Fit NY seniors

New York Seniors Pay More for Prescription Drugs While Pharmaceutical Profits Soar:

An Investigation into Prescription Drug Price Discrimination in New York State

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with JPAC for Older Adults and New York Network for Action on Medicare

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Contents

Executive Summary

Part One: New York State Drug Price Survey

Thousands of New York senior citizens without prescription drug coverage face *price discrimination* by pharmaceutical manufacturers. A price survey of 143 randomly selected pharmacies in all 31 New York congressional districts, conducted by the national consumer group Public Citizen and the New York StateWide Senior Action Council, with assistance from the JPAC for Older Adults and members of the New York Network for Action on Medicare, shows seniors are being charged retail prices *more than double* the prices charged by prescription drug makers to their most favored customers like HMOs, large insurers and federal agencies.

Senior volunteers surveyed the prices of ten of the most widely prescribed drugs for older adults at randomly selected pharmacies in the state of New York. The retail price was compared to the best federal price, which according to the U.S. General Accounting Office is equivalent to the price pharmaceutical manufacturers charge their most favored customers. Prices charged to local seniors were *more than double - about 106% more* - than the most favored customer price.

For the top ten drugs used by seniors to treat a variety of illnesses, those in New York paid between 63% and 262% more than drug companies' most favored customers:

Drug	Condition Treated	Price Difference
Fosamax	osteoporosis	98% more
Lipitor	cholesterol	63% more
Norvasc	blood pressure	112% more
Pepcid	ulcer	71% more
Prevacid	ulcer	149% more
Prilosec	ulcer	118% more
Rezulin	diabetes	81% more
Ticlid	stroke	124% more
Zocor	cholesterol	262% more
Zoloft	depression	91% more

Part Two: Medicare Beneficiaries' Drug Coverage and Pharmaceutical Industry Price Discrimination and Profits

Instead of offering most favored prices to Medicare beneficiaries because of their huge collective buying power, pharmaceutical makers practice price discrimination against seniors and people with disabilities by charging them their highest retail prices. One out of three Medicare beneficiaries - 14 million older adults and people with disabilities - have no prescription drug coverage. They constitute a far larger purchasing block than any current customer receiving best price treatment from the pharmaceutical manufacturers.

Millions of American seniors are suffering under this discriminatory pricing since Medicare does not cover outpatient prescription drugs. In addition to the 14 million beneficiaries who have no coverage for prescription drugs and therefore pay high retail prices totally out-of-pocket, many more older adults have inadequate or insecure insurance coverage with high deductibles and co-payments and low annual caps. Moreover, Medicare HMOs and employer plans are reducing drug coverage or raising costs for retirees.

The pharmaceutical industry profits handsomely from price discrimination. For decades, brand name prescription drug makers have consistently been among the most profitable industries in America. In 1998, pharmaceutical companies ranked first among all industries in rates of return on equity, assets, and revenues. CEOs of the top ten pharmaceutical companies last year averaged $20 million in annual compensation, including stock options, and now hold nearly $1 billion in stock options.

The industry claims that high U.S. prescription drug prices are necessary to fund research and development. But R&D is a lower priority than profits for the manufacturers. In 1998, the top ten firms put one-and-a-half times as much money into profits as into research and development. Moreover, not everyone pays such high prices. Foreign consumers get U.S.-made drugs at a fraction of the price paid by American senior citizens because their governments negotiate fair prices with prescription drug makers.

Congress is currently considering legislation to prohibit price discrimination

against seniors and people with disabilities in the Medicare program and to add a comprehensive prescription drug benefit to Medicare:

- "The Prescription Drug Fairness for Seniors Act" (H.R.664/S.731) would harness the buying power of 39 million Medicare beneficiaries to allow seniors and the disabled access to the same low prices as drug companies' most favored customers. Pharmacies would purchase prescription drugs for Medicare beneficiaries from the manufacturer at the same low prices charged favored customers such as the Departments of Defense and Veterans Affairs and other large purchasers. Since these prices are nearly half the retail prices paid by Medicare beneficiaries without prescription drug coverage, seniors will benefit from large cost savings even after fair pharmacy dispensing fees are included. H.R. 664/S. 731 have more support than any other prescription drug reform legislation in Congress - 135 House co-sponsors and 12 Senate co-sponsors as of October 21, 1999.
- President Clinton and Congressional leaders have proposed that a comprehensive prescription drug benefit be added to Medicare. To be cost effective, such a benefit must use the bargaining power of the federal government and Medicare beneficiaries to negotiate significantly lower drug prices - similar to the savings that could be achieved under the "Prescription Drug Fairness for Seniors Act." Negotiating fair prices is the first step in constructing an affordable benefit plan - with low premiums, low or no co-payments, and good coverage for those with high as well as low or moderate drug expenditures.

