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Retirees and Pharmaceutical Costs: is There Really a Crisis?

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Retirees and Pharmaceutical Costs: Is There Really a Crisis?

Submitted To
Center for Public Service
Masters of Healthcare Administration Program
Seton Hall University

By

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A research project submitted in partial fulfillment
of the requirements for
Degree of Healthcare Administration

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My capstone project analyzes the crisis of retirees on a fixed income due to high pharmaceutical costs.

I hoped to prove that the opinion that there exists a state of crisis that is being popularized by politicians and the media is really just existing at the individual level rather than a widespread epidemic. I believe that the "crisis" is being exploited for political gain, as there can be painted a clear "good guy/bad guy" situation, with the pharmaceutical companies being the latter. Additionally, the AARP-age group is a strong supporter to have on one's side in politics. Politicians are playing to this fact and are proposing policies that disregard the economic repercussions that will surely be suffered through their attempts to cap prices and restrict the pharmaceutical industry. In their efforts to win support from this influential group of aging Americans they will, in the end, harm them.

For my literature review, I have chosen thirteen articles on the topic of drug costs and their effect upon the elderly. The majority of these articles review the current political climate and the propositions before our government to rectify the skyrocketing costs of prescription drugs.

Of the thirteen articles, twelve take the stance that those on a fixed income are suffering. They are the most in need, thus, those most affected. The pharmaceutical industry comes out looking the greedy, bad guy, and there must be legislation put in place to regulate their actions. Each article, however, puts a different twist on the information, with some citing failings of statistics, others looking at specific diseases, etc. They differ enough from each other to keep the reading both interesting and insightful.

There is one piece, however, which takes on an entirely different viewpoint on this situation, "Our phoniest drug war," by Doug Bandow. This article made this assignment all the more interesting. After reading and reviewing one dozen articles which presented the same problems, arguments and conclusions, I got to lucky number thirteen – a relatively short piece which makes the bold statement, "there is no crisis." The following is a summary of each piece:

1. *"How Medicare beneficiaries pay for prescription drugs"*

This article outlines the sources of the crisis of drug costs and the elderly.

For retirees, most health benefit supplements come from employer-sponsored health plans. These generally impose steep co-pays for prescription drugs. The percentage of employers offering any retiree benefits is steadily declining, and those remaining are requiring that retirees pay a substantial part of their premium. Many of these employers are also requiring that retirees sign up for the Medicare+ Choice plan, which is very restrictive in their drug coverage. Still others "carve-out" drug benefits, offering them at a separate premium. Those retirees with no employer program can purchase the Medigap supplement to Medicare, where prescription benefits carry a high deductible and copay as well as a benefit cap. The elderly poor rarely have employer-sponsored benefits and cannot afford to purchase Medigap policies; - however, Medicaid is available to those who qualify. There exists a real problem for those who lose or try to switch coverage, falling into a gap of no coverage at all. Coverage has proven to be very unstable.

The article goes on to provide Web sites that provide useful information on coverage, such as "Medigap Compare," and "HFCA."

2. *"Restricting drug choice can increase health care usage"*

This article presents the findings of a survey conducted at the Institute for Clinical Outcomes Research of the School of Medicine, University of Utah, regarding prescription spending.

The questions asked were not new ones: "who spends more, younger or older patients, for what ailments and generic versus high cost." The conclusions presented were not unexpected: younger patients spend less and on fewer prescriptions per year. Of the studied diseases, arthritis, heart disease, etc., the elderly received more prescriptions. It was also concluded that if access to drugs were limited, the elderly would be

more affected, except in the case of asthma. The study also found that increased usage of generic drugs resulted in even higher costs among the elderly. Generics use is not cost-containment appropriate for the elderly.

This last conclusion was the one I found most interesting; however, neither the article nor the study explained why generics caused higher costs. This would have been a fresher point to elaborate upon, since generics are traditionally used to cut costs. Why does this fail in this age group?

The use of generics will be discussed again later in my review.

3. *"Drug pricing "powder keg" stirs up US health-care politics"*

This piece looks at both sides of the pharmaceutical cost argument.

The pharmaceutical industry contends that its products are a "wondrous bargain, well worth their rising prices because of the therapeutic benefits they confer for conducting costly research for even better drugs." The consumer and political sides argue that the costs are a burden on needy patients.

The author cites a study by the Library of Congress that finds that due to tax breaks, after-tax profits for the pharmaceutical industry averaged 17% of sales, while other industries weighed-in at just 5%. The industry defends itself against this finding, stating that these tax breaks are received because they invest heavily in much-needed research and development.

The industry is fearful, says the author, of the inevitable price controls and rising antagonism towards them. The elderly are the hardest hit by the high prices, but they are politically well organized, and are "courted by office-seeking politicians."

4. *"Editor's Pick"*

This piece asks the questions: "Is there a maximum amount of profit that companies should earn?" And, "Should our elderly, the most medication-dependent sector of society, be held hostage to corporate greed?"

Its answer is to blame drug companies for creating unnecessary demand for their products through direct-to-consumer advertising. "\$905 million was spent by the industry in the first half of 1999 alone, up 43% from the prior year." The author contends that these ads change the physician-patient relationship, creating fear and demand in the patient, who in turn demand the prescription from their doctor. Rather than argue, the doctor usually complies.

Do these ads empower the patient? Are they a consumer service as argued by the industry? The author does not support this defense, and believes that urgent action is needed to curtail this excess of the drug industry.

This is an interesting approach, I think, to blame advertising. My question after reading this article is, how does this differ from any other industry that puts a commercial on TV in order to influence perspective

customers? I personally cannot see why any industry does not have the right to promote their product via mass media.

5. *"Bitter pills"*

This article sites the statistic that one in three seniors have no drug insurance. It goes on to say that in the US, prescription costs are the highest in the world – nearly twice what Europeans and Canadians pay for the same drugs.

