Prescription Drugs

Health Reform

file prescription Drugs

AARP

June 27, 2000

Dear Representative:

The need for prescription drug coverage in Medicare is no longer a question of debate. Prescription drugs are as much a part of modern medicine as doctor and hospital services. It only stands to reason that Medicare should provide such coverage for older and disabled Americans, just as employer-sponsored insurance does for many younger Americans.

In the bills coming before the House this week, each party has taken a different path to providing prescription drug coverage in Medicare. While we recognize that there can be different approaches to addressing this issue, we also know that a solution that can stand the test of time will require true bipartisanship. We therefore urge both sides to begin a discussion that will promote the strengths of each proposal while minimizing their respective weaknesses.

We are pleased that both the House Republican and Democratic bills include a voluntary prescription drug benefit in Medicare – a benefit to which every Medicare beneficiary is entitled. Further, both bills provide for a benefit that would be available in either fee-for-service or managed care settings. And while there are differences, both bills describe the core prescription drug benefit in statute. These are important steps and represent real progress over the past year.

AARP will continue to measure Medicare prescription drug benefit proposals against our principles, including: the need for a benefit that is available to all; provides affordable, meaningful and dependable coverage; is workable; and fosters high quality health care now and in the future.

The legislation being debated and voted this week raises many questions that must be addressed. Key among these is whether the proposed 5-year (2001-2005) $40 billion federal subsidy that was included in the Budget Resolution is adequate both to assure an affordable benefit and to create a broad insurance risk pool and stable program. Beginning with the President's proposal last year to provide a prescription drug benefit that would cost approximately $40 billion over 5 years, and then again this year in the Congressional Budget Resolution, policy makers in both parties have grappled with this challenge.

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Esther "Tess" Canja, President Horace B. Deets, Executive Director

AARP has consistently called for a more adequate federal subsidy for two interrelated reasons:

1. Affordability. Under each proposal beneficiaries generally would be liable for a 50 percent coinsurance on prescription drugs (in addition to any deductible such as that included in the Ways and Means reported bill). Beneficiaries would also be responsible for costs above the benefit limit, until reaching a "catastrophic limit" in both bills. In addition, they would be subject to a monthly premium. In the Democratic proposal, the monthly premium is set at $25.00 per month for the first year. In the Ways and Means proposal, plans' premiums are estimated to average $37.00 per month in the first year.

   Both bills protect those with incomes below 135 percent of poverty ($11,300 per individual, $15,200 per couple) and partially protect those with incomes between 135 percent and 150 percent of poverty ($12,500 per individual, $16,900 per couple). But for millions of older persons – middle income singles and couples – the monthly premiums, coupled with the 50 percent coinsurance, may prove too high a cost. As a result, many beneficiaries may elect not to participate in the benefit.

   For example, in the case of both proposals, Mrs. Jones, a single woman living alone on a $15,000 annual income, would pay a 50 percent coinsurance on all of her medicines, the monthly prescription drug premium (in addition to the basic Medicare Part B premium), the deductible if there is one, and the negotiated price for all prescriptions between the benefit limit and the out-of-pocket cap. If Mrs. Jones has very high drug costs she would clearly come out ahead. However, if she anticipates that her drug costs would continue where they are now – around $50.00 per month ($600 per year), and compared this to the cost of a Medicare benefit – the premium, coinsurance, and any deductible – she might conclude that the benefit is not worthwhile for her. Without enrollees like Mrs. Jones – i.e., beneficiaries with modest drug costs – in the risk pool, the benefit could become very expensive for other enrollees.

2. The need for a healthy risk pool. Both Congress and the President agreed early in this debate that any plan must be voluntary. The two alternatives are structured so as to minimize the tendency toward risk selection, i.e., "cherry picking." Yet the success of these proposals, as with virtually any proposal, rests on whether the program is attractive enough to beneficiaries to draw a broad risk pool; i.e., to attract not only those who are sick, but also those who are healthy. To accomplish this, the vast majority of beneficiaries must view the benefit package and the amount they will pay (in deductibles, coinsurance and premiums) as a "good buy." Without a broad risk

pool the cost for individuals who do sign up will eventually prove unaffordable, leading either to a cutback in the benefit, or to an even higher federal contribution.

While preliminary estimates of the percent of beneficiaries who will participate in each of these plans have been high, we are concerned that when beneficiaries sit at their kitchen tables and assess whether this coverage is a good buy for them, they will add up their premium, 50 percent coinsurance, any deductible, and their likely exposure to the "doughnut" between the benefit limit and the out-of-pocket cap. Without a higher federal subsidy to reduce the premium and strengthen the benefit it is unclear whether beneficiaries with average to low costs will opt to take this coverage.

We are mindful of the importance of fiscal discipline, which helped get us to the point where the federal budget is running surpluses. This fortunate development makes it far more possible to adopt a prescription drug benefit in Medicare. But as our healthy economy and budget surplus make additional funds available, the inadequacy of the $40 billion five-year federal subsidy must be addressed.

Ways and Means Bill

Beyond the question of the level of subsidy, the Ways and Means-reported bill raises some important questions that must be resolved before we believe our members would support it. Key among these are:

- The language of the bill provides an assurance that "The Medicare Benefits Administrator shall assure that each individual who is enrolled under part B...has available a...prescription drug plan." If there is no private entity offering, then the bill calls on the Administrator to structure a plan so that Medicare bears a greater share of the risk – in effect making Medicare the insurer of last resort. **Given the dependence on private sector entities (e.g., Pharmacy Benefit Managers [PBMs] and insurance companies) to offer coverage, will these entities agree to share risk with Medicare to provide prescription drug coverage? And, will the dependence on private entities result in much higher costs to beneficiaries for the same or similar benefits?**

- The bill creates a standard benefit package, but also allows for actuarially equivalent plans to be offered. **Will the benefits be meaningful and dependable – from year-to-year and plan-to-plan, and not be subject to the volatility that has developed in the Medicare managed care market?**

