice what the insurance companies pay for the same drugs. More than a third of Maine's seniors have no prescription coverage.

The pharmaceutical industry hasn't given its side of the story yet but even if the explanation sounds reasonable on its face — say, that managed care companies are like Wal-Marts that can buy in volume, thus buying for less — the higher price is still being paid by people who can't afford it.

No matter how the issue is dissected, it still looks unfair.

Allen should continue his probe. He's uncovered another way in which drugs cost far too much in this country and in which the heavy machinery of our free market economy rolls right over those with the least power and ability to pay.

The Boston Globe

SATURDAY, SEPTEMBER 26, 1998

Elderly make Capitol Hill pitch to lower cost of prescriptions

By Chris Black
GLOBE STAFF

WASHINGTON — In two weeks, Vi Quirion, a senior citizen from Waterville, Maine, will take a field trip to Canada with her friends and neighbors to stock up on prescription drugs that cost half the amount she pays in Maine.

Quirion has arthritis and a stomach ailment. Supported by two metal canes, she labored to the lectern of a Capitol Hill news conference yesterday to explain that many senior citizens pay more than twice as much for prescriptions as preferred customers that buy drugs in bulk, such as large health maintenance organizations, hospital chains, and the federal government. Under Canada's national health insurance system, prescription prices are heavily subsidized.

"I can't afford to pay my prescriptions and gas and eat, too," Quirion said. "We should not have to live like that."

A study conducted by the Democratic staff for the House Government Reform and Oversight Committee in seven congressional districts, including Representative Tom Allen's district in Maine, found that older Americans and other uninsured consumers pay 106 percent more for the 10 best-selling prescription drugs than the drug companies' preferred customers.

For example, the study found that Tielid, a drug used by stroke victims, costs \$118.06 per prescription at retail but only \$33.57 for favored customers, a 252 percent difference. Zocor, a drug used to treat high cholesterol, costs preferred customers \$42.95 and regular retail customers \$104.98, a 144 percent difference.

The study said large corporate and institutional customers of the drug companies were able to buy drugs at discounted prices, but the most vulnerable consumers, the uninsured and others without insurance coverage for prescriptions, were paying full price and effectively subsidizing the more well-heeled consumers.

Representative John F. Tierney, a Salem Democrat, said an analysis of prices in his district found retail prices for the 10 drugs were 110 percent higher than the price charged to preferred customers.

"This is unfathomable and biased," he said.

Allen led a group of Democrats in proposing legislation yesterday that would require drug companies to sell prescription drugs at the same low price offered preferred customers to pharmacies that serve Medicare recipients.

The lawmakers charged that the major pharmaceutical companies are making record profits at the expense of senior citizens. Pharmaceutical

companies maintain they need to charge full price for prescription drugs to subsidize research and development of new life-saving drugs.

"We are determined to assure that no older American will ever again have to choose between buying food and taking the drugs needed to maintain their health," said Allen, a first-term Democrat.

The legislation faces an uphill battle and is not likely to be considered until next year because Congress is scheduled to adjourn in two weeks. No Republicans support the bill, and the drug companies are expected to be strongly opposed.

"The well-meaning efforts of the bill's sponsors unfortunately are likely to backfire on America's seniors," said Alan F. Holmer, president of the Pharmaceutical Research and Manufacturers of America, a trade association. "In a very real sense, this bill is a dagger pointed at the hearts of America's senior citizens. If price controls are imposed, there will be less investment in research and development, and far fewer new cures and treatments."

The industry spends \$21 billion a year on research and development of new drugs.

According to the American Association of Retired persons, more than 75 percent of all Americans over age 65 take prescription drugs. Medicare does not provide prescription drug coverage.

A New Look at Medicare Drugs

In 1994, the Clinton administration tried to reform Medicare's prescription drug program. It sought to change the fee-for-service system that simply pays bills from hospitals and doctors into a managed care system wherein the government would negotiate fees in advance and reward drug companies for keeping costs under control. Although Medicare covers only a handful of drugs used in hospital critical care wards, the politically mighty drug industry saw federal price controls as a threat to its \$20 billion in annual profits. Its lobbyists succeeded in shooting them down, contending that a fee-for-service system would somehow make more drugs available to patients at lower costs.

Now, a newly released study commissioned by Congress shows that just isn't so. Comparing the prices that Medicare paid last year for 34 critical drugs to the prices the Veterans Administration paid for the same drugs in purchasing them directly, the study found that Medicare paid from 15% to an astounding 1,600% more than the VA.

Moreover, Medicare patients, rather than gaining access to a wider range of appropriate drugs than VA patients, often received the most costly and heavily hyped brand-name drugs when less expensive generic drugs would have worked just as well or better.

On Wednesday, the National Bipartisan Commission on the Future of Medicare will meet to advise Congress on how to address the problems highlighted in the federal study. As a first step, the commission ought to rally behind a sensible bill recently introduced by Reps. Thomas H. Allen (D-Maine), Henry A. Waxman (D-Los Angeles) and others to allow Medicare recipients to purchase outpatient drugs at reduced prices negotiated by the government.

The Allen/Waxman bill charts a sensible

middle course between widely diverging strategies now being proposed in Congress to improve Medicare.

On one side of the debate stand Republican senators like James M. Jeffords (R-Vt.), who is trying to extend the maximum period a company can exclusively market a brand-name drug (and thus prohibit competitors from making more economical generic equivalents) to 20 years from 14. That's exactly the wrong prescription. As the new federal Medicare study makes clear, the solution is to use fewer, not more, brand-name drugs.

On the other side of the debate stands the chairman of the Medicare Commission, Sen. John B. Breaux (D-La.), who wants to make Medicare cover all medically necessary prescription drugs. Medicare was created in 1965 to cover all of the elderly's health care needs, and Breaux rightly argues that prescription drugs have become "as important as a hospital bed was in 1965, perhaps more so." Breaux's solution currently lacks political viability, but it will gain more support if, as market analysts are now predicting, more HMOs drop their prescription drug plans for the elderly next year.

Washington shouldn't seek to undermine the profits that have motivated American drug companies to innovate far more than their competitors abroad. At the same time, however, the Medicare Commission and Congress have a duty to ensure that those profits are derived from good medicine practiced in a competitive, free marketplace, not extorted through shady deals and slick promotion. Thus the proposal to have the government negotiate the same low prices for its elderly as it secures for its veterans makes sense, especially if Medicare stops spending twice what it should on the few medications it does pay for.

Los Angeles
Times
12/1/98
editorial

HCPA
6/2/98

**** D R A F T ****

Options for a Medicare Drug Benefit

Introduction

A substantial portion of Medicare beneficiaries have no insurance coverage for prescription drug expenses: in 1995, more than 15 million beneficiaries, or about 41 percent of the Medicare population, were without some form of drug coverage. Currently, there are several sources of drug coverage for Medicare beneficiaries (see Table 1). Of the 59 percent (21.6 million) with drug coverage, most receive benefits from employer-sponsored insurance (47 percent). Another 14 percent have individually-purchased drug insurance. Eleven percent receive coverage through Medicare Risk HMOs. Beneficiaries with full Medicaid benefits and those qualified as QMBs/SLMBs only comprise 19 percent of those with drug coverage. About 3 percent of beneficiaries with drug coverage receive benefits from VA, State pharmaceutical assistance programs for low-income elderly, or other government programs.

Table 1. Prescription Drug Insurance Coverage of Medicare Beneficiaries, 1995			
Total # of Medicare Beneficiaries, 1995	Total # of Medicare Beneficiaries with Coverage	Percent of Total Medicare Beneficiaries with Coverage	
86,715,768	21,638,632	59%	
Type of Coverage	Total # of Medicare Beneficiaries with Coverage	Percent Distribution	Average Annual Per Capita Out-of-Pocket Expenditures on Drugs
Employer-sponsored drug insurance	10,158,291	47%	\$249
Private-purchased drug insurance	3,060,626	14%	\$427
Medicare Risk HMO drug coverage	2,413,943	11%	\$160
Full Medicaid drug coverage	2,359,751	11%	\$104
QMB/SLMB Medicaid coverage	1,666,034	8%	\$157
VA, State Pharmaceutical Assistance programs, or other drug coverage	732,229	3%	\$264
Switched Coverage During the Year*	1,247,758	6%	\$290
No drug coverage	15,077,136	41% of total Medicare beneficiaries	
* Indicates beneficiaries who were covered under one form of insurance for part of the year and then switched at some point during the year. For example, beneficiaries who are in FFS and then switch to an HMO, or to Medicaid.			
Source: HCFA/Office of Strategic Planning. Data from the Medicare Current Beneficiary Survey, 1995			

The remainder of this paper reviews possible options for a Medicare prescription drug benefit. The first section (Option 1-6) discusses options for drug coverage under Medicare. These options would cover both fee-for-service and managed care populations. The second half of paper (Options A-C) discusses possibilities for drug coverage primarily through the Medicare+Choice part of the program.

Options for a Medicare Drug Benefit

Option 1

Benefit, Eligibility, and Financing

- **Full drug benefit for all Medicare enrollees - cover all approved drugs**
 - ▶ non-voluntary, part of standard Medicare benefit package
 - ▶ with deductibles and coinsurance, increase in the Part B premium
 - ▶ other financing from general revenues and rebates
 - ▶ with or without a cap on Medicare expenditures
 - ▶ with or without a cap on beneficiary out-of-pocket expenditures
 - ▶ with or without a rationalizing of the overall Medicare benefit package so that Medigap coverage is no longer needed

History: The Health Security Act

The Health Security Act included a full drug benefit, covering all approved drugs, biologicals, and insulin with a deductible that started at \$250, 20% co-insurance, an increase in the Part B premium that equaled 50% of the portion of the monthly actuarial rate attributable to the drug benefit, and an out-of-pocket cap starting at \$1,000. General revenues financed 43% of incurred costs; deductibles and coinsurance, 36%; premiums, 13%; and rebates, 8%. Formularies were prohibited. A DUR program was to be established, and the Secretary was given authority to use PBM firms to administer the benefit. All pharmacies receiving Medicare payments were required to accept assignment. The legislation did not require a maintenance of effort for employers. The estimated total cost of the benefit for CY 1996, on an incurred basis, was \$19.2 billion. The cost to the Federal government, after premiums, cost sharing, etc., was estimated to be \$13.5 billion.

Discussion

The most significant policy issue associated with this option would be the high cost of this benefit to the program. The overall net cost to the Federal government would depend on what portion of the cost was financed through the beneficiary premium, deductible, and co-insurance.

However, this option would be consistent with recent efforts to “modernize” the Medicare benefit package, and would make it more comparable to private health insurance drug coverage.

A full drug benefit could lead many employers to drop drug coverage for their retirees, resulting in significant savings for employers. However, depending on the level of out-of-pocket costs associated with this benefit, this could impact negatively on some beneficiaries who now pay little or nothing for employer-sponsored drug coverage. In addition, some beneficiaries may be forced to drop their Medigap coverage, if they can no longer afford both the increased Part B premiums and their Medigap premiums. However, if a full drug benefit is incorporated into an overall restructuring and “rationalizing” of the Medicare benefit package such that beneficiary cost sharing was reduced, Medigap policies would be less necessary and may be unattractive to beneficiaries.

In addition, State and Federal Medicaid programs could experience significant savings for dual eligible beneficiaries, since Medicare would become the primary payer for drug coverage. These savings could perhaps be used to finance some of the costs of the benefit.

Option 2

Benefit, Eligibility, and Financing

- **Catastrophic drug benefit for all Medicare enrollees**
 - ▶ non-voluntary, part of standard Medicare benefit package
 - ▶ high deductible, co-insurance
 - ▶ other financing from increase in Part B premium, general revenues, and rebates
 - ▶ with or without a cap on Medicare expenditures
 - ▶ with or without a cap on beneficiary out-of-pocket expenditures

History: The Medicare Catastrophic Coverage Act

The Medicare Catastrophic Coverage Act of 1988 included coverage of outpatient prescription drugs, biologicals, and insulin, with some limitations. The deductible started at \$550 in 1990, and was to increase such that an average of 16.8% of Part B enrollees would have expenditures that exceeded the deductible every year. There was no out-of-pocket cap for drug expenditures. Coverage of outpatient prescription drugs and beneficiary coinsurance was phased in to allow a build up of reserves: most drugs were not covered until 1991; coinsurance was set at 50% in 1991, 40% in 1992, and 20% thereafter. In addition, the benefit was to be “prefunded” by an additional supplemental premium beginning in 1990. The supplemental premium was income-related: beneficiaries paid an additional amount, based on their income tax liability, for both the new catastrophic benefits as well as the drug benefit. The regular Part B premium was also increased beginning in 1991 to finance the benefit. Formularies were prohibited. A DUR program was to be established, and the Secretary was given authority to contract with a variety of entities to administer the benefit. Participating pharmacies were required to accept assignment. The legislation included a one-year maintenance of effort provision in the form of additional benefits or refunds required for employers who provided coverage that duplicated Medicare

benefits (excluding drugs). The bill also established the Federal Catastrophic Drug Insurance Trust Fund. The estimated total cost of the benefit, on an incurred basis, for CY 1991 was \$3.1 billion. The cost to the Federal government after premiums, cost sharing, etc., was estimated to be \$1.3 billion.

