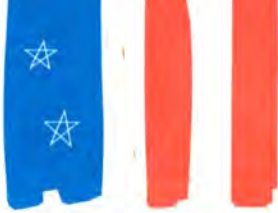


DRUGS

DRUGS

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**RACIAL/ETHNIC DRUG USE COMPARISONS**  
**1992 "Monitoring the Future Study"**

Racial/ethnic comparisons of drug use prevalence and trends among African-Americans, Hispanics, and whites reveal clear findings contrary to most popular stereotypes. According to the 1992 SAMHSA Household Survey, for example, more than **76 percent of all current illicit drug users are white**. Most instructive, however, are comparisons among teens done by the Institute for Social Research at the University of Michigan which are summarized below and detailed in the attached tables.

- African-American teens are currently **the least likely to try or use** every category of illegal drugs, including alcohol and tobacco.
- African-American teens' lower prevalence/usage levels are across eighth, tenth, and twelfth grade age groups -- suggesting that these differences **almost certainly are not due to any impact of dropout rates**.
- The lower usage rates among African-American teens are directly correlated with **their stronger anti-drug attitudes of perceived risk/harm and social disapproval**.
- The rate of decline in usage rates among African-American teens since the mid-1980's has been greater than that of white teens.
- New analyses done by Dr. David Hawkins of the University of Washington, to be released in April 1994, suggests one of the key factors in African-American teen resistance is **parental involvement in setting "no use" as the behavior standard and social norm**.

TABLE 10

Racial/Ethnic Comparisons of Lifetime, Annual, Thirty-Day, and Daily Prevalence of Use of Various Types of Drugs Eighth, Tenth, and Twelfth Graders

NOTE: Percents represent averages of 1991 and 1992 data<sup>a</sup>

Grade:	<u>Marijuana</u>			<u>Inhalants<sup>b</sup></u>			<u>Hallucinogens</u>			<u>LSD</u>			<u>Cocaine</u>		
	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th
<b>Lifetime:</b>															
White	9.9	23.0	36.3	18.4	18.1	19.3	3.6	7.2	10.8	3.0	6.7	10.1	2.3	3.7	7.0
Black	7.4	16.2	23.3	10.3	8.6	6.8	0.9	0.8	1.1	0.7	0.7	0.9	1.0	1.3	2.4
Hispanic	19.0	26.9	40.7	19.6	14.1	16.6	6.1	6.0	9.3	5.3	5.2	8.4	5.9	6.7	12.1
<b>Annual:</b>															
White	6.4	17.0	24.9	10.1	8.3	7.2	2.2	4.9	7.0	1.9	4.6	6.5	1.2	2.1	3.3
Black	4.1	7.6	11.5	4.4	3.6	2.5	0.7	0.2	0.7	0.5	0.2	0.6	0.7	0.6	1.3
Hispanic	11.9	18.9	24.7	10.4	6.4	6.1	3.8	3.6	4.7	3.3	3.2	4.1	3.1	3.7	5.3
<b>30-Day:</b>															
White	3.3	9.0	14.1	4.7	2.9	2.4	0.8	2.0	2.5	0.7	1.9	2.2	0.5	0.7	1.3
Black	2.0	3.6	6.1	2.4	2.0	1.5	0.4	0.2	0.3	0.3	0.1	0.3	0.4	0.1	0.7
Hispanic	6.4	10.4	12.7	5.5	3.0	2.5	1.9	1.4	1.5	1.7	1.2	1.2	1.7	1.1	1.9
<b>Daily:</b>															
White	0.2	0.9	2.1	—	—	—	—	—	—	—	—	—	—	—	—
Black	0.1	0.3	0.6	—	—	—	—	—	—	—	—	—	—	—	—
Hispanic	0.3	0.8	2.1	—	—	—	—	—	—	—	—	—	—	—	—

NOTE: The following sample sizes are based on the 1991 and 1992 surveys combined.

<u>Sample Sizes:</u>	<u>8th Grade</u>	<u>10th Grade</u>	<u>12th Grade</u>
White	21900	19600	21500
Black	4200	3900	3900
Hispanic	3400	2600	2600

TABLE 10 (cont.)

**Racial/Ethnic Comparisons of Lifetime, Annual, Thirty-Day, and Daily  
Prevalence of Use of Various Types of Drugs  
Eighth, Tenth, and Twelfth Graders**