- The bill authorizes the Administrator to review compliance with the benefit coverage, subsidy, and actuarial equivalence requirements established in the bill. **Will the Medicare Benefits Administration be given the resources to carry out the authority to scrutinize drug plans to assure that beneficiaries receive the reinsurance subsidy and prescription drug discounts outlined in the bill?**

- The bill calls for the creation of a companion agency within HHS to administer the prescription drug benefit and the Medicare+Choice program. **How will the creation of two separate agencies to administer Medicare make the operation of the program more efficient?** By keeping Medicare within the Department of Health and Human Services, the Ways and Means proposal assures that the Administrators, as well as the Secretary would continue to be accountable to Congress for the operation of the program. **How will the Ways and Means proposal ensure seamless administration of both traditional fee-for-service and private health insurance options?**

Democratic Alternative

The Democratic alternative also raises some important questions:

- Beneficiaries will have a monthly premium of $25.00 in 2003 and a 50 percent coinsurance until they reach the benefit cap. As under the Ways and Means bill, they must also pay the full negotiated price of their prescriptions between the benefit cap and the stop-loss level ($4000 in the Democratic alternative). **While the value of the federal subsidy to beneficiaries is higher than in the Ways and Means bill, will beneficiaries find the monthly premium to be affordable enough to enroll in Part D?**

- The bill provides a broad zone of "non-interference by the Secretary" of HHS not to interfere in negotiations between benefit administrators and manufacturers or wholesalers. **Will this compromise the Secretary's ability to hold down overall program costs, which will, in turn, drive beneficiary premiums?**

- **What level of discount will benefit administrators be able to negotiate given that all prescription drugs are covered regardless of whether the medicine is included in a formulary?**

- **Given the current constraints on HCFA resources, will the Administrator of HCFA have the necessary resources and flexibility to effectively oversee Medicare fee-for-service, Medicare+Choice and the new prescription drug plans?**

Our members – and your constituents – have sent us a clear message: we need prescription drug coverage in Medicare now. AARP is determined to work with Members of Congress on both sides of the aisle to bring about bipartisan legislation that is consistent with our principles. It is on that basis – bipartisanship and consistency with our principles – that AARP will decide which legislation that it will support or oppose. AARP urges Members of Congress to work together with the President toward meaningful bipartisan legislation that creates dependable and affordable prescription drug coverage for all beneficiaries and strengthens Medicare for the future.

Sincerely,

Horace B. Deets

Horace B. Deets

Re Prescription Drugs

February 7, 2000

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: ANN O'LEARY

CC: MELANNE VERVEER

SUBJECT: PRESCRIPTION DRUGS

The purpose of this memo is to highlight the problem of prescription drug pricing in New York by calling to your attention a report prepared for Rep. Louise Slaughter as part of the investigation of prescription drug price discrimination conduced by the House Committee on Government Reform. In addition, I have included background information on the Administration's prescription drug proposal and the legislative proposals currently on the Hill.

Report on Extent of Problem in New York

In 1998, the Government Reform Committee began an investigation of drug companies' pricing practices and their impact on senior citizens without prescription drug coverage. The study included reports from over 140 Congressional districts, including the 28th Congressional District of New York (Rep. Slaughter's district). The study investigated the five brand name 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 major findings of the study include:

- Senior citizens pay more than twice as much for these drugs than do the drug companies' most favored customers;
- Price differentials are far higher for drugs than they are for other goods – the price differential for the prescription drugs included in the study was 109%, while for other items it was only 22%;
- Pharmaceutical manufacturers, not drug stores, appear to be responsible for the discriminatory prices that older Americans pay for prescription drugs. The study compared average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. The comparison revealed that New York pharmacies appear to have relatively small markups between buying the drugs and selling them to customers.

Administration's Proposal

The President's budget includes a comprehensive plan to reform and modernize Medicare. As part of this package, the Administration proposes to modernize benefits including adding a long overdue, voluntary prescription drug benefit. The proposed prescription drug benefit would be voluntary, available and affordable to all beneficiaries, including low-income beneficiaries who would pay low to no costs for coverage. For most beneficiaries, the benefit would cost $26 per month in the first year (and rise to approximately $50 per month by 2009). Beneficiaries would

pay no deductible and, when fully phased-in, would cover expenses up to $5,000. It would be administered by private organizations like pharmaceutical benefit managers (PBMs) and would give financial incentives to employers who currently offer retiree prescription drug benefits to maintain coverage. Finally, a reserve fund would be created for debt reduction or, if there is bipartisan consensus, to strengthen the Administration's drug benefit by adding protections against the cost of catastrophic drug expenses.

To date, the Administration has not come out in support of the Dorgan-Snowe International Drug-Parity Act. We have only commented on the bill behind the scenes by urging for adequate funding for the FDA to develop and implement quality controls for the prescription drugs re-entering the U.S. Instead, we have urged for a prescription drug package that would work to solve the problem of over-priced prescription drugs and the problem of the lack of coverage by Medicare rather than focusing on the political ploy of bringing prescription drugs back into the States.

Legislative Background

The Hill is tackling the prescription drug problem within three distinct areas: (1) expanding prescription drug coverage (2) reducing prices of prescription drugs (3) international drug parity/re-importation of prescription drugs.

Expanding Prescription Drug Coverage

Congressmen Stark and Dingell and Senators Kennedy and Rockefeller have introduced a more expensive and comprehensive but complicated prescription drug benefit. While promising front end and catastrophic coverage, it leaves seniors with drug costs of $1,500 to $3,200 exposed and vulnerable. With a 75 percent premium subsidy, our actuaries estimate that it costs nearly $300 billion over 10 years (compared to our $116 billion).

