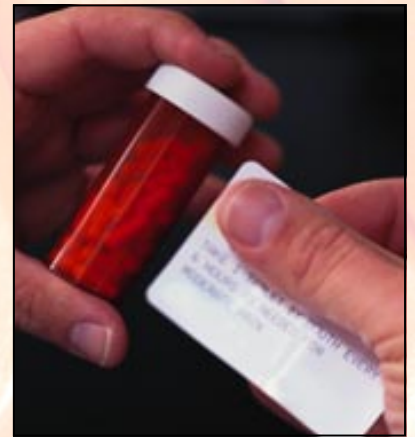


Paying the Price

The High Cost of Prescription Drugs for Uninsured Americans

October 2004



Colorado Public Interest Research Group

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CoPIRG

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Acknowledgements

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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 Denver, Colorado:

- On average, uninsured consumers in Denver pay 77% more than the federal government for 12 common prescription medications.
- Uninsured consumers in Denver pay 73% 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 Denver pay twice as much—102% 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.

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 Denver, Colorado:

- On average, uninsured consumers in Denver pay 77% more than the federal government for 12 common prescription medications.
- Uninsured consumers in Denver pay 73% 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 Denver pay twice as much—102% 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 Denver	% more paid by uninsured in Denver
Synthroid	\$9.20	\$24.08	162%	\$23.87	159%
Zyrtec	\$43.30	\$73.37	69%	\$71.09	64%
Ambien	\$73.13	\$103.30	41%	\$101.80	39%
Lipitor	\$47.05	\$80.65	71%	\$77.25	64%
Levoxyl	\$10.27	\$17.70	72%	\$17.91	74%
Allegra	\$54.77	\$93.34	70%	\$94.51	73%
Premarin	\$15.53	\$38.73	149%	\$38.81	150%
Norvasc	\$45.39	\$72.38	59%	\$70.75	56%
Singulair	\$58.35	\$105.19	80%	\$105.55	81%
Effexor XR	\$51.46	\$109.72	113%	\$110.13	114%
Ortho Tri-Cyclen	\$18.72	\$43.24	131%	\$43.41	132%
Zithromax	\$31.71	\$57.30	81%	\$54.96	73%
Average	\$38.24	\$68.25	78%	\$67.50	77%

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 Denver	% more paid by uninsured in Denver
Synthroid	\$5.54	\$24.08	335%	\$23.87	331%
Zyrtec	\$18.54	\$73.37	296%	\$71.09	283%
Lipitor	\$47.40	\$80.65	70%	\$77.25	63%
Premarin	\$6.15	\$38.73	530%	\$38.81	531%
Norvasc	\$50.04	\$72.38	45%	\$70.75	41%
Singulair	\$62.15	\$105.19	69%	\$105.55	70%
Effexor XR	\$50.39	\$109.72	118%	\$110.13	119%
Ortho Tri-Cyclen	\$19.12	\$43.24	126%	\$43.41	127%
Zithromax	\$35.30	\$57.30	62%	\$54.96	56%
Average	\$32.74	\$67.18	105%	\$66.20	102%

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 \$6.50 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 Zithromax, 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	Levoxyl	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	\$94.51	\$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	\$101.62	\$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

