

HB

452

ALASKA STATE LEGISLATURE

Sponsor



Statement

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Representative David Guttenberg

HB 452

"An Act establishing the Alaska Prescription Drug Task Force; and providing for an effective date."

Last year, Americans spent more than four times as much money on health care as on national defense. The Alaska Legislature's recent PERS/TRS debate focused attention on the rising cost of health care, but no pending bills address the high and rising cost of prescription drugs and the role those prices play in the bigger picture of health care.

Prescription drugs are the fastest growing component of health care expenditures. Those rising costs are imposing an ever-increasing economic burden on Alaskans. Our citizens should not have to choose between putting food on their tables or purchasing prescription drugs.

Pharmaceuticals are a vital component of health care in preventing and treating illness and helping to avoid more costly medical problems. However, rising costs have greatly reduced availability of prescription drugs. I began looking into the reasons why drug costs are rising and found some disturbing statistics:

- In 2003, nationwide spending on prescription drugs was \$179.2 billion, almost 4½ times larger than the \$40.3 billion spent in 1990;
- Between 1995 and 2002, the average increase for drug expenditures was 15% higher than for any other type of health expenditure;
- In 2001, nearly 1 in 4 seniors reported skipping doses or not filling prescriptions because of the cost;
- In 2002, 10 pharmaceutical companies amassed profits greater than the other 490 companies in the *Fortune 500* combined;

HB 452 will create a Prescription Drug Task Force within the Alaska Department of Health and Social Services. This Task Force will find ways to reduce the cost of prescription drugs and increase affordable access to prescription drugs for Alaskans.

Ten members representing various entities and business sectors will sit on the task force and will gather information from industry, government, citizens, and other sources. Subsequent present reports to the Governor and to the Legislature will suggest actions to increase access to and reduce the cost of prescription drugs.

I urge your support of this bill.

Representative.David.Guttenberg@legis.state.ak.us
<http://guttenberg.akdemocrats.org>

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Representative David Guttenberg
District 8

SECTIONAL ANALYSIS FOR HB 452

“An Act establishing the Alaska Prescription Drug Task Force; and providing for an effective date.”

Section 1: Uncodified law adding a new section to state the Legislative findings and purpose

Section 2: Uncodified law adding a new section to establish the Alaska Prescription Drug Task force. The Task Force consists of ten members and sets out the guidelines for the duties and objectives of the task force. Sets the timeline for the reporting of the Task Force’s findings to the Legislature and the Governor.

Section 3: Effective Date for Section 2.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB452-DOLWD-WC-04-21-06
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Department: Labor and Workforce Development
 Title: Alaska Prescription Drug Task Force RDU: Workers' Compensation
 Component: Workers' Compensation
 Sponsor: Representative Guttenberg
 Requester: House HES Component Number: 344

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: None
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

The task force is established in the Department of Health & Social Services and they have submitted a fiscal note to support all costs for this activity. The legislation is not expected to have a financial impact on the Department of Labor and Workforce Development.

Prepared by: Paul F. Lisankie, Director Phone: 465-6059
 Division: Workers' Compensation Date/Time: 4/21/06 10:25 AM
 Approved by: Greg O'Claray, Commissioner Date: 4/21/2006
 Agency: Department of Labor and Workforce Development

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: HB452-DHSS-FMS-04-20-06

() Publish Date: _____

Revision Date/Time (Note if correction): _____

Dept. Affected: Health & Social Services

Title ESTABLISHING THE ALASKA PRESCRIPTION DRUG TASK FORCE RDU Departmental Support Services

Component Commissioner's Office

Sponsor GUTTENBERG

Requester HOUSE (HES)

Component No. 317

Expenditures/Revenues: (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services	82.7					
Travel	16.5					
Contractual	10.0					
Supplies	5.0					
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	114.2	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	114.2					
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	114.2	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary	1					

ANALYSIS: (Attach a separate page if necessary)

This bill creates the Alaska Prescription Drug Task Force in DHSS and requires it to present its findings and recommendations to the Legislature by the 30th day of the 2007 legislative session. The bill requires the task force to meet at least three times and to hold public hearings, but it may meet more often. The 10 task force members are to serve without pay, but will be reimbursed for per diem and travel. Meetings can be held by teleconference; it is assumed the group would meet face-to-face at least twice and that two DHSS employees would also travel to staff the meetings. One non-perm position is required to staff the task force for FY07, and associated costs are itemized on page 2.

It is assumed the task force will disband after making its report.

(Continued on Page 2)

Prepared by: Janet Clarke
Division: Finance and Management Services
Approved by: Karleen Jackson, Commissioner
Agency: Department of Health and Social Services

Phone 465-1630
Date/Time 03/01/2006
Date 04/20/2006

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

PERSONAL SERVICES (\$82.7)

One non-perm position would be needed for FY07 to coordinate the work of task force, perform research, write its final report and conduct needed followup - Health Planner II (Range 19 - \$82.7)

TRAVEL (\$16.5)

12 travelers are assumed:

\$688 ea. (\$600 airfare + \$42 per diem + \$26 car + \$20 parking) times two meetings = \$16,512

CONTRACTUAL (\$10.0)

Office space for non-perm employee; telephone, computer usage and other centralized services costs, publication and distribution costs for report.

SUPPLIES (\$5.0)

Personal computer for employee, miscellaneous office and publication supplies for employee and task force members.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 452
 () Publish Date: _____

Revision Date/Time (Note if correction): 4/23/06 11:17 a.m. Dept. Affected: Administration
 Title An Act establishing the Alaska Prescription Drug RDU Centralized Administrative Services
Task Force.... Component Retirement and Benefits
 Sponsor Representative Guttenberg, Kerttula
 Requester House Health, Education, and Social Services Component No. 64

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: 0.0
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This legislation establishes a 10-member task force to consider strategies to manage the increasing costs of prescription drugs and to increase affordable access to prescription drugs for all state residents.

Participation on the Alaska Prescription Drug Task Force will have no fiscal impact on the Division of Retirement and Benefits.

Prepared by: Melanie Millhorn, Director Phone 465-4408
 Division Retirement and Benefits Date/Time 4/23/06 11:17 a.m.
 Approved by: Mike Tibbles, Deputy Commissioner Date 4/24/2006
 Agency Department of Administration



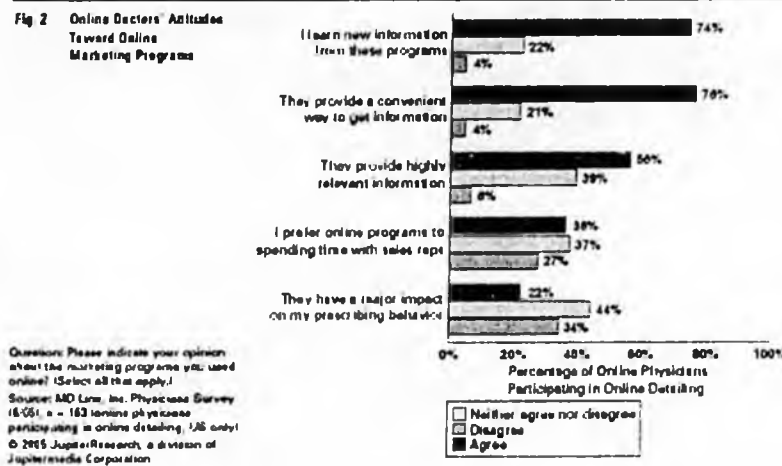
Consumers Union® PRESCRIPTION FOR CHANGE

DETAILING

According to research from Health Strategies Group, "[t]he average primary care physician interacts with 28 sales representatives each week; the average specialist interacts with 14." While this represents a significant amount of time, 2 hours and 13 minutes a week in 2004 per doctor, this is 20% less time than in 1999, where doctors spent 2 hours and 46 minutes a week meeting with sales reps.^c

DRUG REPS PER PHYSICIAN			
Year	Physicians (P) ^a	Detailers (D) ^b	Ratio D to P
2000	813,869	74,865	1 to 11
2002	853,187	93,612	1 to 9
2003	871,535	94,407	1 to 9
2004	884,974	101,531	1 to 9

Fig 2 Online Doctors' Attitudes Toward Online Marketing Programs



For a variety of reasons (e.g. time, professional concerns about information quality, online learning opportunities), 22% of doctors said they see fewer sales reps than in the past.^d According to the table above, this does not appear to be due to a drop in the number of sales reps. It could be related to online detailing. Sixty-five percent of "online doctors"^e participated in online detailing in 2005.^f (See Figure 2)

Another way of looking at influence is to consider professional advertising expenditures per physician. The table at the right uses the cost of sales rep visits (excluding samples) to determine cost of all sales rep visits per physician.

COST OF SALES REP VISITS PER PHYSICIAN			
Year	Physicians ^g	Sales Rep Visit Cost (\$) ^h	\$ per Dr.
2000	813,869	5,137,000,000	\$6311.83
2002	853,187	6,198,000,000	\$7264.53
2003	871,535	6,938,000,000	\$7960.67
2004	884,974	7,336,000,000	\$8289.51

^a American Medical Association. Available online at: <http://www.ama-assn.org/ama/pub/category/12912.html>.

^b Matthew Arnold. "Flexible Forces." *Medical Marketing & Media*. November 2005.

^c Ashley Mahoney, Rayna Herman. "2005 Access Report: The current state of pharma sales." *Pharmaceutical Representative*. July 1, 2005.

^d Monique Levy, Jupiter Research. *Online Marketing to Physicians: Evaluating Physicians' Responsiveness to Online Detailing*. September 1, 2005.