NOTE: Percents represent averages of 1991 and 1992 data<sup>a</sup>

Grade:	Crack			Other Cocaine <sup>c</sup>			Heroin			Other Opiates			Stimulants <sup>d</sup>			Barbiturates <sup>d</sup>		
	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th
<b>Lifetime:</b>																		
White	1.2	1.6	2.7	2.0	3.4	6.2	1.2	1.2	1.1	—	—	7.4	11.2	14.7	16.7	—	—	6.5
Black	0.6	0.7	1.1	0.8	1.1	2.1	0.7	0.5	0.6	—	—	2.0	6.5	5.6	4.8	—	—	2.2
Hispanic	3.1	2.4	5.7	5.2	6.2	10.4	2.2	1.4	1.7	—	—	4.8	11.2	11.7	12.6	—	—	5.6
<b>Annual:</b>																		
White	0.7	0.9	1.3	0.9	1.9	3.0	0.6	0.6	0.5	—	—	4.1	6.8	9.4	8.8	—	—	3.5
Black	0.4	0.3	0.6	0.6	0.5	1.0	0.4	0.3	0.4	—	—	0.9	3.3	2.8	2.3	—	—	1.1
Hispanic	1.9	1.5	2.7	2.6	3.4	4.3	1.4	0.7	0.9	—	—	2.1	7.2	6.2	6.1	—	—	2.2
<b>30-Day:</b>																		
White	0.3	0.3	0.6	0.4	0.6	1.1	0.3	0.2	0.2	—	—	1.3	3.0	3.9	3.4	—	—	1.4
Black	0.3	0.1	0.4	0.3	0.1	0.6	0.1	0.1	0.3	—	—	0.5	1.5	1.4	0.9	—	—	0.5
Hispanic	1.0	0.5	1.1	1.4	0.9	1.5	0.7	0.2	0.6	—	—	0.7	3.6	2.8	1.6	—	—	0.7
<b>Daily:</b>																		
White	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Black	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Hispanic	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

(Table continued on next page)

TABLE 10 (cont.)

**Racial/Ethnic Comparisons of Lifetime, Annual, Thirty-Day, and Daily  
Prevalence of Use of Various Types of Drugs  
Eighth, Tenth, and Twelfth Graders**

NOTE: Percents represent averages of 1991 and 1992 data<sup>a</sup>

Grade:	Tranquilizers <sup>d</sup>			Alcohol			Been Drunk <sup>e</sup>			5+ Drinks			Cigarettes			Smokeless Tobacco <sup>f</sup>			Steroids <sup>e</sup>		
	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th
<b>Lifetime:</b>																					
White	3.9	6.6	7.3	71.7	84.8	89.7	27.3	51.9	69.7	—	—	—	45.8	57.3	65.7	11.6	15.2	—	1.8	1.7	2.1
Black	2.2	2.0	2.5	64.0	78.0	80.1	21.3	36.5	36.7	—	—	—	32.3	40.9	44.4	4.6	6.3	—	1.5	1.2	0.8
Hispanic	5.6	6.9	6.5	71.9	83.6	89.9	32.5	49.5	65.9	—	—	—	51.0	54.7	64.8	6.1	8.3	—	2.2	2.0	3.2
<b>Annual:</b>																					
White	2.0	4.0	3.7	56.3	74.1	80.2	18.9	42.2	57.7	—	—	—	—	—	—	—	—	—	1.1	1.0	1.4
Black	0.9	0.9	1.3	43.4	60.6	63.6	12.0	22.6	22.9	—	—	—	—	—	—	—	—	—	0.7	0.7	0.6
Hispanic	2.7	2.9	2.4	58.1	72.0	80.3	21.7	37.4	45.9	—	—	—	—	—	—	—	—	—	1.2	1.2	1.9
<b>30-Day:</b>																					
White	0.7	1.5	1.3	26.6	44.1	56.9	7.7	21.6	34.7	—	—	—	16.2	24.1	31.8	8.3	11.4	—	0.5	0.5	0.7
Black	0.4	0.3	0.5	18.6	30.2	32.0	5.4	9.4	11.0	—	—	—	5.3	6.6	8.8	1.8	2.9	—	0.3	0.5	0.6
Hispanic	1.0	1.3	0.9	31.0	41.0	53.8	9.9	16.2	27.2	—	—	—	16.7	18.3	25.0	4.2	6.2	—	0.5	0.6	1.0
<b>Daily:</b>																					
White	—	—	—	0.5	1.3	3.6	0.1	0.3	0.8	12.7	23.2	32.1	7.7	14.5	20.5	2.0	3.8	—	—	—	—
Black	—	—	—	0.5	0.9	1.9	*	0.5	0.6	9.6	15.0	11.3	1.4	2.8	4.3	0.3	0.5	—	—	—	—
Hispanic	—	—	—	1.1	1.6	3.6	0.1	0.3	1.0	20.4	22.9	31.0	7.3	8.4	12.5	0.8	1.1	—	—	—	—

NOTE: '—' indicates data not available.

<sup>a</sup>Data from two years have been combined to increase subgroup sample sizes.

<sup>b</sup>12th grade only: Data based on five questionnaire forms. N is five-sixths of N indicated.

<sup>c</sup>12th grade only: Data based on four questionnaire forms. N is four-sixths of N indicated.

<sup>d</sup>Only drug use which was not under a doctor's orders is included here.

<sup>e</sup>12th grade only: Data based on two questionnaire forms. N is two-sixths of N indicated.

<sup>f</sup>8th and 10th grades only: Data based on one questionnaire form. N is one-half of N indicated.



## PARTNERSHIP FOR A DRUG-FREE AMERICA

### THE IMPACT OF ILLEGAL DRUGS ON OUR MOST CRITICAL DOMESTIC PROBLEMS

**I. Drug abuse must remain one of the nation's top domestic priorities and requires understanding, attention, and action from all levels of the public and private sectors.** Millions of our children, adolescents, young adults and adults are impaired by or addicted to illegal drugs -- an individual and collective tragedy, and a problem of immense proportions. In 1992, nearly 23 million Americans used illegal drugs, 11.4 million used at least monthly, with approximately 6 million addicted. Yet the real pervasiveness of this problem is not immediately apparent through just the numbers or direct impact on the lives of the users and addicts. Illegal drugs are also inextricably involved, and a significant factor, in most of our other social issues. Aggressive action to reduce drug use and addiction is necessary to real improvement in these other ills and the overall quality of life in America.