Discussion

Given the past experience with the Catastrophic Coverage Act, it is clear that there is the potential for less broad-based public support for this option. However, this will vary depending on how the financing is structured and the scope of the benefit. Since nearly 60 percent of beneficiaries now have some drug coverage (but generally not catastrophic-type coverage), the public may not be willing to support an option where all beneficiaries are required to pay an additional premium for a benefit that only a small portion will ever use. On the other hand, if the premium is reasonable to beneficiaries, and the benefit relatively accessible, it could be viewed as an important addition or "safety net" to their insurance coverage.

To address the concern that many beneficiaries may perceive this as having to pay more for a benefit they are unlikely to use, Medigap policies would have to be adjusted to avoid duplication of coverage, or this benefit may not be appealing particularly for those retirees who pay for their employer coverage, or who purchase Medigap policies with drug coverage.

Under this option, the benefit would not necessarily replace employer-sponsored coverage, so there would not be the same level of savings to employers (or States) as in the first option.

Option 3

Benefit, Eligibility, and Financing

- **Limited drug benefit for all Medicare enrollees - cover certain classes of drugs**
 - ▶ non-voluntary, part of standard benefit package
 - ▶ with deductibles and coinsurance
 - ▶ other financing from increase in Part B premium, general revenues, and rebates
 - ▶ with or without a cap on Medicare expenditures
 - ▶ with or without a cap on beneficiary out-of-pocket expenditures

Discussion

Under this option, Medicare would limit its coverage of drugs to certain classes of drugs. In some cases, this is an extension of Medicare's current rules for drug coverage (e.g., coverage of immunosuppressants). This approach also is consistent with several of the State-only prescription drug coverage programs for low-income elderly, where they only cover drugs that are used to treat certain conditions common among the elderly population. This option could be viewed as an "incremental" approach to a full drug benefit. Initially, the costs to the Federal government for this option could be limited, depending on the coverage decisions. And if the costs to the beneficiary are minimal, there may be more public support for this coverage option

that the catastrophic benefit, since beneficiaries may view themselves as more likely to utilize this benefit.

This option would not be consistent with the approach to drug coverage in the private sector, and determining which conditions to cover would be subject to significant political pressure and lobbying. Again, depending on the extensiveness of the coverage, employers may not be able to drop drug coverage for retirees. Some beneficiaries who now pay for employer or Medigap coverage may feel they are paying “twice” for drug coverage.

Option 4

Benefit, Eligibility, and Financing

- **Optional drug coverage: full or catastrophic benefit**
 - ▶ voluntary, beneficiaries choose to purchase for an additional premium

Discussion

This option could include either the full or catastrophic coverage outlined above, but beneficiaries could choose whether or not to purchase the benefit. This option could be viewed as providing additional choices to beneficiaries, in particular, a choice that we know beneficiaries want. However, the financing structure for this option could be a significant barrier to developing an attractive offering, given the high likelihood of adverse selection. Given our inability to predict an individual’s health needs from year to year, it would be almost impossible to set the “right” premium level. A “death spiral” could result if the premium is set too low and then raised in subsequent years. The increase in the premium causes less needy beneficiaries to drop out, leaving only higher cost beneficiaries, which again would result in increases in the premium. And if the premium becomes too expensive, the potential for this to be viewed as an additional “choice” for beneficiaries is greatly reduced, and could diminish public support for the benefit.

However, this benefit could be structured to include a number of provisions to protect against some of the adverse selection described above. For example, the premium could vary according to the age a beneficiary chooses to buy into the benefit. Similar to the current Part B enrollment process and premium rate structure, there could be a one-time open enrollment window when beneficiaries first become eligible for Medicare benefits, and then restricted enrollment periods with waiting time and higher premium rates for those who choose to wait. In addition, there could be a “lock-in” similar to the Medicare+Choice program, to prevent beneficiaries from buying in only when they most need the benefit.

The interaction between this option and managed care offerings may also be an issue. This option may be more, or less, attractive than managed care options, and may have consequences for selection issues.

Option 5

Benefit, Eligibility, and Financing

- **Drug benefit for low-income beneficiaries only**
(OMB developing this option)

Option 6

- **Medicare as purchaser only**
 - ▶ Medicare runs a limited mail order prescription drug service
 - ▶ Competitive bidding

Discussion

Under this option, the Medicare program would not provide any new drug coverage or benefits. Instead, Medicare would use its purchasing power to get discounts on drugs for beneficiaries. The program could negotiate with manufacturers or retail pharmacy chains for discounted rates, based on expected volume. However, if only certain vendors are used, there could be significant political pressure from those who end up being shut out of the market (e.g., the small independent pharmacies).

Beneficiaries would not object to this option, since it would offer them the ability to obtain drugs at a lower price. There would be administrative costs to the program. Some of these administrative costs could be financed through small beneficiary co-payments or fees, or through rebates. However, this option would not guarantee coverage or affordability, and still leaves many beneficiaries at risk for high out-of-pocket costs.

The State low-income elderly prescription drug programs, or the Medicaid programs, may also be interested in “piggybacking” on the purchasing power of Medicare, in order to help them realize the same savings for their programs. The combined effect could have a significant impact on the marketplace. There may be a question of whether this option would result in a cost shift to individual purchasers, as drug manufacturers and retailers attempt to compensate for the “discounts” provided to Medicare beneficiaries. However, this issue of the effect on the marketplace also extends to the other options.

Options for Drug Benefit Through Medicare+Choice Plans Only

Option A

Benefit, Eligibility, and Financing

- **Require M+C plans to include drugs without changing current payment rates**
 - ▶ provided to all enrollees
 - ▶ there could be cost-sharing for the benefit
 - ▶ Medicare specifies scope of benefit (as above in fee-for-service)
 - ▶ in areas with no M+C plans, original Medicare could offer a drug benefit

Background and Implications

Most Medicare HMOs currently are able to offer additional benefits (i.e. non-Medicare-covered benefits) at the current rates of payment. As of May, 1998, 67 percent of plans include drug coverage as part of the basic benefit package (i.e., the package financed by the Medicare payment). HMOs are also allowed to charge a premium (and/or impose other charges) for "mandatory supplemental benefits," which are benefits that a beneficiary is required to purchase as a condition of enrollment. Numerous legislative proposals in the past have included a requirement that the Medicare managed care benefit package include drugs as a benefit.

This option could help reduce the adverse selection that fee-for-service Medicare has experienced *vis-à-vis* risk HMOs. At the same time, it may place financial pressure on HMOs, especially in the context of reductions in payment rates under the Balanced Budget Act of 1997.

This option may limit the growth of the M+C program as plans think twice about entering new areas in which they would be the only option available (other than Medigap) that offered drugs. MSA plans and private fee-for-service plans that would otherwise have large service areas (because their service area is the area from which they draw enrollment, rather than the area in which services must be made available and accessible) might choose to have reduced service areas to avoid being the only plan with a drug benefit in some areas.

Variation on Option. A variation on this option is to specify what the non-Medicare package of an M+C plan will include, and make drugs the first covered item among additional benefits a plan offers.

Medicare managed care plans are currently allowed to choose the manner in which they comply with the statutory requirement of providing additional benefits to enrollees. Additional benefits must be provided when the payment from HCFA exceeds the revenue needs of the plan to provide the Medicare benefit package. "Additional benefits" are defined to include both reductions in premiums and other allowed charges for the Medicare benefits, as well as the provision of additional items and services not covered by Medicare. Almost all Medicare managed care plans use the option of reducing premiums as the first level of additional benefits. (Plans also "waive" premium amounts they could otherwise collect. The waiver of premiums is supposed to be financed from non-Medicare revenue, though it appears clear that Medicare revenue is used for this purpose.)

Addition to Option. Currently, one-fourth of Medicare beneficiaries live in areas where there are no Medicare managed care options available. As part of this option, Medicare could offer its own drug coverage in areas where there are no managed care plans. Because Medicare HMOs are not available in all parts of the country, the option of making drugs available only through M+C plans would not provide access to drug coverage in non-HMO areas (generally rural areas). To address this concern, Medicare itself could offer drug coverage in non-managed-care areas. To completely parallel the option under managed care, there would not be any additional cost for the Trust Funds, and therefore beneficiaries would have to pay the full cost of the benefit. The benefit could be either optional or mandatory (as discussed above, in the fee-for-service section).

There would be a number of administrative issues with this option. For example, would drug coverage in Medicare fee-for-service be discontinued in an area as soon as an M+C plan became available?

Option B

Benefit, Eligibility, and Financing

- **Require M+C plans to include drugs as an optional supplemental benefit**
 - ▶ enrollees may decline coverage
 - ▶ financed through enrollee premiums and cost-sharing

Discussion

M+C plans are permitted to offer supplemental benefit packages that enrollees can choose to purchase at an additional premium. Under the proposed option, Medicare could specify that at least one available supplemental package consist of a drug benefit.

This is not a significant departure from the status quo, especially since it involves no financial assistance for the purchase of the optional coverage. Many Medicare risk plans already include optional supplemental coverage that includes drugs or enhances drug coverage available in the basic benefit package. This option would make drug options more available.

This option would give rise to concern on the part of health plans similar to those described above (adverse selection *vis-à-vis* fee-for-service Medicare, fear of entering new areas), and similar administrative issues would arise.

Option C

Benefit, Eligibility, and Financing

- **Require M+C Plans to Include Drugs as a Benefit; Increase Payment Rates to Cover All or Some of the Costs**
 - ▶ provided to all enrollees
 - ▶ paid for out of Medicare Trust Funds

- ▶ enrollees could only be charged for cost-sharing specified by Medicare

Discussion

Under current rules, M+C plans must provide at least the Medicare level of benefits and may (under certain conditions) charge Medicare beneficiaries for the cost of Medicare's deductibles and coinsurance not included as part of the Medicare payment rate. This option would call for increasing the payment rate to M+C plans because they are being asked to cover a benefit not currently included in the Medicare benefit package.

This option diverges from the neutral policy the Administration has maintained with respect to any preference given to traditional fee-for-service Medicare versus Medicare managed care. More than in the case of option A above, this kind of option should include comparable availability of drug coverage for the one-fourth of Medicare beneficiaries residing in areas with no managed care options.

While this option may induce more people to enroll in managed care, it is unclear whether the very sick, who now prefer fee-for-service, will view the availability of drugs as an attractive enough inducement to enroll. If the very sick continue to not enroll, this option will exacerbate the selection bias that currently exists.

New Medicare Drug Benefit

In this paper, we describe issues involved in the administration of a new Medicare drug benefit. We discuss the problems that would be addressed by developing a drug benefit as well as possible financing mechanisms, administering bodies, benefit designs, rebate options, cost-sharing issues, managed care options and interactions with other health care providers. In addition, we discuss the possibility of a drug benefit only for low-income Medicare beneficiaries as well as cost-containment strategies for the new benefit.

I. Administrative Issues

A. Problem Statement: What are we trying to address. A drug benefit provided by the Medicare program could serve to both modernize the benefit structure of the program and address a possible lack of access to drugs faced by Medicare beneficiaries.

Modernize benefit structure. The current Medicare benefit structure has remained largely unchanged since the inception of the program in 1965. The benefit structure was created to mirror the structure of private health plans, but has not adapted with changes to these plans. The most notable omission to the current Medicare benefit structure is prescription drugs, a common benefit of most health insurance plans today. For example, the FEHB Blue Cross Blue Shield Standard Option plan offers a relatively generous prescription drug benefit.¹ In addition to mirroring private health plans, medical practices have become extremely reliant on pharmacological therapies. For example, it is standard protocol to prescribe aspirin after a first-time heart attack to prevent future heart attacks. Including a prescription drug benefit in Medicare's benefit structure would acknowledge changing medical practices and enable physicians to coordinate benefits to Medicare enrollees.