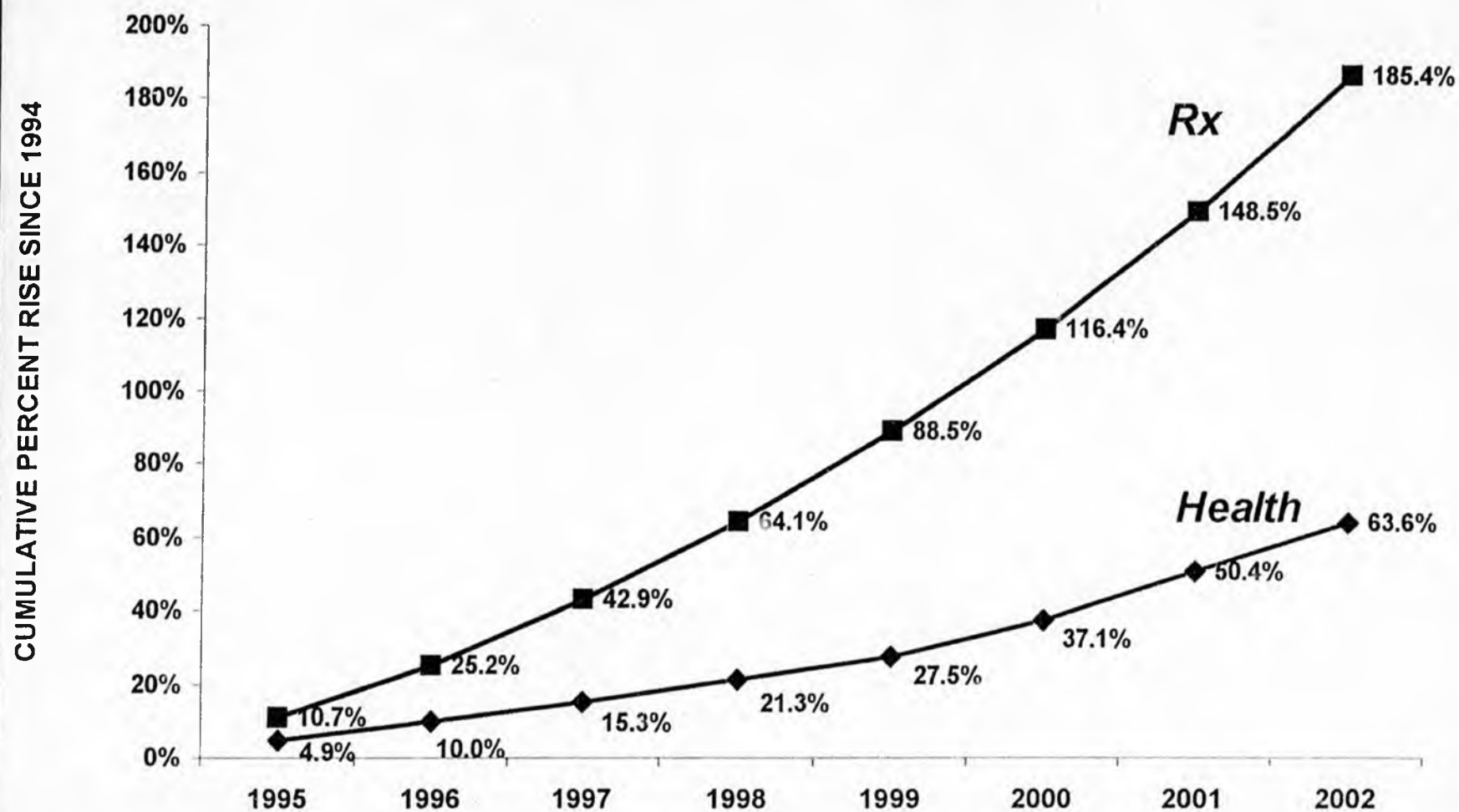
^e Defined as physicians who use the internet for work-related activities. (Jupiter Research)

^f Monique Levy, Jupiter Research. September 1, 2005.

^g IMS Health. Total US Professional Promotional Spend by Type, 2004. Available online at: <http://www.imshealth.com/ims/portal/front/articleC/0.2777.6599.49695992.75406357.00.html>.

^h Matthew Arnold. November 2005.

Rx SPENDING RISES MUCH FASTER THAN TOTAL HEALTH SPENDING, 1994 - 2002



Prescription Drug Trends

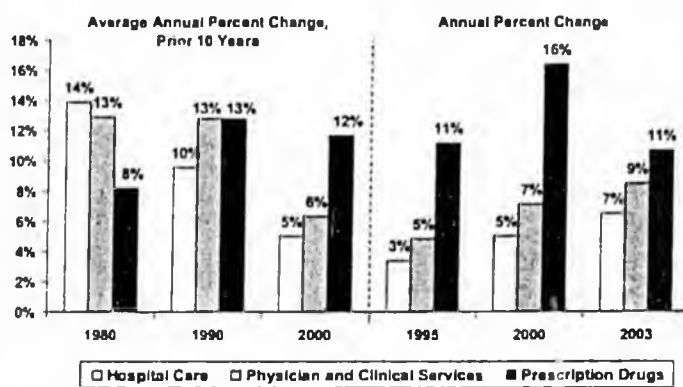
Overview

Prescription drugs are a vital component of health care in preventing and treating illness and helping to avoid more costly medical problems. However, rising costs and implementation of the new Medicare drug benefit have raised concerns about the affordability and availability of prescription drugs, prompting the need for a better understanding of the pharmaceutical market and for new approaches to rising costs.

Rising Expenditures for Prescription Drugs

Spending in the US for prescription drugs was \$179.2 billion in 2003, almost 4½ times larger than the \$40.3 billion spent in 1990. Although 2003 prescription drug spending was a relatively small proportion (11%) of national health care spending compared to spending for hospital care (31%) and physician services (22%), it was one of the fastest growing components, increasing at double digit rates from 1995 to 2003. From 2002 to 2003, national prescription spending increased 11%, compared to 7% for hospital care and 9% for physician services. However, the rate of increase in prescription spending has declined from a high of 20% in 1999, to 15% in 2002, and 11% in 2003 (Figure 1).¹

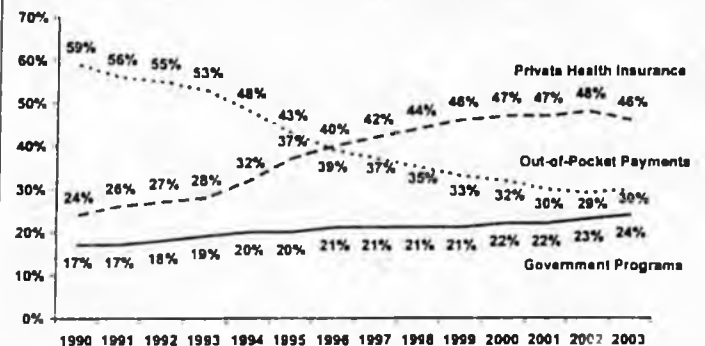
Figure 1: Annual Percentage Change in Selected National Health Expenditures, 1980-2003



Source: KFF analysis of National Health Expenditures data from Centers for Medicare & Medicaid Services at <http://www.cms.hhs.gov/statistics/nhe/default.asp>

The share of prescription drug expenses paid by private health insurance increased substantially over the past decade (from 24% in 1990 to 46% in 2003), contributing to a decline in the share that people pay themselves (from 59% in 1990 to 30% in 2003) (Figure 2). Private insurance spending for prescription drugs rose by 7% in 2003, much slower than the 16% increase in 2002.²

Figure 2: Percent of Total National Prescription Drug Expenditures by Type of Payer, 1990-2003



Note: Out-of-Pocket Payments includes direct spending by consumers for health care goods and services not covered by a health plan and cost-sharing amounts (coinsurance, copayments, deductibles) required by public and private health plans. It does not include consumer premium payments and cost sharing paid by supplementary Medicare policies, which are included in the Private Health Insurance category.

Source: KFF analysis of National Health Expenditures data from Centers for Medicare & Medicaid Services at <http://www.cms.hhs.gov/statistics/nhe/default.asp>

Factors Driving Increases in Prescription Spending

Three main factors drive increases in prescription drug spending: the increasing number of prescriptions (utilization), price increases, and changes in the types of drugs used.

- Utilization.** From 1994 to 2004, the number of prescriptions purchased increased 68% (from 2.1 billion to 3.5 billion), compared to a US population growth of 12%. The average number of retail prescriptions per capita increased from 7.9 in 1994 to 12.0 in 2004.³ The percent of the population with a prescription drug expense in 2002 was 61% (for those under age 65) and 91% (for those 65 and older).⁴
- Price.** Retail prescription prices⁵ (which reflect both manufacturer price changes for existing drugs and changes in use to newer, higher-priced drugs) increased an average of 8.3% a year from 1994 to 2004 (from an average of \$28.67 to \$63.59),⁶ more than triple the average annual inflation rate of 2.5%.⁷
- Changes in Types of Drugs Used.** Increases in prescription spending generally result from newer, higher-priced brand name drugs whose availability is affected by the research and development (R&D) activities of pharmaceutical manufacturers and government-supported research. Manufacturer R&D spending increased from \$13.4 billion (17.3% of sales) in 1994 to an estimated \$38.8 billion

The Henry J. Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

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(15.9% of sales) in 2004.⁸ New drug use is also affected by the number of new drugs (new molecular entities) approved by the US Food and Drug Administration, which has fluctuated over the past decade, with 21 approvals in 1994 and 36 approvals in 2004.⁹

Both prescription use and shifts to higher-priced drugs are affected by advertising. Manufacturers spent \$11.9 billion for advertising in 2004 (excluding the \$15.9 billion in retail value of drug samples), with \$7.8 billion (66%) directed toward physicians and \$4.0 billion (34%) directed toward consumers. Spending for direct-to-consumer advertising – typically to advertise newer, higher-priced drugs – was 15 times greater in 2004 than in 1994.¹⁰

From 1995-2002, pharmaceutical manufacturers were the nation's most profitable industry. In 2004, they ranked third, with profits (return on revenues) of 16%, compared to 5% for all Fortune 500 firms.¹¹

Insurance Coverage for Prescription Drugs

Employers are the principal source of health insurance in the United States, providing coverage for 174 million (nearly 60%) of Americans in 2004.¹² About 60% of employers offered health insurance to their employees in 2005, and 66% of those employees took their employers' coverage. Others may have obtained coverage through a spouse. Nearly all (98%) of covered workers in employer-sponsored plans had a prescription drug benefit in 2005.¹³

The traditional Medicare program (the federal health program for the elderly and disabled) has not provided coverage for outpatient prescription drugs. About one-quarter (27%) of seniors age 65 and above, and one-third of poor (34%) and near-poor (33%) seniors, had no drug coverage in 2003.¹⁴ That will change January 1, 2006 when, as authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare will begin a voluntary prescription drug benefit. To provide some assistance in the years prior to 2006, the law created a Medicare-endorsed discount card program to give beneficiaries greater access to negotiated discounts on their prescription drug purchases. The discount card program also included a temporary transitional assistance program that provided \$600 per year in subsidies to low-income beneficiaries without drug coverage from other sources in 2004 and 2005.

Lack of drug insurance can have adverse effects. A 2005 survey found that uninsured adults (51%) are twice as likely as insured adults (25%) to say that they or a family member cut pills, did not fill a prescription, or skipped medical treatment in the past year because of the cost.¹⁵ For seniors age 65+, the survey found that those with no drug coverage were more likely than those with drug coverage to not fill a prescription or to skip or take a smaller dose due to costs in 2003 (37% vs. 22%).

Private and Public Responses

Employer-sponsored health plans have responded to increasing prescription drug costs by establishing tiered cost-sharing formulas and increasing drug copayments. In 2005, about three-quarters (74%) of workers with employer-sponsored coverage had a cost-sharing arrangement with 3 or 4 tiers, over 2½ times the proportion in 2000 (27%). Copayments for nonpreferred drugs (those not included on a formulary or preferred drug list) have doubled from an average of \$17 in 2000 to \$35 in 2005. Copayments for preferred drugs (those included on a formulary or preferred drug list, such as a brand name drug without a generic substitute) increased by 69%, from \$13 in 2000 to \$22 in 2005.¹⁶

Medicaid is the joint federal-state program that pays for medical assistance to low income individuals and families. Outpatient prescription drug spending has steadily increased as a share of overall Medicaid spending from 5.6% in FY1992 to 13.4% in FY2003.¹⁷ In a 2005 survey of 36 states + DC, all (100%) attempted to control drug costs by requiring prior authorization, 95% imposed limits on quantities dispensed per prescription, 92% required the use of generics, 81% charged limited copayments for prescription drugs, and 68% used preferred drug lists.¹⁸ On January 1, 2006, drug coverage for those eligible for both Medicare and Medicaid will be shifted from Medicaid to Medicare as a result of the Medicare Modernization Act, although states will be required to provide payments to the federal government to finance this coverage.

