AARP™ Rx Watchdog Report

MAY 2007

A CONSUMER NEWSLETTER ON PRESCRIPTION DRUG PRICE TRENDS

Hispanics and African Americans Troubled By High Cost of Prescription Drugs

People put their health and the well-being of their families at risk when they cannot afford prescription drugs they need or if they try to save money by taking them in ways other than directed.

AARP commissioned telephone interviews in December 2006 with 1,000 Hispanics 18 and over and 1,000 African Americans 18 and over to examine how members of these communities cope with the cost of prescription drugs.

People were asked about their experience paying for prescription drugs and whether they supported legislative initiatives in their states to lower the cost of drugs. Examples of such remedies include preferred drug lists (PDLs), bulk purchasing programs and requirements that drug companies report various marketing costs. Support for these measures is strong among both groups. (See chart.)

About three-fourths of those interviewed bought prescription drugs during the past year, 73 percent of Hispanics and 76 percent of African Americans. About four in 10 individuals in both groups had some difficulty paying for their drugs, Hispanics, 41 percent, and African Americans, 38 percent. When asked about their ability to pay for prescription drugs over the next two years, 61 percent of Hispanics expressed concern as did 68 percent of African Americans.

High costs led about one-third of the interviewees in both groups to take potentially risky measures. One fourth of Hispanics delayed filling a prescription as did 27 percent of African Americans; 16 percent of Hispanics skipped doses as did 22 percent of African Americans, and 14 percent of Hispanics took less medicine as did 27 percent of African Americans.

According to a 2007 Kaiser Family Foundation report, white Americans are more likely to have health insurance and prescription drug coverage than other racial and ethnic groups while African Americans are most likely to be enrolled in Medicaid or have some other public insurance.

AARP 2006 Prescription Drug Study With Hispanics and African Americans is at **aarp.org.**

Strong Support for Legislation to Lower Drug Costs

Are you in favor of state initiatives that:

establish a program to cover more people and fewer drugs or more drugs and fewer people?

	MORE PEOPLE	MORE DRUGS
African American	59%	39%
Hispanic	59%	37%

allow state to do "bulk purchasing" and pass savings to low-income earners?

	YES
African American	87%
Hispanic	88%

require drug companies to disclose marketing to doctors?

	YES
African American	79%
Hispanic	81%

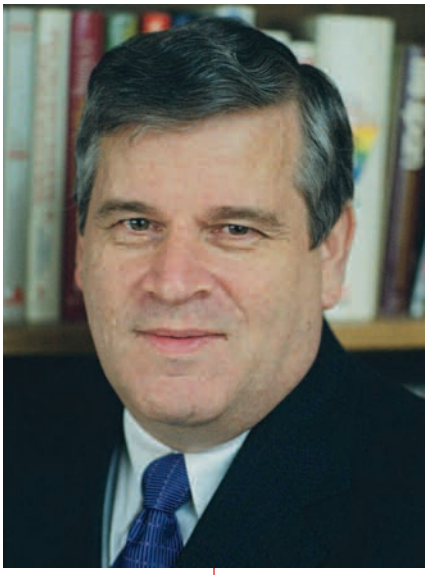
These results are based on telephone interviews in December 2006 with 2,000 people age 18 and over, 1,000 of whom were African Americans and 1,000 of whom were Hispanic. These data appear in *AARP 2006 Prescription Drugs Study With Hispanics and African Americans.*

The Man Who Really Watches Rx Drug Prices

Interview with Stephen Schondelmeyer
Part 2

Dr. Stephen Schondelmeyer is a professor of pharmaceutical economics at the University of Minnesota where he also serves as the director of the PRIME Institute, a group that conducts research on pharmaceutical management and economics.

As co-author of AARP's quarterly reports on trends in brand-name and generic drug pricing, Schondelmeyer analyzes data that helps track manufacturers' price changes for drugs commonly prescribed to older Americans. He has followed industry pricing trends for more than 25 years.



In this interview, he talks about the importance of getting good value for our prescription dollars and the role of pharmacy benefit managers (PBMs) — organizations that contract with employers and Medicare Part D to administer prescription drug benefits.

PBMs receive rebates from drug manufacturers without ever revealing the amount of those rebates to their clients. Companies argue that disclosure would force them to give lower rebates. What do you think of these arguments?

In some contexts, lower rebates may be a very good idea. Higher rebates often equate to higher drug prices overall. For example, a PBM may get a high amount of rebate on a drug that costs $150 and no rebate on a generic that costs $30, but a larger rebate does not result in lower cost. The real question is: how do we get the most value for every health care dollar we spend? The answer comes down to net cost and net benefit, not the percent or amount of rebates. In fact, there's some evidence to suggest that PBMs actually favor higher-priced drugs over lower-cost drugs and generics in order to offer higher amounts of rebates to insurance plans and employers.

Why do those negotiating on behalf of employers accept these one-sided arrangements?

It's a very complex market. Consultants advising employers on choosing a prescription drug plan often focus either on rebates or on discounts off of the average wholesale price (AWP). Both are really misleading price measures. Negotiators haven't yet learned to focus on true net costs because it's a very, very complex market with a complex set of pricing schemes. I don't know of any textbook that you can go to read about the level of detail and hidden pricing schemes that exist in this market. There's no accessible place to learn these subtleties.

Has the introduction of Medicare Part D had any effect on the increase in drug prices?

We saw drug prices go up dramatically just before and just after the introduction of Medicare Part D. This isn't unusual. There seems to be a relationship between price increases in drugs and government actions.