Drug makers claim that prices have risen due to several factors, such as new medications are "breakthrough" drugs which are helping people to live longer; the number of years it takes to bring a drug to the market; due to price controls abroad, they are forced to make up the difference in this country; the increase in outpatient services, where most policies do not cover prescriptions as opposed to inpatient care where these same drugs are covered.

The industry believes that drug prices have become a political topic, as it is easy to exploit the "good guy- bad guy" scenario in this issue, and that possible drug-price cutbacks will take their toll on research, especially in rare diseases. They also fear that federal dollars used to fund drug benefits will mean cuts elsewhere in healthcare, as federal funds are finite.

Much like in the article presented, "Editor's Pick," this piece also places blame upon the rising awareness of patients due to direct advertising by the pharmaceutical industry. New Zealand and the US are the only nations that currently allow such advertising.

6. *"Prescription drug spending: The impact of age and chronic disease status"*

The authors here open their piece with this statistic, which sums up the nature of the elderly— drug cost crisis:

"... The elderly account for 34% of total pharmaceutical expenditures, although they make up 12% of the population," and they further conclude that, "significant pharmaceutical spending is for the treatment of chronic conditions ..."

Chronic disease is the most important determinant of drug expenditure. Among the elderly, 36%, state the authors, had three or more chronic conditions and accounted for 57% of drug spending by this age group. Of these conditions, arthritis and hypertension are the most common. The highest spending is for the treatment of diabetes, emphysema, and heart disease.

The findings of the authors also show the importance that outpatient services have upon expenditures. The data also indicate how drug use is distributed nationally by therapeutic class. Additionally, they've found that patients are more responsive to increases in drug prices as they affect their budget more and this causes changes in behavior. This information can be used selectively in benefit design.

In general, I found the conclusions presented by this study confusing and difficult to understand. The data on therapeutic classes and cost shifting were not made clear enough to the reader.

7. "Prices, patients, risks and research"

"...the appearance of expensive new therapies is dividing the population into the "haves" with insurance coverage of prescription drugs and the "have nots"...." Many seniors, the author points out, fall into the "have nots." This fact is putting pressure upon Congress to provide Medicare, outpatient drug benefits. Much like the earlier reviewed article, "Drug-pricing powder keg," this piece argues that price regulation will take its toll on research and development, thus hurting these same consumers in the end.

The article goes on to describe various plan options, such as "catastrophic" plans which target chronic and specific diseases only, incremental approaches, and broad plans with copays and deductibles. A major problem, as pointed out by the author, is that these plans will increase government influence over prices. Additionally, manufacturers would be under pressure to get on "preferred lists" of formulae.

There is also the problem with generics, where the government is pressuring the FDA to approve these lower-cost drugs faster. However, if we go back to the earlier -reviewed article, "Restricting drug choice can increase health care usage," the authors there concluded that generics do not contain costs for the elderly. If you take this as fact, this government measure will not help the group it is intending to relieve.

The FDA, in turn, is actually seeking to increase their efforts to reduce risks and improve quality in drugs, including generics, by tightening their standards of evolution. They are taking a "safety first" approach, which the author supports. They are also seeking to protect consumers from less-expensive Internet purchasing, where product quality is questionable.

8. "States' Rx for drug costs"

In this piece, the author explores how different states are working to curtail the hardships placed upon the elderly by increasing drug prices. The opening statement illustrates the crisis, as it describes a 67 year-old woman who has had to return to work in order to pay her \$469 per month ulcer medication bills. Another story is of a Florida retiree who spends nearly one-half of her yearly-fixed income on her prescriptions for a lung ailment. Florida offers no drug-coverage plan.

An example of one state that is working to ease such suffering is Maine, where the "Low Cost Drugs for The Elderly" program went into effect in 1999, and now pays 80% of the costs for those in need. Maine has the nation's first law that includes price controls on prescriptions. Maine also created the "Maine Rx" program which allows any resident without prescription coverage to purchase drugs at a discount, which is based upon Medicaid rates. However, this program has been challenged in court by the pharmaceutical industry and could set precedent for programs in other states.

As of December 1999, 16 states had some form of drug assistance for seniors. By 2000, this had increased to 22. Other states, such as Iowa and New Hampshire, have initiated buying "clubs" offering a discount. These subsidies are being funded by tobacco-settlement funds. Maine, New Hampshire, and Vermont has instituted a joint "pharmacy - benefits manager," who will create educational programs for doctors and patients in cost effective medical regimes. The author points out that such state programs are costly and that this is preventing many states from setting up similar state-funded plans. Many

opponents believe that this issue is not one that should be dealt with on a state level and must be a federal one, citing that a "patchwork" of state plans will create chaos in the pharmaceutical industry.

I found this article quite informative. Instead of painting all of the negatives and crises, it presents various positive approaches which the states are attempting. The sidebars also do a fine job of summarizing various state's actions.

9. *"Persistence of use of lipid-lowering medications: A cross-national study"*

When I came across the title of this article, I thought it was about a specific medical study, rather than an investigation into drug/price effects on the elderly. As I read on; however, I found it a piece useful to my review, because it shows how patients failed to continue their regiment of lipid-lowering medications due to the costs involved. It additionally shows how their health suffered because of this. These lipid-lowering drugs are used by patients at the highest risk for cardio-vascular disease, namely the elderly, poor and minorities. This piece is the best illustration of the crisis of prescription costs and the elderly that I've come across, as it is very specific, showing the regiment necessary to maintain health and the effects caused by disruption in this regiment.

The studies were described fully, coming to the conclusion that the lower the income level, the higher the rate of noncompliance. The data were adjusted for such contributing factors as side effects and inconvenience. In fiscally generous insurance systems, compliance was highest. The more cost out-of-pocket, the lower the compliance.

10. *"The price isn't right"*

This article makes an interesting opening statement, "... astronomical prices are rooted in government-funded research, necessitating that government policy needs to bring prices and research priorities down to earth."