Reducing Prices of Prescription Drugs

Congressmen Allen, Waxman, Turner, and Berry have introduced legislation (the "Allen bill") that would require pharmacists serving seniors to provide them with access to the same discounts they provide to Federal and corporate purchasers. This policy is viewed by the drug industry as straight-up price controls, and this criticism has been validated by a number of businesses, insurers, and elite policy validators. Congressman Allen, a "New Democrat" from Maine, counters that this policy is not price controls, since the drug industry can choose the level of discounts it provides to large purchasers and thus the discount provided to Medicare beneficiaries through their local pharmacists. The bill, which has a broad based collection of Democratic sponsors (over 130 sponsors including Blue Dogs, New Dogs, and traditional liberals), is not going anywhere and has very few advocates in the Senate, but is attractive to many because there are no new Federal costs since it provides no new insurance coverage; rather, it simply requires access to discounts that are currently unavailable.

Congresswoman Thurman recently offered a version of the Allen bill during the Ways and Means markup of the BBA provider giveback legislation. It was rejected along party lines with

subcommittee Chair Thomas arguing that this was the wrong vehicle to use for broad Medicare reform. (Parenthetically, Mr. Thomas does not appear to have problems with including GMNE reforms, which have nothing to do with the BBA and are harmful to New York teaching hospitals, in the package to submitted to the floor last week.)

International Drug Parity/Re-Importation of Prescription Drugs

Senators Dorgan and Snowe have introduced bi-partisan legislation that would permit the re-importation of prescription drugs from Canada to pharmacies in the United States in order to access the discounts that Canadian pharmacists receive. The FDA has raised strong safety concerns about this legislation, but it can be cited as an example of the frustration members of Congress and the public at large are having with the price differentials between drugs sold in Canada and the United States, even though these medications were initially manufactured in this country.

Other Legislative Proposals

Numerous other prescription drug initiatives have either been unveiled or suggested by members of Congress. Senators Wyden and Snowe have introduced legislation to provide subsidies for HMOs and Medigap plans to offer prescription drug coverage. (We have criticized this legislation because it is a block grant approach that undermines Medicare's guarantee of coverage and does not provide for a workable fee-for-service benefit, thus making access to affordable prescription drugs impossible for millions of beneficiaries living in rural communities.)

In November, Senators Breaux and Frist offered a prescription drug benefit in the context of broader Medicare reforms; their plan includes a Medicaid benefit for beneficiaries up to 150 percent of the poverty level. (We have criticized this benefit as inadequate because over half of the seniors without prescription drug coverage have incomes over 150 percent of the poverty level.)

The Republican tax package included a tax deduction to offset the cost of prescription drug insurance for seniors. This proposal was widely criticized because the seniors who most need the drug benefit do not file taxes and would not be eligible for the tax deduction, and because the proposal does nothing to make affordable insurance more accessible.

FREQUENTLY ASKED QUESTIONS ABOUT THE INTERNATIONAL PRESCRIPTION DRUG PARITY ACT S. 1191

Introduced in the Senate by Senator Byron L. Dorgan (D-ND), along with Senators Olympia Snowe (R-ME), Paul Wellstone (D-MN), and Tim Johnson (D-SD)

What does the International Prescription Drug Parity Act do?
The bill would allow U.S. consumers access to lower priced prescription drugs by allowing their pharmacists to import prescription drugs into the United States. These are the same drugs available in the United States, manufactured by the same company, frequently made in the same plant, and sold under the same brand name.

This would address the absurd situation where American consumers are paying substantially higher prices for their prescription drugs than are the citizens of Canada, Mexico, and other countries. The International Prescription Drug Parity Act amends the Federal Food, Drug, and Cosmetic Act to allow American pharmacists and distributors to import prescription drugs into the United States *as long as they are approved by the U.S. Food and Drug Administration and manufactured at FDA-inspected facilities*. Pharmacists and distributors will be able to purchase these drugs at lower prices and then pass the huge savings along to American consumers.

Why is this bill needed?
Under federal law, pharmaceutical companies and individual consumers are the only ones allowed to import drugs approved by the U.S. Food and Drug Administration into this country.

Yet, if an American pharmacist or distributor wants to purchase these FDA-approved drugs at the much-lower prices available in other countries and pass the savings along to their customers, they are prohibited by law from doing so. The irony is that many of these drugs are made in our country and shipped to pharmacists and distributors in other countries for sale at lower prices there, but American pharmacists and distributors cannot reimport these drugs made in the United States back into this country. We need to amend current federal law to allow pharmacists and distributors to buy drugs, which are approved for sale in the United States, from other countries to take advantage of the lower prices available there. This is a common-sense thing to do. It is pro-business, pro-consumer and pro-American.

What is the price difference between prescription drugs sold in the United States and other countries?
A number of studies over the past decade, as well as anecdotal evidence, confirms that there is a significant price difference for drugs between the United States and other countries. For instance, a 1999 review by Senator Dorgan's office of a dozen of the most commonly used prescription drugs revealed that North Dakota consumers pay, on average, 205% more than their Canadian counterparts. Similarly, a study by the National Council of Senior Citizens of the top 10 prescription drugs used by older Americans found that in every instance, U.S. citizens were paying significantly more for the same drugs than Canadian and Mexican consumers. A U.S.

General Accounting Office study in 1991 studied 121 drugs and found that, on average, they cost 32 percent higher than the same products in Canada.

In fact, the following chart shows that the same drug that costs a senior citizen in the United States $1.00 costs seniors in other countries a fraction of that price:

Country	Price
United States	$1.00
Germany	$0.71
Sweden	$0.68
United Kingdom	$0.65
Canada	$0.64
France	$0.57
Italy	$0.51

Who supports the International Prescription Drug Parity Act?
This bill has been endorsed by Families USA, Public Citizen, the National Community Pharmacists Association, and the North Dakota Pharmaceutical Association.

Who opposes the International Prescription Drug Parity Act?
As one would expect, the bill is opposed by the pharmaceutical manufacturing industry.

What are some of the claims the big drug companies make about this legislation?
One claim that the pharmaceutical companies make is that this legislation could cut into the amount they spend on research. However, only about 20 cents of each prescription drug dollar is spent on research and development – about the same as the manufacturers spend on advertising and marketing – and even less (between 5 and 25 cents) is spent on actual production of the drug.