The industry makes some claims that Medicare Part D offers pricing transparency because you can go

AARP RX WATCHDOG REPORT

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online and find out what the retail price, or the co-pay, of a specific drug is to the consumer. But that doesn't tell you the cost structure to the Medicare program as a whole, the amount we subsidize as taxpayers, or if that price is lower than what Medicaid paid for dual eligible persons before they were moved to Medicare Part D. [Dual eligible refers to people who qualify for both Medicare and Medicaid. These individuals, who had prescription drug coverage under Medicaid, were moved to Medicare Part D in January 2006.] Without being able to compare those price pieces, we don't actually have transparency.

You have said drug companies practice a form of price discrimination. What do you mean?

The industry has chosen to charge the highest price to retail pharmacies — chain and independent pharmacies. Drug makers have historically seen that as the broadest market segment where they wanted to set a high standard price against which all other discounts could be given.

So now, in a small town, you might find a 150 bed hospital getting lower prices on certain medications than a large chain like CVS or Walgreens. Drug firms charge lower prices to hospitals because if you start a patient on an ulcer drug in the hospital, that patient will be on that drug for a very long time and have to buy it in the retail environment at higher prices.

The irony is that today the cash-paying retail customer accounts for less than 5 to 10 percent of the total market. In the early 1980's, 80 to 85 percent of prescriptions were sold to customers paying cash out of pocket. Now cash-paying consumers are the smallest piece of the market and people who are left paying these higher prices are the ones who can least afford it.

If drug companies are going to have discriminatory pricing policies, they should use as their base the group with the largest share of the market. Today, that is the insured market and PBMs.

In an era when people with prescription drug coverage pay relatively modest co-pays for most medications, why are drug prices such an issue of concern?

The price of drugs is preventing some people from getting the care they need. If prices were lower — and they could be in some cases — we could care for more people at the same or a lower cost. We can't sustain the recent rate of price growth in brand-name pharmaceuticals out into the future.

I believe in value-based pricing. The current system is not making the types of price-value decisions that have to be made. When the industry talks about focusing on quality and outcome, they omit pricing. Yet price is *always* part of the value equation.

What will ultimately bring down the high rate of growth in brand-name prescription drug prices?

True transparency would be a major step. And that would probably require some regulation at a minimum. In almost all of our dealings — with the stock market, credit cards, loans or with all sorts of routine purchases — we have regulations that require transparency and disclosure. The pharmaceutical industry argues that practices that usually drive down prices — transparency, disclosure, free trade — wouldn't work for them. And they get people to believe it.

What are your thoughts about the current state of the pharmaceutical industry?

I honestly value the industry. It produces products that save lives, prevent disability and ease suffering. But we need it to be responsive to the needs of society, of consumers and the marketplace. The pharmaceutical industry is in much the same position as auto companies were in 1970s. Back then, American automobile manufacturers made gas guzzlers and grew complacent from lack of competition. Then, Japanese and European automobile manufacturers started selling fuel efficient cars in this country and effectively challenged domestic manufacturers. The auto industry fought back not with better products but with requests for protection — government loans, subsidies and curbs on imports.

Today, drug manufacturers want protection from imports, they want the government to subsidize their research, they want government programs that protect their secretive pricing strategies. The public should put more pressure on manufacturers to compete and to become truly innovative rather than giving us more me-too drugs with a new name and a higher price.

FRANCE

A Prescription for Protecting High Quality Health Care

by Frédéric Badey

The French health care system was ranked the world's best by the World Health Organization in 2000. Today, rapid growth in expenditures threatens the sustainability of France's universally recognized high quality health care.

One challenge the nation faces is restraining the growth in spending on prescription drugs. As part of its national health insurance system, France provides universal prescription drug benefits to residents, thus spending more per person on pharmaceuticals than any other country in Europe.

In 2005, sales of reimbursed prescription drugs, including both brand-name and generics, were €24.4 billion (about $32 billion), up from the 1995 figure of €13.4 billion (about $17.5 billion).

Regulating pharmaceutical markets plays an important role in curtailing the growth in drug spending. As a policy decision, regulation is undertaken with the following in mind: cost containment, efficiency, quality and equity as well as industrial achievements and competitiveness.

The French prescription drug pricing system is based on a collaborative effort between the Leem, an umbrella organization for the pharmaceutical industry, and the government committee known as CEPS. CEPS sets the reimbursement price of a drug based on three essential criteria: the price of similar treatments already available on the market, increased effectiveness of a new product and predicted sales volume. If a drug is not a candidate for reimbursement by the health care system, the company is free to market the product without any price constraints.

Since reforms that began in 2004, France has moved to limit the growth of drug prices and expenditures.

Measures aimed at reducing expenditures include increasing the use of generics, introducing reference pricing, fixing prices for hospitals, reducing the reimbursement level for non essential drugs (essential prescriptions are reimbursed without any co-payment), and promoting "self-medication". Having "behind the counter" drugs, with distribution supervised by a pharmacist, may bring — due to non capped growth — a burst of oxygen to the pharmaceutical industry.

There are also measures to encourage better use of innovative drugs and to improve the quality of information and prescribing.

Despite criticism that these reforms would be difficult to implement, the results have been impressive: the French government has saved one billion euros (about $1.3 billion) since changes were implemented and savings of another billion is expected for 2007 due to increased use of generics.

This article is part of a series of *AARP Rx Watchdog* reports on how drug prices are determined in a number of nations.

Critics also charge that the program is weakening the pharmaceutical industry. However, exports of French pharmaceutical rose 9.2 percent in 2005 to €16.7 billion (about $22 billion), nearly double the projected increase.

The French system is far from perfect. By sharing experiences with the high cost of prescription drugs from both sides of the Atlantic, learning from each other and working together, we may improve what we stand for: the health of our citizens.

Frédéric Badey is attaché for pharmacy and biotechnology at the French Embassy in Washington, D.C.

More information on the French health care system is available at **http://www.ambafrance-us.org/news/statmnts/2007/universal.pdf**