Lack of access due to affordability. Many Medicare beneficiaries currently receive a prescription drug benefit through purchasing supplemental insurance (i.e., Medigap), employer-sponsored supplemental insurance, managed care plans, or by qualifying for Medicaid assistance or other Federal benefits (e.g, Veterans health benefits). However, there is a significant proportion of Medicare beneficiaries who do not have access to a prescription drug benefit. Medigap insurance that includes a drug plan is very expensive. Employers have increasingly dropped supplemental insurance for retirees, and managed care plans that include a drug plan are not uniformly distributed throughout the country. Due to these market trends, many Medicare beneficiaries are forced to assume all of the costs of prescription drugs by paying out-of-pocket, leading them to consume fewer prescription drugs than those with a prescription drug plan. Policies could be

¹The FEHPB Blue Cross Blue Shield Standard Option plan includes a prescription drug benefit. Members must meet a \$50 annual drug deductible, and must pay a 20 percent co-pay for drugs purchased at member pharmacies or a 40 percent co-pay at non-member pharmacies. Members pay a \$12 co-pay for prescription drugs purchased through the plan's mail service prescription drug program.

designed to address this lack of access through targeted programs for middle-low and low-income beneficiaries

B. Financing Mechanism. A new drug benefit could be financed in several different ways.

Part B Structure. A prescription drug benefit could be financed through the Part B Trust Fund, funded with its current structure of 25 percent premiums and 75 percent general revenues. If current Part B benefits were not reduced, beneficiary premiums would increase and/or additional general revenues would be required. Including the drug benefit in Part B Trust Fund may add additional strain to the Part B Trust Fund which, according to the Medicare Trustees, is projected to grow faster than the HI Trust Fund.

Separate Trust Fund. Alternatively, to reduce strain on the Part B Trust Fund, a new prescription drug benefit could be financed through the creation of a new trust fund. The trust fund could be funded through premiums, general revenues, payroll taxes, or dedicated tax revenues. Creating a separate trust fund may facilitate policy makers to impose fiscal discipline on the new benefit and allay critics' fears that a prescription drug benefit would further drain the Part A and Part B Trust Funds.

Appropriated Entitlement. Like the Medicaid program, the drug benefit could be financed through General Fund revenues as an appropriated entitlement with an open ended spending level. This may be an option for financing; however, OMB would not recommend this option as it leaves the Medicare program vulnerable to unexpected increases in drug expenditures.

Capped Entitlement. Like the Children's Health Insurance Program, the drug benefit could be financed as a capped entitlement with a finite level of spending determined for a 5 or 10 year time period. This would isolate the drug benefit from the yearly appropriations process, while limiting the federal government's financial exposure in any one year.

Discretionary Appropriation. Like other public health programs, the level of spending could be determined each year through the discretionary appropriations process. This limits the federal government's exposure in each year, but leaves the program vulnerable to cuts that the Administration would not support.

C. Administering Body. There are a number of options for administering a new Medicare drug benefit.

HCFA administers the program. One option is to have HCFA administer the prescription drug benefit. The advantages to HCFA administration are: 1) all Medicare benefits would be coordinated through one agency; 2) no need to create a new federal bureaucracy; 3) the ability to negotiate deep discounts; and 4) the ability to coordinate fraud and abuse efforts throughout the program. The disadvantages to HCFA administration is that it may create political pressures to cover drugs that are not medically necessary and/or cost effective. Congress may mandate HCFA to include unnecessary drugs in its formulary.

Independent agency administers the program. To relieve HCFA of the political pressures, an independent agency could be established to administer the program. Depending on its level of oversight from the Congress and the Administration, an independent agency would have the ability to limit the formulary to only those drugs that are deemed to be medically necessary and cost effective. Further, if cost-control measures are needed to contain spending on drug benefits, an independent agency may be more able to reduce payments to manufactures or limit benefits than HCFA.

Drug administration contracted out to private firms. HCFA could contract with pharmacy benefit managers (PBMs). PBMs administer the prescription drug part of health insurance plans on behalf of plan sponsors, such as self-insured employers, insurance companies, and health maintenance organizations. Alternatively, Medicare beneficiaries could be given a voucher and purchase prescription drug benefits on the open market. Private firms would be charged with developing formularies and negotiating with drug manufactures.

HCFA could contract with a PBM in several different ways:

- 1) *Sole Source / Competitive Bidding.* Medicare could establish a process whereby PBMs in each region competitively bid to provide Medicare services. Once a contract was awarded, the winning PBM in each region would be the sole-source benefits manager for a beneficiary in that area. Medicare could also provide the choice of several different PBMs in each region.
- 2) *Capitation Versus Fee-For-Service.* Medicare could arrange to pay PBMs a capitated rate for the provision and management of all drug benefits. This would place the risk on the PBMs. Medicare could also pay PBMs on a fee-for-service basis. Medicare could also maintain its current payment methodology: capitation to Medicare+Choice plans and fee-for-service where Medicare+Choice plans are unavailable.
- 3) *Claims Processing.* PBMs process benefit claims and prepare periodic payment and drug utilization reports for plan customers. Medicare drug benefit claims could be processed by the PBMs themselves. Medicare contracts arranged for any purpose should be subject to contractor reform and open bidding.

D. Benefit Design. There are several benefit design issues which would have to be addressed.

Formulary Development and Management. A formulary is a list of prescription drugs, grouped by therapeutic class, that are preferred by a health plan sponsor. Drugs are included on a formulary not only for reasons of medical value but also on the basis of price. PBMs use formularies to help control drug costs by (1) encouraging the use of formulary drugs through compliance programs that inform physicians and enrollees about which drugs are on the formularies; (2) limiting the number of drugs a plan will cover; or (3) developing financial incentives to encourage the use of formulary products.

1) *Open formularies* are often referred to as "voluntary" because enrollees are not penalized if their physicians prescribe nonformulary drugs. Thus, under an open formulary, a health plan sponsor provides coverage for both formulary and nonformulary drugs.

2) *Incentive based formularies* provide enrollees financial benefits if their physicians prescribe formulary drugs. Under this arrangement, the health plan sponsor still reimburses enrollees for nonformulary drugs but requires them to make higher co-payments than for formulary drugs.

3) *Closed formularies* take financial incentives one step further by limiting coverage to formulary drugs only. Therefore, if a enrollee's physician prescribes a nonformulary drug, the enrollee may have to pay full cost of that prescription. However, the health plans cover nonformulary products when physicians determine that they are medically necessary for their patients.

Drug Utilization Review (DUR). DUR programs analyze patterns of drug use to prevent contradictions and adverse interactions. PBMs use this information to make prescription substitution recommendations to physicians and inform plans and physicians about physicians' prescribing patterns. DUR can be done retrospectively and/or prospectively.

1) *Under retrospective review*, PBMs study the drug utilization statistics of a customer's enrollees to identify any instances in which physicians prescribed potentially inappropriate medications. If PBMs identify inappropriate patterns of prescribing or consumption, they will attempt to contact and educate physicians about more appropriate and potentially cost-effective treatments.

2) *Under prospective review*, PBMs use a computer link with network pharmacists to review each prescription before it is dispensed. Prospective DUR helps PBMs to identify whether there is a generic or formulary alternative to the prescribed drug and whether the drug will duplicate an existing prescription or will adversely interact with other drugs the patient is using.

Generic Substitution. Generic substitution interventions switch medications from brand-name drugs to chemically equivalent generic drugs. The Medicare benefit could include incentives for physicians to utilize generic substitutions. These incentives could also expand to the beneficiary by requiring additional copayments for the use of brand name drugs.

Disease management. Disease management programs try to improve the care delivered to specific group of patients, such as those with diabetes, by recommending particular therapies or patient self-management techniques. PBMs use physician and patient education materials to emphasize shared responsibility and cost-effective approaches. The Medicare benefit could require disease management.

Mail-Order Pharmacy Benefit. PBMs operate mail order pharmacies that allow enrollees to

obtain prescriptions, particularly maintenance prescriptions, by mail. Medicare could provide an incentive for beneficiaries to utilize mail-order benefits.

E. Drug Pricing. As in the Medicaid drug program, a Medicare drug program could establish both a maximum price paid for drugs, as well as a requirement that drug manufacturers provide a rebate due to the volume of drugs that Medicare would be buying. In Medicaid, the price limit for multiple source drugs is 150% of the estimated wholesale cost of the least expensive therapeutic equivalent. All other drugs have an aggregate limit of the lesser of (a) the pharmacy's usual and customary charge to the general public and (b) the estimated acquisition cost plus a dispensing fee.

Under Medicaid law drug manufacturers are required to pay Medicaid rebates in return for a guarantee that the State Medicaid program will cover all the manufacturer's drugs. The rebate for single source and innovator multiple source drugs (i.e. brand name drugs) is either the difference between the average manufacturer price (AMP) and the best price (i.e. the lowest price offered by the manufacturer to any entity) or 15.1% of the AMP. The best price determination excludes the prices charged to Veterans Administration, DOD, PHS, and State-only pharmaceutical programs.

There is an additional rebate equal to the amount that the AMP increases over and above the CPI-U. The rebate for non-innovator multiple source drugs (i.e. generic drugs) is 11% of the AMP.

Recently the Inspector General has called for the rebate to be calculated based on Average Wholesalers Price (AWP) instead of the AMP. According to the IG this would have resulted in an additional \$1.15 billion in rebates for calendar years 1994-96 for only the top 100 drugs. HCFA has disagreed with this recommendation and instead is planning a comprehensive study of the AWP. (Medicare currently pays 95% of the AWP for the limited drugs it currently covers.) The establishment of a Medicare drug benefit could be coupled with legislative changes to the Medicaid rebate program

In addition to the Medicaid rebates, federal law establishes mandatory price discounts for PHS-funded clinics and public disproportionate share hospitals, as well as requires manufacturers to offer discounted prices to the Veterans Administration.

A Medicare drug rebate program could also be established, as well as a limit on prices paid for drugs by Medicare. Any rebate offered to Medicare, however, is likely to increase prices charged to other federal programs and private payers.

F. Cost-Sharing. The benefit could include copays, deductibles and/or a higher premium. The premium imposed for this benefit could be flat or income-related. Under the Catastrophic Coverage Act of 1988, both a flat premium and an income-related premium were paid by enrollees for drug coverage. The flat premium was set in the act for each year. The income-related premium was capped at \$800 per person in 1989, rising to approximately \$1,200 in 1994. The Act adjusted the premiums so that in the long run 63 percent of the total financing came

from the income-related premium.

Medicare could also include a cap on benefits similar to that of many Medicaid plans. Many states place limitations on the quantity of drugs dispensed by limiting the number of prescriptions that can be filled or refilled in a certain time period. They may also place limits on the quantity per prescription (for example, a 30 day supply or 100 unit limit). These quantity limits are generally maximums, though minimums are also applied in certain cases, such as for maintenance drugs.

Cost-sharing could also be used as a mechanism for cost containment (see cost containment section).

G. Managed Care or FFS. As of June 1997, 33 percent of Medicare beneficiaries did not have access to a Medicare+Choice risk plan. The majority of beneficiaries without access live in rural settings. Thus, a drug benefit that is solely provided to managed care enrollees would not be available to a third of beneficiaries. The issue of how to develop a drug benefit that would be required by Medicare+Choice plans is being developed in the options paper.

H. Interactions. A Medicare drug benefit would have an effect on several programs.

DoD. Currently, DoD provides drugs to any military retiree that is seen at a military treatment facility (MTF). However, if a military retiree chooses to use their Medicare benefits rather than be seen at an MTF, they cannot obtain drugs from the DoD benefit. If Medicare were to offer a benefit, many military retirees who are enrolled in Medicare could choose to use their Medicare benefits rather than to be seen at a military treatment facility.

VA. The VA situation is similar to that of the DoD. VA provides drugs to any military retiree that is seen at a VA facility. A Medicare drug benefit would also produce an incentive for VA eligibles to use their Medicare benefits rather than the VA hospitals.