Consumers are turning to a variety of methods to reduce their prescription costs, including requesting cheaper drugs or generic drugs from their physicians, using the Internet and other sources to make price comparisons, using over-the-counter instead of prescribed drugs, buying drugs in bulk and pill-splitting, using mail-order pharmacies, using pharmaceutical company or state drug assistance programs, and using Medicare discount drug cards.¹⁹

Drug importation has received attention as a way to address expensive drug prices in the US. Importation of pharmaceutical products from Canada using Internet orders and cross-border visits totaled \$760 million in sales, or 0.3% of the total US market, in 2004.²⁰ An equivalent amount of prescription drugs is estimated to enter the US from the rest of the world, mostly through the mail and courier services.²¹

Proponents of permitting Americans to import drugs from Canada or other countries argue that prescription expenses have become a significant burden on families and third-party payers and that it is unfair to deny them access to the lower prices available abroad. Permitting importation also is seen as a way of reducing domestic prices, because manufacturers would be forced to lower their prices to compete with the lower costs of imported drugs. Opponents argue that it is difficult and costly to assure the safety of imported drugs. Opponents also argue that importation is likely to increase prices or reduce supply in countries exporting drugs to the US, so that manufacturers and foreign governments would likely take steps to limit exports to the US.

Outlook for the Future

Annual increases in US spending for prescription drugs are projected to rise from 10.7% in 2003 to 11.9% in 2004, and then decline to 9.7% in 2014. Increased spending due to increased prescription use by Medicare beneficiaries under the new Medicare Part D coverage is expected to be offset by increased availability and use of lower-cost generic drugs, more people covered under tiered copayment drug plans, fewer blockbuster drugs, and more drugs shifting to over-the-counter status.²²

REFERENCES

- Centers for Medicare & Medicaid Services, National Health Accounts, at <http://www.cms.hhs.gov/statistics/nhe/default.asp>.
- Ibid.*
- KFF calculations using data from IMS Health at www.imshealth.com and Census Bureau at <http://www.census.gov>. The number of prescriptions per capita (12.0 in 2004) differs from that at <http://www.statehealthfacts.kff.org> (10.7 in 2003) because the data come from different sources (IMS Health vs. Verispan).
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- Retail prescription prices reflect the prices paid by insured and uninsured patients, and do not reflect rebates, discounts, and other payments that in effect lower the cost of prescriptions.
- KFF calculations using data from National Association of Chain Drug Stores, "Industry Facts-at-a-Glance," at <http://www.nacds.org>, based on data from IMS Health.
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- Pharmaceutical Research and Manufacturers of America, *Pharmaceutical Industry Profile*, various years, at <http://www.phrma.org/publications>; reflects data from PhRMA members only (approx. 80% of total R&D in 2004).
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- Kaiser Family Foundation/Commonwealth Fund/Tufts-New England Medical Center 2003 National Survey of Seniors and Prescription Drugs, Additional Charts and Tables, April 2005, Figure 3, at <http://www.kff.org/medicare/med041905pka.cfm>.
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- Kaiser Commission on Medicaid and the Uninsured, *Medicaid Prescription Drug Spending and Use*, June 2004, at <http://www.kff.org/medicaid/7111a.cfm>, with FY2003 data from *Medicaid and Outpatient Prescription Drugs*, March 2005, at <http://www.kff.org/medicaid/1609-03.cfm>; percentages include estimates of Medicaid managed care spending for prescription drugs.
- Kaiser Commission on Medicaid and the Uninsured, *State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update*, October 2005, Fig. 3, at <http://www.kff.org/medicaid/7381.cfm>.
- D Herrick, National Center for Policy Analysis, *Shopping for Drugs: 2004*, NCPA Policy Report No. 270, October 2004, at <http://www.ncpa.org/pub/st/st270>.
- Medical Marketing & Media*, "The IMS Health Report – Pressure Zone," May 2005, p. 45, at <http://offlinehbpl.hbpl.co.uk/Misc/MMM/Features/MAY05%2036-50%20IMS.pdf>.
- U.S. Department of Health and Human Services Task Force on Drug Importation, *Report on Prescription Drug Importation*, December 2004, p. ix, at <http://www.hhs.gov/importtaskforce/Report1220.pdf>.
- S Heffler et al., "U.S. Health Spending Projections For 2004-2014," *Health Affairs*, Web Exclusive, February 23, 2005, pp. W5-74 to W5-85; see <http://www.cms.hhs.gov/statistics/nhe/projections:2004/proj2004.pdf>.

For More Information:

In addition to the Kaiser Family Foundation reports in the Endnotes above, this Fact Sheet (#3057-04) and the following reports are available on the Foundation's website at <http://www.kff.org>: *Trends and Indicators in the Changing Health Care Marketplace* (#7031), *Prescription Drug Trends—A Chartbook Update* (#3112), *Medicare Prescription Drug Benefit Fact Sheet* (7044-2), *Resources on the Medicare Prescription Drug Benefit, Federal Policies Affecting the Cost and Availability of New Pharmaceuticals* (#3254), and *Current Trends and Future Outlook: Findings from the Kaiser/Hewitt 2004 Survey on Retiree Health Benefits* (#7194). See also <http://www.statehealthfacts.org> for state-specific prescription drug utilization, sales, and average prices (under Health Costs & Budgets), and <http://www.kaiserEDU.org> (Prescription Drugs) for Issue Modules and a Tutorial on prescription drugs.

Paying the Price

The High Cost of Prescription Drugs for Uninsured Americans

October 2004



AKPIRG

Paying the Price

**The High Cost of Prescription Drugs
for Uninsured Americans**

AKPIRG

October 2004

Acknowledgements

Written by Lindsey Johnson, Consumer Advocate with AkPIRG.

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Executive Summary

Millions of uninsured and underinsured Americans struggle to afford the medicines they need, even forgoing medically necessary drugs when prices are out of reach. When discussing the high cost of prescription drugs, politicians often focus on the financial burden carried by senior citizens. Unfortunately, high prescription drug prices are a problem for Americans of all ages, not just the elderly.

As prescription drug prices have increased, so has the number of uninsured and underinsured Americans. In 2003, 45 million Americans under the age of 65 did not have health insurance; millions more with health insurance lacked prescription drug coverage. Young adults (ages 19 to 34) accounted for 40% of the non-elderly, uninsured population in 2003. Meanwhile, the pharmaceutical industry continues to record enormous profits, often by blocking consumer access to equally effective but less expensive medication.

Uninsured consumers carry the full cost of overpriced prescription drugs. The federal government uses its buying power to negotiate lower prices for the drugs it purchases for its beneficiaries – such as veterans, government employees and retirees. In addition, consumers with health insurance coverage pay only a portion of the discounted price negotiated by their insurance company. Uninsured consumers, with no one to negotiate on their behalf, pay the highest prescription drug prices not only in America, but in the rest of the industrialized world as well.

In late summer of 2004, the National Association of State Public Interest Research Groups (PIRGs) conducted a

survey of more than 400 pharmacies in 19 states across the country and Washington, DC to determine how much uninsured consumers are paying for 12 prescription drugs commonly used by adults under age 65. We then compared these prices with the prices the pharmaceutical companies charge one of their “most favored” customers, the federal government, and also with the prices paid by consumers in Canada.

Our survey showed that the uninsured pay a huge price for prescription drugs, especially when compared with the prices paid by the federal government and our neighbors to the north. Key findings include:

In Alaska:

- On average, uninsured consumers in Alaska pay 80% more than the federal government for 12 common prescription medications.
- Uninsured consumers in Alaska pay 80% more for Zithromax than the federal government pays for the same prescription. Zithromax is an antibiotic commonly used to treat pneumonia and other infections.
- On average, uninsured consumers in Alaska pay twice as much—109% more—for drugs purchased at their local pharmacy than they would pay if they purchased the same drugs from a Canadian pharmacy.

Nationally:

- Uninsured Americans pay 78% more on average for 12 common prescription drugs than the federal government pays for the

same medications. The price differences range from 41% more for Ambien, a sleep aid, to 162% more for Synthroid, which treats thyroid disorders.

• Many of the drugs featured in the PIRG survey treat chronic conditions – meaning that even small savings add up quickly. An uninsured person regularly taking Allegra to control his/her allergies, for example, would pay at least \$1,120 for a year's supply. The federal government, on the other hand, would pay on average \$657 for the same quantity of Allegra – a savings of \$463.

• Uninsured Americans, on average, pay twice as much as Canadians—105% more—for nine of the common prescription medications we surveyed. The price differences range from 45% more for Norvasc, which treats high blood pressure, to 530% more for Premarin, a necessary hormone treatment for millions of women.

• An uninsured woman regularly taking Premarin would pay at least \$465 for a year's supply in the United States. A woman purchasing her year's supply of Premarin from a Canadian pharmacy would pay just \$74—a savings of \$391.

The need for state and federal action to lower drug prices has never been greater.

Although federal lawmakers are aware that Americans pay the highest prescription drug prices in the world, they have yet to take substantive action to address the problem. Frustrated by inaction at the federal level, states across the nation are taking on the task of providing their uninsured and underinsured citizens with access to

affordable prescription drugs. The state PIRGs support a range of strategies to lower the cost of prescription drugs that include:

- ✓ Creating prescription drug-buying pools at the state level that would allow businesses, the government and individuals of all ages to use their combined buying power to negotiate lower drug prices, similar to what the federal government and big HMOs do;
- ✓ Expanding the use of preferred drug lists (PDLs), which provide state governments with information about the most cost-effective treatment for a particular condition. State governments can use PDLs to make purchasing decisions that ensure patients get the most affordable and most effective treatment possible;
- ✓ Increasing scrutiny of pharmaceutical benefit managers, the pharmaceutical "middlemen" who manage the prescription drug care for millions of Americans under a veil of secrecy and often act against their clients' best interests;
- ✓ Regulating the marketing practices of pharmaceutical companies that drive up the prices of prescription drugs and encourage patients and doctors to favor the newest and most expensive drugs regardless of their effectiveness; and
- ✓ Providing consumers with immediate price relief by legalizing the importation of lower-priced prescription drugs from Canada and other countries with drug regulatory systems similar to ours as a stopgap measure until comprehensive reform passes.