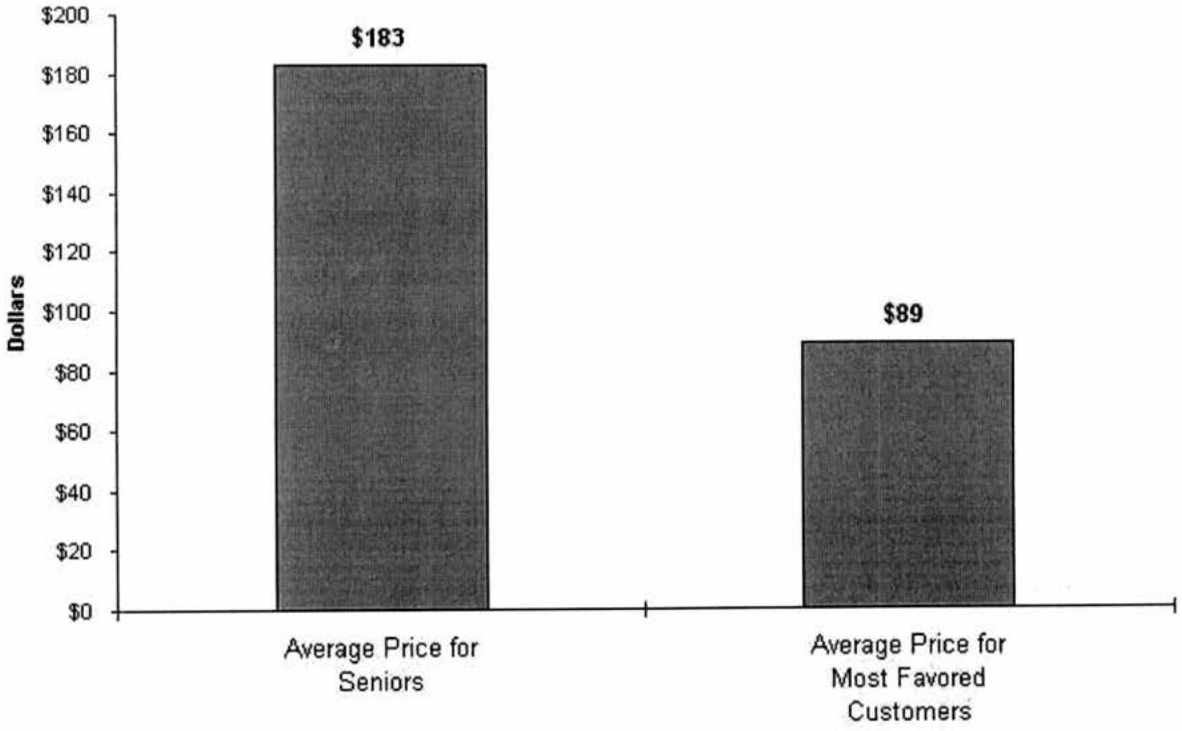
Thirteen U.S. Representatives from New York, including Gary Ackerman, Joseph Crowley, Michael Forbes, Maurice Hinchey, Carolyn Maloney, Carolyn McCarthy, Michael McNulty, Gregory Meeks, Jerry Nadler, Major Owens, Jose Serrano, Louise McIntosh Slaughter, and Anthony Weiner are already sponsors of "The Prescription Drug Fairness Act for Seniors" (H.R. 664/S. 731). New York seniors and people with disabilities want the other members of our congressional delegation to sponsor H.R. 664 and S. 731 and to support a comprehensive Medicare prescription drug benefit that negotiates lower drug prices for beneficiaries.

Part One:
New York Seniors Pay More than Twice as Much as Most Favored Customers

The prescription drug price survey conducted by Public Citizen and New York StateWide Senior Action Council, with assistance from JPAC for Older Adults and members of the New York Network for Action on Medicare, found that New York seniors and the disabled without prescription drug coverage are victims of price discrimination by pharmaceutical manufacturers. The random sampling of 143 local pharmacies in the New York State found that seniors pay more than twice as much for retail prescription drugs as most favored customers such as HMOs, large insurers and federal agencies like the Departments of Veterans Affairs and Defense. For standard dosages of ten brand name patent drugs most commonly prescribed for seniors, the survey found that New York older adults pay about 106% more than most favored

customers - $183 versus $89 for equivalent dosages.[1]

New York Area Prescription Drug Price Survey Comparison of Average Prices for Seniors and Most Favored Customers



Instead of offering most favored customer prices to New York Medicare beneficiaries because of their collective buying power, the survey found that pharmaceutical makers practice price discrimination against seniors by charging them their highest retail prices. The retail price that these seniors pay, as compared to the most favored customer price, ranged from 262% more for the cholesterol drug Zocor to 63% more for the cholesterol drug Lipitor.

Table 1: New York Prescription Drug Price Survey Results

Prescription Drug	Use	Median Retail Price For Senior Citizens	Most Favored Customer/ Best Federal Price*	Price Differential for Seniors Who Pay Retail
Fosamax	Osteoporosis	$213	$111	98%
Lipitor	Cholesterol	$200	$127	63%
Norvasc	Blood Pressure	$127	$64	112%
Pepcid	Ulcer	$58	$38	71%
Prevacid	Ulcer	$399	$164	149%
Prilosec	Ulcer	$125	$61	118%
Rezulin	Diabetes	$160	$93	81%
Ticlid	Stroke	$74	$37	124%
Zocor	Cholesterol	$233	$68	262%
Zoloft	Depression	$240	$130	91%
Average price (Mean)		$183	$89	106%

*(*Includes $4 markup to reflect reasonable pharmacy dispensing fee. See Survey Methodology at the end of this section for sources and notes.)*

Osteoporosis is a major threat for 28 million Americans, 80% of whom are women. One out of every two women and one in eight men over 50 will have an osteoporosis-related bone fracture in their lifetime. The survey found that New York seniors pay ***98%*** more for Merck's osteoporosis drug ***Fosamax*** than most favored customers.