Medicaid/State-only plans. As Medicaid and other state-only programs currently pay for drugs for low income Medicare beneficiaries, a Medicare drug benefit would be a windfall to States. Consideration could be given to maintenance of effort requirements on States to ensure that they continue to provide some funding for pharmaceuticals, either in their Medicaid programs and/or their State-only programs.

Medigap. A Medicare drug benefit would necessitate changes to the Medigap insurance market as several of the Medigap plans include drugs.

II. Coverage of Drugs for Low-Income Persons

Much of the concern around insurance coverage for pharmaceutical benefits is related to low

income persons who cannot afford Medigap plans which offer drugs and/or who do not have access to employer-sponsored wrap-around benefits. Options could be developed which would address drug coverage for low-income persons only, or which would subsidize the cost of drug coverage to low income persons while allowing higher income persons to buy into a drug benefit.

Medicaid Drug Only Coverage. At least 11 states currently offer a state-only drug benefit for low income elderly and/or disabled. The federal government could create a similar nationwide program that would provide drug coverage to this population. The program could be targeted to Medicare-only eligibles (elderly and/or disabled), but administered through the Medicaid program. Medicaid is designed to serve a low income population, whereas Medicare currently is not structured to operate a means tested program. Targeting the program to only the low income reduces the concerns about crowding out private employers' coverage, as many of the low income would not have private wrap-around coverage.

Various design options exist which would change both the cost and the administration of the program. For instance, the federal government could make this an optional or mandatory program for the State Medicaid agencies. A mandatory program would be a boon to some states with current state-only programs, but would be seen as burdensome by other states. The Federal matching rate could range 0% to 100%. Income limits could be set with a mandatory minimum, but allow for higher state eligibility cutoffs. Individuals could be allowed to spend down to be eligible, or could be eligible through net income alone. The benefit could be the same as Medicaid, i.e. first cost coverage, or could be designed as a cost sharing program with deductibles.

Subsidized Coverage for Low Income Persons. Should the Administration choose to provide a drug benefit to all Medicare beneficiaries, the program could still be designed to financially subsidize only or mostly low income persons. For instance, the Part B premium could be increased to account for the cost of the drugs. This increase could reflect either 25% of the cost of the drugs (i.e. continue to current premium structure), or could reflect 100% of the costs of the drugs. In either case, low income persons could be shielded from the some or all of the cost of the increase. Medicare could reduce the premium directly to low income beneficiaries, or Medicaid could pay for the increased premium for low income beneficiaries (those with incomes above Medicaid eligibility levels), while the beneficiary remains responsible for the "normal" Part B premium.

Requiring all but low income beneficiaries to pay for drug coverage would ensure that beneficiaries who currently pay for their own drugs continue to do so. Such a proposal, however, might not forestall employers dropping of a drug benefit. The States would also pick up some of the burden as they would pay for the higher Part B premiums of dual eligibles and QMBs, although they would be relieved of the cost of drug provision for these populations.

Discretionary Program to Provide Drug Coverage to Low Income Persons. Similar to the current State-only programs which provide drugs to low income Medicare beneficiaries, a discretionary program could be created which either directly or through the States provides drug coverage only. In essence, this could be providing another Medigap package that was tailored only to the

low income population and provided only one service. Such a program could be appropriated each year, as is the current AIDS Drug Assistance Program. If the program was run by the States, issues to be addressed would include how to distribute the funds and whether the State programs would be covered by the federal discount program which requires manufacturers to offer mandatory price discounts to federal agencies and their designees.

III. Cost Control Measures

While drug expenditures take up only 6% of total health care expenditures, in the last several years this sector of the health care market has been growing much faster than average. In 1996 while national health expenditures grew by only 4.4%, prescription drug growth increased by 9.2%. Prescription drugs have witnessed a three year trend of increases in utilization overshadowing prices as the primary factor accounting for growth. Three main reasons for the increased growth are pointed to.

Managed care organizations appear to be substituting cheaper drug therapies in place of more expensive services, such as hospitals and physicians. This is especially true for antidepressants which shorten inpatient mental hospital stays and expensive psychotherapy. Likewise the use of narcotic analgesics in conjunction with surgery enables patients to avoid or shorten inpatient hospital stays.

Pharmaceutical companies have increased their direct-to-consumer advertising the expenditures for which doubled in 1996. The cost of this advertising is reflected in the increased drug costs, as well as increased demand by patients for more expensive name brands.

The number of new drugs approved by FDA hit a record high of 53 in 1996. The net increase in product mix and the effect of new costlier therapies also added to growth in prescription drugs. In the coming years, however, many drugs approved in the 1970's and 1980's will be coming off patent which may hold down pharmaceutical price increases for years to come.

Establishing a new drug benefit under Medicare exposes the program to a new benefit with a potential for explosive growth over the next few years. Several options are available to limit Medicare's exposure should drug expenditure growth be greater than anticipated. These options could be used individually or in tandem to control costs. In each of these scenarios a global drug budget would be estimated as part of the budget process.

Cuts in Physician Payments. Physicians could be held accountable financially should the drug budget be overspent, as physicians are in control of the drug prescriptions. Should global drug budget be exceeded, the difference could be deducted from the physicians' expenditures by ratcheting down the conversion factor in the subsequent year. This could be done across the board for all physicians or could be targeted to groups of physicians or specialists who were likely to be causing the increase. Effective targeting of cuts would rely on the ability to measure and predict drug budgets by groups of physicians, or even on an individual level.

Increases in Beneficiary Co-Payments, Deductibles and Premiums. Beneficiaries could be held accountable for overspending in the global drug budget by increasing co-payments, deductibles or premiums in the year following the over expenditures. If drug growth continues to result from increased utilization, the increased co-payments may serve to decrease future growth in utilization as well as make up for prior budget overruns.

Reduce Payments to the Pharmaceutical Firms. As discussed above, a Medicare drug rebate program could be established to ensure that Medicare takes advantage of its buying power. To offset expenditures above the global drug budget, further rebates could be required from the drug manufacturers. These rebates could be based just on drugs expenditures above the global budget, or on all drug expenditures throughout the fiscal year.

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News

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For Immediate Release

IMS HEALTH REPORTS 3.4 PERCENT ANNUAL RATE OF CHANGE FOR U.S. PRESCRIPTION DRUG PRICES

Industry Sales Growth Reaches a Record 17.6 Percent

PLYMOUTH MEETING, PA, August 13, 1998 -- IMS HEALTH (NYSE: RX) today reported that the annual rate of change for prescription pharmaceuticals in the U.S. was 3.4 percent for the second quarter of 1998 compared to the same period for 1997. This rate is 0.3 percentage points higher than the annual measurement reported for the prior six months, which held at 3.1 percent. IMS HEALTH is the world's leading provider of information solutions to the pharmaceutical and healthcare industries.

The overall rate of inflation in prescription drug pricing for the second quarter of 1998 is in line with the measurement reported previously for May 1998 versus May 1997. The figure remains below the double-digit rates reported elsewhere for the same time periods.

Modest Upward Trend Since Mid-1997

The overall rate of change in prescription drug prices rose gradually throughout 1997 before pausing in the first quarter of 1998. The upward trend continued in the second quarter of 1998.

Prices for brand pharmaceuticals rose by 4.3 percent in the second quarter of 1998 versus the same quarter in 1997. The increase was offset by a decrease of 5.1 percent in generic drug prices (See Table), the same rate as recorded in the fourth quarter of 1997.

Sales Growth Continues at Record Pace

Overall prescription sales volume for the six channels of distribution audited by IMS HEALTH grew by 17.6 percent for the second quarter of 1998 versus the same period a year ago. The net growth for pharmaceutical sales, removing the impact of price changes, was 14.2 percent.

This second quarter industry growth rate of 17.6 percent is the highest measured, surpassing the 17.3 percent recorded in third quarter 1997 and even the yearly double-digit growth rates of the late 1980s. By comparison, the peak annual growth rate recorded during the 1980s was 15.5 percent for 1987 over 1986.

"There is some indication that drug prices are starting to climb upward," commented Myron Holubiak, general manager of The Plymouth Group, the consulting arm of IMS HEALTH. "In spite of the rise in drug prices, the substantial rate of growth in the pharmaceutical industry continues to be driven by non-price factors." Price accounted for only 3.4 percentage points of the 17.6 percent growth. Of the 14.2 percent real growth, new products and line extensions accounted for 7.3 percent and volume and mix categories accounted for 6.9 percent.

The inflation rate measured by IMS HEALTH, at 3.4 percent, is far below the Producer Price Index, Industry Weighted, which increased to 20.5 percent for June 1998 versus June 1997, as measured by the Bureau of Labor Statistics through a basket of goods approach. The Consumer Price Index for all items was 1.7 percent for the same time period.

Retail Sector Biggest Driver of Overall Trend

Prescription drug prices for the retail sector rose by a weighted average rate of 3.9 percent for the second quarter of 1998 versus the same period a year ago. This figure is up slightly from the annual rate of 3.8 percent reported for the first quarter of 1998. Consistent with the overall market trend, prices of brand-name drugs in the retail sector moved up 5.0 percent, while generic prices decreased 6.6 percent.

"The retail sector is a significant barometer of overall market trends," stated Holubiak. "It accounts for more than two-thirds of the industry's sales dollars, making the retail sector the largest driving force behind the overall annual price change rate of 3.4 percent."

Rate for Brands through Non-Retail Sector Increases

For the non-retail distribution channels, pharmaceutical prices were 2.0 percent higher in the second quarter of 1998 compared to the same period a year ago. "This increase reflects a wide range of rates among the non-retail distribution channels," noted Susan Capps, senior manager, Pricing Studies at IMS HEALTH. Non-injectable brand-name drugs had a weighted-average annual price increase of 4.9 percent, up over the annual rate of 3.8 percent reported in the first quarter of 1998. Non-injectable generic drugs had a price decrease of 2.5 percent.

"Interestingly, prices for prescription drugs purchased by non-federal hospitals increased 2.4 percent, the highest in several years," commented Capps. "Prices for injectable and non-injectable drugs purchased by non-federal hospitals rose 2.0 percent and 3.4 percent, respectively. This was driven primarily by brand-name drugs." For the non-retail injectable market, the overall rate of price change remained low at 0.5 percent.

Inflation for Top 10 Drugs Remains Below Industry Totals

Prices for the top 10 selling prescription drugs increased 2.2 percent overall and 2.8 percent for the retail sector, when comparing the second quarter of 1998 to the second quarter of 1997. These measurements exclude any new products that were not on the market during the base 1997 period. The rates, while up slightly from the first quarter 1998 figures, remain below the overall market inflation for all brands – 4.3 percent overall and 5.0 percent for retail pharmacy market.

"We are continuing to see pharmaceutical manufacturers raise prices selectively," commented Holubiak. "The top selling products have an aggregated inflation rate well below the overall rates, indicating that other products had higher price increases, which brought the averages to levels above 4 percent."

Rate for Quarter Remains Below Double-Digit Reports

"When taking a comprehensive view of the market, we are not seeing the overall double-digit price increases reported elsewhere," Holubiak said. "The rate of change appears to remain within overall economic indicators. As I remarked previously, the acceptance of newer, advanced drugs continues to proceed at a rapid rate, thus influencing a market-basket approach to calculating purchaser outlay for prescription pharmaceuticals. This challenges the market basket approach to measuring the true economic impact of drugs, since the newer therapies may be providing significant incremental benefit that is not captured in these types of analyses."

Figures Reflect Acquisition Prices of 20,000 Products

IMS HEALTH's acquisition-price database encompasses more than 20,000 pharmaceutical products and is updated continuously. The database reflects invoice-based discounts for pharmaceutical purchases through six audited channels of distribution. It does not include subsequent, off-invoice rebates that, if considered, could further reduce drug purchase prices. IMS HEALTH calculates all price changes on a weighted average level, based on unit volume. As a result, the rate of price change is driven by those products with the highest unit volume. All rates calculated by IMS HEALTH use actual transaction prices, not list prices such as Average Wholesale Price (AWP).

IMS HEALTH

IMS HEALTH is the world's leading provider of information solutions to the pharmaceutical and healthcare industries. With more than \$1 billion in 1997 revenue, IMS HEALTH operates in over 90 countries. IMS HEALTH is the largest pharmaceutical manufacturer information partner, with over 40 years' experience in the industry. Key products and services integral to customer day-to-day operations include: market research for prescription and over-the-counter pharmaceutical products; sales management information to optimize sales force productivity; technology enabled selling solutions for sales and marketing decision-making; technologies systems and information services that support managed care organizations. Additional information and previous press releases are available at IMS HEALTH's web site: <http://www.imshealth.com>.