The author explains that private-sector labs claim to be responsible for breakthroughs in drugs. This is their great defense - limit prices and you will "short circuit the current medical revolution." But, this defense falls short. The author states that every independent study that investigates sources of medical innovation comes to the conclusion that it is public-sector research, not private, which has led to the majority of significant advances. To support this, the author tells the story of a boy with Gaucher disease, a genetic disorder. The price of treatment of this ailment is nearly one quarter of a million dollars per year. The technology to treat this is government developed, from the National Institutes of Health. The government; however, transferred the intellectual property to a private company, which now produces the treatment. And, this scenario is not a unique one.

A 1997 National Bureau of Economic Research study showed that public research led to 15 of the 21 drugs considered having the highest therapeutic value introduced between 1965 and 1992. The same study also found that 60% of 32 innovative drugs would not have been discovered or would have taken longer to discover without research contributions from government labs and noncommercial institutions.

In other words, it is the taxpayer that is funding research, not the pharmaceutical manufacturers. In fact, the author says, most of the research by private labs is aimed at stealing marketshare from competitors or replacing their own products coming off patent.

The author blames the government's inability to track tax-payer funded research, and adds that if the government was to increase public funding of research, they could control prices without the feared effects on research and development.

I found this article extremely interesting. Much of my other reading speaks of the industry defense concerning research and development, but this author completely tears that apart, putting research funding in a whole new light. That's precisely why I chose this article for review.

11. *"Prescription drugs and the elderly: Issues and options"*

This article states many of the points of crisis and the supporting statistics that my other article choices used to describe the problem of drug costs and the elderly. I feel no need to review those again; instead, focusing on the public policy options presented by the author.

If prescription drug coverage for the elderly were to be extended, there are issues that need resolution, namely, "Who?" "What?" and "Who will pay for it?" The author outlines four policy options to answer these questions.

- a.) Encourage state pharmaceutical assistance programs. Offering matching grants will encourage more states to develop assistance programs for those not covered by Medicaid. The advantage is that it could be targeted at the lowest-income elderly and would allow state discretion. The disadvantage is that both the federal and state governments need to find funding for this program.
- b.) Require all Medigap policies to cover prescription drugs. The advantage here is that it will eliminate the possibility of adverse selection, assuring fair, stable benefits. The disadvantage is that this will not cover the elderly without supplemental coverage. Also, there exists no contribution to cost containment.
- c.) Extend Medicare benefits to cover prescription drugs while reducing the deductible to a more affordable level. The advantage is that enrollment could be more universal and that the concentrated market power of Medicare could be used to contain costs. The disadvantage is that it could lead to redistribution of income from those who have coverage to those who don't. Also, it will substitute public financing for private.

The author concludes that there needs to be a better understanding for more informed debate before any options can be chosen.

12. *"Making sense of drug prices"*

In this article, the author makes and defends the following statement:

"Any form of price regulation, including the setting of uniform prices within the United States or cross-nationally, would discourage innovation and competition. The best way to make drugs more affordable for the elderly would be to allow them to choose among competing private sector plans."

The author contends that studies that present drug price as higher in the US than other countries are flawed. First, because the study samples include only leading branded products and did not consider generic substitutes. Second, the studies did not account for volume discounts in the US. And, third, because arithmetic averages were calculated using unweighted averages. If these items were corrected, the author believes studies would show that US drug prices are far from the highest in the industrialized world.

It is also suggested that studies of domestic prices are flawed as well. The House Committee on Government Reform and Oversight reached misleading conclusions, mainly because they compared retail prices to Federal Supply Schedule prices. These prices are at "different levels of the distribution chain," and cannot be fairly compared, as the FSS involves favored-customer discounts.

Another misconception involves proposed plans that will offer a discount to elderly customers. If discounts were to be given to elderly cash-paying customers who do not participate in a managed program, how would it be done? Since they purchase directly from a pharmacy, manufacturers would have to provide the pharmacy with a discount. There is no assurance that these discounts would then be passed along to customer.

Going back to the opening quote, the author believes that competition would be the best answer to the elderly problem. Customers could select programs based upon their preferences and out-of-pocket costs. Competition would regulate the prices. It is concluded that rather than focus on the profits of pharmaceutical manufacturers, we would be better served looking at laws, regulation and taxes that would encourage healthy levels of research and development investment.

13. *"Our phoniest drug war"*

This article describes the "lack" of a problem with drug prices. The author goes as far as to say, "There is no crisis."

"The biggest complaint about prescription drugs is the cost, even though Americans devote more money to alcohol and almost as much to tobacco." This statement sums up the attitude of the author.

He sites analysts William Orzechowski and Robert Walker, saying that 70% of the elderly spend less than \$500 per year on pharmaceuticals and only 4% spend more than \$2,000 per year. Also, that two-thirds have some sort of coverage for pharmaceuticals.

He agrees that pharmaceutical spending has increased, but that this had lead to the misperception of runaway prices. The increase, he explains, is in total outlay, not average price. Government estimates are flawed due to poor sampling, ignoring generics, falling new-drug prices, and drug quality.

The author goes on to blame the FDA regulations for as much as doubling the cost of new drugs. He adds that any new drug policy would inflate demand and spending and lead to price and use controls.

It is concluded that the government should "do no harm." By destroying the pharmaceutical industry, no one would get financial relief.

While I'm not sure I can agree with the positions taken by the author, the article does make me question the current state of drug costs on the elderly and the propositions before government to correct the situation. This author and his stance is most in line with the stance that I have taken on this issue, that there does not exist a wide spread crisis and reigning in the pharmaceutical industry will serve no one.

In conclusion, after looking at the summaries of these collected readings, it is evident to me, with the exception of the last piece, that the authors believe something must be done to aid the crisis of drug costs and the elderly. It is debatable how dire the actual crisis is, as the data available is believed to be flawed. Each article presents different causes and different options to correct the problem, but there exists agreement that those currently before Congress are under too much outside influence to be properly designed. Options will have negative repercussions if great care isn't taken in their design. Policy cannot serve all parties.

To support my stance on the issue of drug costs and those on a fixed income, my chosen methodology was to first administer a survey to the group in question, namely retirees. This would give me a good statistical basis to prove or disprove my point. I also sent out interview-type questionnaires to subjects functioning in different arenas in healthcare, namely healthcare provider, pharmaceutical representative and elected officials from the sample community. This would provide an opportunity to compare and contrast the beliefs and attitudes of these varying subjects.