One-third of those over 65 have **high cholesterol**, a prime risk factor for life-threatening heart diseases and strokes if it is not controlled. The survey found that New York seniors pay ***63%*** more for Warner Lambert's ***Lipitor*** and ***262%*** more for Merck's ***Zocor*** than most favored customers.

High blood pressure (**hypertension**) affects almost 40% of those over 65. For New York seniors, Pfizer's ***Norvasc*** to control high blood pressure is priced ***112%*** higher than the company charges its most favored customers.

Nearly 25 million Americans currently suffer from **ulcer disease**; the condition is more common in those over 65 than in younger people. New York seniors pay ***71%*** more for Merck's ***Pepcid***, ***149%*** more for Abbott's ***Prevacid***, and ***118%*** more for AstraZeneca's ***Prilosec*** than the companies charge their most favored customers for the same drug.

Diabetes afflicts twice as many people over 65 as under that age; about 12.5% of seniors have the condition. Warner Lambert's diabetes drug ***Rezulin*** costs New York seniors ***81%*** more than the company's most favored customers pay.

Those over 65 are almost ten times more likely to suffer a **stroke** than younger persons. Roche's stroke medication ***Ticlid*** costs New York seniors ***124%*** more than most favored customers pay.

Late-life **depression** affects six million seniors, most of them women; older people with significant symptoms of depression have roughly 50% higher healthcare costs than non-depressed seniors. Pfizer's anti-depressant ***Zoloft*** is

91% more expensive for New York seniors than for most favored customers.

Stories of New York Seniors Who Can't Afford Prescription Drugs

There are thousands of senior citizens and people with disabilities in New York without any prescription drug coverage. Thousands more are having a hard time trying to pay for their prescription drugs. Here are the stories of six older adults from New York struggling to get the drugs they need. They would all benefit from legislation that would allow them to purchase drugs at the most favored prices paid by HMOs, large insurers, and federal agencies.

Judith Weiss is a 55 year old New York City resident who became disabled in 1983 because of a brain tumor and complications from its treatment. Even with the AARP discount program she uses, she must have $150 each month to pay for her two regular medications, including Zocor for high cholesterol. This uses up virtually all her monthly income beyond basic necessities because she lives on Social Security Disability income and interest from a very small inheritance. In fact, although she understands that it actually ends up costing her even more, she usually has to use her credit card to make sure that she does not run out of medications as she juggles her bills, including out-of-pocket costs that Medicare does not cover. She finds that she must put off a lot of things, like dental work. Judith wants Congress to take on the problem of high drug prices and include prescription drugs in the Medicare program.

Joan Cronin, who is 73 years old, retired from the insurance business. Last year she underwent bypass surgery and now must take Cardizem, Digoxin, and Captopril in addition to Lipitor for high cholesterol and Vioxx for severe arthritis. Joan must pay about $215 each month just for these medications, which is more than 25% of her income, and admits to taking fewer Lipitor and Vioxx than her doctor prescribed in order to stretch her prescriptions for these expensive drugs. Sometimes, her pharmacist gives her credit so she does not have to go without drugs until her next Social Security check arrives. Joan uses high doses of over-the-counter medications for pain although they are not as effective. Joan lives in federally subsidized housing for the elderly in New York City.

Ruth Pitts is a 78 year old retired Medicaid and home care worker with diabetes and high blood pressure who depends upon the pharmacy at her public hospital clinic to cover her medications. However, Ruth needs a brand of insulin that the clinic does not provide, so she must pay $67 a month at another pharmacy. This one medication alone uses more than one-quarter of her $245 Social Security income. If not for her small savings and living in public housing in New York City, she could not survive. This new medication cost is a significant burden, and Ruth is worried about prices continuing to rise.

Mr. and **Mrs. Andrew Popovics** are in their 70s and live in Westchester County. Mr. Popovics worked as an elevator inspector, his wife as a book-keeper. Mr. Popovics has a history of heart attacks and had angioplasty two years ago. They both have several chronic medical conditions, among them serious heart disease, and take multiple medications daily including Procardia for angina, Norvasc to control blood pressure, Relafen for arthritis, Vasotec for hypertension, Coumadin, an anti-coagulant, Catapres patches for hypertension, K-dur, a potassium supplement, Prilosec for ulcers, and netoclopramide for nausea. They also must take antibiotics like Ceftin or Cephalixin from time to time. From January through September, they have already spent about $5,000 on prescription drugs, after spending $70 for a drug discount program. Based

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SECTION: Section C; Page 2; Column 1; Business/Financial Desk

LENGTH: 826 words

HEADLINE: Economic Scene;
Rebates could smooth the way for a Medicare reform plan.

BYLINE: By Michael M. Weinstein; This is Michael M. Weinstein's final Economic Scene column. He is returning to The Times' Editorial Board.

BODY:

IS a flawed experiment in redesigning Medicare better than no experiment at all?