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August 13, 1998

Table
Second Quarter 1998 vs. Second Quarter 1997
Price Changes for Prescription Drugs in U.S. Market

Market	Percent Change Q2 '97 to Q2 '98		
	TOTAL	BRANDS	GENERICS
Total Market	3.4	4.3	-5.1
Retail Pharmacies	3.9	5.0	-6.6
Hospitals	2.4	2.8	-1.2
Injectables	2.0	2.3	-0.8
Non-Injectables	3.4	4.3	-1.9
Clinics	-0.8	-0.8	-0.4
Injectables	-2.9	-3.1	0.9
Non-Injectables	5.2	6.1	-2.6
Staff-Model HMOs	6.0	6.6	-0.9
Injectables	3.8	3.9	1.7
Non-Injectables	6.5	7.3	-1.1
Long-Term Care Facilities	5.0	5.6	-2.0
Injectables	4.9	5.2	0.3
Non-Injectables	5.0	5.7	-2.2
Federal Facilities	-0.4	0.3	-5.5
Injectables	-1.8	-1.5	-5.3
Non-Injectables	0.0	0.8	-5.5

Source: IMS HEALTH, a healthcare information company

PRESCRIPTION DRUG COST
FILE

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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. Several 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 seven congressional districts: the 1st district of Maine, represented by Rep. Thomas H. Allen; the 2d district of Texas, represented by Rep. Jim Turner; the 1st district of Arkansas, represented by Rep. Marion Berry; the 5th district of Wisconsin, represented by Rep. Thomas Barrett; the 1st district of Michigan, represented by Rep. Bart Stupak; the 13th district of Ohio, represented by Rep. Sherrod Brown; and the 29th district of California, represented by Rep. Henry A. Waxman.

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, the first national analysis of its kind, 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 over twice as much for the drugs as the drug companies' favored customers. The study found that this is an unusually large price differential -- nearly five times greater than the average price differential for other consumer goods.

It appears that drug companies are engaged in a form of "discriminatory" pricing that victimizes those who are least able to afford it. Large corporate 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 ten 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 seven congressional districts from 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 ten drugs investigated in this study, the average price differential was 106% (Table 1). This means that senior citizens and other individuals who pay for their own drugs pay more than twice as much for these drugs than do the drug companies' most favored customers.

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

Prescription Drug	Manufacturer	Use	Prices for Favored Customers	Retail Prices for Senior Citizens	Price Differential for Senior Citizens
Ticlid	Hoffman-LaRoche	Stroke	\$33.57	\$118.06	252%
Zocor	Merck	High Cholesterol	\$42.95	\$104.98	144%
Norvasc	Pfizer Inc.	High Blood Pressure	\$58.83	\$112.22	91%
Prilosec	Astra/Merck	Ulcers	\$58.38	\$111.21	90%
Relafen	Smithkline Beecham	Arthritis	\$62.58	\$116.92	87%
Procardia XL	Pfizer Inc.	Heart Problems	\$67.35	\$125.49	86%
Vasotec	Merck	Blood Pressure	\$56.08	\$103.62	85%
Fosamax	Merck	Osteoporosis	\$31.86	\$58.03	82%
Cardizem CD	Hoechst Marrion Roussel	Angina/Hypertension	\$99.36	\$173.29	74%
Zoloft	Pfizer, Inc.	Depression	\$123.88	\$211.75	71%
Average Price Differential					106%

- **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 1,407%. An equivalent dose of this drug would cost the manufacturers' favored customers only \$1.78, but would cost the average senior citizen almost \$27.00. For Micronase, a diabetes treatment manufactured by Upjohn, an equivalent dose would cost the favored customers \$6.89, while seniors are charged an average of \$47.14. The price differential was 584%.

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
Synthorid	Knoll Pharmaceuticals	Hormone Treatment	\$1.78	\$26.83	1407%
Micronase	Upjohn	Diabetes	\$6.89	\$47.14	584%

- 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 ten prescription drugs was 106%, 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. The differential between retail prices and the published national Average Wholesale Price is only 4%. 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 seven congressional districts in different parts of the United States. Significant price differentials were found in all congressional districts, with very little variation. The highest price differential was 127% in California, while the lowest price differential was 98% in Michigan and Ohio. The price differential was 105% in Maine, Arkansas, and Wisconsin, and 103% in Texas. 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

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).

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 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 1.

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 seven 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 ten patented, nongeneric drugs with the highest annual sales to older Americans in 1997. The list was obtained from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE). The PACE program is the largest out-patient prescription drug program for older Americans in the United States for which claims data is available and is used in this study, as well as by several other analysts, as a proxy database

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

¹² *Id.* at 19.

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 seven congressional districts. The seven districts where the study was conducted were the 1st District in Maine (Rep. Thomas H. Allen), the 2d District in Texas (Rep. Jim Turner), the 1st District in Arkansas (Rep. Marion Berry), the 5th District in Wisconsin (Rep. Thomas M. Barrett), the 1st District in Michigan (Rep. Bart Stupak), the 13th District in Ohio (Rep. Sherrod Brown), and the 29th District in California (Rep. Henry A. Waxman). The locations of the districts where pharmacies were surveyed for this study are shown in Appendix D. A total of 75 pharmacies in the six districts -- 46 independent stores, and 29 chain stores -- were surveyed. Pharmacies were surveyed in rural, urban, and suburban areas, and in a range of high-, low-, and middle-income neighborhoods.

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-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.

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

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

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 1997 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

IV. DRUG COMPANIES CHARGE OLDER AMERICANS DISCRIMINATORY PRICES

A. Discrimination in Drug Pricing

For the ten 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 106% (Table 1). The study thus showed that the average price that older Americans and other individual consumers pay for these drugs is more than double the price paid by the drug companies' favored customers, such as large insurance companies and HMOs.

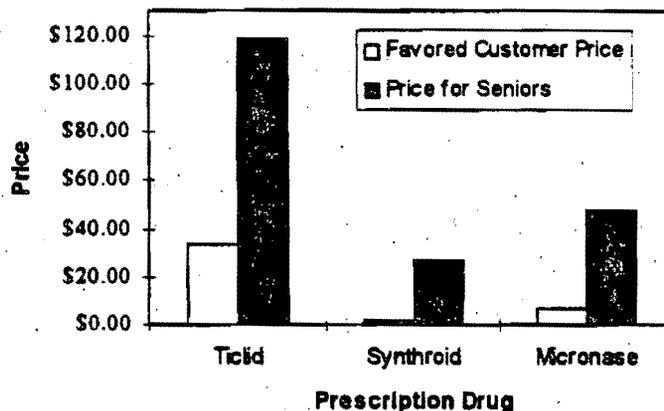
¹⁵ Medical Economics Company, Inc., *1997 Drug Topics Red Book*.

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

For individual drugs, the price differential was even higher. Among the ten best selling drugs, the highest price differential was 252% for Ticlid, a stroke treatment manufactured by Hoffman-LaRoche. 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 1,407%. An equivalent dose of this drug would cost the most favored customers only \$1.78 but would cost the average senior citizen in the United States \$26.83. For Micronase, a diabetes treatment manufactured by Upjohn, the price differential was 584% (Figure 1).

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



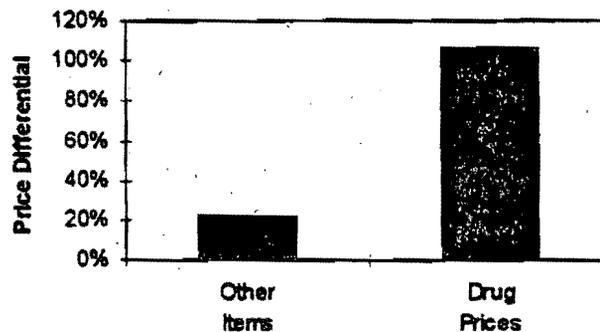
Every drug looked at in this study had a large price differential. Among the ten best selling drugs, two (Ticlid and Zocor) had price differentials that exceeded 140%, and five more (Norvasc, Prilosec, Relafen, Procardia XL, and Vasotec) had price differentials of over 85%. The lowest price difference was still high -- 71%, for Zoloft.

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 nearly five times larger than the average price differential for other consumer goods (Figure 2). This indicates that a volume effect is unlikely to explain the large differential in prescription drug pricing.

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



C. Drug Company Versus Pharmacy Responsibility

The study also sought to determine whether drug companies or retail pharmacies 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 ten most common drugs was only 4% higher 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

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

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

(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. Eight of the ten most popular prescription drugs in this survey -- Zocor, Norvasc, Prilosec, Procardia XL, Relafen, Vasotec, Fosamax, and Zoloft -- 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).

105TH CONGRESS
2D SESSION

H. R. 4627

To provide for substantial reductions in the price of prescription drugs for Medicare beneficiaries.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 25, 1998

Mr. ALLEN (for himself, Mr. TURNER, Mr. TIERNEY, Mr. WAXMAN, Mr. BERRY, Mr. BARRETT of Wisconsin, Mr. BROWN of Ohio, Mr. STUPAK, Mr. WEYGAND, Mr. STARK, Ms. KILPATRICK, Mr. KUCINICH, Mr. SANDERS, Mr. CUMMINGS, Mr. SERRANO, Mr. THOMPSON, Mr. POMEROY, Mr. JOHNSON of Wisconsin, Mr. FRANK of Massachusetts, Mr. SANDLIN, Ms. STABENOW, Mr. YATES, Mr. BORSKI, Mr. FROST, Mr. DAVIS of Illinois, Mrs. THURMAN, Mr. KIND, and Mr. ABERCROMBIE) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for substantial reductions in the price of prescription drugs for Medicare beneficiaries.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Prescription Drug
5 Fairness for Seniors Act of 1998".

1 **SEC. 2. FINDINGS AND PURPOSES.**

2 (a) FINDINGS.—The Congress finds the following:

3 (1) Manufacturers of prescription drugs engage
4 in price discrimination practices that compel many
5 older Americans to pay substantially more for pre-
6 scription drugs than the drug manufacturers' most
7 favored customers, such as health insurers, health
8 maintenance organizations, and the Federal Govern-
9 ment.

10 (2) On average, older Americans who buy their
11 own prescription drugs pay twice as much for pre-
12 scription drugs as the drug manufacturers' most fa-
13 vored customers. In some cases, older Americans pay
14 over 15 times more for prescription drugs than the
15 most favored customers.

16 (3) The discriminatory pricing by major drug
17 manufacturers sustains their annual profits of
18 \$20,000,000,000, but causes financial hardship and
19 impairs the health and well-being of millions of older
20 Americans. More than one in eight older Americans
21 are forced to choose between buying their food and
22 buying their medicines.

23 (4) Most federally funded health care programs,
24 including Medicaid, the Veterans Health Administra-
25 tion, the Public Health Service, and the Indian
26 Health Service, obtain prescription drugs for their

1 beneficiaries at low prices. Medicare beneficiaries are
2 denied this benefit and cannot obtain their prescrip-
3 tion drugs at the favorable prices available to other
4 federally funded health care programs.

5 (5) It has been estimated that implementation
6 of the policy set forth in this Act will reduce pre-
7 scription prices for Medicare beneficiaries by more
8 than 40 percent.

9 (6) In addition to substantially lowering health
10 care costs for older Americans, implementation of
11 the policy set forth in this Act will significantly im-
12 prove the health and well-being of older Americans
13 and lower the costs to the Federal taxpayer of the
14 Medicare program.

15 (b) PURPOSE.—The purpose of this Act is to protect
16 Medicare beneficiaries from discriminatory pricing by drug
17 manufacturers and to make prescription drugs available
18 to Medicare beneficiaries at substantially reduced prices,
19 by allowing pharmacies to purchase drugs for Medicare
20 beneficiaries at the substantially reduced price available
21 under the Federal Supply Schedule.

22 **SEC. 3. MEDICARE BENEFICIARY DRUG BENEFIT CARD.**

23 The Secretary of Health and Human Services shall
24 furnish to each Medicare beneficiary a drug benefit card
25 that enables the beneficiary to purchase covered prescrip-

1 tion drugs from participating pharmacies at reduced
2 prices pursuant to section 4.