End Notes

- ¹ National Association of Chain Drug Stores, "2003 Community Pharmacy Results," downloaded September 17, 2004, at http://www.nacds.org/user-assets/PDF_files/2003results.PDF.
- ² Dee Mahan, "Sticker Shock: Rising Prescription Drug Prices for Seniors," Families USA, June 2004.
- ³ David Gross, "Trends in Manufacturer Prices of Brand Name Prescription Drugs Used by Older Americans, 2000 through 2003," AARP Public Policy Institute, May 2004.
- ⁴ David Gross, "Trends in Manufacturer Prices of Brand Name Prescription Drugs Used by Older Americans, 2000 through 2003—First Quarter Update," AARP Public Policy Institute, July 2004.
- ⁵ For an excellent summary of the Medicare Prescription Drug Benefit, see the Kaiser Family Foundation Fact Sheet titled: "The Medicare Prescription Drug Law," Fact Sheet #7044, published in March 2004, available at www.kff.org.
- ⁶ U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2003.
- ⁷ Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2003 Data Update Highlights," issued on September 27, 2004: Figure 6.
- ⁸ Kaiser Commission on Medicaid and the Uninsured, Fact Sheet #1420-06, September 2004.
- ⁹ *ibid*
- ¹⁰ Bill Brubaker, "Drug Spending Falls As Co-Payments Rise," *Washington Post*, October 9, 2002: E03.
- ¹¹ "Pharmaceuticals Rank as Most Profitable Industry, Again." Public Citizen, April 2002.
- ¹² "Profiting from Pain: Where Prescription Drug Dollars Go," Families USA, July 2002.
- ¹³ Public Citizen Congress Watch, "2002 Drug Industry Profits: Hefty Pharmaceutical Margins Dwarf Other Industries," June 2003. Available at www.citizen.org/documents/Pharma_Report.pdf.
- ¹⁴ Pharmaceutical Research and Manufacturers of America, "Intellectual Property Overview," <http://www.phrma.org/issues/intprop/>.
- ¹⁵ Pharmaceutical Research and Manufacturers of America, "Why Do Prescription Drugs Cost So Much?... and Other Questions About Your Medicine," available at www.phrma.org/publications/publications/brochure/questions/questions.pdf.
- ¹⁶ Public Citizen, "Would Lower Prescription Drug Prices Curb Drug Company Research and Development?," http://www.citizen.org/congress/reform/drug_industry/r_d/articles.cfm?ID=7909, accessed October 11, 2004.
- ¹⁷ Scott Hensley, "Drug Prices Rise at Faster Clip, Placing Burden on Consumers," *Wall Street Journal*, April 15, 2002.
- ¹⁸ "Profiting from Pain: Where Drug Dollars Go," Families USA, July 2002, 3.
- ¹⁹ Julie Appleby, "Drugmakers spend more on dividends than research," *USA Today*, October 11, 2004.
- ²⁰ Marcia Angell, M.D. *The Truth About Drug Companies: How they Deceive Us and What to Do About It*, Random House, New York, 2004: 179.
- ²¹ Gardiner Harris and Joanna Slater, "Generic Drug Makers Use Altered Copies to Outmaneuver Patients in Legal Battles," *Wall Street Journal*, April 17, 2003.
- ²² Wyeth obtained the 6-month extension referenced here legally. Under The Best Pharmaceuticals for Children Act (enacted in 1997 and recently reauthorized until 2007), drug companies that test their drug for use in children are given an additional six months of market exclusivity for that drug. (Pub L. No. 107-109). Wyeth tested Effexor for use in children. Although Wyeth did not find the drug to be more effective for treating pediatric depression than a placebo, the company still received the 6-month exclusivity extension.
- ²³ From testimony submitted by Congressman Henry Waxman at "Hearing on Publication and Disclosure Issue in Anti-Depressant Pediatric Clinical Trials" in Subcommittee on Oversight and Investigations of the House Energy and Commerce Committee, September 9, 2004
- ²⁴ "Generic Drug Entry Prior to Patent Expiration: An FTC Study", Federal Trade Commission, July 2002.
- ²⁵ *ibid*