No, says Karen Ignagni, who represents managed care plans that are fighting to block demonstrations intended to foster competition. The problem, she says, is that the demonstrations, scheduled to begin in 2001, "leave out the Government's fee-for-service plan, tilting competition unfairly against private plans."

Len Nichols, an economist at the Urban Institute and a member of the committee of independent experts that designed the demonstrations, disagrees. He acknowledges that the proposed competition, at Congress's instruction, is far from ideal. But, he says, the demonstrations "can still yield invaluable lessons for Congress as it ponders a national fix of Medicare."

Private plans and physicians are lined up behind Ms. Ignagni. Economists line up behind Mr. Nichols. Congress is on the verge of siding with the industry, putting the demonstrations on hold. But Mr. Nichols thinks he has a way out of the impasse if Congress acts soon.

Congress ordered the Administration in 1997 to create demonstrations to test ways to make Medicare competitive. The competition that already exists between private managed care plans and the Government's fee-for-service plan is crimped because the Government decides how much to pay private plans. Sometimes it pays too little, driving private plans out of local markets. Sometimes it pays too much, creating waste at taxpayer expense. The demonstrations would use market forces to reveal the right price rather than letting the Government flail about for the right price.

Congress prohibited the committee from subjecting the Government-run plan to competition. That, says Ms. Ignagni, "means that private plans will be paid less than the Government plan, forcing the private plans to crimp on benefits while the Government plan goes unscathed."

"That's unfair competition," she said.

That is no doubt true. The issue that separates Mr. Nichols from Ms. Ignagni is whether the flaw is fatal.

The committee chose Phoenix and Kansas City as the first two demonstration sites. Political opposition exploded. In many regions, the cost of fee-for-service medicine is sky high because doctors are in the habit of prescribing costly drugs, tests and procedures. In these high-cost regions, the

Government automatically dishes out more money to private plans. The plans use the revenue windfall to draw the elderly away from the Government plan by offering them additional benefits, like drug coverage and low co-payments.

The plans are delighted with the cozy arrangement. So, too, are their physicians and patients. But the plans are understandably petrified by competitive bidding, flawed or otherwise. Once firms are driven to compete for business by setting low premiums, the largess under the current system could evaporate. The committee's goal is to reduce premiums to a level sufficient to cover guaranteed benefits and not a penny more. That is Ms. Ignagni's worst nightmare.

Mr. Nichols provides a powerful rejoinder to Ms. Ignagni. The demonstrations, he said, "can still reveal how to create vigorous competition among plans and provide an inkling about potential savings from competition." He compares the demonstration to the methods used by major employers to control health care costs. "Take a General Motors that decides to add managed care to its fee-for-service offering," Mr. Nichols said. "It would not think to tie payments to managed care plans to the bloated costs of running fee-for-service. Instead, it would solicit bids. That is what the demonstration proposes to do."

But Mr. Nichols acknowledges that under current law, private plans have too few tools to attract enrollees. Toward that end, the committee met last week and decided to ask Congress to allow plans to offer rebates -- in the form of lower monthly Medicare premiums. Rebates can provide powerful recruiting tools and perhaps give beneficiaries in demonstration sites something tangible if the demonstrations go forward. That could dissolve some of the opposition.

The notion of providing rebates to enrollees who choose low-cost private plans is hardly heretical. It lies at the heart of President Clinton's plan as well as the plan proposed by Senator John Breaux of Louisiana and Representative Bill Thomas of California. The prominence of those plans might soften Congressional opposition to the idea.

It is ludicrous for Congress to overhaul Medicare without first testing its ideas. Yet it looks increasingly clear that political opposition from vested interests will continue to block demonstrations. Last week's initiative by the committee offers a way to convince beneficiaries to become allies rather than opponents of reform. If so, then the Congressional delegations from Phoenix and other demonstration sites might turn a tad less resistant to a first, important step in redesigning Medicare.

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on the last couple of years, Mr. Popovics expects that their out-of-pocket total for prescription drugs for the year will be somewhere between $8,000 and $9,000, which will be close to one-third of their income from Social Security and their pensions.

Janice Prince is a 56 year old resident of Erie County and became a Medicare beneficiary a few years ago following job-related injuries that resulted in disability. Even with her disability check and a good pension her medication costs have been so overwhelming that at times she has had to turn to her church for help and also rely on samples from her doctors. With diabetes, high blood pressure, serious asthma, and complications from back and neck injuries, her monthly prescriptions (including Norvasc [for blood pressure], Zestoretic [for hypertension], Glucophage [diabetes], Glucotrol [diabetes], albuterol [asthma], bronchosol [asthma], Cipro [antibiotic], estaderm patches [prevention of osteoporosis], Daypro [osteoarthritis], Lortab [pain], Zomig [migraine], and Darvocet [pain]) amount to $700 to $800. Even with a discount program she subscribes to for $96 a year, prescription medicines take more than one-third of her monthly income. She notes that this does not include other medical supplies and equipment she also needs. She says, "Even though I am really handicapped, I have become involved in this issue of the prices of prescription drugs because I know it means so much to many people. I have been so scared, so lost - sometimes I just didn't know which way to tur n. It is a frightening thing to be without a critical medication and end up in a hospital emergency room."

Survey Methodology

The survey followed standard methodological protocols for a cross-sectional study with descriptive and analytic components.