In May of 2001, I met with the Cedar Grove New Jersey Senior's Club to administer a survey discussing the problem retirees on a fixed income face regarding the high cost of prescription drugs. I chose this group because all members must be over 55 years old and retired. They are also members of one geographic community, which is for the most part typical of suburban New Jersey. By administering this survey, I was hoping to establish the level of "crisis" that existed within this community regarding their situation with high drug costs. A copy of this survey can be found in Exhibit 5.

Cedar Grove, where this sample was taken, is a small suburb of 11,731 people located in Northern New Jersey. Those 65 years and older account for 21.23% of its population. Nearly 95% of the population is white. With a median household income of over \$55,000 and only 332 persons living in poverty, it could be said that this town is moderately affluent. It should be noted that Cedar Grove is home to a county hospital where many of those labeled as impoverished reside. A table of demographics is provided in Exhibit 1.

Of the 90 surveys administered, 62, or 68.89% were returned. The questions focus upon the medical history of the participants and the type of coverage they hold, as well as the personal affect drug costs have had on their lifestyle. The participants were instructed too not respond to questions that they felt invaded their privacy or made them feel uncomfortable.

Of those sampled, the average age was 75 years old. 68% were female and 32% male. The average length of residence was 36 years. The average rate number of years retired was just over 12.

In looking at these statistics along with my observations from our meeting, I would say that the majority of the sample were outgoing and involved and had lived in the community long enough to establish a support network of friends. I believe this important because these people were not isolated, but active members, as opposed to being homebound and of poorer health, which would have skewed the data.

The first question concerning health asked, "For what conditions do you regularly take prescription medication?" This question was trying to establish the routine involved with the sample's prescription costs. The results are illustrated in Exhibit 2. The majority, at 41%, regularly take drugs for high blood pressure. This was followed with 21% for "Other." The majority of conditions listed under "Other" were for

cholesterol and thyroid related conditions. Heart conditions (17%), glaucoma (5%), diabetes (4%) and depression (3%) followed these.

The next question assessed the general health of the sample, by asking what chronic diseases they suffer from. This response is illustrated by Exhibit 3. The majority, at 30%, suffered from heart conditions. This was followed closely by arthritis at 26%. The remaining disorders were cancer (15%), respiratory ailments (13%), other (8), stroke (5%) and glandular (3%). The "Other" consisted of disorders such as reflux and aneurysms.

The next group of questions centered on the sample's insurance coverage, in an effort to illustrate how much coverage the group had, why they chose their plans and the costs involved. It also looked for lapses in coverage, such as too few participants holding MediGap policies.

When asked if they carried traditional Medicare or HMO's, a large majority, 86%, participated in traditional Medicare. When citing their reasons for this, most replied that they distrusted HMO's, and that they wanted freedom to choose their own physicians. Most of those who chose HMO have cited their reason as being that this was the plan provided by their employer upon retirement. Many did not like the fact that HMO's did not allow a patient to choose their own physicians.

Perhaps, due to the ages of the participants, they have had little experience with HMO's, as they are a relatively new choice. Their feelings of distrust and unreliability may stem from this, as well as dislike of a system that places restrictions on their care. The younger generations are more comfortable with HMO's as they have been raised in a culture that supports their use.

When asked if they carry a MediGap policy, 53% stated that they did not. Of the 47% that did carry this coverage, the average price paid per month was \$96. It is important to note that many of the participants with MediGap received it free or substantially subsidized as part of their retirement package, thus skewing the results. If these outliers are removed, the average monthly price paid is \$127. The main reason cited for carrying this additional coverage was that it supplements Medicare. For those on a fixed income, coverage at this price could be difficult to afford, and the fact that nearly half of the sample did carry it was surprising. I expected that fewer could afford it's high premium.

The final group of questions asks about the choices made and hardships endured due to the cost of prescriptions. The results can be reviewed in the graph in exhibit 4.

The first question asked, "Have you ever not filled a prescription due to its cost?" 85% of the sample said "No."

The second question, "Have you ever rationed your medication to make your prescriptions last longer?" was answered "No" by 87% of the sample.

The results of the third question were similar, "Have you ever postponed paying bills or reducing food outlays due to the cost of your medication?" 94% said "No", they have not.

Those who answered "Yes" to these questions were obviously in the vast minority; however, in a town with this level of affluence and in a group with this level of insurance coverage, the fact that there were those who do have to make these sacrifices in order to pay for their medications was surprising. One of the participants added commentary to their answers, stating that ... "although they themselves had no problems associated with their prescription costs, that they knew of others in the community who did, and they felt it was a disgrace and wanted something done to prevent this from happening."

I was very satisfied with the results of this survey. I felt the conclusions derived at from the sample provided great insight into the state of "crisis" regarding prescription drug costs. The participants were more than willing to be a part of my study, leading me to believe that politicians should go to their constituents more often before forming their own opinions on this topic. Perhaps then any legislation presented and/or voted upon would be better designed and more serving of all parties involved.

For the next part of my analysis of the effects of prescription drug prices, I looked to the various articles that I presented in my literature review. Of the thirteen, all asked essentially the same questions; yet, depending upon the point of view of the author took different stances. Is there or is there not a crisis? Who caused the crisis? Will price cap policies do more harm than good? And, what should a federal policy include?

I prepared a questionnaire/interview using these four questions, then presented them to six interviewees, each coming from a different arena. The aim was to compare the responses of each for differing opinions based upon their participation in Healthcare. By looking at the varying perspectives, I was searching for any agreement on the issues, as well as looking to see how differing arenas influence these opinions.