*State
Recommendations*

Background: The High Cost of Prescription Drugs

American consumers pay too much for prescription drugs. In 2003, Americans spent \$203.1 billion on prescription drugs, an increase of \$20.4 billion from the previous year.¹ While some of that increase can be attributed to additional unit sales, skyrocketing prescription drug prices are the biggest driver of increased spending on prescription drugs. A study by Families USA, a non-profit advocacy group, found that prescription drug costs increased at more than three times the rate of inflation from January 2003 to January 2004.² AARP tracked prices for the 197 brand name drugs most widely used by seniors and found that they increased in price by 27.6% on average from 2000 to 2003, compared with a general inflation rate of just over 10%.³ AARP also found that pharmaceutical companies actually increase their drug prices more than once a year; manufacturers increased the price of 106 of the 197 drugs most frequently used by senior citizens over the three-month period ending in March 2004.⁴

The Cost to Uninsured, Non-Elderly Americans

Both policy makers and non-profit advocacy groups often focus on the inordinate burden that prescription drug costs place on the elderly. Many seniors live on fixed incomes that increase only slightly with inflation. As prescription drug costs rise faster than the rate of inflation, health care consumes more and more of their limited annual incomes. In recognition of senior citizens' need for

Analysis: The Medicare Prescription Drug Benefit

Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act in late 2003. Unfortunately, the benefit created by the legislation provides only limited prescription drug coverage for most beneficiaries and does nothing to lower the overall price of drugs for all Americans.

Until private prescription drug plans become available in 2006, Medicare beneficiaries can enroll in an interim discount card program. Once a Medicare recipient selects a drug discount card, he or she is limited to the discounts available through that card for the next year. The companies selling the drug discount cards, however, can change the drug list and discounts at any time. Because enrollees have neither the freedom to change plans, nor the ability to predict prices, real competition between card providers does not exist. Drug card providers have little incentive to lower prices. Moreover, the legislation specifically prohibits Medicare administrators from negotiating drug prices with the pharmaceutical companies, which would have lowered both the cost to seniors for their medication and the overall cost of the program to taxpayers.

The Medicare legislation also does not address the cost of prescription drugs for non-Medicare recipients, including the millions of uninsured who are left to pay the full high price for their medication.

prescription drug coverage, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.⁵ Unfortunately, the benefit created by the legislation provides only limited prescription drug coverage for most beneficiaries (see box).

In addition to seniors, many non-elderly consumers are unable to afford their prescription drug medication. While Medicare beneficiaries have insurance that generally covers doctors and hospital care, increasing numbers of non-elderly (under 65 years of age) uninsured Americans struggle to pay for all of their health care. The number of non-elderly uninsured Americans grew to approximately 45 million in 2003, an increase of 1.4 million from 2002.⁶ Young adults (ages 19 to 34) accounted for 40% of the non-elderly, uninsured population in 2003.⁷

Lacking health insurance is a tremendous barrier to obtaining needed health care. According to a survey conducted by Kaiser Family Foundation in 2003, 37% of uninsured people did not fill a prescription because of cost. Almost half (47%) of the uninsured postponed seeking any medical care because of cost.⁸ Even after an uninsured person finally decides to seek medical care, that person is often unable to pay for the treatment that his or her doctor prescribes.

Having drug coverage does not necessarily translate into being able to afford prescription drugs; many plans require patients to make large co-payments or spend somewhere between \$100 and \$500 in deductibles before covering most services.⁹ The more a person has to pay for a drug, the less likely he or she is to have it filled. A study published in the *Journal of the American Medical Association* found that increasing co-payments from \$5 to \$10 per prescription reduced consumer spending on

drugs by 22%.¹⁰ Co-payments have greatly increased as employers have looked for ways to cut rising health care costs.

Drug Prices Rise As Industry Thrives

The high price of prescription drugs has helped the pharmaceutical industry remain consistently profitable, even in a stagnant economy. In 2001, it ranked first of any industry in rates of return on equity, assets, or revenues.¹¹ Families USA, meanwhile, found that the pharmaceutical industry has been the most profitable industry in the United States for the past 10 years, and that it "was five-and-one-half times more profitable than the average for Fortune 500 companies."¹² Similarly, Public Citizen released a study finding that the combined profits for the 10 drug companies in the Fortune 500 (\$35.9 billion) amounted to more than the profits for all the other 490 businesses put together (\$33.7 billion) in 2002.¹³

The industry insists that its high prices are justified by the amount of money it must spend in researching and developing new medications. According to one industry source, the cost of research and development (R & D) averages \$800 million or more for a single compound.¹⁴ Another industry source suggests that out of 5,000 drugs under development, only five are likely to be tested in clinical trials and only one will be approved for patient use, meaning that industry must invest heavily in medicines that never turn a profit.¹⁵ The inherent risks of R & D and the need to recover losses from failed trials both necessitate and justify the cost of its products, the argument continues. According to the industry, lowering prices will result in less investment in R & D and fewer new and innovative drugs on the market.

Yet R & D is actually a much lower priority for drug companies than they suggest. First, the government funds a substantial portion of the research and development required to produce any given medicine. One group has estimated that R & D can cost companies no more than \$240 million per drug, once government-funded research and tax deductions are taken into account,¹⁶ rather than the industry figure of \$800 million. While \$240 million is still a substantial sum of money, these figures suggest that the pharmaceutical industry's research and development expenses may be far lower than advertised.

In addition, despite the steep climb in the cost of prescription drugs, the Food and Drug Administration (FDA) approved only 17 new drugs in 2002, the fewest in a decade. Some suggest that this drop in new medications has prompted "companies to keep profits flowing the old-fashioned way: by charging more for their existing products."¹⁷

Furthermore, the pharmaceutical companies spent greater portions of their net revenue on marketing, advertising, and administrative costs than on R & D in 2001. In fact, one study found that eight major American pharmaceutical companies spent more than twice as much on marketing and administrative costs than on R & D. And in 2001, the major pharmaceutical companies put only 11% of their revenue into R & D, but counted 18% of revenue as profits.¹⁸ Recent evidence also suggests that major drug companies spend a greater percentage of their money on buybacks of company stock and dividends to shareholders. Pfizer, the largest drug company in the world, spent 210% (\$22.2 billion) more on stock buybacks and dividends than it did on research in the past 18 months.¹⁹

Drug Companies Exploit Loopholes to Delay Generic Competition

In response to concerns about the struggling generic industry and the pharmaceutical industry's frustration with the lengthy FDA approval process, Congress enacted the Drug Price Competition and Patent Term Restoration Act, commonly referred to as the Hatch-Waxman Act, in 1984. The legislation increased the number of generic drugs available to consumers by simplifying the approval process for generic companies. This provision increased the generic share of the prescription drug market from 20% at the time of enactment to nearly 50% of the current market.²⁰ Unfortunately, the legislation also gave the pharmaceutical industry a new set of weapons to delay the approval of generic equivalents.

In order to receive FDA approval to market a generic drug, the generic manufacturer must prove the brand-name drug's patent has either expired or is no longer valid. If the brand-name company retaliates with a lawsuit, which is common, FDA automatically delays the generic company's claim for 30 months while it investigates the dispute. The Hatch-Waxman Act also gave brand-name manufacturers the ability to submit patents on multiple aspects of the same drug, thereby extending the number of times the company can invoke the 30-month delay. Companies have filed patents on everything from the color of a capsule to the shape of a bottle, all in an attempt to extend their control over a specific brand-name drug. By filing new patents after the first lawsuit, then suing for infringement of those patents, brand name drug companies can obtain successive 30-month stays. Researchers have found that the average number of patents filed on brand-name medications has increased from 2 to 12 in the past 10 years.²¹

An additional six months of exclusive marketing rights can be extraordinarily profitable. When Wyeth Pharmaceuticals was granted an additional six months of exclusivity for its anti-depressant Effexor,²² it earned an additional \$72 million dollars.²³ By exploiting the legal loopholes created in the Hatch-Waxman Act, brand-name drug manufacturers have succeeded in maintaining monopoly rights to prescription drugs long after the original patent expired.

Drug Companies Engage in Collusion and Price Manipulation

In order to avoid the costly legal battles described in the previous section, some brand-name drug companies opt for a less expensive alternative. Rather than spend millions defending themselves against lawsuits, companies holding expired or invalid patents decide instead to cut their losses and make a deal with their competitors. The brand-name companies pay the generic manufacturer to postpone entry into the market, and they agree on a settlement. In June 2002, the Federal Trade Commission (FTC) challenged interim settlements for three drug products. In the challenges, the Commission alleged that "the brand-name drug company paid the first generic applicant not to enter the market, thereby retaining its (unused) 180-day marketing exclusivity and precluding the FDA from approving any eligible subsequent generic applicants."²⁴ The FTC found that the brand-name manufacturer and generic manufacturer were illegally colluding to prevent competition and preserve the drug's high price.²⁵

Other lawsuits allege that some companies have systematically overcharged consumers for their medicines or waged misinformation campaigns against competitors. Wyeth-Ayerst Laboratories, for example, has been accused of maintaining a 99% monopoly

over its estrogen supplement Premarin by waging a misinformation campaign about its generic competitor, Cenestin, to discourage consumers from purchasing the cheaper drug. Even as Wyeth-Ayerst worked to keep Cenestin off formularies—the list of medications covered by any given health plan—it continued to increase the price of Premarin.²⁶ Knoll Pharmaceuticals (now owned by BASF) also was accused of waging a misinformation campaign about generic competition for Synthroid, its drug to treat hyperthyroidism. Knoll maintained in both advertisements and communication with state and federal regulators, consumers, pharmacists, and the medical community that there was no "substitute for Synthroid" despite evidence in hand proving that the generic version of Synthroid was biologically equivalent and an effective substitute.²⁷

Several state PIRGs have joined labor unions, senior citizen advocates and other consumer groups in litigation coordinated by the Prescription Access Litigation Project (PALP), challenging numerous unfair drug company price manipulation tactics. In July 2004, PALP announced a \$29 million settlement with GlaxoSmithKline over charges that it used illegal tactics to maintain its patent on Augmentin, a popular antibiotic used in the treatment of a variety of common infections.²⁸

Pharmacy Benefit Managers Use Deceptive Trade Practices

Pharmacy Benefit Managers (PBMs), the pharmaceutical "middlemen," arrange sales programs between drug manufacturers and health care plan providers (such as state health benefit programs, large businesses, and HMOs) seeking to reduce the cost of their prescription drug plans. PBMs provide pharmacy coverage to more than 150 million American consumers;²⁹ three PBMs—

Medco, Caremark and Express Scripts—currently control approximately 80% of the lucrative market. Overall, the nation's employers spend more than \$70 billion through PBMs.³⁰ Despite the impact of PBMs on health care spending, tremendous secrecy surrounds how PBMs conduct business. Recent investigations charge that PBMs exploit their ability to negotiate secret deals and increase their revenues without passing cost savings on to clients.