- Drugs are a direct factor in nearly half of all **homicides and violent crimes**, and are overwhelming our law enforcement, criminal justice and correctional systems. Drug dealing has helped make our cities unsafe, and normal family and community life nearly impossible in many urban areas.
- Drugs account for the majority of the acceleration in the **spread of the AIDS** virus -- IV needle sharing, sexual transmission to and among women who are their sex partners, and in pediatric AIDS among children who are born to these women.
- Drugs are a **health hazard**, implicated as major risk factors in numerous other infectious diseases like tuberculosis, and in trauma, mental illness, and other physiological conditions. This also results in thousands of drug-exposed infants, higher morbidity rates, significantly higher healthcare costs, and an over-extended healthcare system.
- Drugs are a primary factor in at least half of **family violence** and one-third of **child abuse** incidents, destroying families and throwing our child welfare system into crisis. Violence and injury that is often related to drug abuse are responsible for three-quarters of adolescent deaths.
- Drugs in and around schools help create a climate that is **destructive to teaching and learning**, and are a factor in between one-third and one-half of our alarmingly high dropout rates. This also inhibits our ability to improve the education and training of the future workforce.
- Drugs are a primary factor among the majority of the **homeless population**, particularly the "new homeless" who are increasingly young women and their children. This is placing an enormous burden on our urban social systems.
- Drugs within the **workforce and workplace** -- two-thirds of drug users are employed -- have a significant human and financial impact on our economic productivity, global competitiveness, and safety on the job.

**II. Real progress has been achieved in drug abuse prevention and in understanding what works. However, current and planned resource allocation, national leadership, and public focus are insufficient to maintain that progress and threaten future success.**

■ Since the mid-1980's there has been significant improvements in social attitudes towards illegal drugs, and a dramatic decrease in the number of new triers and non-addicted users. Importantly, however, most recent trends among young teens indicate an erosion in their key anti-drug attitudes of risk and disapproval, resulting in higher usage rates of marijuana, LSD, cocaine, and inhalants.

■ Although fewer young people are falling into addiction, what evidence we have on addicted use and the approximately 6 million addicts suggests little progress in treating or reducing their numbers or usage habits.

**III. Prevention and treatment are effective and cost-efficient strategies for reducing illegal drug use and addiction, and their impact on our other social problems.** There is increasingly broad consensus about what has been learned and what must now be done -- a national and bipartisan call to action -- recognizing that each of us has a role to play in the solutions and all of us have a stake in the outcome.

■ Maintaining the prevention process of denormalization is basic to long-term success. It is critical to recognize that drug use is at its core the result of the demand we as individuals and society create for these substances. Increasing the attitudes of perceived risk and social disapproval is essential to preventing trial and reducing non-addicted use. **The essence of denormalization is establishing and reinforcing non-use as the behavioral standard and social norm.** The focal point of this process is at the community level -- changes in individual attitudes and behavior supported by community consensus against drugs. More resources need to be directed and coordinated to local public/private prevention partnerships. A combination of effective in-school education and broad community involvement, including parents, employers, media, law enforcement and healthcare professionals, have been shown to significantly reduce adolescent drug use.

■ Greater availability, effectiveness, and access to treatment are critical to reducing the impact of drugs on the nation. When prevention fails and the decision to use or not use drugs is replaced by the disease of addiction, it is critical to recognize that addiction is a treatable disease. It is estimated that the current system can treat less than one-fifth of the total addicted population. Most critical is the lack of treatment availability for "disordered" drug abusers, many of these within our criminal justice system. Also critically needed is more treatment for HIV infected, pregnant and homeless drug abusers. Current treatment needs require improvements in quality as well as quantity. More and earlier intervention is needed by families, the judicial system, and employers to drive people into treatment.

**THE WRONG MESSAGE OF  
LEGALIZING ILLICIT DRUGS**

Any policy discussion that includes consideration of legalizing illicit drugs reflects either a complete misunderstanding or ignorance of the key factors that affect trial and use of these substances. Legalization sends the societal message of public approval, eroding the anti-drug attitudes of our youth and encouraging them to try and use illegal drugs. What we need is the reverse — establishing the unequivocal message that our public behavior standard and social norm is "no use," continuously reinforced through the attitudes of harm/risk and social disapproval that are proven inhibitors to our youth trying and using these substances.

First, it is critical to recognize that drug abuse is, at its core, the result of the demand we as individuals and society create for these drugs. Prior to drug use becoming the disease of addiction, all drug trial and use is the result of decisions/choices we make to use or not use. The primary determinant in these decisions are the attitudes of 1) perceived harm/risk and 2) social disapproval. This is true across ethnicity, demography and geography. All progress in reducing drug use and, ultimately, addiction, is the result of increasing anti-drug attitudes in order to change the behavior.

The message of legalization is precisely antithetical to everything we've learned about preventing the demand for illegal drugs. The epidemic of illegal drug use over the past three decades was the result of these substances, their use, and their users becoming "normalized" -- perceived as benign and an accepted part of normal social behavior. Normalization has led to nearly 80 million Americans having tried illegal drugs. Because we did not understand the impairment and harm that results from using illegal drugs, we passively and actively moved away from the behavior standard and social norm of no-use.