One questionnaire went to a representative of the pharmaceutical industry, Ms. Yolanda Burdsy, Quality Assurance Specialist. The second went to Dr. Veronica Santilli, practicing physician, President of a large pediatric practice and member of the Board of Empire Blue Cross Blue Shield. The third went to a healthcare administrator, Dr. Raul M. Abad, Vice President of Medical Affairs for Easton Hospital in Easton, Pennsylvania. For the last group of three, I thought it important to get the opinions of elected officials that represent the geographic sample. As political figures, it is this group who could at some point be voting on actual legislation regarding drug policies. One went to the Town Council of Cedar Grove and was answered by the Mayor's Office, another went to Acting New Jersey State Senator Kevin J. O'Toole, and the last was sent to the offices of House Representative Bill Pascrell of New Jersey who also represents Cedar Grove. Their responses are as follows:

Looking first to Yolanda Burdsy- Pharmaceutical Quality Assurance Specialist

1. Do you believe that there does or does not exist a state of crisis regarding prescription drug prices and their effects upon those on a fixed income? Why or Why Not?

Although it is no surprise that drug prices are progressively increasing due to many driving factors in the changing paradigm of healthcare delivery a state of crisis is truly a concept that may be defined accordingly through the eye of the beholder. The effect of sharply rising drug prices upon those individual with fixed income may be quite devastating. However, governments that impose price controls and other market interventions delay research and limit access to new drugs and therapies; and if consumers throughout the world remember that governments which impose price controls are not getting what they bargained for they will put into perspective that an increase in drug price is necessary to facilitate the research, production, and distribution that is needed accordingly. In addition governments aren't achieving the long term savings they hoped for and patients are often denied access to the newest drugs for years after they are available to the rest of the world. Yes many individuals existing and surviving on limited means financially may view this paradigm in a crisis mode however, these price hikes are warranted.

2. If "Yes, you do believe there exists a crisis," what do you believe is the main contributor, the Pharmaceutical industry seeking to maximize profits, or the current lack of a Federal policy to regulate prices?

In my eyes the main contributors that have driven this crisis into existence during this era of healthcare delivery are rates of growth in pharmaceutical spending in many markets with widespread interventions have been no different from those in markets with few so why decrease the source of profitable funding?

Secondly widespread access to new drugs for widely under-treated conditions such as heart disease and depression have been delayed in many countries that have price control policies in place.

3. Do you believe that a policy that imposes caps on prescription prices will have a negative effect upon Pharmaceutical industry investment in research and development? Why or Why Not?

Yes I believe that policies that impose caps on prescription prices will have negative repercussions upon the pharmaceutical industry investment in research, development and overall. For example, Japan, which has severe market restrictions, has less access to new medical therapies than any other G-7 nation. Of the 230 new pharmaceutical products launched around the world since 1985, more than half are not available in Japan. In the United Kingdom, statins, an important new weapon in the fight against high cholesterol and heart disease, are prescribed less than half as often as they are in the United States.

4. In your opinion, what is the single most important item a government policy on prescription drug prices must contain?

The adoption of policies that encourage research into new products but control health care costs in the long run is a crucial component to incorporate within the government policy on prescription drug prices. Innovation will be rewarded and cost savings achieved if producers are allowed to recoup research investments early in a product's life cycle in exchange for tighter controls later. In addition, the encouragement of policies that create greater access to treatments so doctors and physicians, not government bureaucrats, are making treatment decisions should be emphasized and strengthened

Ms. Burdsy admits that some individuals are existing in a "crisis mode," however, price hikes are necessary. Crisis, as she states, is in the "eyes of the beholder." Ms. Burdsy states that the use of price caps will have a negative effect upon research and development and will cause restricted access to new therapies. The items that a federal drug policy must include, says Ms. Burdsy, is an encouragement to invest in research and rewards innovation and cost control. Ms. Burdsy's opinions are in line with my own, supporting my stance that there does not exist a wide-spread crisis concerning pharmaceutical costs, and that caps are not an acceptable answer.

Next, we look at the response of Dr. Raul Abad, V.P. Medical Affairs:

1. Do you believe that there does or does not exist a state of crisis regarding prescription drug prices and their effects upon those on a fixed income? Why or Why Not?

Yes, there is a crisis. The prices keep going up and the average income, especially elderly, remains the same. Many more drugs are being prescribed and patients have to get what has been prescribed for them.

2. If "Yes, you do believe there exists a crisis," what do you believe is the main contributor, the Pharmaceutical industry seeking to maximize profits, or the current lack of a Federal policy to regulate prices?

Primary is the pharmaceutical industry seeking to maximize profits. Secondary is the generic medications that are sometimes not really the same as what was ordered.

3. Do you believe that a policy that imposes caps on prescription prices will have a negative effect upon Pharmaceutical industry investment in research and development? Why or Why Not?

Yes, it would have a negative effect because it will cut back on the capital available for research. The first thing that is cut is always research and development.

4. In your opinion, what is the single most important item a government policy on prescription drug prices must contain?

The Federal government would impose a certain percentage on the base price markup, not necessarily a cap to only charge certain amounts. Also, utilize a certain percentage for research and development.

Dr. Abad supports the stance that there does exist a crisis. Perhaps this is because, in his past experience as a practicing neurosurgeon, he has been involved with first-hand situations of patients unable to afford prescriptions. He does, however, agree that price caps and restrictions are not the answer. His suggested policy using profit percentage caps is interesting. This is similar to the utility industry, where profits are held in line in such a way. Perhaps this could be a viable option, but only if the industry itself is allowed to participate in the setting of such percentages. Otherwise, I believe they will have the same negative effects as outright price capping.

The next questionnaire contains the responses of Dr. Veronica Santilli.

1. Do you believe that there does or does not exist a state of crisis regarding prescription drug prices and their effects upon those on a fixed income? Why or Why Not?