3 **SEC. 4. PARTICIPATING PHARMACIES.**

4 (a) **AGREEMENTS TO PARTICIPATE.**—Any qualified
5 pharmacy may enter into an agreement with the Secretary
6 that enables the pharmacy to sell covered outpatient drugs
7 to holders of Medicare drug benefit cards at a reduced
8 price, by authorizing the pharmacy to operate as a partici-
9 pating pharmacy under this Act.

10 (b) **RIGHT OF PARTICIPATING PHARMACIES TO OB-**
11 **TAIN DRUGS.**—An agreement under this section shall enti-
12 tle the participating pharmacy to purchase any covered
13 outpatient drug that is listed on the Federal Supply
14 Schedule of the General Services Administration at the
15 participating pharmacy discount price for that drug deter-
16 mined under subsection (d).

17 (c) **QUANTITY OF DRUGS PURCHASED.**—An agree-
18 ment under this section shall permit the participating
19 pharmacy to purchase under this Act as much of a covered
20 outpatient drug as is sold by the pharmacy to holders of
21 Medicare drug benefit cards.

22 (d) **PARTICIPATING PHARMACY DISCOUNT PRICE.**—

23 (1) **IN GENERAL.**—The Secretary shall deter-
24 mine a participating pharmacy discount price for
25 each covered outpatient drug.

1 (2) DETERMINATION.—The participating phar-
2 macy discount price for a covered outpatient drug
3 shall be determined by adding—

4 (A) the price at which the drug is available
5 to Federal agencies from the Federal Supply
6 Schedule under section 8126 of title 38, United
7 States Code; plus

8 (B) an amount that reflects the adminis-
9 trative costs incurred by the Secretary in ad-
10 ministering this Act.

11 **SEC. 5. ADMINISTRATION.**

12 (a) IN GENERAL.—The Secretary shall administer
13 this Act in a manner that uses existing methods of obtain-
14 ing and distributing drugs to the maximum extent pos-
15 sible, consistent with efficiency and cost effectiveness.

16 (b) REGULATIONS.—The Secretary shall issue such
17 regulations as may be necessary to implement this Act.

18 **SEC. 6. REPORTS TO CONGRESS REGARDING EFFECTIVE-**
19 **NESS OF ACT.**

20 (a) IN GENERAL.—Not later than 2 years after the
21 date of the enactment of this Act, and annually thereafter,
22 the Secretary shall report to the Congress regarding the
23 effectiveness of this Act in—

24 (1) protecting Medicare beneficiaries from dis-
25 criminatory pricing by drug manufacturers; and

1 (2) making prescription drugs available to
2 Medicare beneficiaries at substantially reduced
3 prices.

4 (b) CONSULTATION.—In preparing such reports, the
5 Secretary shall consult with public health experts, affected
6 industries, organizations representing consumers and
7 older Americans, and other interested persons.

8 (c) RECOMMENDATIONS.—The Secretary shall in-
9 clude in such reports any recommendations they consider
10 appropriate for changes in this Act to further reduce the
11 cost of covered outpatient drugs to Medicare beneficiaries.

12 **SEC. 7. DEFINITIONS.**

13 In this Act:

14 (1) COVERED OUTPATIENT DRUG.—The term
15 “covered outpatient drug” has the meaning given
16 that term in section 1927(k)(2) of the Social Secu-
17 rity Act (42 U.S.C. 1396r-8(k)(2)).

18 (2) MEDICARE BENEFICIARY.—The term
19 “Medicare beneficiary” means an individual entitled
20 to benefits under part A of title XVIII of the Social
21 Security Act or enrolled under part B of such title,
22 or both.

23 (3) MEDICARE DRUG BENEFIT CARD.—The
24 term “Medicare drug benefit card” means such a
25 card issued under section 3.

1 (4) SECRETARY.—The term “Secretary” means
2 the Secretary of Health and Human Services.

3 **SEC. 8. EFFECTIVE DATE.**

4 The Secretary shall implement this Act as expedi-
5 tiously as practicable and in a manner consistent with the
6 obligations of the United States.

○

Drug Benefit Structure Options for Medicare Beneficiaries

August 21, 1998

Administrative Assumptions. To simplify the analyses, assume that the non-managed care benefit options would be administered in as efficient a way as possible. Medicare would establish a process whereby PBMs in each region competitively bid to provide Medicare services. Once a contract is awarded, the winning PBM in each region would be the sole-source benefits manager for a beneficiary in that area.

OPTIONS

I. BENEFIT FOR ALL MEDICARE BENEFICIARIES

Assume:

- Mandatory, not optional, to avoid selection
- Part B benefit; premium not distinguished from other Part B benefits (25 percent)
- Managed care plans would have to offer this benefit as a minimum; rates would not be increased to reflect costs to plans that did not offer this benefit or level of benefits before.
- No change to Medicaid law (i.e., since Medicare is primary over Medicaid, there would be Medicaid savings, but states would have to pay the additional 25 percent premium)
- No recapture of employer payments
- Change in Medigap law to prohibit comparable drug coverage

Benefit Design:

	Annual Deductible	Coinsurance	Out-of-Pocket Limit
a. FEHB Blue Cross/Blue Shield Standard	\$50	20%	\$1,000*
b. Base Coverage	\$250	20%	\$1,000
c. Catastrophic plan	\$1,000	None	\$1,000

* Note: There is no specific drug cap; the general cap is \$2,700 for the standard plan

II. BENEFIT FOR LOW-INCOME BENEFICIARIES ONLY

Assume:

- Administered through Medicaid; new optional benefit; no state mandate
- Builds on current eligibility categories for QMB, SLMB and QI programs. No spend-down

Benefit Design:

	Eligibility	Coinsurance	Matching Rate
a. QMB	Income up to 100% Assets at or below 200% of SSI limit	None	FMAP
b. QI	Income up to 185% of poverty Assets at or below 200% of SSI limit	None for those below poverty \$1-2 coinsurance per prescription for those above poverty	100 percent

III. BENEFIT FOR BENEFICIARIES IN MANAGED CARE

Assume:

- All participating Medicare managed care plans must offer at least the base benefit from Option I
- No additional premium is allowed
- No change in Medigap or Medicaid

Benefit Design:

	Payment Adjusted	FFS Benefit
a. Required	No	No
b. Required plus adjustment	Yes	No
c. Requirement plus FFS Catastrophic	No	Yes: Catastrophic coverage option

**Prescription Drug Pricing in the 1st Congressional District in Maine:
An International Price Comparison**

Prepared for Rep. Thomas H. Allen

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

October 24, 1998

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EXECUTIVE SUMMARY

This report, which was prepared at the request of Rep. Thomas H. Allen, compares prescription drug prices in the 1st Congressional District of Maine with drug prices in Canada and Mexico. The report finds that senior citizens and other consumers in Mr. Allen's congressional district who lack insurance coverage for prescription drugs must pay far more for prescription drugs than consumers in Canada and Mexico. These price differentials are a form of price discrimination. In effect, the drug manufacturers appear to be engaged in "cost shifting." They charge low prices to consumers in Canada and Mexico and appear to make up the difference by charging far higher prices to senior citizens and other individual consumers in the United States.

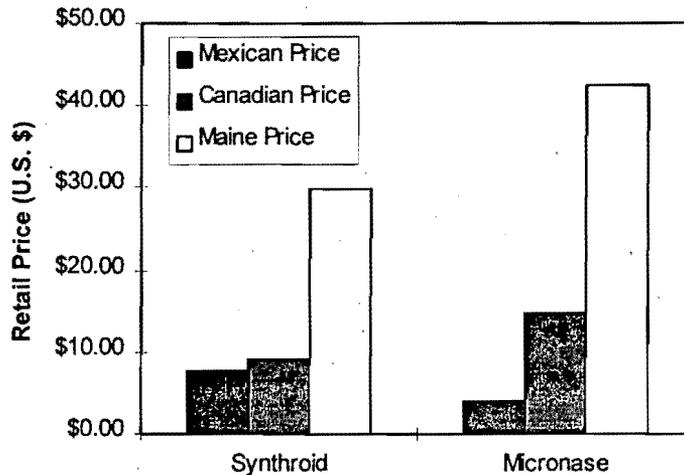
This study investigates the pricing of the ten brand name prescription drugs with the highest dollar sales to the elderly in the United States. The study compares the prices that senior citizens who buy their own prescription drugs must pay for these drugs in Mr. Allen's district with the prices that consumers who buy their own drugs must pay for the same drugs in Canada or Mexico. The study finds that the average prices that senior citizens in Mr. Allen's district must pay are 72% higher than the average prices that Canadian consumers must pay and 102% higher than the average prices that Mexican consumers must pay (Table 1).

Table 1: Maine Seniors Pay Significantly Higher Retail Prices for Prescription Drugs Than Consumers in Canada or Mexico.

Prescription Drug	U.S. Dosage and Form	Canadian Retail Price	Mexican Retail Price	Maine Retail Price	Canada-Maine Price Differential	Mexico-Maine Price Differential
Zocor	5 mg, 60 tablets	\$43.97	\$47.29	\$103.92	136%	120%
Ticlid	250 mg, 60 tablets	\$52.35	\$39.61	\$117.96	125%	198%
Prilosec	20 mg, 30 cap.	\$53.51	\$29.46	\$111.89	109%	280%
Relafen	500 mg, 100 tablets	\$59.55	\$49.26	\$116.39	95%	136%
Zoloft	50 mg, 100 tablets	\$124.41	\$155.52	\$213.28	71%	37%
Procardia XL	30 mg, 100 tablets	\$72.82	\$87.78	\$118.85	63%	35%
Fosamax	10 mg, 30 tablets	\$45.01	\$51.33	\$61.66	37%	20%
Vasotec	10 mg, 100 tablets	\$73.42	\$57.03	\$96.49	31%	69%
Norvasc	5 mg, 90 tablets	\$87.71	\$88.08	\$111.71	27%	27%
Cardizem CD	240 mg, 90 tablets	\$142.70	\$88.14	\$174.99	23%	99%
Average Differential					72%	102%

In the case of two additional drugs considered in the study, Synthroid and Micronase, Maine senior citizens were forced to pay at least three times, and in one case more than ten times, more than Canadian or Mexican consumers (Figure 1).

Figure 1: Price Differentials for Two Popular Drugs



This is the second congressional report on drug price discrimination requested by Mr. Allen. The first report showed that senior citizens in Mr. Allen's district are forced to pay substantially more for their prescription drugs than are the drug companies' favored domestic customers, such as large insurance companies, large HMOs, and the federal government.¹ This report shows that senior citizens in Mr. Allen's district are also forced to pay far more for their prescription drugs than are consumers in other countries. Taken together, the two studies indicate that senior citizens and other U.S. consumers who buy their own drugs are at the bottom of a complex drug pricing hierarchy. As a result, they are forced to pay more for their prescription drugs than both favored institutional buyers in the United States and individual consumers in other countries.

¹ Minority Staff Report of the House Committee on Government Reform and Oversight, *Prescription Drug Pricing in the 1st Congressional District in Maine: Drug Companies Profit at the Expense of Older Americans* (October 9, 1998).

I. INTRODUCTION

In the United States, drug manufacturers are allowed to discriminate in drug pricing. As one industry analysis commented, “[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.’”² 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.”³

The extent of this price discrimination in Maine was first documented in a report released by Rep. Thomas H. Allen.⁴ This report found that senior citizens and others in Maine who lack insurance coverage for prescription drugs pay approximately twice as much for their prescription drugs as the drugs companies’ most favored customers, such as large insurance companies, large HMOs, and the federal government. Mr. Allen’s study also found that this discriminatory pricing imposes severe hardships on senior citizens, many of whom are on fixed incomes and must choose between purchasing their prescribed medications and paying for other necessities such as food.

The governments of Canada and Mexico do not allow drug manufacturers to engage in price discrimination. In Canada, approximately 35% of prescription drugs are paid for by the government for beneficiaries of government health care programs.⁵ In Mexico, 30% of prescription drugs are paid for by the government under similar circumstances.⁶ The rest of the population in these two countries must either buy their own drugs or obtain prescription drug insurance coverage. To prevent the drug companies from charging individual consumers excessive prices, both the Canadian and Mexican governments regulate prices for patented prescription drugs.⁷ Drug manufacturers do not have to sell their products in Canada or Mexico,

² Herman Saftlas, Standard & Poor’s, *Healthcare: Pharmaceuticals*, Industry Surveys 19-20 (December 18, 1997).