The reverse process of "denormalization" that began with the death of Len Bias in 1986 has resulted in a decline of more than 50% in the number of Americans using illicit drugs. This fact is not well known, and probably is responsible for the much of the sense of hopelessness and helplessness that often surrounds the issue of drug abuse. As a nation, we began to recognize the harmfulness of drug use, and we began to re-establish the social norm of no-use. All the declines in trial and non-addicted use of illicit drugs are directly correlated with the increase in the attitudes of perceived harm/risk and social disapproval.

Importantly, however, most recent trends among young teens indicate an erosion in their key anti-drug attitudes of risk and disapproval, resulting in higher usage rates of marijuana, LSD, cocaine and inhalants. Further confusion in the behavior standard and social norm of no use, especially consideration of legalizing (read "normalizing") illicit drugs will, surely accelerate this disturbing trend and put us back into the drug epidemic of the 1970's and early 1980's.

## CHAPTER 1

# What Are Community Coalitions Against Substance Abuse?

Almost 2,200 groups lead or sponsor community coalitions fighting substance abuse throughout the nation. In fact, coalitions from every state responded to the Join Together survey. (See **Figure B**.)

The survey reveals common characteristics among community coalitions that distinguish them from other groups concerned with substance abuse. These characteristics include their broad membership base, their leadership, and their budgets. In addition, community coalitions tend to address a wide variety of issues identified by the community, commonly referred to as systemwide change, rather than focusing their work on a single area, and these groups are more likely to focus on changing community environments than on addressing individual needs.

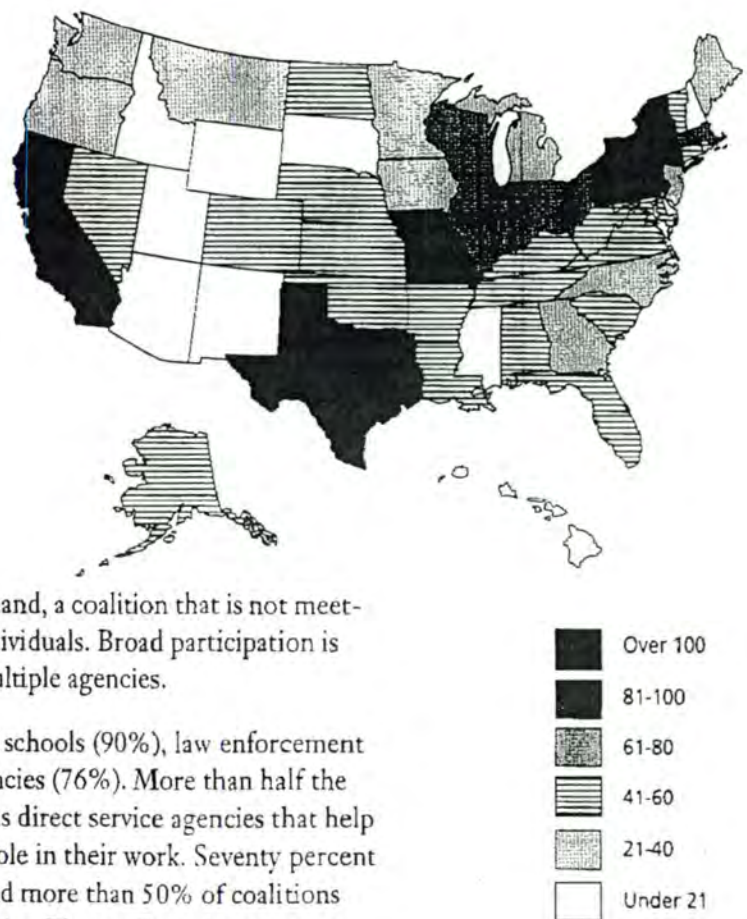
## Who Participates in Coalitions?

**Current Membership:** Membership is an important measure of a coalition's legitimacy. A coalition with sustained participation by its members is probably doing a good job. On the other hand, a coalition that is not meeting its goals quickly loses support from groups and individuals. Broad participation is also essential to carrying out programs that involve multiple agencies.

The membership of almost all coalitions include local schools (90%), law enforcement agencies (85%), and alcohol and drug prevention agencies (76%). More than half the coalitions named other major local institutions, such as direct service agencies that help people with alcohol and drug problems, as playing a role in their work. Seventy percent of respondents said treatment providers participate and more than 50% of coalitions include governmental health and human service agencies. **Figure C** on the next page shows the percent of groups involved in coalitions.

**Potential Membership:** The survey reveals that not all institutions that are members of community coalitions take an active role in the coalition's work. (See the ratings coalition leaders give major institutions in Chapter 4.) Even active participation by some business people or clergy does not mean that the entire business or religious community has been mobilized. Nevertheless, it does mean that key footholds have been established.