By and large, there really is no crisis regarding prescription drug prices. There are those, however, who would like the government to provide prescription benefits to Medicare patients and have exaggerated the inability of those on fixed incomes to access the drugs they need. My reasons are as follows:

- *All Medicare patients have the option to opt for Medicare Managed Care Plan, which provides an allowance for prescription drugs.*
- *Many states have prescription plans, which senior citizens can participate in for a small premium. In New York State, senior citizens can subscribe for the Epic Program, through which prescription drugs can be obtained for small or no co-pays.*
- *Truly indigent patients are eligible for Medicaid coverage in addition to Medicare. These patients do not pay for drugs.*
- *Physicians always have samples in office that they give free of charge to those without prescription coverage.*
- *Generic prescription drugs, which are comparable to brand names, can be obtained at reduced cost.*
- *Several senior citizens on fixed incomes have ability to access their drugs through wholesale pharmacy concerns for small service charges through their union or as part of their retirement benefits.*

2. If "Yes, you do believe there exists a crisis," what do you believe is the main contributor, the Pharmaceutical industry seeking to maximize profits or the current lack of a Federal policy to regulate prices?

Those who believe that there is an existing prescription drug crisis for seniors on fixed incomes are mainly concerned with the lack of federal regulation of drug prices and lack of prescription drugs as part of the benefit package of Medicare.

3. Do you believe that a policy that imposes caps on prescription prices will have a negative effect upon Pharmaceutical industry investment in research and development? Why or Why Not?

I absolutely believe that any cap or other regulatory activity on prescription drug prices definitely will thwart the research into and development of new drugs. Pharmaceutical companies are primarily interested in profits. These profits are distributed to stockholders in part, but much of these profits are put back into new drug research. It is more important to urge the pharmaceutical companies to develop voluntary programs (grants), which would allow qualified patients to receive company sponsored discounts on drugs. In additions the companies can provide vouchers, which could be distributed through providers of health services, senior centers and pharmacies. The federal government should urge and facilitate the development of quality generic drug substitutes and encourage physicians to prescribe these, when feasible.

4. In your opinion, what is the single most important item a government policy on prescription drug prices must contain?

The most important item, which any government policy on prescription drugs needs to contain, is the Drug companies, which can demonstrate that they are willing to work with consumers, directly or through state subsidized prescription programs, should be given recognition through tax relief, special creation of a system which provides for greater competition among producers of pharmaceutical, consideration by the FDA and recognition for their humanitarian activities.

Dr. Santilli supports my opinion that there does not exist a state of crisis. I was surprised at this, believing that she would share the stance of fellow physician, Dr. Abad, due to her first hand experience with patients. Her answer to question three is quite interesting, specifically in her suggestions that pharmaceutical companies take on a voluntary stance on price discounting and her thoughts on the government promotion of generic drug production.

The following are the responses submitted on behalf of the Cedar Grove Mayor, Mr. Joseph Torlucci:

1. Do you believe that there does or does not exist a state of crisis regarding prescription drug prices and their effects upon those on a fixed income? Why or Why Not?

I do believe there is a state of crisis regarding prescription drug prices I base this determination on personal knowledge with family, including 2 elderly parents.

2. If "Yes, you do believe there exists a crisis," what do you believe is the main contributor, the Pharmaceutical industry seeking to maximize profits, or the current lack of a Federal policy to regulate prices?

I do not necessarily believe that the industry tries to "maximize profits"- yet there certainly is a need for more governmental intervention.

3. Do you believe that a policy that imposes caps on prescription prices will have a negative effect upon Pharmaceutical industry investment in research and development? Why or Why Not?

Caps, if not reasonably set - certainly will curtail R & D.

4. In your opinion, what is the single most important item a government policy on prescription drug prices must contain?

Permitting a drug company to extend patents on drugs in exchange for creating cost controls to the benefit of consumers.

The responses of Mayor surprised me. As a politician, I thought there would be support for increased government intervention; However, a very interesting idea was his patent extension grant in return for the industry to cut its own costs. I can see where this would serve as a great incentive for cuts - it gives the industry two things: the patents it needs to maximize their profits longer on individual products as well as an opportunity for implementing a cost program themselves. This strikes me as a rather mild form of intervention worth looking into further.

Representatives O Toole and Pascrell chose not to participate in this project. After first contacting them by mail, then later by phone, both offices refrained from providing comments on this issue. Perhaps due to its controversial nature and the timelines of the politics involved, there was some fear that providing formal responses could come back and haunt them. This was quite disappointing. Their comments would have been interesting and important, giving insight into the politics behind my topic. The responses of the Mayor of Cedar Grove did; however, show me a bit of this.

To conclude, I had thought prior to receiving the completed questionnaires, that there would be less agreement in the responses. I had expected that the pharmaceutical representative would fall to the left side, denying any crisis, and that the politicians would fall to the far right, claiming the existence of an extreme crisis, blaming the pharmaceutical industry. I also thought the physicians would fall somewhere in between. Looking at the opinions, there is no extreme left or right.

It is important to note that each interviewee; although approaching the questions from varying perspectives, all agree that caps on pharmaceutical prices are not the answer to the problem of high costs. All agree that this would do more harm than good, negatively affecting research and development. There is disagreement on the existence or level of crisis; however, each provides interesting ideas as to what future legislation must include in order to be effective. Overall, I was quite satisfied with the results of this part of my study.

Closing Notes

The media coverage and the statistics out there tell us that there exists a crisis in this country concerning the high cost of prescription prices on those on a fixed income. The industries and politicians argue back and forth as to why and how great. By looking at my sample, one really cannot see a crisis. If this sample is a fairly good representation of the population of this country, then perhaps the crisis is not as great as we're led to believe. I do think that this is a good representation of the high population, suburban, Northeast portion of the United States. Any future studies into this situation must use a sample similar to mine - one that is suburban and as "average" as possible. Using lower-income, inner city or too affluent a sample would generate unrealistic, skewed data. It would be interesting to sample similar populations from varying regions of the country to compare and contrast the data for more complete conclusions. I do think that this study was weak due to its limit to one sample.

As generations become less dependent upon Social Security for their retirement and also are more open to less costly managed care programs, I believe the "crisis" perceived will lessen. Price caps and restrictions are not the answer. By tying the hands of industry, inevitably it is the consumer who will suffer. Cut the profits for the pharmaceutical industry and they will answer with a cut to research and development as well as the production of drugs for less-profitable and more rare conditions.