The fact is that profits exceed research costs at the top ten U.S. drug companies. Pharmaceutical companies' after-tax profits averaged 17 percent from 1994 to 1998, compared with 5 percent for all other industries, according to a December, 1999, report from the non-partisan Congressional Research Service (CRS).

In addition, American taxpayers heavily subsidize pharmaceutical research. For instance, in 1996 alone, the pharmaceutical industry was able to reduce its tax liability by $3.8 billion using a variety of tax credits. As a result, according to the CRS, drugmakers pay significantly less in taxes than other industries: The average effective tax rate for pharmaceutical companies was 16.2 percent from 1993 to 1996, compared to the average effective tax rate of 27.3 percent for all other major industries.

Another popular claim of the pharmaceutical industry is that this bill would import other countries' price controls. The International Prescription Drug Parity Act merely extends the benefits of free trade to buyers of prescription drugs. Drug manufacturers already benefit from free trade by buying the ingredients for their products at the lowest prices on the world market, and in fact, many of the ingredients they use can be imported free of tariffs. This bill would

merely enable American consumers to make the global economy work for them, too.

The truth is that drug companies do not set U.S. prices to cover research costs, they set them to maximize profits. They can set drug prices at extraordinary levels in our country because current law protects them from competition.

Claims vs. Facts
The International Prescription Drug Parity Act
(S. 1191/H.R. 1885)

CLAIM: *The FDA opposes the bill.*

FACT: The FDA has not taken a position on this bill. A National Public Radio story aired in July incorrectly reported that FDA opposes this legislation, and NPR later issued a correction at FDA's request. The legislation's authors consulted closely with the FDA in drafting S.1191/H.R. 1885 and incorporated many of its suggestions into the legislation that was introduced.

Dr. Jane Henney, the current FDA Commissioner, has expressed concern about the current situation whereby individual American consumers are traveling to foreign countries and bringing back prescription drugs – sometimes without even a prescription and without any assurance that the drugs are being properly stored or transported. S. 1191/H.R. 1885 would help to eliminate the need for patients to travel to other countries to get more affordable medications by allowing their pharmacists to do so under more controlled conditions.

CLAIM: *The legislation will reduce pharmaceutical research.*

FACT: Pharmaceutical manufacturers say that this legislation could cut into the amount they spend on research. What they don't mention is their extraordinary profit margins – the industry's 18% average profit margin was recently described by the *Wall Street Journal* as the "envy of the corporate world." Perhaps the manufacturers' claims would be believable if drug companies actually devoted a substantial share of their revenue to research. However, only about 20 cents of each prescription drug dollar is spent on research and development, and even less – between 5 and 25 cents – is spent on actual production of the drug. And the fact is that profits exceed research costs at the top ten U.S. drug companies.

Research and the resulting new miracle drugs cannot help American patients if they cannot afford them. Of course, pharmaceutical manufacturers perform important and life-saving research that should not be jeopardized but nor should Americans subsidize the drug R&D for the entire world.

CLAIM: *Savings realized by pharmacists and wholesalers will not be passed along to consumers.*

FACT: The pharmacy marketplace is highly competitive. Community pharmacies generally have modest gross margins and low profits. In addition, their customers who do not have insurance coverage for prescription drugs are extremely price sensitive and will take their business to mailorder companies or elsewhere if the lower prices are not passed on. As a result, pharmacists will have little choice but to pass the lower costs on to their customers.

CLAIM: *The bill poses health and safety risks because it will allow prescription drugs to be adulterated or become subpotent during foreign handling.*

FACT: Drugs are already frequently imported into this country. However, only

manufacturers are allowed to reimport prescription drugs which were made in the United States. S. 1191/H.R. 1885 applies only to drugs that have been approved by the Food and Drug Administration (FDA) and made at FDA-approved facilities using "good manufacturing practices." In addition, the pharmacists and wholesalers who would be able to import drugs into the U.S. under S.1191/H.R. 1885 would have to meet the same stringent standards for quality shipment and storage already in place for manufacturers.

CLAIM: *The bill imports other countries' price controls.*

FACT: This bill merely extends the benefits of free trade to buyers of prescription drugs. Drug manufacturers already benefit from free trade by buying the ingredients for their products at the lowest prices on the world market, and in fact, many of the ingredients they use can be imported free of tariffs. Our bill would merely enable American consumers to make the global economy work for them, too.

According to the legislation's opponents, prescription drugs are less expensive in other countries because those countries' governments keep prices artificially low, not because U.S. prices are unreasonably high. If pharmaceutical companies really are unable to achieve a profit in those other countries, one would reasonably expect them not to compete in those markets. Obviously, this is not the case.

Even if one is willing to agree that U.S. consumers should subsidize lower prices and pharmaceutical research for the rest of the world, this implies that there is a correlation between the cost of research and prescription drug prices that just does not exist in reality. For example, the cancer drug Taxol is marketed at a wholesale price of nearly 20 times its manufacturing cost, even though the drug was largely developed and tested by the National Institutes of Health, not by the manufacturer, at a cost to American taxpayers of $30 million.

The truth is that drug companies do not set U.S. prices to cover research costs, they set them to maximize profits. They can set drug prices at extraordinary levels in our country because current law protects them from competition.

CLAIM: *The legislation won't do anything to ensure drug coverage for Medicare beneficiaries who could still have difficulty paying for their medicines even if the bill were enacted.*

FACT: True. But the legislation will make such coverage more feasible and affordable. About 19 million elderly Americans have little or no prescription drug coverage, and more than 2 million older Americans pay more than $100 a month for their medication. S. 1191/H.R. 1885 would save these senior citizens an average of 34 percent.

A prescription drug benefit for Medicare beneficiaries would be more affordable for our nation if Americans were charged wholesale prices comparable to those charged for the same drugs in Canada. According to one study, our nation would save more than $16 billion annually if we could buy medications at the Canadian prices – money which could be used to provide help to Americans who are currently without prescription drug coverage.