In April 2004, 19 states settled deceptive trade practice claims against Medco Health Solutions, Inc. Medco is the nation's largest PBM, with 2002 net revenues of more than \$32 billion and a network of 55,000 pharmacies.³¹ The complaint alleged that Medco encouraged physicians and other prescribers to switch patients to different prescription drugs without disclosing that the switches benefited Medco by increasing rebates from drug manufacturers. The complaint also alleged that Medco misrepresented its actions by claiming that the switch would result in savings to both patients and health care plans.³² In reality, the switches they encouraged often increased costs, primarily in follow-up doctor visits and tests. For example, Medco switched patients from certain cholesterol medications (such as Lipitor) to alternative treatments (such as Zocor), which required patients to pay for follow-up costs.³³ Medco paid \$29 million to settle the deceptive trade allegations; \$2.5 million to identifiable patients who incurred expenses related to a switch between cholesterol controlling drugs; and \$6.6 million to states in fees and costs.

On August 4, 2004, the New York Attorney General's office announced it had filed suit against Express Scripts for "conducting elaborate schemes" that added millions of dollars in prescription drug costs to the state's health plan.³⁴ The lawsuit alleges that Express Scripts encouraged drug

switches that increased its revenue at the expense of the health plan and its members. Specifically, Express Scripts would switch members from a brand name drug losing patent protection to another brand name drug, one not facing generic competition but made by the same manufacturer. The suit also charges that the company would induce physicians to switch a patient's prescription from one prescribed drug to another drug manufactured by a company paying Express Scripts for new prescriptions. The suit further alleges that Express Scripts disguised millions of dollars in rebates it received from drug manufacturers as various types of administrative fees when it should have passed the rebates onto the health plan.³⁵ Nineteen other states are currently investigating Express Scripts on similar charges.³⁶

Drug Companies Limit Information on the Safety and Efficacy of Their Products

Often, several competing prescription drugs are available to treat one condition, such as depression or high cholesterol. However, consumers and doctors have few resources for determining which prescription is safest, most effective, and most affordable. Pharmaceutical companies frequently patent new prescription drugs that are either equivalent or less effective than less expensive options, such as drugs available in generic form, over-the-counter medication, or lifestyle changes. Unfortunately, pharmaceutical companies generally do not conduct head-to-head comparisons of drugs that treat the same condition; they prefer the less risky approach of competing through marketing, which encourages doctors and consumers to use the newest and usually most expensive treatments.

Not only do pharmaceutical companies discourage comparisons of drugs within the same class, they also control the dissemination and interpretation of their clinical trial results. In June 2004, the Attorney General of New York filed a lawsuit against GlaxoSmithKline, alleging that the company committed fraud by both concealing and failing to disclose negative information about its depression drug Paxil.³⁷ GlaxoSmithKline completed five studies on the use of Paxil in children; four failed to demonstrate that Paxil was more effective than a placebo and suggested a possible increased risk of suicidal behavior. Not only did GlaxoSmithKline fail to include this information in the "Medical Information Letter" it sent to physicians, it also failed to publish the negative clinical trial results.³⁸ GlaxoSmithKline reached a settlement with the State of New York that includes payment of \$2.5 million as well as an agreement to publicly disclose information on clinical studies of its drugs.³⁹ In September 2004, an FDA advisory committee^a concluded that the increased risk of suicidality in pediatric patients applied to all the drugs studied (Prozac, Zoloft, Remeron, Paxil, Effexor, Celexa, Wellbutrin, Luvox and Serzone) in controlled clinical trials. Shortly thereafter, FDA announced support for the advisory committee's recommendation to strengthen the warning label for antidepressant usage in children.⁴⁰

^a FDA uses advisory committees to gain expert advice about scientific and public health issues and/or regulatory decisions. On September 13-14, 2004, the Psychopharmacologic Drugs and Pediatric Advisory Committees held a joint meeting to consider the occurrence of suicidality in the course of treating pediatric patients with various anti-depressants. FDA is not required to follow the recommendations of its advisory committees; the agency announced a few days after the joint meeting that it "generally supports the recommendations." (From testimony of Dr. Robert Temple, Director of Medical Policy at FDA's Center for Drug Evaluation and Research, before the U.S. House Subcommittee on Oversight and Investigations, September 23, 2004.)

Around the same time, in September 2004, drug giant Merck announced a voluntary worldwide withdrawal of its blockbuster pain-relief drug, Vioxx. Merck stopped selling Vioxx after a long term study, financed by the company, showed that people taking the drug had more cases of heart attack, stroke or blood clot than people taking a placebo.⁴¹ Since Vioxx went on the market in 1999, the prescription has been dispensed 84 million times.⁴² Many experts in the medical field had raised questions about the safety of the medication for nearly four years; many others are raising similar questions about the FDA's failure to recall the drug in the face of this medical evidence. In 2000, a study by the *New England Journal of Medicine* found rates of heart attacks were higher in patients taking Vioxx than in patients taking an older drug. After that study, FDA required Merck to add a warning to Vioxx's label. Another study released by cardiologists in 2001 reiterated the findings of the 2000 study.⁴³ This news, combined with the high cost of Vioxx, caused some insurers to remove Vioxx and similar pain medications from their list of preferred drugs. Although an August 2004 French study found that high doses of Vioxx triple the rate of heart attack, FDA approved Vioxx for use in children just a few weeks later.⁴⁴ Merck continued to assert that the drug was safe—even as recently as three days before announcing its decision to withdraw the drug from the market.⁴⁵

Drug Companies Spend Millions Lobbying to Maintain High Prices

In June 2004, Public Citizen released a report detailing the amount of money the drug industry—broadly defined as brand-name, generic and biotech drug makers, pharmacy benefit managers, distributors, and related advocacy groups—spent

lobbying Congress in 2003. According to the report, "the drug industry hired 824 individual lobbyists in 2003—an all-time high. That's more than eight lobbyists for each member of the U.S. Senate. In 2002, based on a more narrowly defined survey, the drug industry spent \$91.4 million and hired 675 lobbyists."⁴⁶ Drug industry spending on lobbying in 2003 rose to a record \$108.6 million; brand-name manufacturers alone spent nearly \$80 million on lobbying, or 73% of the industry total. The Pharmaceutical Research and Manufacturers of America (PhRMA), the

industry's leading trade association representing more than 40 brand-name drug companies, hired 136 lobbyists in 2003, 24 more than the previous year, and spent more than \$16 million on direct lobbying before Congress, a 12.5% increase from the year before.⁴⁷ According to confidential budget documents, PhRMA does not confine its financial influence to federal decision-makers. For the fiscal year that began on July 1, 2003, PhRMA had budgeted \$48.7 million for advocacy at the state level as well.⁴⁸

Survey Findings

While the pharmaceutical industry is among the most profitable industries in the world, millions of uninsured and underinsured Americans struggle to afford the medicines they need, even forgoing medically necessary drugs when prices are out of reach. When discussing the high cost of prescription drugs, politicians often focus on the financial burden carried by senior citizens. Unfortunately, high prescription drug prices are a problem for Americans of all ages, not just the elderly.

The federal government uses its buying power to negotiate lower prices for the drugs it purchases for its beneficiaries—such as Veterans, government employees and retirees. Consumers with health insurance coverage pay only a portion of the discounted price negotiated by their insurance company. Unfortunately, 45 million uninsured Americans have no one doing the same on their behalf.

In late summer of 2004, the National Association of State Public Interest Research Groups (PIRGs) conducted a survey of more than 400 pharmacies in 19 states across the country and Washington, DC to determine how much uninsured consumers are paying for 12 prescription drugs commonly used by adults under age 65. We then compared these prices with the prices the pharmaceutical companies charge one of their “most favored” customers, the federal government, and the prices paid by consumers in Canada.

Our survey demonstrates that the uninsured pay unjustly high prices for prescription drugs in the United States—especially when compared with the prices paid by the federal government and our neighbors to

the north. Tables 1 and 2 detail the results of our survey. Key findings include:

In Alaska:

- On average, uninsured consumers in Alaska pay 80% more than the federal government for 12 common prescription medications.
- Uninsured consumers in Alaska pay 80% more for Zithromax than the federal government pays for the same prescription. Zithromax—an antibiotic prescribed to treat various bacterial infections, such as pneumonia—is the most commonly dispensed antibiotic in America.
- On average, uninsured consumers in Alaska pay twice as much—109% more—for drugs purchased at their local pharmacy than they would pay if they purchased the same drugs from a Canadian pharmacy.

Nationally:

- Uninsured Americans pay 78% more on average for 12 common prescription drugs than the federal government pays for the same medication. The price differences range from 41% more for Ambien, a sleep aid, to 162% more for Synthroid, which treats thyroid disorders.
- Many of the drugs featured in the PIRG survey treat chronic conditions—meaning that even small savings add up quickly. An uninsured person regularly taking Allegra to control his or her allergies, for example, would pay on average \$1,120 for a year’s supply. The government, on the other hand, would pay only \$657 for the same quantity of Allegra—a savings of \$463.

- Uninsured Americans, on average, pay twice as much as Canadians—105% more—for nine of the common prescription medications we surveyed. The price differences range from 45% more for Norvasc, which treats high blood pressure, to 530% more for Premarin, a necessary hormone treatment for millions of women.

- An uninsured woman regularly taking Premarin would pay on average \$465 for a year's supply. A woman purchasing her year's supply of Premarin from a Canadian

pharmacy would pay \$74—saving \$391 a year.

Refer to Appendix A for a detailed breakdown of the average cost of these prescription drugs in all of the states and major metropolitan areas surveyed.

Table 1. 12 Common Prescription Drugs: Prices Paid by Uninsured Consumers vs. the Federal Government

	Federal supply price	Average price paid by uninsured nationally	% more paid by uninsured nationally	Average price paid by uninsured in Alaska	% more paid by uninsured in Alaska
Synthroid	\$9.20	\$24.08	162%	\$25.78	180%
Zyrtec	\$43.30	\$73.37	69%	\$73.44	70%
Ambien	\$73.13	\$103.30	41%	\$102.95	41%
Lipitor	\$47.05	\$80.65	71%	\$83.96	78%
Levoxyl	\$10.27	\$17.70	72%	\$18.36	79%
Allegra	\$54.77	\$93.34	70%	\$87.91	61%
Premarin	\$15.53	\$38.73	149%	\$41.90	170%
Norvasc	\$45.39	\$72.38	59%	\$79.61	75%
Singulair	\$58.35	\$105.19	80%	\$106.58	83%
Effexor XR	\$51.46	\$109.72	113%	\$105.21	104%
Ortho Tri-Cyclen	\$18.72	\$43.24	131%	\$42.60	128%
Zithromax	\$31.71	\$57.30	81%	\$57.06	80%
Average	\$38.24	\$68.25	78%	\$68.78	80%

Table 2. Nine Common Prescription Drugs: Prices Paid by Uninsured American Consumers vs. Canadian Consumers

	Price in Canada	Average price paid by uninsured Americans	% more paid by uninsured Americans	Average price paid by uninsured in Alaska	% more paid by uninsured in Alaska
Synthroid	\$5.51	\$24.08	335%	\$25.78	365%
Zyrtec	\$18.54	\$73.37	296%	\$73.44	296%
Lipitor	\$47.40	\$80.65	70%	\$83.96	77%
Premarin	\$6.15	\$38.73	530%	\$41.90	581%
Norvasc	\$50.04	\$72.38	45%	\$79.61	59%
Singulair	\$62.15	\$105.19	69%	\$106.58	71%
Effexor XR	\$50.39	\$109.72	118%	\$105.21	109%
Ortho Tri-Cyclen	\$19.12	\$43.24	126%	\$42.60	123%
Zithromax	\$35.30	\$57.30	62%	\$57.06	62%
Average	\$32.74	\$67.18	105%	\$68.46	109%

Policy Recommendations

Although the prescription drug crisis is undeniably complex, simple and readily available policy options do exist and could be immediately implemented. Some of these recommendations have already been employed at the state level. The state PIRGs support the following state and federal strategies to lower the cost of prescription drugs:

Create Prescription Drug Buying Pools

The state PIRGs support creating prescription drug-buying pools at the state level that would allow businesses, the government and individuals of all ages to use their combined buying power to negotiate lower drug prices, similar to what is done by the federal government and big health insurance providers. Specifically, this would:

- Give the state government the ability to negotiate substantial rebates from drug companies and discounts from retailers, then pass those savings along to participants; and
- Provide tools to help persuade drug companies to negotiate prices in good faith, including public disclosure of uncooperative companies.