Survey Drug Sample
The ten drugs selected for this survey were the most widely prescribed prescription drugs for senior citizens drawn from the 1998 list of the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE), as determined by dollar volume of sales. PACE is the largest state pharmaceutical assistance program for older adults and is frequently used as a data base for studies on prescription drug utilization by seniors. The dosages were the most commonly prescribed amounts according to the PACE data base. The top ten drugs did not include any generic drugs.

The ten drugs and their most commonly prescribed dosages were Fosamax (10 mg, 100 tablets), Lipitor (10 mg, 100 tablets), Norvasc (5 mg, 90 tablets), Pepcid (20 mg, 30 tablets), Prevacid (30 mg, 100 capsules), Prilosec (20 mg, 30 capsules), Rezulin (400 mg, 30 tablets), Ticlid (250 mg, 30 tablets), Zocor (20 mg, 60 tablets), and Zoloft (50 mg, 100 tablets).

Most Favored Customer/Best Federal Price
The most favored customer price was determined by the best federal price, usually the federal supply schedule price, provided by the Pharmacy Strategic Benefit Mangement Group of the Department of Veterans Affairs, which oversees the federal supply schedule prices. Neither the pharmaceutical industry nor the HMOs and large insurers make public drug prices paid by most favored private sector customers. But the U.S. General Accounting Office has found that "federal supply schedule prices represent the best publicly available

information of the prices that pharmaceutical makers charge their most favored customers."[2]

Because the most favored customer/best federal price does not include a pharmacy dispensing fee, an average fee was added. Large purchasers like the federal and state governments and HMOs negotiate a fixed dispensing fee per prescription. Here are some sample fixed dispensing fees:

- HMOs: Specific fees are proprietary information, but industry observers indicate the fee is $4.00 or less per prescription paid to participating pharmacies.[3]
- New York: The federal government requires states to establish "a reasonable dispensing fee" for the pharmacies participating in the Medicaid prescription drug program.[4] The New York dispensing fee is $3.50/$4.50 per prescription.[5]
- Other states: Eleven states (including New York) have pharmacy assistance programs to help subsidize prescription medicines for senior citizens. These programs pay dispensing fees to participating pharmacies, ranging from $2.50 to $4.75, and average $3.64 per prescription. The New York EPIC program pays $2.75-3.00.[6]

Based upon the best evidence, a $4 dispensing fee was added to the most favored customer/best federal price for each prescription.

Pharmacies
143 retail pharmacies in New York State were selected randomly from the phone book Yellow Pages [a 95% confidence level].

Survey Administration, Quality Control, and Data Management
A draft survey instrument and written instructions to solicit surveys were developed. A pretest was administered to five retail pharmacists. The results were evaluated and the instrument, instructions, and training curriculum were modified to improve the administration of the survey questionnaire.

The final standard survey instrument was designed. Revised instructional materials, including an interviewing script explaining the study, were prepared. Interviewers were recruited and received training on interviewing techniques, the questionnaire, and a script. Interviewers were supervised by staff of survey sponsor organizations. Pharmacists in 143 drug stores in New York State were interviewed with the survey instrument and script during weekday morning and afternoon hours by the volunteer interviewers. A condition of the interivew was anonymity for individual respondents. Results were analyzed by Public Citizen staff. Questionnaires were dated, coded for anonymity, and entered into a standard statistical spreadsheet program.

Part Two:
Skyrocketing Prescription Drug Costs Hit Seniors Hard

Prescription drugs are the fastest growing health care expenditure in the United States. The number of retail prescriptions grew 8% from 1998 to 1999, rising to

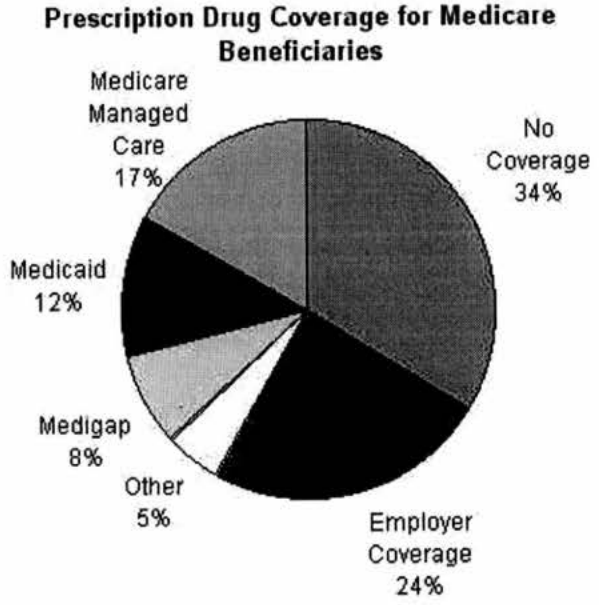
almost three billion prescriptions annually.[7] But prices for prescription drugs are rising even faster. Americans will spend more than $121 billion for retail pharmaceutical drugs in 1999, an increase of 18% over 1998.[8] Prescription drugs rank behind only hospital and physician costs among all health care expenditures.[9]