Certainly, there are areas that need improvement, and everyone would benefit from some sort of policy change concerning certain costs of medications. By looking at this simple survey, the results show us an important fact, namely that many of those falling into this age group suffer from the same conditions. Therefore, any future policy should focus upon these conditions. Why couldn't a plan support subsidies for high blood pressure and arthritis's medications? Or, perhaps there could be a subsidy plan that uses a scale approach covering more for common- ailment prescriptions and scaling down for lesser. Answers can be found that are more industry-friendly. In the writing of future policy, it would be in the best interest of all parties if it were co-written by three parties - the Federal government, the AARP and a representative board from the pharmaceutical industry. Any policy writing that shuts out the pharmaceutical industry or a body representing the elderly would generate regulations that would damage both groups.

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EXHIBITS

EXHIBIT 1

Geographic Sample Area Demographics Cedar Grove, New Jersey (1990 U.S. Census Data)

Population (1996 estimate):	11,731
Race:	
White:	94.62%
African American:	2.32%
Other:	3.08%
Median Age:	41.80 Years
65 and Older:	21.23%
Number of Households with persons over 65:	1,361
Number of Households Receiving Social Security:	1,351
Per Capita Income:	\$23,052
Median Household Income:	\$55,464
Number of Persons in Poverty:	332
Median Value of a Single Family Home:	\$213,300

EXHIBIT 2
Alliments Demanding Routine Prescription Use

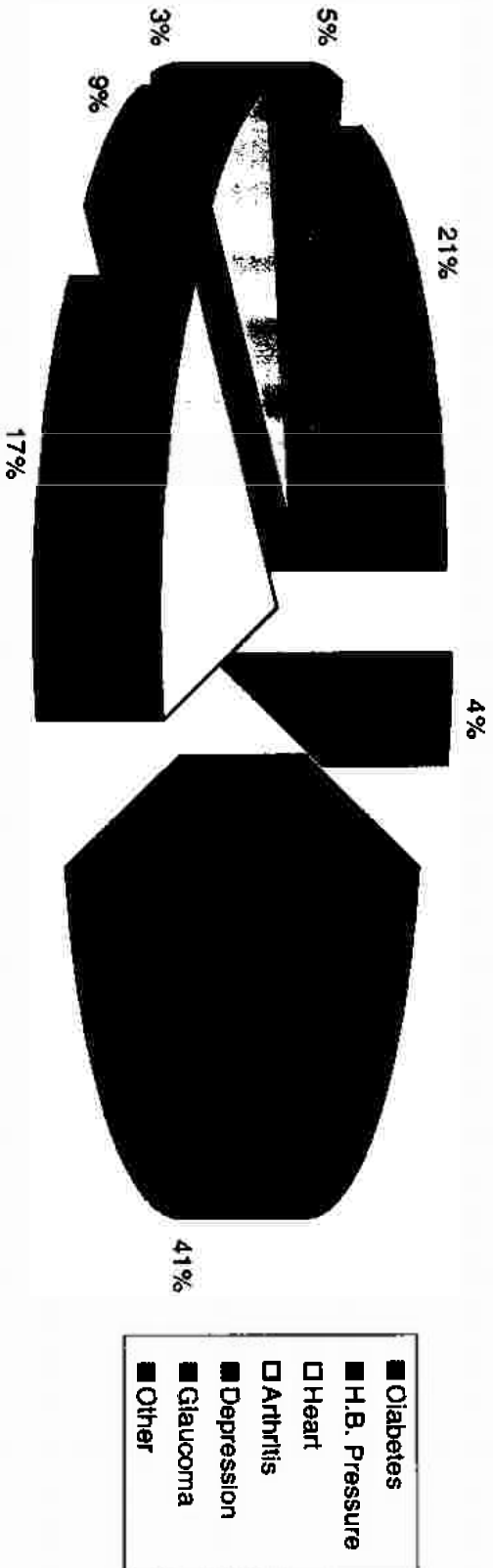
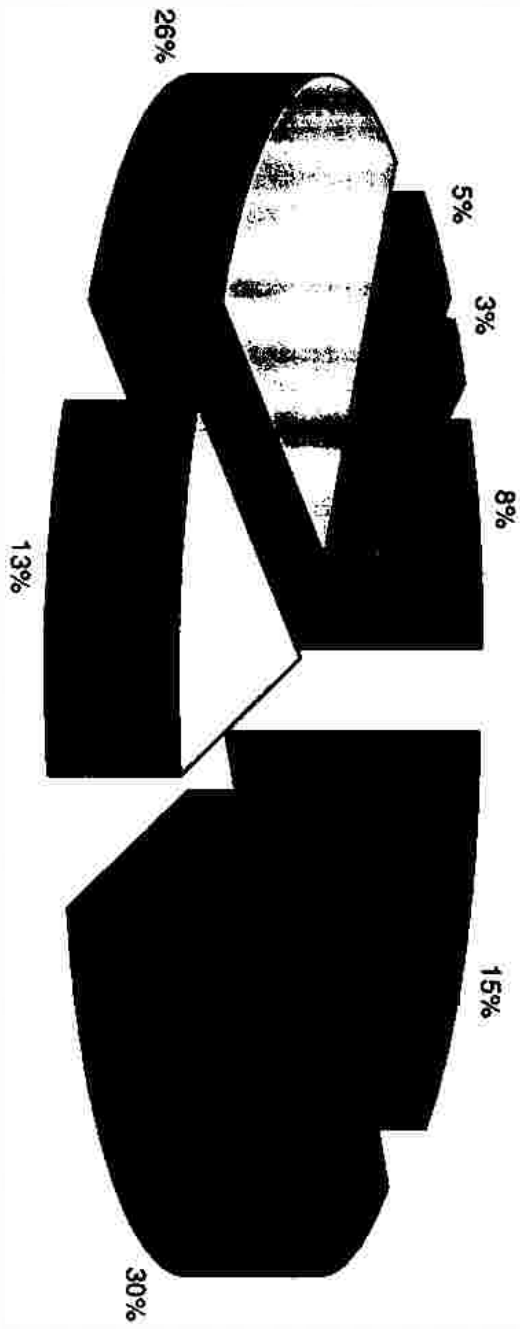
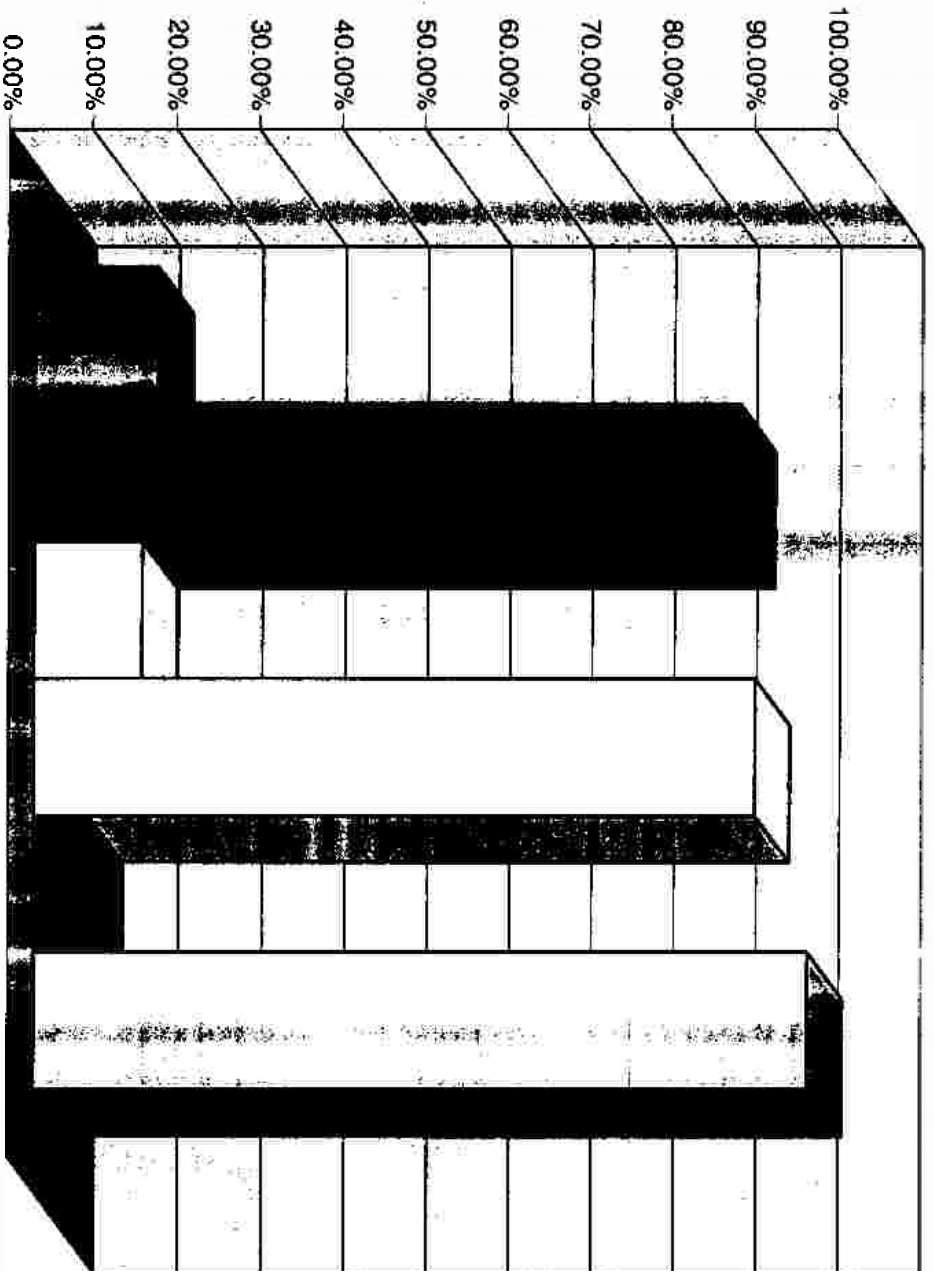