In May 2000, the Maine legislature passed the Maine Rx Program, which allowed the state to negotiate fairer drug prices for all residents, regardless of income level or age, by using the buying power of its Medicaid program. The Pharmaceutical Research and Manufacturers Association filed a lawsuit on the basis that the program interfered with interstate commerce. In May 2003, the U.S. Supreme Court decided in favor of Maine. Concerned over future legal

Interstate Buying Pools

States are banding together to leverage their market power to lower the price of prescription drugs and reduce inefficiencies in the purchase of medication for their residents.

The RxIS Coalition, an arrangement between Delaware, Missouri, New Mexico, West Virginia, and most recently Ohio, negotiates manufacturer discounts for prescription drugs for state employees using a single PBM.

In April 2004 the U.S. Department of Health and Human Services (HHS) Secretary approved plans by five states (Michigan, Vermont, New Hampshire, Alaska, and Nevada) to pool their collective purchasing power to gain deeper discounts on prescription medications for their state Medicaid programs. In 2004, Michigan estimates that it will save \$8 million; Vermont \$1 million; Alaska \$1 million; New Hampshire \$250,000; and Nevada \$1.9 million. Minnesota and Hawaii have submitted plans to HHS in order to join. Minnesota estimates that it could save \$11 million.

Source: "State Purchasing Pools for Prescription Drugs: What's Happening and How Do They Work?" an issue brief from the National Governors Association Center for Best Practices, available at www.nga.org.

challenges, the Maine legislature enacted changes to the program in June 2003 that limited participation to Maine residents with incomes under 350% of the federal poverty level and to individuals whose drug expenses exceed 5% of their income.

Increase Competition from Low Cost Generic Drugs

The state PIRGs support legislation that would close the loopholes in the Hatch-Waxman Act and prevent pharmaceutical companies from using costly tactics to delay the introduction of generic drugs. The state PIRGs also call on FDA to take a more proactive role to prevent the practices commonly used by pharmaceutical companies to extend their patents.

Expand Use of Preferred Drug Lists

The state PIRGs support expanding the use of "preferred drug lists," or PDLs. Panels of experts develop PDLs by evaluating the effectiveness and price of similar medications then placing the equally effective yet lower cost medications on the lists. Health care providers and state governments use these PDLs when making purchasing decisions, ensuring that patients get the most cost-effective drugs available while encouraging drug manufacturers to offer competitive prices. Evidence-based review programs (see box) are a perfect complement to PDLs; experts can rely on research from evidence-based review to make well-informed decisions about which drugs to include on the PDLs.

Regulate the Marketing Practices of the Pharmaceutical Industry

Both consumers and doctors are increasingly inundated with information about brand-name prescription drugs. Neither doctors nor consumers can rely on the information provided by pharmaceutical companies. The state PIRGs support the following strategies to end or limit direct-to-consumer advertising and restrict

Evidence-Based Review

Evidence-based review programs can help health care providers and state governments make well-informed decisions about which drugs to place on Preferred Drug Lists.

With the support of consumer advocacy groups, including OSPIRG, Oregon state lawmakers created "The Drug Effectiveness Review Project" in 2002. The project established a database of unbiased scientific evidence, "evidence-based research," regarding the safety and effectiveness of drugs that treat the same condition. Oregon uses the research to make cost-effective drug purchasing decisions for its Medicaid program, but the information is also available to the public. A central website, www.OregonRx.org, provides consumers with a helpful tool to sort through the available prescription medications to treat their conditions.

Instead of purchasing multiple drugs within the same treatment class (such as competing name brand drugs), government programs can purchase the best and most cost-effective medications. Evidence-based research rewards effective low cost drugs and could reduce the number of high cost drugs that are not an improvement on existing medication options. In many cases, the research has found that the newest and most expensive prescriptions are not any better than older, cheaper medications.

As of April 2004, 10 other states (Alaska, Idaho, Kansas, Michigan, Minnesota, Missouri, North Carolina, Washington, Wisconsin, and Wyoming) had joined with Oregon to fund evidence-based research.

Sources: The Oregon state website on evidence-based research, www.OregonRx.org; AARP, Rx Watchdog Report, Vol. 1, Issue 2, July 2004, "AARP Building a Functioning Market for Prescription Drugs."

pharmaceutical company marketing to doctors:

□ *End or Limit Direct-to-Consumer Advertising*

The state PIRGs support legislation to end the practice of direct-to-consumer advertising, which encourages consumers to request the newest and often most expensive treatment regardless of proof about the drug's superiority. Physicians tend to prescribe the requested drug, often despite their ambivalence about the treatment choice.⁴⁹ The state PIRGs also support interim steps to close loopholes in the legislation that allows direct-to-consumer advertising. For instance, a drug manufacturer does not have to include information about the side effects of a drug in an advertisement if the advertisement does not explicitly say what the drug is used to treat.

Over the past few years, several states, including Massachusetts, California, Vermont and West Virginia, have introduced legislation to regulate direct-to-consumer advertising or passed resolutions asking Congress to limit prescription drug advertising.⁵⁰

□ *Restrict Marketing to Doctors*

The state PIRGs support legislation to limit pharmaceutical promotion to physicians (detailing). Some legislative options that state PIRGs support or have supported in the past include:

✓ Codifying the PhRMA and American Medical Association guidelines for interactions between doctors and pharmaceutical company representatives.

Recently, the state of California enacted legislation, sponsored by CALPIRG, to codify previously unenforceable voluntary

guidelines on gift-giving to doctors. The legislation also requires drug companies to make their internal guidelines on gift-giving available on their websites.⁵¹

✓ Placing strict monetary limits or outright bans on gifts from pharmaceutical companies to doctors.

Minnesota was the first state to cap gift value at \$50 per gift, with some exceptions, in 1993. In 2004, the Minnesota legislature introduced but did not pass a bill to lower the cap from \$50 to \$20.⁵²

✓ Improving doctor and drug company disclosure, such as requiring pharmaceutical companies to report the value, nature, and purpose of any gift or economic incentive over a certain value given to a health care provider.

In the past two years, Maine and Vermont have enacted, and more than 15 state legislatures have considered, some disclosure requirements for drug companies or doctors.⁵³

Increase the Transparency of PBMs

Pharmacy Benefit Managers (PBMs), the pharmaceutical "middlemen", manage the prescription drug care for millions of Americans. PBMs negotiate deals from pharmaceutical companies on behalf of insurers, state health programs, and large businesses. These deals, however, are shrouded in secrecy and are the basis for allegations that PBMs fail to act in their clients' best interests. The state PIRGs support efforts to increase transparency and accountability for PBMs.

In 2003, South Dakota enacted legislation to regulate PBMs. Under the legislation, a PBM is required to perform its duties in "good faith" and to disclose to its clients the

amount of all rebate revenues and the nature, type and amounts of all other revenues that the PBM receives from each pharmaceutical manufacturer or labeler with whom the PBM has a contract.⁵⁴

Legalize Prescription Drug Importation

To provide consumers with immediate relief from the high cost of prescription drug prices, the state PIRGs support legislation to legalize prescription drug importation as an interim solution for the millions of consumers who cannot afford to purchase their medication. Legalizing prescription drug importation through legislation such as the bi-partisan Dorgan-Snowe proposal in the 108th Congress will give consumers timely access to affordable medication and

pressure the pharmaceutical industry to lower the prices of prescription drugs sold in America.

Although federal legislative proposals have stalled, numerous states and cities have implemented programs to help employees and consumers import prescription medication. For example, the state of Rhode Island enacted a law in 2004 to allow pharmacies licensed in Canada to do business in Rhode Island. FDA, however, continues to frustrate states' efforts to help their residents import prescription drugs. Vermont filed a lawsuit against the FDA in August 2004 after the agency rejected the state's request to set up a pilot program to demonstrate how importation could be done safely.⁵⁵

Consumer Tips

✓ **Beware of brand name generics.**

A testimony to the effectiveness of the pharmaceutical industry is the emergence of "brand name generics," generic equivalents of popular brand name drugs made by companies that spend money on advertising to distinguish their products from other generic versions. One of the drugs included in our survey, Levoxyl, is a brand name generic version of another drug in our survey, Synthroid. Both are top sellers, and both are priced higher than equally effective generic versions. See the price comparisons for Synthroid below. The prices represent the cost of a one month's supply (30 tablets); we used Walgreen's website price for 100 tablets to calculate the cost of a month's supply.

Prescription Drug Version	Prescription Drug Name	Average Price in Survey	Price on Walgreen's Website*
Original, Brand Name	Synthroid	\$24.08	\$19.20
Generic, Brand Name	Levoxyl	\$17.70	\$15.90
Generic	Levothyroxine	n/a	\$11.40

*prices downloaded from www.walgreens.com on October 5, 2004.

✓ **Always ask if there is a generic version of your prescription.**

Ask your doctor or your pharmacist for a generic version of your prescription medication or do some research by looking at an online drugstore. Generic drugs are much cheaper than their brand name counterparts. For example, the price of the most popular brand of birth control in America, Ortho Tri-Cyclen, is much higher than its generic equivalent, Tri-nessa. On Walgreen's website, a month's supply of Ortho Tri-Cyclen costs \$41.99. The generic version, Tri-Nessa, costs only \$29.99—nearly 30% less.

✓ **Be sure to tell your doctor if you are not able to afford the medication that he or she prescribed you.**

If a doctor writes you a prescription, he or she expects that you will fill it and take it as directed. Your doctor might have free samples available or might be able to prescribe a different medication that is less expensive.