³ *Id.* at 19.

⁴ *Prescription Drug Pricing in the 1st Congressional District in Maine: Drug Companies Profit at the Expense of Older Americans*, *supra* note 1.

⁵ Health Canada, *National Health Expenditures in Canada 1975-1996: Fact Sheets*, 12 (June 1997).

⁶ National Economic Research Associates, *Financing Health Care: The Health Care System in Mexico*, 78 (August 1998).

⁷ Congressional Research Service, *Prescription Drug Price Comparisons: The United States, Canada, and Mexico* (January 1998).

but if they do, they cannot sell their drugs at prices above the maximum prices established by the government.

This report is the first effort to compare retail prices that senior citizens in Maine must pay for prescription drugs with the prices at which the same drugs are available in Canada and Mexico.⁸ It finds that senior citizens in Maine who lack prescription drug benefits must pay far more for prescription drugs than consumers in Canada and Mexico. The drug companies thus appear to engage in two distinct forms of price discrimination: (1) as documented in Mr. Allen's first report, the drug companies are forcing senior citizens in Maine to pay more for prescription drugs than more favored U.S. customers, and (2) as documented in this report, the drug companies are forcing senior citizens in Maine to pay more for prescription drugs than consumers in more favored countries.

II. METHODOLOGY

A. Selection of Drugs for This Survey

This survey is based primarily on a selection of the ten patented, nongeneric drugs with the highest annual sales to older Americans in 1997. The list was obtained from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE). The PACE program is the largest out-patient prescription drug program for older Americans in the United States for which claims data is available. It is used in this study, as well as by several other analysts, as a proxy database for prescription drug usage by all older Americans. In 1997, over 250,000 persons were enrolled in the program, which provided over \$100 million of assistance in filling over 2.8 million prescriptions.⁹

In addition to the top ten drugs for seniors, this study also analyzed two additional prescription drugs, Synthroid and Micronase. These popular prescription drugs were included in

⁸ In a 1992 study, *Prescription Drugs: Companies Typically Charge More in the United States Than in Canada*, the U.S. General Accounting Office compared producer prices for prescription drugs in Canada and the United States. This study did not include information on retail prices. In a 1998 study, *International Comparison of Prices For Antidepressant and Antipsychotic Drugs*, Public Citizen compared wholesale prices for newly developed antipsychotic and antidepressant drugs. This study also did not compare retail prices paid by consumers, but instead looked at pharmacy acquisition costs. The study also only looked at a small class of drugs. Neither of these studies included information on prices in Maine.

⁹ Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly* (January 1 - December 31, 1997).

the study because the earlier analysis indicated that there is substantial discrimination in the pricing of these drugs.

B. Determination of Average Retail Drug Prices in Maine

In order to determine the prices that senior citizens are paying for prescription drugs in Maine, the minority staff and the staff of Mr. Allen's congressional office conducted a survey of nine drug stores -- six independent pharmacies and three chain stores -- in Mr. Allen's congressional district. Mr. Allen represents Maine's 1st Congressional District, which includes Portland and southern Maine.

C. Determination of Average Retail Drug Prices in Canada and Mexico

Retail prices for prescription drugs in Canada and Mexico were determined via a survey of four pharmacies in Canada and three pharmacies in Mexico. In Canada, pharmacies were surveyed in three provinces: Ontario, British Columbia, and Nova Scotia. In Mexico, pharmacies were surveyed in Ciudad Juarez, just across the border from El Paso, Texas. No significant price differences were observed between prices at different pharmacies in Canada; similarly, no significant price differences were observed between prices at different pharmacies in Mexico.

Prices from Canadian pharmacies were determined in Canadian dollars, and prices from Mexican pharmacies were determined in pesos. All prices were converted to U.S. dollars using exchange rates in effect on October 5, 1998.

D. Selection of Drug Dosage and Form

In comparing drug prices, the study generally used the same drug dosage, form, and package size used by the U.S. General Accounting Office in its 1992 report, *Prescription Drugs: Companies Typically Charge More in the United States Than in Canada*. For drugs that were not included in the GAO report, the study used the dosage, form, and package size common in the years 1994 through 1997, as indicated in the *Drug Topics Red Book*.¹⁰

All prescription drugs surveyed in this report were available in Canada in the same dosage and form as in the United States. In Mexico, several drugs were not available in the same dosage and form. In these cases, prices of equivalent quantities were used for the comparison. For example, in the United States the drug Zocor is commonly available in containers containing five mg. tablets, while in Mexico Zocor is available only in containers containing ten mg. tablets. To compare Zocor prices, this report compared the cost of 60 five mg. tablets of Zocor in the

¹⁰ Medical Economics Company, Inc., *Drug Topics Red Book* (1997).

United States with the cost of 30 ten mg. tablets in Mexico. Several drugs are also sold under different names in Mexico. The Mexican equivalents of U.S. brand names were determined using the 44th edition of the *Diccionario de Especialidades Farmaceuticas* (1998).

III. FINDINGS

A. Senior Citizens in Maine Pay More for Prescription Drugs Than Consumers in Canada

Consumers in Canada obtain prescription drugs in one of two primary ways. Approximately 35% of the prescription drugs sold in Canada are paid for by the provincial governments on behalf of senior citizens, low-income individuals, and other beneficiaries of government health care programs. The rest of the population in Canada must either buy their own drugs or obtain prescription drug insurance coverage.

The regulatory system in Canada protects individual consumers who buy their own drugs from price discrimination.¹¹ The Patent Medicine Price Review Board (PMPRB), established under the Ministry of Health by a 1987 law, regulates the maximum prices at which manufacturers can sell patented medicines.¹² If the Board finds that the price of a patented drug is excessive, it may order the manufacturer to lower the price, and may also take measures to offset any revenues it has received from the excess pricing.¹³ Pharmacy dispensing fees for individual retail customers are not controlled by the government. Each pharmacy sets its usual and customary dispensing fee and must register this fee with provincial authorities.¹⁴

¹¹ Patented Medicine Price Review Board, *Regulation of Drug Prices: The Role and Impact of the Patented Medicine Price Review Board* (1992) (online at www.atreide.net/PMPRB/subm.html).

¹² The PMPRB establishes a set of guidelines to determine if manufacturers prices are excessive. Under these guidelines, the prices of new drugs must not exceed the maximum price of other drugs that treat the same disease. For “breakthrough” drugs, introductory prices must not exceed the median of the foreign prices of the drugs. Subsequent price increases are limited to changes in the Consumer Price Index.

¹³ These may include further reductions in the price of the drug, reductions in the price of another of the manufacturer’s drugs, or additional payments directly to the Canadian government.

¹⁴ These fees are generally only a small part of the overall prescription drug prices. In Ontario, for example, pharmacies are currently charging usual and customary dispensing fees ranging from \$1.99 to \$16.95. Ontario Drug Benefit Formulary Program, *ODB Facts*:

This study indicates that the Canadian system produces prescription drug prices that are substantially lower in Canada than in the United States. Average retail prices for the top ten drugs for seniors were 72% higher in the United States than in Canada (Table 1). For all ten drugs, retail prices were higher in the United States. For three drugs, Zocor, Ticlid, and Prilosec, the U.S. prices were more than twice as high as the Canadian prices. The highest price differential among the top ten drugs was 136%, for Zocor, a cholesterol medication manufactured by Merck.

For other drugs, price differentials were even higher. Synthroid is a hormone treatment manufactured by Knoll Pharmaceuticals. For this prescription drug, senior citizens in Maine pay an average retail price of \$29.80, while consumers in Canada pay only \$9.25 -- a price differential of 222%. Similarly, for Micronase, a diabetes drug manufactured by Upjohn, Maine senior citizens pay prices that are 188% higher than Canadian consumers.

This finding is broadly consistent with the findings of other analyses. In 1992, GAO looked at the prices that drug companies charge wholesalers for 121 prescription drugs and found that these prices were, on average, 32% higher in the U.S. than in Canada. According to GAO, "government regulations and reimbursement practices contribute to lower average drug prices in Canada. In setting prices, manufacturers of patented drugs must conform to Canadian federal regulations that review prices for newly released drugs and restrain price increases for existing drugs."¹⁵

GAO also investigated whether this price differential was attributable to differences in the costs of production and distribution. GAO found that drug costs -- such as research and development -- are not allocated to specific countries, and the costs of production and distribution make up only a small share of the cost of any drug. The study concluded that "production and distribution costs cannot be a major source of price differentials."¹⁶

B. Senior Citizens in Maine Pay More for Prescription Drugs Than Consumers in Mexico

As in Canada, consumers in Mexico also obtain prescription drugs in one of two primary ways. Approximately 30% of the prescription drugs sold in Mexico are purchased by the government and provided to eligible citizens at a significant discount through the social security

Dispensing Fees (June 1998).

¹⁵ U.S. General Accounting Office, *Prescription Drugs: Companies Typically Charge More in the United States Than in Canada*, 2-3 (September 1992) (GAO-HRD-92-110).

¹⁶ *Id.* at 14.

system.¹⁷ The rest of the population in Mexico must either buy their own drugs or obtain prescription drug insurance coverage.

The regulatory system in Mexico, like the system in Canada, protects individual consumers who buy their own drugs from price discrimination. Drug prices and rates of price increases in Mexico are controlled by the Ministry of Commerce and Economic Development (known by its Spanish acronym, Secofi) under the Pact For Economic Stability and Growth.¹⁸ Under the Mexican law, manufacturers and the government engage in negotiations to determine the nationwide maximum prices for prescription drugs.¹⁹ Pharmaceutical products are prepackaged and stamped with the maximum sales price, guaranteeing consistent prices throughout the country.

This study indicates that the Mexican system produces prescription drug prices that are substantially lower in Mexico than in the United States. Average retail prices for the top ten drugs for seniors were 102% higher in the United States than in Mexico (Table 1). For all ten drugs, retail prices were higher in the United States. For four drugs, Zocor, Ticlid, Relafen, and Prilosec, the U.S. prices were more than twice as high as the Mexican prices. The highest price differential among the top ten drugs was 280%, for Prilosec, an ulcer medication manufactured by Astra/Merck.

For other drugs, price differentials were even higher. In the case of Micronase, senior citizens in Maine pay an average retail price of \$42.50, while consumers in Mexico pay only \$4.05 -- a price differential of 950%. Similarly, in the case of Synthroid, Maine senior citizens pay prices that are 288% higher than Mexican consumers.

These findings are consistent with those of other experts. While there have been few direct comparisons of prices in the United States and Mexico, the Congressional Research Service has found that differences in the regulatory systems between the two countries result in the large price differentials. CRS concluded that "of greater importance in explaining price

¹⁷ *Financing Health Care: The Health Care System in Mexico*, *supra* note 6

¹⁸ Jeanne Grant, *Headaches for Pharmaceuticals*, *Business Mexico*, 8f (August, 1991).

¹⁹ The final negotiated price is based on a number of factors, including the purchasing power of the Mexican population, the availability of generic substitutes or other drugs that treat similar diseases, and other economic factors, such as the manufacturers cost to produce the product.

differentials in drug prices in Mexico and the United States is the fact that price controls and government procurement policies are in place in Mexico, and have been for some time.”²⁰

²⁰ *Prescription Drug Price Comparisons: The United States, Canada, and Mexico*, *supra* note 3.

Medicare Prescription Drug (INDEX)
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MEMORANDUM

October 23, 1998

FROM: Sally T. Burner
Office of the Actuary
Health Care Financing Administration

SUBJECT: Estimated Short-Range Financial Effects of Alternative Proposals To Cover Prescription Drugs Under Medicare

This memorandum presents the estimated financial effects in fiscal years 2000-2009 under eight alternative proposals to add coverage of prescription drugs to the Medicare program.

Table 1, attached, summarizes the key provisions of the proposals. The proposals differ primarily by (i) which beneficiaries would be eligible for the new coverage (all, low-income only, or managed care enrollees only); (ii) whether Medicare capitation payments to managed care plans would be increased to reflect the mandatory drug coverage; and (iii) by beneficiary cost-sharing requirements (principally low, medium, or high deductible).