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- ²⁶ Patrick Cafferty, "Collusion and Other Anticompetitive Practices: a Survey of Class Action Lawsuits Against Drug Manufacturers," Families USA, April 2002.
- ²⁷ *ibid*
- ²⁸ Prescription Access Litigation Project, "Consumers and Third Party Payers Reach \$29 Million Settlement With GlaxoSmithKline in Antitrust Drug Lawsuit," press release, July 9, 2004.
- ²⁹ David Balto. "Beginning Steps for PBM Reform," The Food and Drug Law Institute, Update Issue 4, July/August 2004.
- ³⁰ Milt Freudenheim, "Big Employers Join Forces to Negotiate Lower Drug Prices," *New York Times*, June 12, 2004.
- ³¹ David Balto. "Beginning Steps for PBM Reform," The Food and Drug Law Institute, Update Issue 4, July/August 2004.
- ³² "New York, 19 States Settle Deceptive Trade Practices Claims Against Medco Health Solutions," Office of New York Attorney General Eliot Spitzer, April 26, 2004.
- ³³ *ibid*
- ³⁴ "Express Scripts Accused of Defrauding State and Consumers Out of Millions of Dollars," Office of New York Attorney General Eliot Spitzer, August 4, 2004.
- ³⁵ *ibid*
- ³⁶ California Healthline, "Pharmacy Benefit Manager Express Scripts Faces Investigations by 20 States," July 29, 2004. Available at <http://www.californiahealthline.org>.
- ³⁷ "Settlement Sets New Standard for Release of Drug Information," Office of New York Attorney General Spitzer, August 26, 2004.
- ³⁸ *ibid*
- ³⁹ *ibid*
- ⁴⁰ Food and Drug Administration, "FDA Statement on Recommendations of the Psychopharmacologic Drugs and Pediatric Advisory Committees," press release, September 16, 2004.
- ⁴¹ Mary Duenwald, "One Lesson From Vioxx: Approach New Drugs with Caution," *New York Times*, October 5, 2004.
- ⁴² Julie Appleby and Matt Krantz, "Merck Estimates \$2.5B Impact From Pulling Vioxx Plug," *USA Today*, September 30, 2004.
- ⁴³ *ibid*
- ⁴⁴ *ibid*
- ⁴⁵ "Vioxx creator Merck insists drug is safe," *Columbia Daily Tribune*, August 27, 2004.
- ⁴⁶ Public Citizen Congress Watch, "The Medicare Drug War: An Army of Nearly 1,000 Lobbyists Pushes a Medicare Law that Puts Drug Company and HMO profits Ahead of Patients and Taxpayers," June 2004.
- ⁴⁷ *ibid*
- ⁴⁸ Robert Pear, "Drug Companies Increase Spending on Efforts to Lobby Congress and Governments," *New York Times*, June 1, 2003.
- ⁴⁹ Barbara Mintzes, et al, "How does direct-to-consumer advertising (DTCA) affect prescribing? A survey in primary care environments with and without legal DTCA," *Canadian Medical Association Journal*, September 2, 2003.
- ⁵⁰ National Conference of State Legislatures, "2003 Prescription Drug State Legislation" and "2004 Prescription Drug State Legislation," available at <http://www.ncsl.org/programs/health/drugdisc04.htm>
- ⁵¹ CALPIRG, "Governor Signs Drug Marketing Bill, Vetoes Bills on Bulk Purchasing and Drugs from Canada," press release, September 30, 2004, www.calpirg.org.
- ⁵² *ibid*
- ⁵³ *ibid*
- ⁵⁴ South Dakota Board of Pharmacy News, April 2004 issue, www.state.sd.us/doh/pharmacy/April04.htm.
- ⁵⁵ Patricia Barry, "States Defy FDA on Drug Importation," AARP Bulletin, October 2004.
- ⁵⁶ These tips were adapted from the afterword of *The Truth About Drug Companies*, by Dr. Marcia Angell, p. 261.
- ⁵⁷ NDC Health data, available at www.rxlist.com.
- ⁵⁸ *ibid*

⁵⁹ "Sticker Shock: Rising Prescription Drug Prices for Seniors" Families USA, June 2004.

⁶⁰ Description information referenced at: <http://www.nlm.nih.gov/medlineplus/druginformation.html>, a service of the U.S. National Library of Medicine and National Institutes of Health.

⁶¹ National Association of Chain Drug Stores, "2003 Community Pharmacy Results," downloaded September 17, 2004, at http://www.nacds.org/user-assets/PDF_files/2003results.PDF.

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