Prescription Drug Pricing in the 28th Congressional District of New York: Drug Companies Profit at the Expense of Older Americans

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Prepared for Rep. Louise McIntosh Slaughter

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

November 4, 1998

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EXECUTIVE SUMMARY

This staff report was prepared at the request of Rep. Louise McIntosh Slaughter of New York. In Ms. Slaughter's district, as in many other congressional districts around the country, older Americans are increasingly concerned about the high prices that they pay for prescription drugs. Ms. Slaughter requested that the minority staff of the Committee on Government Reform and Oversight investigate this issue.

Numerous studies have concluded that many older Americans pay high prices for prescription drugs and have a difficult time paying for the drugs they need. This study presents new and disturbing evidence for the cause of this difficulty. 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 a senior citizen in Ms. Slaughter's district paying for his or her own prescription drugs must pay, on average, more than twice as much for the drugs as the drug companies' favored customers. The study found that this is an unusually large price differential -- almost 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 their 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. A case study in Ms. Slaughter's congressional district illustrates these hardships. Preventing the pharmaceutical industry's discriminatory pricing -- and thereby reducing the cost of prescription drugs for seniors and other individuals -- will improve the health and financial well-being of millions of older Americans.

A. Methodology

This study investigates the pricing of the five brand name 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 Ms. Slaughter's congressional district in New York. 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 retail prices and prices for favored customers for other consumer items.

B. Findings

The study finds that:

- **Older Americans pay inflated prices for commonly used drugs.** For the five drugs investigated in this study, the average price differential was 109% (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 Five Best-Selling Drugs for Older Americans in New York 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 New York Senior Citizens	Price Differential For New York Senior Citizens
Zocor	Merck	Cholesterol	$42.95	$109.36	155%
Prilosec	Astra/Merck	Ulcers	$56.38	$118.75	111%
Procardia XL	Pfizer Inc.	Heart Problems	$67.35	$133.89	99%
Norvasc	Pfizer Inc.	High Blood Pressure	$58.83	$116.08	97%
Zoloft	Pfizer Inc.	Depression	$123.88	$225.78	82%
Average Price Differential					**109%**

- **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 in New York was 1,511%. An equivalent dose of this drug would cost the favored customers only $1.75, but would cost the average senior citizen in New York over $28.00. For Micronase, a diabetes treatment manufactured by Upjohn, an equivalent dose would cost the favored customers $10.05, while seniors in New York are charged $44.58. The price differential was 344%.

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

Prescription Drug	Manufacturer	Use	Prices for Favored Customers	Retail Prices for New York Senior Citizens	Price Differential for New York Senior Citizens
Synthorid	Knoll Pharmaceuticals	Hormone Treatment	$1.75	$28.20	1511%
Micronase	Upjohn	Diabetes	$10.05	$44.58	344%

- **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, one would expect that there would be some difference between retail prices and "favored customer" prices. However, the study found that the differential was much higher for prescription drugs than it was for other consumer items. The study compared the price differential for prescription drugs to the price differentials on a selection of other consumer items. The average price differential for the five prescription drugs was 109%, 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 prices being paid by seniors in Ms. Slaughter's congressional district, 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 New York 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 retail prices in New York are only 2% higher than the published national Average Wholesale Price. The differential between retail prices and a second indicator of pharmacy costs, the prices from one wholesaler, is still only 27%. This indicates that it is drug company pricing policies that appear to account for the inflated prices charged to older Americans and other customers.

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.

Older Americans spend almost three times as much of their income (21%) on health care than those under the age of 65 (8%),[2] and more than three-quarters of Americans aged 65 and over are taking prescription drugs.

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

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

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

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

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

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

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

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

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

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

Medicare beneficiaries without public or private prescription drug coverage are the group at most 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]

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

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

[8] Senate Report 36, *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?

Rep. Louise McIntosh Slaughter of New York asked the minority staff of the Committee on Government Reform and Oversight to investigate 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 in her congressional district. This report presents the results of this investigation.

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, prepared at Ms. Slaughter's request, attempts to quantify the extent of price discrimination and its impact on senior citizens in New York.

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

III. METHODOLOGY

A. Selection of Drugs for This Survey

This survey is based primarily on a selection of the five patented, non-generic drugs with the highest annual sales to older Americans in 1997. The list was obtained from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE). The PACE program is the largest outpatient prescription drug program for older Americans in the United States for which claims data is available, and is used in this study, as well as by several other analysts, as a proxy database for prescription drug usage by all older Americans. In 1997, over 250,000

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

[12] *Id.* at 19.

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 Seniors in New York

In order to determine the prices that the elderly are paying for prescription drugs in New York, the minority staff and the staff of Ms. Slaughter's congressional office conducted a survey of eight drug stores -- including three independent and five chain stores -- in Ms. Slaughter's congressional district. Ms. Slaughter represents the 28th district of New York, which includes Rochester and surrounding communities. The location of the stores is shown in Appendix D.

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

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

The FSS is a price catalog containing goods available for purchase by federal agencies. Drug prices on the FSS are negotiated by the Department of Veterans Affairs. The prices on the FSS closely approximate the prices that the drug companies charge their most favored nonfederal customers. According to the U.S. General Accounting Office, "[u]nder GSA procurement regulations, VA contract officers are required to seek an FSS price that represents the same discount off a drug's list price that the manufacturer offers its most-favored nonfederal customer under comparable terms and conditions."[14] Thus, in this study FSS prices are used to represent the prices drug companies charge their most favored customers.

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*

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[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* 6 (June 1997) (emphasis added).

Topics Red Book (the *"Red Book"*).[15] As another measure of wholesale prices, the study used the wholesale prices charged pharmacies by McKesson, the world's largest wholesaler.