In all cases, the drug benefits would be covered under the Supplementary Medical Insurance program ("Part B" of Medicare) and their cost to Medicare would be included in the determination of the monthly SMI premium.¹ Accordingly, 25 percent of the additional Medicare expenditures under these proposals would be financed through higher premiums, and the remaining 75 percent through increased revenue transfers from the general fund of the Treasury. (Option 2.b also involves a "maintenance of effort" payment by the States, as noted below.) This summary of the provisions represents our understanding of the proposals and may be subject to change if we have misinterpreted the specifications or if the proposals are developed further.

The following table shows the estimated total increase in Medicare benefit expenditures during the first 5 and first 10 years under each of the proposals. The 10-year "gross" cost (before reflecting additional premium revenue and reduced Medicaid outlays) generally ranges from \$141 billion for the proposals affecting low-income beneficiaries only to \$523 billion to cover all beneficiaries with a \$50 drug deductible (but no increase in capitation payments). An exception is option 3.a, which would mandate coverage of prescription drugs for Medicare+Choice enrollees only but which would not increase capitation payments; we estimate that this option would result in a negligible savings. Medicare administrative expenses would increase under these proposals but we have not estimated this additional cost.

¹ For options 2.a and 2.b, providing drug coverage to low-income beneficiaries only, we continued to assume that the cost to Medicare would be included in the premium determination, with the result that 25 percent of such costs would be met through premium payments by all beneficiaries. Similarly, option 3.b, mandating drug coverage for managed care enrollees only and adjusting capitation payments accordingly, is assumed to result in an increase in SMI premiums for all beneficiaries. An alternative would be to institute a separate drug-related monthly premium for only those beneficiaries eligible for drug coverage.

Proposal	Estimated total increase in Medicare benefit expenditures, in billions	
	2000-2004	2000-2009
Option 1.a	\$191	\$523
Option 1.b	162	455
Option 1.c	116	350
Options 2.a and 2.b	51	141
Option 3.a	(¹)	(¹)
Option 3.b	63	188
Option 3.c	117	354

Utilization
Assume that
auxiliary
cov.
10% Plans
7%

¹ Savings of less than \$50 million.

The "net" cost to Medicare, after reflecting additional premium income (but not additional administrative expenses), is shown in table 2 (attached). In addition, the estimated net reductions in Medicaid outlays are shown, reflecting (i) somewhat higher outlays for Medicare premiums and coinsurance, but (ii) significantly lower outlays for prescription drugs. Under option 2.b, State Medicaid programs would be required to rebate to the Medicare program an amount equal to their prior drug spending on behalf of dual beneficiaries.² With the exception of options 2.a and 2.b, and again excluding the impact on Medicare and Medicaid administrative costs, the net budget impact of these proposals is generally estimated at a little over 70 percent of the gross increase in Medicare benefit expenditures shown in the table above.

These estimates are based on the intermediate set of economic and demographic assumptions from the 1998 OASDI and Medicare Trustees Reports and assume the same growth trends estimated for overall prescription drug costs, as reported in our most recent projection of national health expenditures.³ Data on individual drug expenditures were drawn from the 1995 Cost and Use file of the Medicare Current Beneficiary Survey, and adjusted for survey underreporting and the induced utilization estimated to result from reduced out-of-pocket costs under the various proposals.

As with any proposal to introduce a new medical benefit, these estimates are subject to substantial uncertainty. Actual future costs could differ significantly from these estimates.

Sally T. Burner
 Sally T. Burner, A.S.A.
 Special Assistant to the Chief Actuary

² For purposes of estimating this transfer, we have assumed that it would be established for all years at an amount equal to the estimated Medicaid spending on prescription drugs in fiscal year 2000. We have also assumed that a Federal requirement for State revenues would be found constitutional, although this outcome seems far from certain.

³ See Sheila Smith *et. al.*, "The Next Ten Years of Health Spending: What Does The Future Hold?" *Health Affairs*, Vol. 17 No. 5 (September/October 1998).

Table 1—Summary of key provisions of alternative proposals to add coverage of prescription drugs to Medicare

Proposal	Eligibility	Adjust managed care payments?	Deductible	Coinsurance	Maximum out-of-pocket cost	
Option 1.a	All beneficiaries	No	\$50	20%	\$1,000	1191
Option 1.b	All beneficiaries	No	\$250	20%	\$1,000	1162
Option 1.c	All beneficiaries	No	\$1,000	None	\$1,000	116
Options 2.a and 2.b ¹	Low-income beneficiaries only:					
	Dual & QMB ²	No	None	None	n.a.	
	SLMB & QI ³	No	None	\$2 per script	n.a.	51
Option 3.a	Managed care enrollees only	No	\$250	20%	\$1,000	
Option 3.b	Managed care enrollees only	Yes	\$250	20%	\$1,000	63
Option 3.c	All beneficiaries:					
	Managed care	No	\$250	20%	\$1,000	
	Fee-for-service	n.a.	\$1,000	None	\$1,000	117

Handwritten notes:
 485 / 6000 a year
 c year
 344
 Medicare enrollees

¹ Under option 2.b, States would be required to rebate to the Medicare program an amount equal to their prior drug spending on behalf of dual beneficiaries. Option 1.a would not require this "maintenance of effort" payment.

² Income and assets meeting existing standards for either full or QMB Medicaid eligibility.

³ Income and assets meeting existing standards for either SLMB, QI1, or QI2 Medicaid eligibility.

Note: For each option, the prescription drug coverage would be classified as a benefit under the Supplementary Medical Insurance program, and its cost would be included in the determination of the monthly SMI premium. Eligibility for the Medicare benefit under option 2 would be determined through the Medicaid program, using the existing income and asset criteria for Medicaid eligibility. For all proposals with drug deductibles, the amount of the deductible would not be indexed in future years. An effective date of January 1, 2000 was assumed for each proposal.

MCBS →

Table 2—Estimated Medicare and Federal Medicaid costs (+) or savings (-) under alternative proposals to add coverage of prescription drugs to Medicare
(In billions)

Proposal	Fiscal year										Total, 2000-04	Total, 2000-09
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009		
Option 1.a												
Medicare expenditures.....	\$20.6	\$37.1	\$40.4	\$44.3	\$48.6	\$53.5	\$59.1	\$65.5	\$72.8	\$80.8	\$191.1	\$522.7
Medicare premiums.....	-4.9	-8.7	-9.5	-10.4	-11.4	-12.5	-13.8	-15.3	-16.9	-18.8	-44.9	-122.2
Net Medicare impact.....	15.7	28.4	30.9	33.9	37.2	41.0	45.3	50.3	55.8	62.0	146.2	400.6
Fed. Medicaid expenditures.....	-1.2	-1.4	-1.5	-1.7	-1.9	-2.1	-2.4	-2.7	-3.1	-3.4	-7.7	-21.4
Net budget impact.....	14.6	27.0	29.4	32.2	35.3	38.9	42.9	47.5	52.8	58.5	138.5	379.1
Option 1.b												
Medicare expenditures.....	17.0	30.9	34.1	37.7	41.8	46.5	51.8	57.9	64.7	72.3	161.6	454.8
Medicare premiums.....	-4.0	-7.2	-7.9	-8.7	-9.7	-10.8	-12.0	-13.4	-14.9	-16.7	-37.5	-105.2
Net Medicare impact.....	13.1	23.7	26.2	29.0	32.2	35.8	39.8	44.5	49.8	55.6	124.1	349.7
Fed. Medicaid expenditures.....	-1.1	-1.3	-1.4	-1.6	-1.8	-2.1	-2.4	-2.7	-3.0	-3.4	-7.3	-20.8
Net budget impact.....	11.9	22.5	24.7	27.4	30.3	33.7	37.5	41.9	46.8	52.2	116.9	328.8
Option 1.c												
Medicare expenditures.....	11.4	21.2	24.1	27.5	31.4	35.7	40.6	46.1	52.4	59.2	115.6	349.6
Medicare premiums.....	-2.5	-4.7	-5.4	-6.2	-7.0	-8.0	-9.1	-10.4	-11.8	-13.4	-25.9	-78.7
Net Medicare impact.....	8.8	16.5	18.7	21.4	24.3	27.6	31.4	35.7	40.5	45.8	89.7	270.8
Fed. Medicaid expenditures.....	-1.0	-1.0	-1.2	-1.4	-1.6	-1.9	-2.2	-2.6	-3.0	-3.4	-6.3	-19.3
Net budget impact.....	7.9	15.4	17.5	19.9	22.7	25.7	29.2	33.2	37.6	42.4	83.4	251.5
Option 2.a												
Medicare expenditures.....	5.5	9.9	10.8	11.9	13.1	14.4	16.0	17.7	19.6	21.7	51.2	140.6
Medicare premiums.....	-1.4	-2.5	-2.7	-3.0	-3.3	-3.6	-4.0	-4.4	-4.9	-5.4	-12.8	-35.2
Net Medicare impact.....	4.1	7.4	8.1	8.9	9.8	10.8	12.0	13.3	14.7	16.3	38.4	105.5
Fed. Medicaid expenditures.....	-2.1	-3.1	-3.4	-3.7	-4.0	-4.5	-4.9	-5.5	-6.0	-6.7	-16.3	-43.9
Net budget impact.....	2.0	4.3	4.8	5.2	5.8	6.4	7.1	7.8	8.7	9.6	22.1	61.6
Option 2.b												
Medicare expenditures.....	5.5	9.9	10.8	11.9	13.1	14.4	16.0	17.7	19.6	21.7	51.2	140.6
Medicare premiums.....	-1.0	-2.0	-2.2	-2.5	-2.8	-3.1	-3.5	-3.9	-4.4	-4.9	-10.4	-30.2
MOE transfer.....	-1.5	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0	-9.7	-20.0
Net Medicare impact.....	2.9	5.9	6.6	7.4	8.3	9.3	10.4	11.7	13.2	14.8	31.1	90.5
Fed. Medicaid expenditures.....	-2.1	-3.1	-3.4	-3.7	-4.0	-4.5	-4.9	-5.5	-6.0	-6.7	-16.3	-43.9
Net budget impact.....	0.8	2.8	3.2	3.7	4.2	4.8	5.5	6.3	7.1	8.1	14.8	46.6
Option 3.a												
Medicare expenditures.....	()	()	()	()	()	()	()	()	()	()	()	()
Medicare premiums.....	()	()	()	()	()	()	()	()	()	()	()	()
Net Medicare impact.....	()	()	()	()	()	()	()	()	()	()	()	()
Fed. Medicaid expenditures.....	()	()	()	()	()	()	()	()	()	()	()	()
Net budget impact.....	()	()	()	()	()	()	()	()	()	()	()	()
Option 3.b												
Medicare expenditures.....	6.2	11.7	13.2	15.0	17.1	19.4	21.9	24.6	27.6	30.8	63.3	187.5
Medicare premiums.....	-1.6	-2.9	-3.3	-3.8	-4.3	-4.8	-5.5	-6.1	-6.9	-7.7	-15.8	-46.9
Net Medicare impact.....	4.7	8.8	9.9	11.3	12.8	14.5	16.4	18.4	20.7	23.1	47.4	140.7
Fed. Medicaid expenditures.....	0.2	0.3	0.3	0.4	0.4	0.5	0.6	0.6	0.7	0.8	1.6	4.7
Net budget impact.....	4.8	9.1	10.2	11.6	13.2	15.0	17.0	19.1	21.4	23.9	49.0	145.4
Option 3.c												
Medicare expenditures.....	11.5	21.5	24.5	27.9	31.8	36.2	41.1	46.8	53.1	60.1	117.2	354.4
Medicare premiums.....	-2.6	-4.8	-5.5	-6.3	-7.2	-8.2	-9.3	-10.6	-12.0	-13.6	-26.3	-79.9
Net Medicare impact.....	9.0	16.7	19.0	21.6	24.6	28.0	31.8	36.2	41.1	46.4	90.9	274.5
Fed. Medicaid expenditures.....	-1.0	-1.0	-1.2	-1.4	-1.6	-1.9	-2.2	-2.5	-2.9	-3.4	-6.2	-19.2
Net budget impact.....	8.0	15.6	17.8	20.2	23.0	26.1	29.6	33.7	38.1	43.1	84.6	255.3

¹ Cost or savings of less than \$50 million.

- Notes: 1. Estimates are based on the intermediate set of assumptions from the 1998 Trustees Reports and data from the Medicare Current Beneficiary survey (1995 Cost and Use File).
 2. Estimates shown exclude changes in Medicare and Medicaid administrative expenses.
 3. See table 1 and accompanying memorandum for summary of proposals.