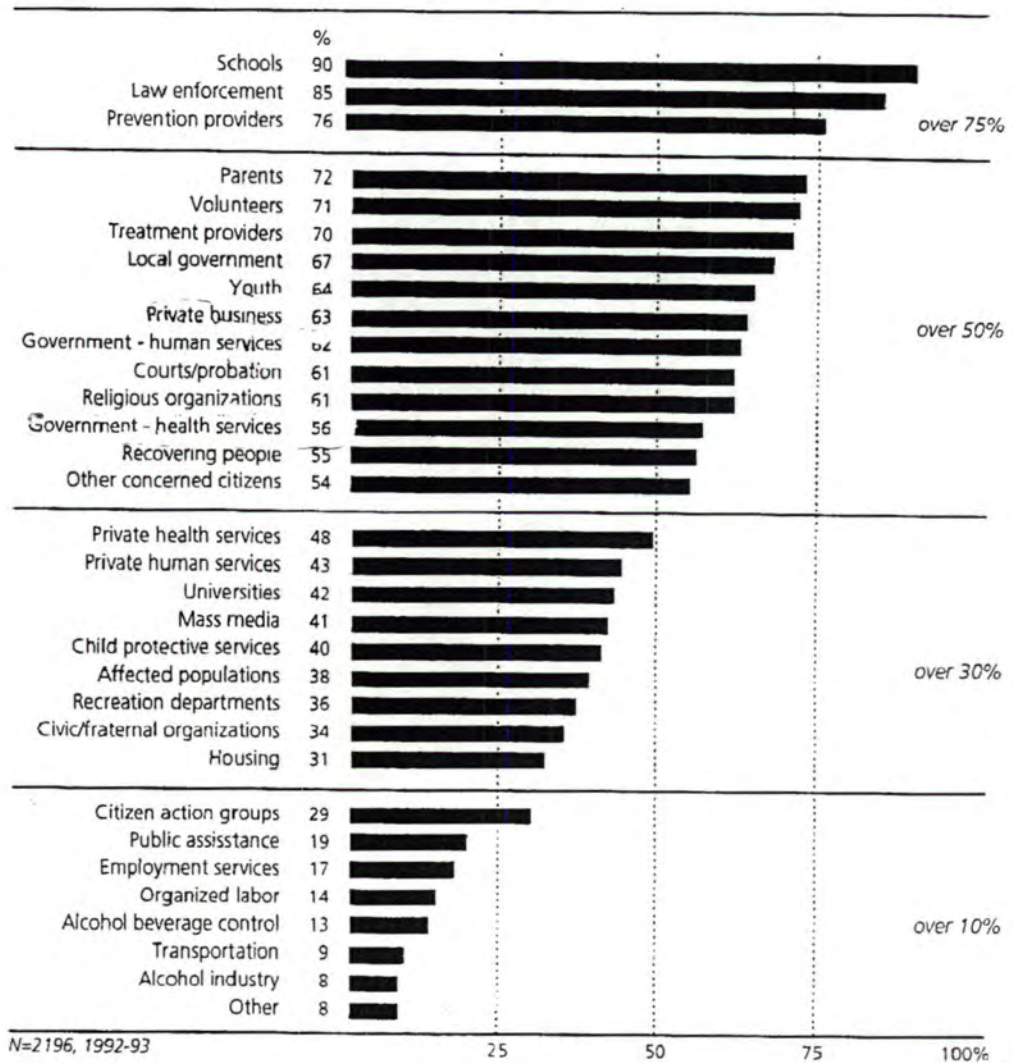
**FIGURE B**  
WHERE CAN YOU FIND COMMUNITY COALITIONS?



N=2196, 1992-1993

**1993 REPORT TO THE NATION**

**FIGURE C  
PARTICIPATION IN  
COALITIONS**



While many key groups actively participate in coalitions' efforts to reduce substance abuse problems, there are a number of institutions that are not yet doing their part in a majority of communities. (Figure D shows which groups increased their participation in coalitions from 1992 to 1993.) The survey shows that each coalition needs to identify the groups that are missing from its membership and then develop ways to involve them in the coalition's efforts. Meeting this challenge requires coalition members to find some mutual benefit to attract additional organizations to participate.

The following are specific groups many coalitions still need as part of their membership base:

**Media:** Increasing public awareness about substance abuse and possible communitywide solutions is key to any coalition's comprehensive strategy. News, advertising, and programming policies strongly affect a community's capacity to address substance abuse issues. The survey revealed that local media leaders and organizations participate in fewer than half (41%) of the nation's coalitions. When these key groups are present, coalitions