EXHIBIT 3
Chronic Diseases Suffered By Sample



- Cancer
- Heart
- Respiratory
- Arthritis
- Stroke
- Glandular
- Other

**EXHIBIT 4
Prescription Cost Affects**



- Left Unfilled - YES
- Left Unfilled - NO
- Rationed Supply - YES
- Rationed Supply - NO
- Reduced Food/Bill Payment - YES
- Reduced Food/Bill Payment - NO

EXHIBIT 5

Justine Maiello

Seton Hall University

Capstone Project: Survey of the impact of increased pharmaceutical costs on retirees on a fixed income

This survey is anonymous and confidential. Feel free to skip any question that you do not feel comfortable answering.

1. What is your Age? _____ Years
2. Sex: M / F
3. How many years have you been retired? _____ Years
4. How long have you lived in this community? _____ Years
5. For what condition(s) do you regularly take a prescription medication?
Please circle all that apply: Diabetes
High Blood Pressure
Heart Ailments
Arthritis
Depression
Glaucoma
Other (please specify) _____

6. Have you had any of the following chronic diseases:
Please circle all that apply: Cancer
Heart Disease
Respiratory Disease
Arthritis
Stroke
Glandular Disorders
Other (please specify) _____

7. Do you participate in A.) Traditional Medicare or B.) Medicare HMO
(please circle one)

8. Why did you choose the plan selected in question #7?

9. Do you have a private Medigap policy? YES / NO

10. If you chose "YES" for question #9, what are you currently paying for it?

\$ _____ /month

11. If you chose "YES" for question #9, why did you choose to participate in

Medigap? _____

12. Have you ever not filled a prescription due to its cost? YES / NO

13. Have you ever rationed your medication to make your prescription last longer due to its cost? YES / NO

14. Have you ever postponed paying bills or reducing food outlays due to the cost of your medications? YES / NO

Thank you for your participation. If you could please return this survey in the attached postage-paid envelope by May 30, 2001