✓ **Shop around; use the phone and the Internet to look for lower drug prices.**

Ask a pharmacist for advice on how to save money on your prescriptions; they might know of discount programs for which you might be eligible. Certain websites also can help consumers compare prices from multiple Internet pharmacies, such as www.pricegrabber.com and www.destinationrx.com. (See tip below about using safe Internet pharmacies.)

✓ **Be careful when purchasing your prescriptions on the Internet.**

Many websites appear legitimate but actually sell counterfeit and unsafe products. The National Association of Boards of Pharmacy developed the Verified Internet Pharmacy Practice Sites (VIPPS) program to certify pharmacies that meet licensing requirements for their state, as well

as for each state to which they dispense pharmaceuticals. For more information on VIPPS, visit <http://vipps.nabp.net/>.

In general, be sure that any Internet pharmacy is licensed by a government authority. Also, never use an Internet pharmacy that does not require a hard copy (faxed or mailed) of your doctor's prescription. Always look for the online pharmacy's address; if the website does not disclose any address or phone number, it is probably not a legitimate business.

✓ **Only import prescription drugs from pharmacies certified by the country in which they are based.**

Several states have set up websites to help their residents import drugs from certified Canadian pharmacies. These websites are generally open to people living outside of the state. The state of Minnesota, for example, maintains www.MinnesotaRxConnect.com to help consumers price Canadian drugs. The Minnesota State Department of Health visited and approved each of the pharmacies included on its website. Another website, www.pharmacychecker.com, is a free service that allows consumers to compare drug prices at a variety of Internet sites. It has rated 44 online pharmacies in the United States, Canada, Mexico, and elsewhere.

Questions to Ask Your Health Care Provider:⁵⁶

✓ **Is this drug more effective than an older, cheaper drug because it is prescribed at a higher dosage? If so, would the older, cheaper drug be as effective if it were given at an equivalent dose?**

Sometimes the best course is simply to increase the dose of an older drug. New drugs are not necessarily better than old ones, and the older the drug, the better its safety record is likely to be.

✓ **Are the benefits worth the side effects, the expense, and the risk of interaction with other drugs I take?**

Every drug has side effects, and the side effects and associated risks may outweigh the benefits of taking a new prescription.

Methodology

The goal of this report was to find out how much uninsured, non-elderly consumers pay for commonly prescribed medications.

How We Selected the Prescription Drugs to Survey

This report surveyed drugs commonly prescribed to Americans under 65. Using data from NDC Health,⁵⁷ we developed a list of the 20 brand name prescription drugs most frequently dispensed to anyone in 2003. We included only brand name drugs and brand name generics; we did not include generic versions of drugs manufactured and sold by multiple companies. The data are based upon more than three billion prescriptions dispensed in 2003.⁵⁸

To focus our study on prescription drugs used by people *under 65*, however, we dropped any drug falling on the list of the top 30 brand-name drugs used by the elderly, based on an analysis by Families USA.⁵⁹ In doing so, we removed two categories of drugs that many people under 65 require—medication to lower cholesterol and medication to lower blood pressure or treat angina. For this reason, we restored Lipitor (the top prescribed drug for the elderly and the top dispensed drug overall) and Norvasc (the top blood pressure/angina drug prescribed to the elderly and the fourth most frequently dispensed drug overall) to the survey list.

We surveyed pharmacies for the following drugs at the noted quantity and dosage.⁶⁰

Lipitor, 10 mg/30 tablets. Lipitor, or atorvastatin, lowers a patient's cholesterol and triglycerides levels in the blood. Lowering these cholesterol levels reduces

the risk of hardened arteries, which leads to heart attacks, strokes and peripheral vascular disease.

Norvasc, 10 mg/30 tablets. Norvasc is a calcium channel blocker that affects the movement of calcium into cells of the heart and blood vessels. It relaxes the blood vessels and increases the supply of blood and oxygen to the heart. Norvasc is prescribed for patients with high blood pressure (hypertension) and can relieve and control angina pectoris (chest pain).

Synthroid, 112 mcg/30 tablets. Levothyroxine sodium is an antineoplastic that is used when a patient's thyroid gland does not produce enough hormone. It also can be used to decrease the size of an enlarged thyroid gland (goiter) and to treat thyroid cancer.

Levoxyl, 112 mcg/30 tablets. Levoxyl is the brand name generic of Synthroid. It too is an antineoplastic that is used when a patient's thyroid gland does not produce enough hormone. It can be used to decrease the size of an enlarged thyroid gland (goiter) and to treat thyroid cancer.

Zithromax, 250 mg/ 6 tablets.^b Zithromax is used to treat bacterial infections in many different parts of the body, including pneumonia. It functions by killing or preventing the growth of bacteria.

Premarin, 0.3 mg/30 tablets. Premarin is a drug composed of the female hormone estrogen and has a variety of uses. It is prescribed to provide additional hormone

^b Surveyors asked for either six capsules or the pre-packaged version of the same dosage, called the Z-Pack.

when the body does not produce enough of its own, especially during menopause or when female development is lacking. It can help prevent the weakening of bones (osteoporosis) as well as function as treatment for both breast and prostate cancer.

Zyrtec, 10 mg/30 tablets. Zyrtec, or cetirizine hydrochlorine, is an antihistamine used to relieve the symptoms of hay fever, such as itching, runny nose, watery eyes and itchy hives, especially heightened during allergy season. Zyrtec treats both seasonal and perennial allergy symptoms.

Allegra, 60 mg/60 tablets. Allegra, or fexofenadine, is an antihistamine used to relieve the symptoms of hay fever and hives of the skin. Allegra treats primarily seasonal allergy symptoms.

Singulair, 10 mg/30 tablets. Singulair, or montelukast, is used in mild to moderate asthma treatment. It helps decrease the severity of the symptoms and reduces the number of acute asthma attacks. It also can help treat seasonal allergies.

Ortho Tri-Cyclen, 1 dispense pack/28 tablets. Ortho Tri-Cyclen is a progestin and estrogen combination that is used as an oral contraceptive to prevent pregnancy. Doctors also prescribe it to prevent acne.

Effexor XR, 75 mg/30 capsules. Effexor is an anti-depressant and anti-anxiety agent that treats depression and certain anxiety disorders.

Ambien, 10 mg/30 tablets. Ambien functions on a short-term basis to treat insomnia by helping patients fall asleep faster and sleep through the night.

How We Conducted the Survey and Calculated Average Retail Prices

We surveyed a total of 468 retail pharmacies in 19 states and Washington, DC in August and September of 2004. We chose to survey retail pharmacies—chain pharmacies, grocery store pharmacies, and mass merchant pharmacies—rather than online retailers or other outlets. Although Internet pharmacy sales are growing, the vast majority of Americans purchase their medications from retail pharmacies. Retail pharmacies filled 3.2 billion prescriptions in 2003, with total sales of \$203 billion.⁶¹

We selected the pharmacies at random from an Internet directory website. Surveyors posed as uninsured, non-senior citizen consumers shopping around for the best prices for their prescriptions. The surveyors found that pharmacists were very helpful and often gave the “uninsured” surveyor useful advice about how to save money on their prescriptions.

How We Compared Results to Federal Supply Schedule Pricing

The most favored customer price used for comparison is the Federal Supply Schedule price, provided by the Pharmacy Strategic Benefit Management Group of the Department of Veterans Affairs, which oversees the Federal Supply Schedule prices. We downloaded the Federal Supply Schedule prices from <http://www.vapbm.org/PBM/prices.htm> on August 10, 2004. The pharmaceutical industry, HMOs, and large insurers do not make public the drug prices paid by most favored private sector customers. The U.S. Government Accountability Office, however, has found that “federal supply schedule prices represent the best publicly available information of the prices that pharmaceutical makers charge their most favored customers.”⁶²

When multiple Federal Supply Schedule prices were available for a specific drug, we used the highest available price. Because the Federal Supply Schedule prices do not include pharmacy-dispensing fees, we added \$0.50 to each price to reflect a generous dispense fee (\$4.50 is the average dispense fee paid to pharmacies by state Medicaid programs). Large purchasers, including HMOs and the federal government, negotiate a fixed dispensing fee per prescription. Most purchasers probably pay a higher fee than state Medicaid programs.

How We Compared Results to Prices From a Certified Canadian Pharmacy

We used a website run by the state of Minnesota, www.MinnesotaRxConnect.com, to obtain comparative drug prices in Canada. As described on the Minnesota website, "This website provides information to Minnesotans about the issues surrounding affordable prescription medicines and information about ordering prescription medicines from Canadian pharmacies featured on the website. The Canadian pharmacies featured on this site are licensed by a Canadian province and governed by the laws and regulation of

Canada. State officials visited the Canadian pharmacies listed on this site and reviewed the pharmacy's facilities, the protocols used for filling prescriptions and the Canadian regulations governing Canadian pharmacies. Many of the regulations governing the pharmacies are similar to regulations applicable to pharmacies licensed by the State of Minnesota."

The website features four different Canadian pharmacies and gives information about both their prescription prices and their shipping charges. The website finds the lowest price from among the four pharmacies for a specific dosage of the prescription drug. For seven of the drugs we compared, the website listed only one quantity and price available for the dosage specified in our survey. For Zyrtec, we selected the price associated with a 3-month supply of 100 tablets, because most consumers would choose both the savings and convenience of ordering a larger supply of a daily medication; the only other option was for 18 tablets. For Zithron,ax, we selected the price associated with six tablets, rather than 30 tablets, because that is the quantity generally prescribed to treat most infections.