1993 REPORT TO THE NATION

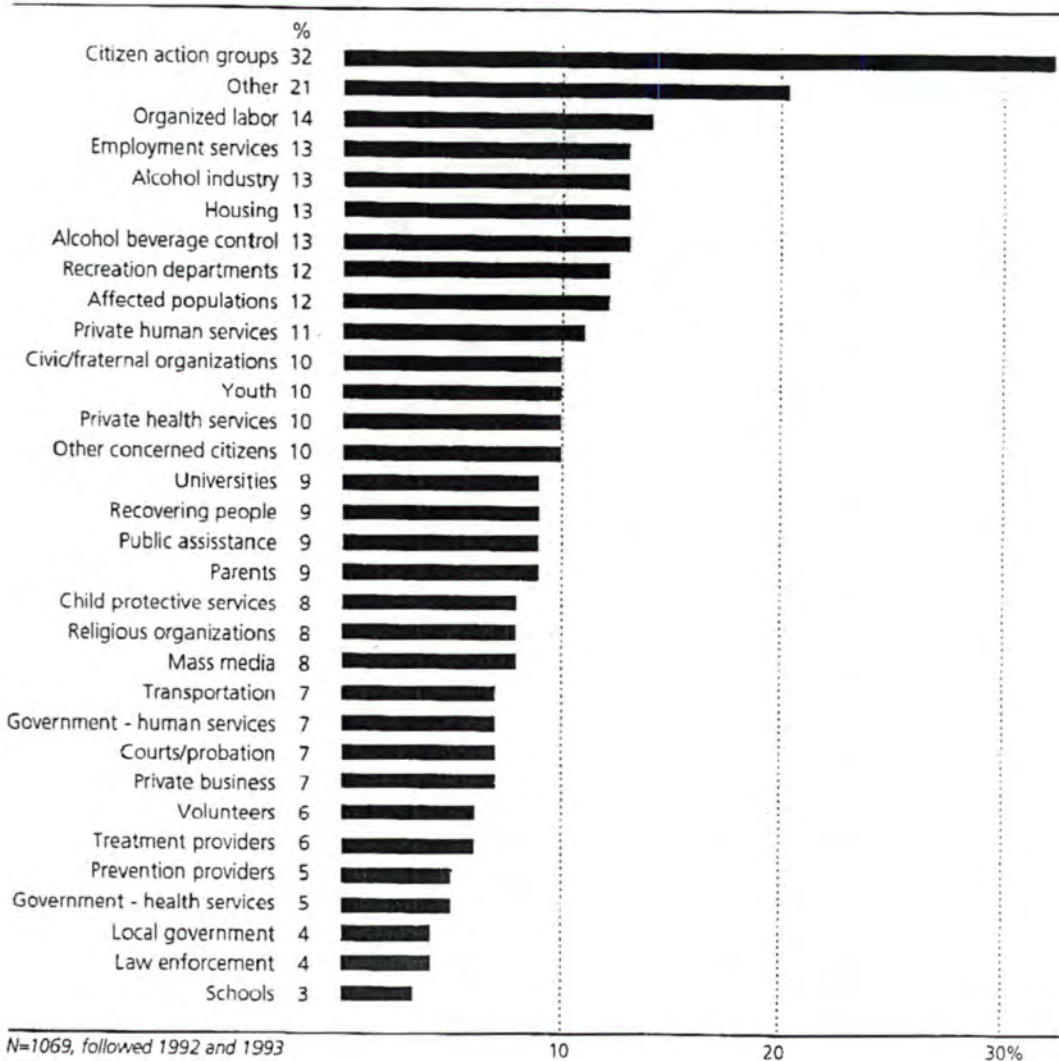


FIGURE D  
GROUPS THAT  
INCREASED  
PARTICIPATION

have a much easier time developing and implementing effective public awareness programs.

**Child Protection Agencies:** A hotly contested issue in many communities is whether parents in treatment should retain custody of their children. Because the threat of losing custody of a child discourages many parents from seeking treatment, public agencies and community coalitions need to provide the resources and support to help parents with substance abuse problems obtain treatment without concern of a custody battle. However, because child protective service agencies participate in fewer than half the coalitions, their absence from the coalition table makes it more difficult to work out a local solution to this issue.

**HOW THE MEDIA INCREASED ONE GROUP'S EFFECTIVENESS**

Strong media support has helped the Fighting Back coalition in Santa Barbara, CA, to be successful. The chairman of the coalition is the publisher of the Santa Barbara News Press. And the general manager of the television station is an active member of the group. With their help, the group launched a media campaign to educate residents about alcohol problems. The media's commitment resulted in weekly television and newspaper features about growing alcohol abuse and directed residents to sources of help. This sustained media coverage has lasted over two years and would not have been possible without this media leadership in the coalition.

**1993 REPORT TO THE NATION**

**FIGURE A  
SURVEY RESPONDENTS**

RESPONDENTS BY YEAR				
	Responded only in 1992	Responded only in 1993	Responded in 1992 and 1993	TOTAL
Lead a coalition	515 (28%)	612 (41%)	1069 (48%)	2196 (40%)
Participate in a coalition	867 (47%)	557 (38%)	819 (37%)	2243 (40%)
Do not lead or participate in a coalition	460 (25%)	304 (21%)	326 (15%)	1090 (20%)
TOTAL	1842	1473	2214	5529

includes 2,196 respondents that answered our survey by May of 1993. (See **Figure A.**) Join Together decided to focus only on this segment of lead agencies because these are the groups that carry out coalitions' activities throughout their communities. Any references in the report to the full 5,500 respondents are clearly indicated. See the Appendix for information about how the survey was conducted.

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## PARTNERSHIP FOR A DRUG-FREE AMERICA

JAMES E. BURKE

# Drugs

### The Problem is Demand

I HAVE BEEN WORKING on the illegal drug problem for the last four and a half years. It's a very complex problem, and depending upon how you look at it, you come out with a different set of answers. I admit having a bias: I have believed from the beginning and believe now more than ever that this is basically a marketing problem. It is driven by demand not by supply. That's an overstatement to be sure, but I believe the most important thing we can do is to move toward changing attitudes and in turn changing behavior, so that we can dry up the demand.<sup>1</sup>

I am going to give you a fairly hopeful presentation. I think I can demonstrate to you that we do know what works; we know why it works; and we know what to do to accelerate the process of turning off illegal drugs that has, blessedly, already begun.

The worst metaphor we ever created was "The War Against Drugs." The reason it's a bad metaphor is it gets everybody's head turned in the wrong direction. It turns drugs into a law and order and an interdiction problem, and while those are very important aspects of the problem, the really important part of this problem is demand.