E. Determination of Drug Dosages

When comparing prices, the study used the same criteria (dosage, form, and package size) used by the GAO in its 1992 report, *Prescription Drugs: Companies Typically Charge More in the United States Than In Canada.* For drugs that were not included in the GAO report, the study used the dosage, form, and package size common in the years 1994 through 1997, as indicated in the *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 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 five drugs investigated in this study, the average price differential between the price that would be paid by a senior citizen in Ms. Slaughter's congressional district and the price that would be paid by the drug companies' most favored customers was 109% (Table 1). The study thus showed that the average price that older Americans and other individual consumers in Ms. Slaughter's district pay for these drugs is almost double the price paid by the drug companies' favored customers, such as large insurance companies and HMOs.

For individual drugs, the price differential was even higher. Among the five best selling drugs, the highest price differential was 155% for Zocor, a cholesterol medication manufactured by Merck. For other popular drugs, the study found even greater price differentials. The drug

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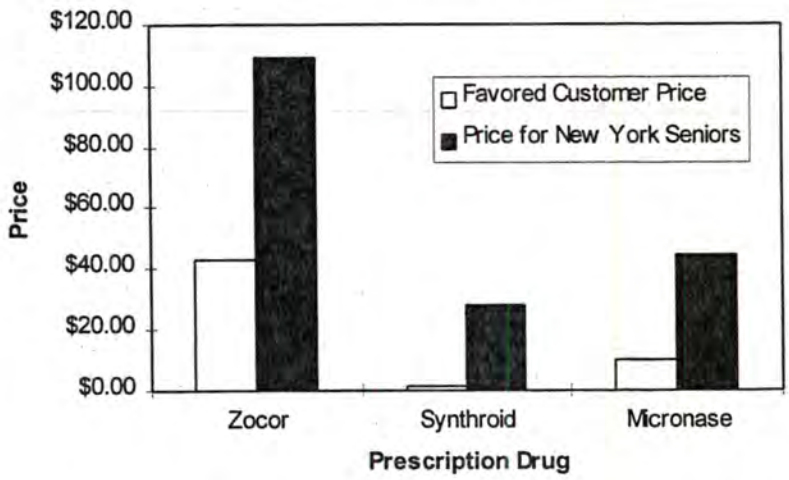
[15] Medical Economics Company, Inc. (1997).

[16] The items used were paper towels, envelopes, rubber bands, toilet paper, pencils, Rolodexes, tape dispensers, waste baskets, correction fluid, post-it notes, paper clips, and scissors.

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 in New York was 1,511%. An equivalent dose of this drug would cost the most favored customers only $1.75, but would cost the average senior citizen in New York $28.20. For Micronase, a diabetes treatment manufactured by Upjohn, the price differential was 344% (Figure 1).

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



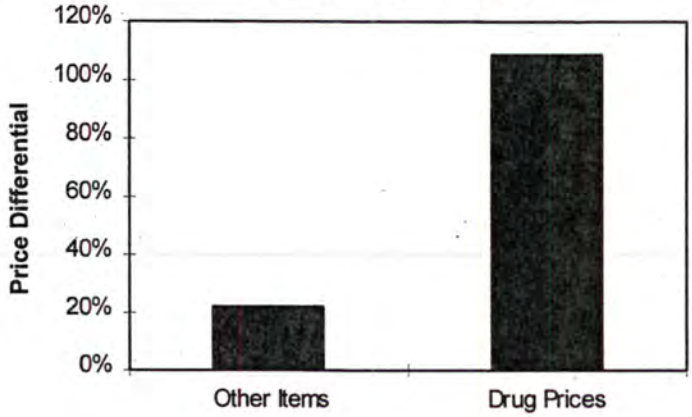
Every drug looked at in this study had a large price differential. Four of the drugs had a price differential of 97% or greater, and the price differential for Zoloft, the lowest of the top five, was still 82%.

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, one would expect that there would be some difference 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 difference between retail prices and the prices charged most favored customers, such as large corporations and institutions, was only 22%. The average price differentials in the case of prescription drugs were thus almost five times larger

than the average price differentials for other consumer goods (Figure 2). This indicates that a volume effect is unlikely to explain the large differentials 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

Finally, the study 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 prices were only 2% higher than the published national Average Wholesale Price, and only 27% above the prices available directly from one large wholesaler (Figure 3). This finding indicates that it is not retail markups, but drug company pricing policies, that account for the inflated prices charged to older Americans and other customers. These findings are consistent with other experts who have concluded that because of the competitive nature of the pharmacy business at the retail level, there is a relatively small profit margin for retail pharmacists.[17]

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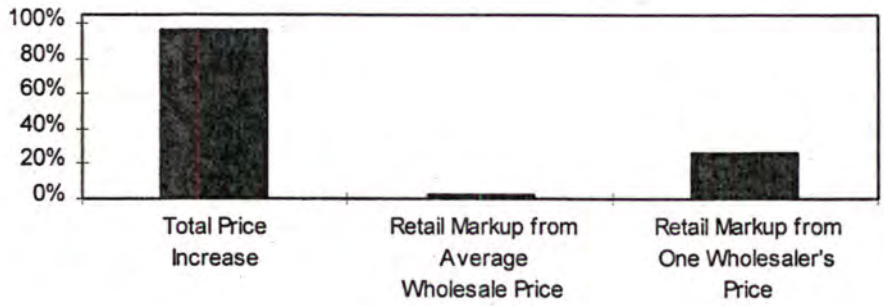
[17] National Association of Chain Drug Stores, *Did You Know . . .* (pamphlet) [citing financial data assembled by Keller Bruner & Company, P.C., Certified Public Accountants (1995)].

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



Moreover, the study found no significant differences in retail prices between pharmacies in different parts of Ms. Slaughter's district. Further, although there were variations in prices between chain and independent pharmacies, these differences were small and not systematic.[18]

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[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. Each of the five most popular prescription drugs in this survey -- Zocor, Norvasc, Prilosec, Procardia XL, 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 1,511%.

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." Wall Street Journal, *Drug Makers Agree To Offer Discounts For Pharmacies*, B4 (July 15, 1998).