Appendix A. Average Retail Prices Paid by Uninsured Consumers for a 30-day Supply of Prescription Medication: By Location

Surveyed Area	Synthroid	Zyrtec	Ambien	Lipitor	Levoxyf	Allegra	Premarin	Norvasc	Singulair	Effexor XR	Ortho Tri-Cyclen	Zithromax	All 12 Drugs
Alaska (statewide)	\$25.78	\$73.44	\$102.95	\$83.96	\$18.36	\$87.91	\$41.90	\$79.61	\$106.58	\$105.21	\$42.60	\$57.06	\$68.78
Albuquerque, NM	\$24.43	\$70.28	\$99.71	\$79.75	\$17.33	\$91.49	\$41.90	\$70.31	\$101.82	\$108.79	\$44.35	\$56.28	\$67.20
Atlanta, GA	\$22.96	\$73.22	\$104.51	\$80.26	\$17.43	\$91.46	\$39.04	\$71.12	\$102.61	\$111.16	\$42.93	\$57.31	\$67.83
Baltimore, MD	\$23.44	\$75.33	\$105.32	\$85.88	\$17.61	\$95.76	\$38.56	\$74.74	\$104.67	\$109.21	\$45.09	\$56.85	\$69.37
Boston, MA	\$24.15	\$78.60	\$109.54	\$85.02	\$18.91	\$100.09	\$38.95	\$78.33	\$112.43	\$118.80	\$44.71	\$59.33	\$72.41
Charleston, WV	\$23.80	\$74.83	\$105.20	\$81.93	\$18.17	\$93.97	\$39.33	\$74.87	\$106.64	\$113.88	\$41.79	\$56.63	\$69.25
Denver, CO	\$23.87	\$71.09	\$101.80	\$77.25	\$17.91	\$94.71	\$38.81	\$70.75	\$105.55	\$110.13	\$43.41	\$54.96	\$67.50
Des Moines, IA	\$22.88	\$70.18	\$98.58	\$77.80	\$17.96	\$89.21	\$36.50	\$69.61	\$98.61	\$104.62	\$42.66	\$54.02	\$65.22
Las Vegas, NV	\$25.90	\$73.93	\$101.98	\$79.13	\$18.22	\$89.91	\$44.34	\$70.94	\$107.90	\$114.48	\$44.05	\$58.81	\$69.13
Nashville, TN	\$23.25	\$71.05	\$101.51	\$79.07	\$17.34	\$92.88	\$35.66	\$68.89	\$101.90	\$106.64	\$41.87	\$56.22	\$66.36
Oakland County, MI	\$24.42	\$73.82	\$102.27	\$81.56	\$15.20	\$97.40	\$39.85	\$71.30	\$106.67	\$118.54	\$41.74	\$63.59	\$69.70
Portland, OR	\$25.16	\$72.88	\$102.89	\$76.27	\$18.38	\$91.66	\$39.79	\$74.39	\$106.15	\$107.79	\$45.09	\$57.74	\$68.18
Providence, RI	\$24.25	\$73.94	\$105.44	\$80.68	\$17.18	\$96.14	\$38.29	\$71.76	\$106.25	\$109.45	\$41.59	\$56.30	\$68.44
Raleigh, NC	\$24.83	\$76.15	\$106.71	\$85.43	\$17.94	\$97.29	\$39.13	\$73.90	\$108.75	\$107.44	\$43.14	\$61.71	\$70.20
San Antonio, TX	\$22.67	\$68.20	\$97.90	\$76.27	\$17.19	\$89.15	\$35.29	\$70.22	\$101.67	\$103.34	\$42.46	\$55.33	\$64.97
St. Louis, MO	\$23.78	\$71.98	\$101.60	\$80.08	\$17.30	\$101.76	\$38.82	\$68.43	\$102.07	\$106.84	\$43.01	\$55.81	\$67.62
Tallahassee, FL	\$23.88	\$71.35	\$99.51	\$75.46	\$17.67	\$81.78	\$35.09	\$67.05	\$102.06	\$107.30	\$42.21	\$57.56	\$65.08
Twin Cities, MN	\$21.89	\$71.20	\$103.27	\$76.48	\$17.01	\$90.61	\$34.61	\$69.73	\$101.99	\$103.32	\$42.75	\$54.37	\$65.60
Vermont (statewide)	\$24.13	\$77.52	\$108.44	\$80.48	\$17.13	\$95.02	\$38.24	\$75.36	\$109.15	\$112.50	\$43.45	\$55.58	\$69.75
Washington, DC	\$26.06	\$78.31	\$106.92	\$90.24	\$19.85	\$98.80	\$40.44	\$76.21	\$110.48	\$115.03	\$45.84	\$60.63	\$72.40
National Average	\$24.08	\$73.37	\$103.30	\$80.65	\$17.70	\$93.34	\$38.73	\$72.38	\$105.19	\$109.72	\$43.24	\$57.30	\$68.25

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⁶² Correspondence by William J. Scanlon, Director, Health Financing and Public Health Section, U.S. Government Accountability Office, April 21, 1999.

What is the National Legislative Association on Prescription Drug Prices?

We are a nonpartisan, nonprofit organization founded and directed by state legislators. The Association was incorporated as a 501c4 nonprofit in 2000. Our mission is to assist legislators who seek to work jointly across state lines to make prescription drugs more affordable and accessible to people in the United States, especially by reducing prescription drug prices.

Some of the activities of the Association include:

- Serving as a clearinghouse for research and information relating to the pricing of prescription drugs and other public policies and strategies that may provide greater access to pharmacy benefits at a fair price;
- Providing a forum for the discussion, development and coordination of public policy strategies to reduce prescription drug prices;
- Encouraging and supporting the enactment of legislation to reduce prescription drug prices;
- Initiating and coordinating communication with members of the United States Congress and with Federal agencies to promote federal laws and policies to reduce prescription drug prices; and
- Urging development of federal and state assistance insurance assistance programs offering prescription drug coverage.

The Association has become a leader in the national discussion on reducing prescription drug prices. Information sharing has played a vital role in progress around the region and the country. The Association has regular meetings that have been described as summits which bring together leaders from around the country to learn about the latest strategies to advance the goal of reducing prescription drug prices and making prescription drugs more affordable. We maintain an electronic distribution list of legislators, administrators, members of the media, and interested groups and citizens from around the country, and produce an weekly electronic newsletter which includes relevant media reports, current state activities, model legislation and policy information including statistics and research.

Current membership includes Maine, Vermont, New Hampshire, Connecticut, Massachusetts, Rhode Island, New York, Pennsylvania, the District of Columbia, West Virginia and Hawaii. In addition, legislators from many other states that are not yet members regularly contact the Association for information and participate in our meetings. Efforts are currently underway to expand membership to include all states serious about obtaining fair prescription drug prices for individuals, businesses, and government. Legislators interested in joining should contact our Executive Director Sharon Treat at nlarx@gwi.net for further information.

National Legislative Association on Prescription Drugs Office

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JOINING THE ASSOCIATION

There are two forms of participation in the National Legislative Association on Prescription Drug Prices:

• **Participation by State Legislatures or Legislative Chambers:**

Formal membership by one or more legislative chamber requires a legislative expression of intent such as a resolution or letter from the presiding officer. Membership entitles the presiding officer of each participating chamber to appoint up to three members of the chamber as Directors of the Association. Our bylaws require both political parties to be represented (no more than two legislators may be appointed from each chamber from the majority party), and a vote by the current Directors of the Association to accept a member state or legislative chamber. Legislative Directors from states or chambers that have joined, and who have filed a required annual disclosure and appointment form with the Executive Director, have full voting rights when voting on resolutions, bylaws, and overall management of the organization. The Executive Committee handles personnel and day to day management.

Dues for 2005-06 have been set at \$20,000 per state. We recognize that it can be difficult to appropriate this sum every year, and we are willing to work with legislators to help them raise the funds. Some states fund the dues from the legislative budget while others have appropriated dues as part of the state budget. It is also possible that a private foundation from your state could partner with you to provide some or all of the funding. Our only restriction is that we do not accept funding from the pharmaceutical industry. If a state is not current in its dues payments, legislators and legislative staff from that state will be charged a registration fee to attend meetings, and will not be able to serve on the Executive Committee beginning in January 2006.

• **Associate Directors:**

If you are a legislator from a state or legislative chamber that is not a member, or a state that is a member but you are not one of the appointed directors, you may in the alternative join as an individual Associate Director. Dues for Associate Directors are \$250 per year. Associate Directors may not vote but otherwise are included in all of the activities of the Association. Associate Directors must annually file a disclosure form with the Executive Director.

For more information and copies of the required disclosure forms, please contact Sharon Treat at nlarx@gwi.net.

Statement



Pharmaceutical Research and Manufacturers of America (PhRMA)

Statement in Opposition to Alaska HB 452

April 24, 2006

Position: PhRMA respectfully opposes Alaska House Bill 452 because it would establish a process to control prescription drug prices, regulate advertising and marketing, determine what information health care practitioners provide to patients, and essentially regulate a private sector industry.

This measure would create a government task force mandated to consider strategies for managing prescription drugs prices, require prescription drug manufacturers to disclose expenditures for advertising and marketing, and create programs to steer health care practitioners to older generic drugs and away from new, cutting-edge brand name prescription drugs. The overall emphasis of the bill is to promote government-dictated price controls.

Price Controls

HB 452 would move Alaska toward government price controls, which PhRMA opposes. PhRMA opposes price controls because they harm the development of new drugs, which can hinder advancement of new cures and ameliorate disease. New medicines are designed to improve patient health and help control costs through decreased hospitalizations, reduced numbers of needed surgeries and lost work productivity.

Advertising, Marketing, And Promotion

Advertising's overarching purpose is to inform and educate consumers about treatable conditions and symptoms and about available therapies. Research shows that communication with the general public about approved drug products through print, broadcast, and electronic media encourages productive dialogue between patients and their physicians. According to Prevention Magazine, it also encourages compliance with physician-prescribed treatment regimens.¹

If the bill is intended to eventually limit advertising and marketing, it should be noted that advertising is protected commercial speech. The landmark U.S. Supreme Court decision, *Central Hudson Gas & Electric Corp. v. Public Serv. Commission Of New York*, established a four-part test to be applied by courts in determining the constitutionality of commercial speech restrictions.² The government may prohibit commercial speech only if the speech is inherently false or misleading or proposes an unlawful transaction. Not only are advertisements for prescription medicines not false or misleading, they are among the most regulated advertisements of any industry.

Government-Determined Prescription Drugs

The bill contemplates the government determining appropriate prescription drug therapies. This measure provides the task force with the ability to establish programs to educate health care practitioners "about

¹ "the National Survey on Consumer Reaction to DTC Advertising of Prescription Medicines", *Prevention Magazine - Men's Health* (2005).

² *Central Hudson Gas & Elec. Corp. v. Public Serv. Commission*, 447 U.S. 557 566 (1980).

the relative costs and benefits of various prescription drugs, with an emphasis on generic substitution for brand-name prescription drugs when available and medically appropriate; prescribing older, less costly drugs instead of newer, more expensive prescription drugs, when appropriate; and prescribing lower dosages of prescription drugs, when available and medically appropriate." The determination regarding the appropriate medication to best treat a specific condition should be left to the properly educated, trained and licensed physicians, not government bureaucrats, who have no knowledge of the patient's medical history. Further, the government should not be responsible for determining the appropriate prescription drug or dosage. Patients should have access to cutting-edge, life saving drugs and this bill would undermine this ability.

Bulk Purchasing

The bill also charges the task force with "coordination among the medical assistance program, the labor-union representatives, and, to the extent possible, in-state hospitals and private insurers toward the development of a uniform prescription drug list that is clinically appropriate and that leverages retail prices." PhRMA has concerns with bulk purchasing programs that include vulnerable populations, such as the medical assistance population. Bulk purchasing programs that include multiple patient populations may not meet the medical needs of individual patients. Diverse populations have unique clinical and therapeutic needs that must be met in their own distinctive manner. For instance, because they may have multiple diseases or be disabled, the medical needs of Medicaid patients may differ from those of patients in the public employee system, which may be different from those of prison inmates.

It is for all these reasons, PhRMA respectfully urges Legislators to oppose HB 452.

The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading pharmaceutical research and biotechnology companies, which are devoted to inventing medicines that allow patients to live longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for new cures. PhRMA members alone invested an estimated \$39.4 billion in 2005 in discovering and developing new medicines. Industry wide research and investment reached a record \$51.3 billion in 2005.