### Good News and Bad News

What do I mean when I say America is turning off drugs? The NIDA (National Institute on Drug Abuse) 1991 household survey (see Figure 1) shows that 75 million Americans have used illicit drugs—which is an undercount, probably by 5 million. That means 80

<sup>1</sup> Europe and Asia don't share the same kind of problem that we have here, but the U.S. Drug Enforcement Agency believes the supply lines are changing—and changing quite dramatically—to the Far East as well as to Europe. I don't know enough to be sure, but I think it is possible that those of you from Europe and East Asia may be at the same place this country was in the late '70s.

...THE PROCESS  
OF TURNING  
OFF ILLEGAL  
DRUGS...HAS,  
BLESSEDLY,  
ALREADY  
BEGUN.

*file / drug*



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

APR 21 1994

The Administrator  
Washington, D.C. 20201

The Honorable Bill K. Brewster  
House of Representatives  
Washington, D.C. 20515

Dear Mr. Brewster:

I am responding to your letter to Mrs. Clinton regarding payment to pharmacists under the proposed Medicare outpatient prescription drug benefit contained in the Health Security Act (HSA). You raised issues in your letter regarding (1) the data utilized to calculate the 90th percentile of actual charges, payment limit, (2) the inclusion of a definition of actual charges and (3) the extension of the Omnibus Budget Reconciliation Act of 1990's moratorium on reductions in payment to pharmacists.

In regard to your first issue of the 90th percentile payment limit, we currently are reexamining this policy. As you may be aware, this provision was part of the payment methodology under the Medicare Catastrophic Coverage Act (MCCA) of 1988. However, unlike MCCA, the drug benefit proposed under HSA would require manufacturers to pay rebates to Medicare. Thus, the 90th percentile payment limit may not be necessary for cost containment purposes under HSA.

Regardless of the merits of the 90th percentile payment limit, the alternative update policy you propose would impact the calculation of all payment limits, including the calculation of estimated acquisition costs. Your proposal would provide updates on a daily basis, while the HSA would update payment limits every 6 months.

As you may be aware, although Medicare providers face price increases from suppliers throughout the year, Medicare rates are updated on an annual basis. Thus, we believe that the 6 month update policy proposed in HSA is a significant accommodation to pharmacists. Updates on a schedule more frequent than proposed would have implications for Medicare beyond pharmacists. In addition, we believe it would be administratively difficult to update national limits on a daily basis given the anticipated volume of one billion prescriptions per year and the use of multiple carriers to process claims.

Page 2 - The Honorable Bill K. Brewster

Finally, it is not clear that such a policy is necessary to protect pharmacists from significant price increases. We believe that the proposed rebate program would significantly constrain the level of price increases from manufacturers to pharmacists. To the extent that manufacturers increase their prices beyond the rate of inflation, as indicated by the Consumer Price Index, they would have to rebate to Medicare the resulting marginal revenues derived from sales to Medicare beneficiaries.

In regard to your second issue on actual charges, we do not believe it is necessary to include a statutory definition of actual charges under the proposed Medicare drug benefit. Unlike some third-party payors, Medicare's carriers uniformly interpret the term "actual charges" when determining payments to physicians and suppliers. The carriers do not calculate actual charges, instead the carrier simply recognizes the actual charge as the amount a physician or supplier actually bills the beneficiary for a particular service or supply.

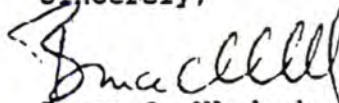
As to the OBRA 90 moratorium, an extension of the provision raises both policy and budget implications.

- ♦ States have reported that the moratorium requires them to pay pharmacists a fixed payment amount despite the fact that ingredient costs for certain prescription drugs have been dramatically reduced due to changing market conditions. For example, when generic products become available, ingredient costs for the brand name drug may decrease significantly. Because of the moratorium, State Medicaid programs would be required to pay the pharmacist the higher ingredient cost established at the time the moratorium became effective.
- ♦ As you are aware an extension of the moratorium was not proposed in the President's budget and the Medicaid baseline includes some slight savings from the expiration of the moratorium.

Clearly the weight one would put on the various policy considerations related to the moratorium would have to be evaluated in the context of the many aspects of a comprehensive health care reform package.

I hope this information has been helpful. I look forward to continuing to work with you as the President's health care reform proposal moves through Congress.

Sincerely,

  
Bruce C. Vladeck  
Administrator

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**BILL M. BREWSTER**  
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February 10, 1994

Mrs. Hillary Rodham Clinton  
Office of the First Lady  
1600 Pennsylvania Avenue, N.W.  
Washington, D.C. 20500

Dear Mrs. Clinton:

As a member of the Ways and Means Committee, which will play an active role in health care reform, I am writing to seek clarification on several sections of the Health Security Act pertaining to the pharmacy services benefit; particularly the proposed Medicare Outpatient Prescription Drug Benefit and the existing OBRA '90 moratorium on reducing pharmacy reimbursement that is due to expire on December 31, 1994.

**Second Previous Payment Period**

A concern with the current Health Security Act language in both S. 1757 and H.R. 3600, is that a payment limit to pharmacy providers for covered outpatient drugs under Medicare unnecessarily uses data 12 to 18 months old to calculate the reimbursement rate for the drug dispensed. As you know, the prices of prescription drugs can increase significantly during 12-18 months, which will result in substantially underpaying the pharmacy. Since drug pricing data is routinely updated daily, I suggest the use of data no more than 30 days old, which was supported by Senator Pryor in the Prescription Drug Prudent Purchasing Act of 1990.