V. THE CONSEQUENCES OF DRUG COMPANIES' DISCRIMINATORY PRICING

There are two conflicting consequences of the current drug industry pricing practices. Although these pricing practices have allowed the drug industry to grow and amass large profits, they have also imposed severe financial hardship on older Americans and others who buy their own drugs.

A. Drug Company Profits

Drug industry pricing strategies have boosted the industry's profitability to extraordinary levels. The annual profits of the top 10 drug companies is nearly $20 billion.[19] Moreover, the drug companies make unusually high profits compared to other companies. The average manufacturer of branded consumer goods, such as Proctor & Gamble or Colgate-Palmolive, has an operating profit margin of 10.5%. Drug manufacturers, however, have an operating profit margin of 28.7% -- nearly three times greater (Figure 4).[20]

These high profits appear to be directly linked to the pricing strategies observed in this study. For instance, Merck, the country's largest pharmaceutical manufacturer, had an increase in profits of 15% to 18% in the second quarter of 1998. According to industry analysts, Merck's increased profits were due in large part to sales of Zocor,[21] which is sold in Ms. Slaughter's district at a price differential of 155%. Zocor itself accounts for 6% of Merck's revenues.[22]

Overall, profits for the major drug manufacturers are expected to grow by about 20% in 1998, compared to 5% to 10% for other companies on the Standard & Poors Index. The drug manufacturers' profits are expected to grow by up to an additional 25% in 1999.[23] According to one analyst, "the prospects for the pharmaceutical industry are as bright as they've even been."[24]

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[19] *See* 1998 Fortune 500 Industry List (www.pathfinder.com/fortune500/indlist.html).

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

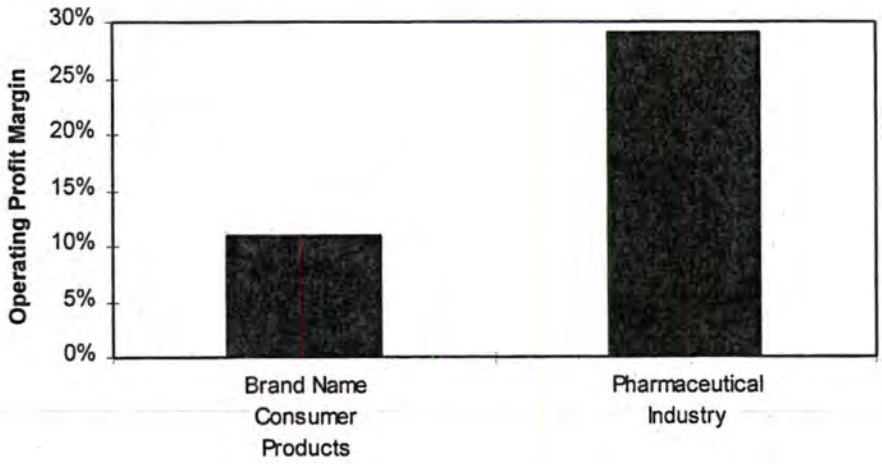
[21] USA Today, *Drugmakers Have Healthy Outlook* (July 20, 1998).

[22] IMS America, *Top 200 Drugs of 1997* (1998).

[23] USA Today, *supra* note 21.

[24] *Id.* at D1.

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



B. What High Drug Prices Mean for Older Americans In New York

While drug companies are thriving under their current pricing strategies, older Americans are not. Surveys indicate that high prescription drug prices impose financial hardships on millions of older Americans. To assess the extent of these hardships, the staff of Ms. Slaughter's office interviewed senior citizens in Ms. Slaughter's district. The following case study illustrates the financial hardship shared by seniors.

Arthur Stefanik. Arthur Stefanik is a 74-year-old resident of Rochester. Mr. Stefanik suffers from heart disease, diabetes, and asthma, and takes four prescription drugs -- Coumadin, Zestril, Morbin inhalers, and Glyburide -- for these conditions.

Mr. Stefanik lives on an income of $1,310, from Social Security and a part-time job. He is forced to spend $150 a month -- approximately one-eighth of his income -- on prescription drugs. Mr. Stefanik says that, because of the high costs, he has trouble affording his medications and has had to skip his asthma medicine or cut down his dosage. This has a direct impact on his health, leading to severe breathing difficulties. He says that it would make a big difference in his quality of life if the cost of prescription drugs were reduced.

Appendix A
Information on Prescription Drugs Analyzed In This Study

			Prices (Dollars)				
Brand Name Drug	**Dosage and Form**	**Indication**	**FSS**	**Major Whole-saler**	**AWP**	**Average Retail Price**	**Price Differential**
Zocor	5 mg, 60 tablets	Cholesterol reducer	$42.95	$85.47	$106.84	$109.36	155%
Prilosec	20 mg, 30 cap.	Ulcer	$56.38	$99.20	$108.90	$118.75	111%
Procardia XL	30 mg, 100 tab.	Heart Problems	$67.35	$105.05	$131.31	$133.89	99%
Norvasc	5 mg, 90 tablets	High Blood Pressure	$58.83	$97.92	$125.66	$116.08	97%
Zoloft	50 mg, 100 tab.	Depression	$123.88	$172.44	$215.55	$225.78	82%
Average Price Differential							**109%**