Prescription drug spending is projected to rise more than twice as fast as all other health care costs this year.[10] The federal Health Care Financing Administration (HCFA) forecasts a 138% increase in total drug spending over the next ten years.[11] This rate of increase would be almost four times the projected growth in the Consumer Price Index, which determines increases in Social Security payments, the lifeblood of many seniors.[12]

Medicare Does Not Cover the Prescription Drugs Seniors Rely On

Medicare recipients are especially dependent on prescription drugs in order to maintain good health. Senior citizens are 12% of the population but account for about one-third of all prescription drug spending.[13] The average Medicare beneficiary fills eighteen prescriptions a year.[14] Moreover, 80% of retired Americans take at least one prescribed drug every day, spending on average $942 a year. [15]

About 39 million Americans have most of their health care costs paid for by Medicare because they are over the age of 65 or disabled. Yet, Medicare offers almost no outpatient prescription drug coverage. Medicare only covers prescription drugs used in a hospital or nursing home, immunosuppressive drugs, erythropoeitin, oral anti-cancer drugs, hemophilia clotting factors, and some vaccines. Generally, any drug that can be self administered is not covered.



One in Three Seniors Has No Drug Coverage; Millions More Need Help

Most Medicare recipients have few options to reduce or contain their prescription costs. At least one in three, or more than 14 million beneficiaries, has no drug insurance coverage at all.[16] They must pay all costs out-of-pocket.

Another 24% of retirees nationwide are covered through employer group plans. But the number of firms offering retiree health coverage has dropped from 40% to 30% in the past four years.[17] And many of these retirees are still at risk since employers are capping prescription drug coverage, charging higher deductibles, and requiring co-payments of as much as $30 per prescription.

About 8% of U.S. seniors purchase expensive Medigap insurance policies, which provide inadequate prescription drug coverage and increase premiums with age. Almost all of the seniors who have purchased Medigap drug coverage are enrolled in two plans with an average annual premium of $1,080, with coverage capped at $1,250 a year, a 50% co-pay and a $250 annual deductible.[18]

Medicaid, the Department of Veterans Affairs, and other public programs provide prescription drug coverage for 17% of beneficiaries, including many of the poorest or most medically needy beneficiaries.

Nationally about one out of six seniors, or 17%, has coverage through Medicare HMOs. More than one-third of California Medicare beneficiaries belong to HMOs.[19] Many participants were recruited by initial offers of free prescription drug coverage, but according to the Health Care Financing Administration, all HMOs will charge co-pays next year, and 86% of HMOs will cap prescription drug coverage in 2000.[20] Almost 60% of all plans will cap coverage below $1,000 and 32% will have a $500 or lower cap. HCFA also reports that HMO co-payments for brand name drugs will increase by 21% and generic co-pays will increase 8% next year. Meanwhile, Medicare HMOs will dump more than 734,000 seniors from coverage in 1999 and 2000.[21]

This patchwork of prescription drug coverage leaves three out of four Medicare beneficiaries without decent, dependable coverage for prescription drugs. If recent trends continue, their drug coverage will continue to erode.

Elderly Struggle with Rising Out-of-Pocket Costs for Drugs
Senior citizens pay on average almost 20% of their income in out-of-pocket health care costs.[22] Medicare beneficiaries pay about half of the cost of their prescription drugs out-of-pocket, while the population as a whole pays just one-third of their total drug costs out-of-pocket. Those with Medigap coverage pay on average 80% of their drug costs out-of-pocket.[23]

Senior citizens need pharmaceutical coverage because they use more drugs than any other age group. But having retired on fixed incomes, too many older adults cannot afford to pay for the prescription drugs they need to stay alive and well.

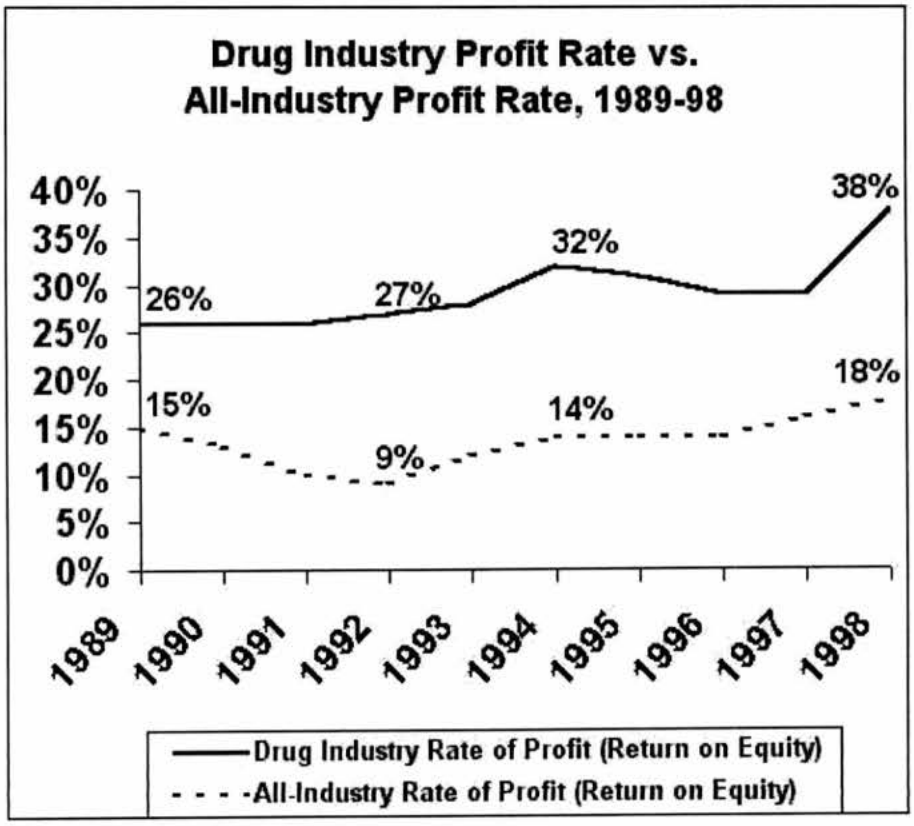
Pharmaceutical Companies Profit Handsomely from Price Discrimination