The legislative language can be found in Title II, Subtitle A of both bills. Specifically, it reads:

"In the case of a covered outpatient drug that is a multiple source drug which had a restrictive prescription, or that is a single source drug, the payment limit for a calculation period is equal to-

- (i) the 90th percentile of the actual charges (computed on the geographic basis specified by the Secretary) for the drug product for the second previous payment calculation period".....

Page 361 (C), Payment Calculation Period

"The term 'payment calculation period' means the 6-month period

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beginning with January of each year and the 6-month period beginning with July of each year."

The language should be changed to state:

In the case of a covered outpatient drug that is a multiple source drug which has a restrictive prescription, or that is a single source drug, the payment limit for a calculation period is equal to-

(i) the 90th percentile of the actual charges (computed on a geographical basis specified by the Secretary) for the drug product for the payment calculation period.

Page 261 (C) Payment Calculation Period

The term "payment calculation period" means the price 30-days prior to the dispensing of the prescription.

Reimbursement rates should reflect a rolling 30-day price. Electronic claims management systems available and fully operational today, and called for in the Medicare Outpatient Prescription Drug Benefit, can be used to calculate the proper reimbursement to the pharmacy providers using very recent data.

The following are three examples of the difference in the drug product price that would be used in making a reimbursement determination under the current language as compared to the proposed version:

Drug Dispensed in December 1993	Reimbursement Determination based on Product Costs of Drug in July 1993	Reimbursement Determination Under New Language
Tegament	\$ 77.90	\$ 83.28
Nytrin	\$103.80	\$113.23
Mevacor	\$110.61	\$119.79

#### Definition of Actual Charge

Again, in the language of the Health Security Act relating to the Medicare Outpatient Prescription Drug Benefit, the product reimbursement formula makes reference to the "actual charges" for the prescription (see citation earlier in this letter). While the term actual charges may be one frequently used in health care contracts, it has become a source of serious contention to community retail pharmacies and the third party programs in which they participate. Payers, with increasing and troubling frequency are assigning to this seemingly self explanatory term new and creative meanings which materially impact the payment to the dispensing pharmacy.

To preempt any potential disagreement on the definition of this term under the Medicare program, I respectfully ask your consideration of the inclusion of a definition of "actual charge". I propose the following:

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**Page 361 (D) Actual Charge**

The term actual charge shall mean the usual and customary price for a prescription that includes cost of goods, dispensing fee, and an administrative charge to provide pharmacy services. These charges may vary depending on volume, and cognitive and administrative services performed.

**OBRA '90 Moratorium**

Secondly, and equally important, is the pharmacy profession's need to seek an extension of the OBRA '90 moratorium on further reduction in pharmacy reimbursement until a health care reform package is passed and implemented. OBRA '90 (Public Law No. 103-55 as amended) under the section entitled, "Treatment of Pharmacy Limits" states:

*During the period beginning on January 1, 1991 and ending on December 31, 1994 (A) a State may not reduce the payment limits established by a regulation under this title or any limitation described in paragraph (3) with respect to the ingredient cost of a covered outpatient drug or the dispensing fee for such a drug below the limits in effect as of January 1, 1991.*

Congress included the moratorium on reducing pharmacy Medicaid reimbursement in OBRA '90 to protect community retail pharmacies from further inequitable payment cuts indiscriminately made by either HCFA or the individual states. In response to the continued increase in prescription drug prices, the two previous Administrations through HCFA and many state Medicaid agencies had previously implemented cuts to reduce community retail pharmacy reimbursement without any consideration of whether the resulting reimbursement was even adequate to cover the pharmacies' costs.

During the extensive debate on prescription drug prices that preceded OBRA '90, Congress acknowledged that it was not community retail pharmacy that was driving up prescription prices and included the moratorium to protect pharmacy until December 30, 1994. Congress also required in OBRA '90 that HCFA perform a study on the adequacy of pharmacy Medicaid reimbursement, which could be used, if necessary, to formulate a new and more equitable Medicaid pharmacy reimbursement methodology. HCFA has indicated to us that the report to Congress on the results of the study are not expected to be available until March, 1994 at the earliest.

In light of the impending results of the OBRA '90 study on the adequacy of community retail pharmacy Medicaid reimbursement, I am requesting your support in amending the Health Security Act to extend the moratorium through the establishment of the approved state plans, at which time Medicaid prescription programs transfer to the jurisdiction of health alliances. This extension of existing law would allow for a reasonable transition from the current Medicaid programs into a reformed health care system. It will also allow time for interested parties to review and react to

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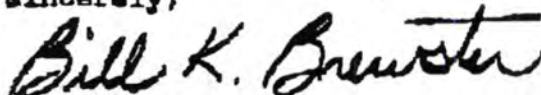
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the HCFA study results and the report to Congress.

Your response on these issues will be greatly appreciated as we mutually seek to meet our goal of meaningful health care reform.

Sincerely,



Bill K. Brewster  
Member of Congress

BB/ln

CC: Ira Magaziner  
Chris Jennings

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News for Lilly Associates Worldwide

Vol. 3 No. 2 March 1995



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