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

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

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

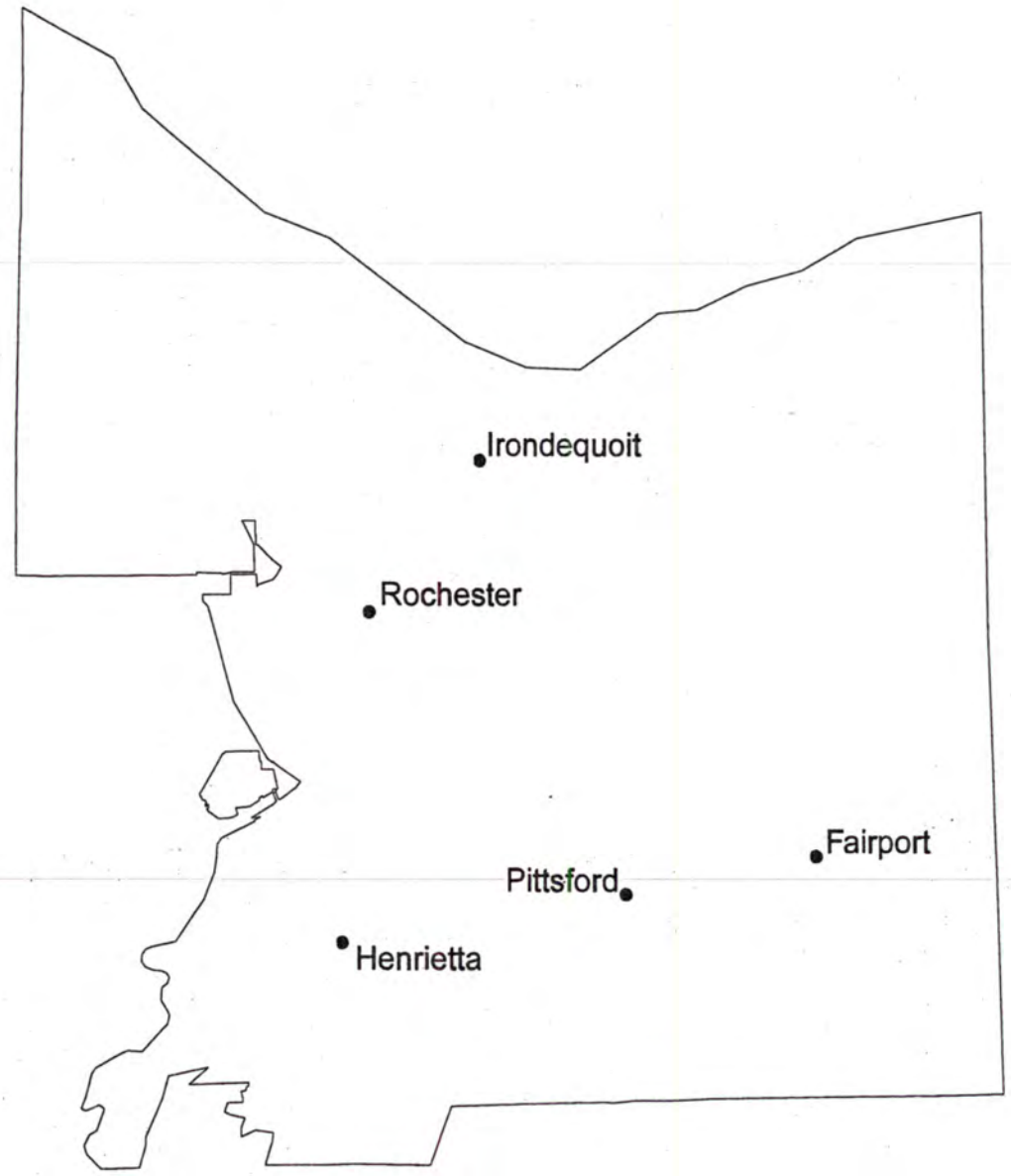
Appendix C

Price Comparisons For Non-Prescription Drug Items

Item	FSS Price	Retail Price	Differential
Toilet Paper, 96 Rolls	$44.74	$47.98	7%
Paper Towels, 30 Rolls	$22.94	$29.98	31%
Envelopes, 500, White, 20 lb. weight	$6.45	$9.49	47%
Scissors	$10.88	$12.99	19%
Rubber Bands, 1 lb.	$2.57	$2.67	4%
Rolodex, 500 Card	$13.24	$14.29	8%
Pencils, #2, 20-pack	$1.03	$1.26	22%
Tape Dispenser	$1.44	$1.69	17%
Wastebasket, Plastic, 13 qt.	$2.95	$3.49	18%
Correction Fluid, 18 ml., dozen.	$6.66	$9.99	50%
Post-It Notes	$2.08	$2.89	39%
Binder Clip, small, 1 box	$0.49	$0.49	0%
Average Price Differential			**22%**

Appendix D

Prescription Drug Price Survey Locations in New York's 28th Congressional District



Geography and Map Division, Library of Congress, October 1998. G-1998-52-S.I.

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Record Type: Record

To: Katharine Button/WHO/EOP, asn@cbsnews.com, aureliamika@worldnet.att.net, senator@sarbanes.senate.gov

cc:

Subject: Fwd: Appeal to officials -Please alert your network

CONCERNED AMERICAN CITIZENS ENCOURAGED TO CONTACT GOVERNMENT OFFICIALS TO
PRESSURE PALESTINIAN AUTHORITY : HONOR SISTER MARIA (STEPHANOPOULOS) AND
SISTER XENIA'S PROTEST -- PROTECT RULE OF LAW IN RELIGIOUS DISPUTE

New York,NY - Concerned American citizens today are urged to join Congresswoman Carolyn Maloney (D-NY)in telling their Members of Congress, Senators and government officials to speak out against the Palestinian Authority's takeover of a Russian Orthodox Monastery in Jericho, where two American nuns remain under siege -- Prisoners of conscience, isolated by Palestinian police and military in a dank and damp shed without without bathing or cooking facilites and under constant threats and insults.

Congresswoman Carolyn Maloney, the chair of the Congressional Hellenic Caucus, sent a letter to Palestinian Authority Chairman Yasser Arafat expressing her outrage that the Palestinian Authority is using police to forcefully evict Sister Maria and Sister Xenia from church property.
Tell your Senators and Members of Congress that the United States has an obligation to pressure Chairman Arafat and Palestinian Authority to adhere to the rule of law when determining ownership of this and other religious buildings. Also ask,where is the protection all holders of U.S. passports are entitled to when traveling or residing abroad? Why is the full protection of the United States not available to these two U.S. citizens.

Both Mrs. Nikki Stephanopoulos and her daughter are urging Maloney, the State Department and other supporters to pressure Palestinian Authority to work fairly with both Churches to reach a fair solution to this conflict through the judicicial process and adhere to the rule of law.

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