The Most Profitable Industry in America
Prescription drug company earnings are skyrocketing along with drug prices. Pharmaceutical manufacturers are the most profitable industry in America - and have been for a long time.

- The prescription drug business ranked most profitable among 37 industries in 1998, as measured by rates of return on revenue, equity, and assets, according to *Fortune Magazine*. The profit rate was an

extraordinary 38% for return on equity.[24]

- Pharmaceutical makers rank as the most profitable industry for the past ten years and are consistently among the top two most profitable industries for the past thirty years.[25]
- In the 1990s, the median profit rate for prescription drug makers has been two-and-a-quarter times that of other Fortune 500 corporations.[26]
- CEOs of the top ten prescription drug makers averaged $10 million each in salary last year - and doubled their compensation by receiving nearly $10 million apiece in stock option grants. Together these ten CEOs held more than $920 million in stock options.[27]



Recent press reports reveal that earnings and profits for the manufacturers of the top ten drugs used by seniors are continuing to increase at double digit rates for the third quarter of 1999. Sales of **Warner Lambert's** anti-cholesterol medication ***Lipitor*** increased by more than two-thirds between the second and third quarters, from $570 million to $960 million, driving company profits up 38 percent over a year earlier.[28] **Pfizer** reported third quarter earnings up 36% over a year earlier, fueled by strong sales of its top drugs, including ***Norvasc*** (the company's top selling drug) and ***Zoloft*** (its second highest seller).[29] "Over the past decade, Merck...has led the industry with $26 billion in sales; names like ***Zocor***, ***Pepcid*** and ***Vasotec*** line America's medicine cabinets."[30] "**Abbott** is profiting from the ulcer drug ***Prevacid***...[in the third quarter]."[31]

Foreign Consumers Pay Less for U.S.-Made Drugs than U.S. Consumers
U.S. pharmaceutical manufacturers charge lower prices overseas for U.S.-made prescription drugs than they charge American consumers. American seniors can cross the border to Canada or Mexico and purchase American-made drugs for 25% to 50% less than at home.[32] The contrast is even greater with other industrial countries: on average, the Swedish pay 69%, the British 64%, the

French 57%, and the Italians only 51% of the prices paid by Americans for the same prescription drugs.[33] Because their governments negotiate fair prices with American drug makers, foreign consumers pay far less than American senior citizens and still benefit from our research and development.

Research and Development Myths and Facts
Pharmaceutical manufacturers deny that they practice price discrimination. Instead, they justify high prices as the cost for research and development. Their industry trade association, Pharmaceutical Research and Manufacturers of America or PhRMA, argues research would decrease and production of wonder drugs would decline if consumers paid lower prices. This scare tactic seeks to obscure the fact that R&D is a much lower priority than profits for this industry.

Table 2 below presents the record of the ten largest U.S. prescription drug makers, which account for more than one-third of industry revenues. Their 1998 annual reports were reviewed to examine how their revenues were allocated between profits and research and development.[34] The findings reveal the hypocrisy of the pharmaceutical industry with regard to R&D.

Table 2: 1998 Profits Vs. R&D: Top Ten U.S. Pharmaceutical Companies

Company	Net income as a percent of net sales	R&D as a percent of net sales	Ratio of net income to R&D
Bristol-Myers Squibb	17.2%	8.5%	2.0
Abbott	18.7%	9.8%	1.9
Merck	19.5%	10.6%	1.8
Schering-Plough	21.7%	12.5%	1.7
American Home Products	18.4%	12.2%	1.5
Pfizer*	24.7%	16.8%	1.5
Warner-Lambert	12.3%	8.6%	1.4
Johnson & Johnson	13.0%	10.3%	1.3
Eli Lilly	22.7%	18.8%	1.2
Pharmacia & Upjohn	10.2%	17.7%	0.6

*Includes Alliance revenue.
(Source: *Fortune Magazine*'s top ten pharmaceutical companies ranked by sales, in this chart in declining order by ratio of net income to R&D. Company figures from 1998 Annual Reports, Table of Consolidated Statement of Earnings.)

One of the top ten put twice as much, and three others put close to twice as much, into profits as went to R&D in 1998. The median firms of the top ten (American Home Products and Pfizer) had profit rates 50% higher than their R&D expenditures. Nine of ten companies had higher profits (net income) than

research expenditures.

Conclusion: Congress Must End Price Discrimination and Let Seniors Use Their Buying Power to Get Fair Drug Prices

While thousands of New York seniors and people with disabilities and millions of disabled and older adults across America face price discrimination by prescription drug manufacturers, Congress is now debating bills that would end this practice of discrimination against seniors and add a comprehensive prescription drug benefit to Medicare.

"The Prescription Drug Fairness for Seniors Act" (H.R. 664/S. 731) would end price discrimination and harness the purchasing power of 39 million seniors and people with disabilities on Medicare. The Act requires pharmaceutical manufacturers to give local pharmacies the same "best" price for Medicare beneficiaries as they give their most favored customers.

Pharmacies would then purchase prescription drugs for Medicare beneficiaries from the manufacturer at the same low prices available to the federal government and other large purchasers. Since these prices are less than half the retail prices paid by Medicare beneficiaries in New York state, seniors would be able to benefit from large cost savings after fair pharmacy dispensing fees are included. The Act creates no federal bureaucracy and requires little taxpayer money. "The Prescription Drug Fairness for Seniors Act" has more support than any other prescription drug reform legislation in Congress - 135 House co-sponsors and 12 Senate co-sponsors as of October 21, 1999.

President Clinton and Congress are also debating adding a comprehensive prescription drug benefit to Medicare. To be truly cost-effective for both seniors and taxpayers, a comprehensive outpatient prescription drug benefit must also use the bargaining power of the federal government and Medicare beneficiaries to negotiate significantly lower drug prices, similar to the "Prescription Drug Fairness for Seniors Act." Negotiated prices are the first step in constructing an affordable benefit plan - one with low premiums, low or no co-payments, and good coverage for those with high as well as low or moderate drug expenditures.

New York seniors and people with disabilities want their U.S. Senators and Representatives to oppose price discrimination against Medicare beneficiaries by pharmaceutical manufacturers. The rest of our federal lawmakers should join the thirteen U.S. Representatives from New York who have already sponsored the "Prescription Drug Fairness for Seniors Act," including Gary Ackerman, Joseph Crowley, Michael Forbes, Maurice Hinchey, Carolyn Maloney, Carolyn McCarthy, Michael McNulty, Gregory Meeks, Jerry Nadler,Major Owens, Jose Serrano, Louise McIntosh Slaughter,and Anthony Weiner. The New York congressional delegation should also support a comprehensive Medicare drug benefit, which also uses the bargaining power of the federal government to reduce drug prices for all seniors.

About Public Citizen, the New York StateWide Senior Action Council, JPAC for Older Adults and the New York Network for Action on Medicare

Public Citizen is a 150,000 member national non-profit, non-partisan public interest group based in Washington, D.C. Public Citizen has 13,485 members and supporters in New York. Since its founding by Ralph Nader in 1971, Public Citizen has fought for consumer rights, government and corporate accountability, campaign finance reform, a clean environment, and health and safety protection through lobbying, public education, research, and media outreach. Public Citizen has launched the Campaign for Affordable Prescriptions to educate the public and mobilize grassroots support for fair pharmaceutical prices. This report was prepared by Congress Watch, a division of Public Citizen.

The New York StateWide Senior Action Council is a statewide grassroots organization of thousands of older adults in the Empire State. The Council also includes more than one hundred organizations, representing a combined membership of tens of thousands of seniors. Founded in 1972 and headquartered in Albany, the Council is a leading advocate for issues affecting the Empire State elderly, especially low income and minority seniors. The Council runs a statewide Patients Rights Advocacy Project. The Council helped to establish the New York state pharmacy assistance program, EPIC, to end mandatory retirement in New York, and to get a limit on balance billing by doctors serving Medicare patients. Most recently, the Council helped win legislative victories expanding participation in EPIC and strengthening patients rights in hospitals and managed care programs.

The Joint Public Affairs Committee (JPAC) for Older Adults is a grassroots organization committed to strengthening the impact of senior citizens on community, institutional and governmental social policy. A citywide, non-sectarian program, JPAC's membership is drawn from more than 200 diverse senior and community groups in New York City. For more than 20 years, JPAC has given older New Yorkers the training, education and support to speak out on critical issues and become engaged in organizing and social change in their communities.

New York Network for Action on Medicare (NYNAM) was started in 1998 by organizations and individuals concerned about how to improve and strengthen the Medicare program. It is a coalition of nearly 70 organizations representing senior citizens, people with disabilities, healthcare workers, physicians, nurses, public health professionals, civic organizations, unions, and healthcare advocates throughout New York State. Several members worked on this survey, including Citizen Action of New York in Binghamton, Disabled in Action, Gray Panthers of Suffolk County, Long Island Coalition for a National Health Plan, and Long Island Progressive Coalition.

Notes

1. The average differential for all ten drugs between the retail price for equivalent dosages paid by seniors and that paid by most favored customers is shown in order to provide a composite overview of the results of this survey. It does not reflect any one individual's experience, since one person would not be taking all ten drugs at the same time. It should also be noted that the time periods vary between drugs, since the survey reports prices for the most commonly prescribed dosage: in some cases, a three months supply; in others, a shorter period.

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Back to the Prescription Drug Home Page

Back to the Health Care Home Page

Back to the Health, Safety and Environment Home Page

Back to the Public Citizen's Congress Watch Home Page