Fact Sheets

SENIORS BEWARE:

The Need For Medicare Prescription Drug Coverage, How Drug Pricing Has Harmed Seniors

and

Debunking the Myths of Drug Makers

Prescription Drug Task Force
U.S. House of Representatives

October 28, 1999

SENIORS BEWARE:
The Need For Medicare Prescription Drug Coverage, How Drug Pricing Has Harmed Seniors and Debunking the Myths of Drug Makers

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INTRODUCTION

RISING PRESCRIPTION DRUG PRICES AND ERODING COVERAGE ARE SQUEEZING SENIORS' INCOME...

When it comes to needed prescription medicines, seniors in America are increasingly under siege. Even as employers are scaling back or dropping retiree health coverage, premiums for supplemental "Medigap" policies with drug coverage have reached unaffordable levels in many markets, and soaring drug budgets are forcing Medicare managed care plans to pull back on prescription drug benefits.

From 1981 to 1999, prescription drug prices increased by 306% while the Consumer Price Index rose only 99%, according to the Bureau of Labor Statistics. In the last year alone, drug spending rose by 18.4% -- driven by a combination of both price inflation and increased utilization.

These rising prices are putting the squeeze on Medicare beneficiaries who have no prescription drug insurance -- more than 15 million, and rising. Medicare's basic benefits package doesn't include outpatient prescription drugs, leaving older Americans with modest, fixed incomes who have chronic health conditions to struggle daily with this questions: should I fill the prescription my doctor ordered, or buy other necessities?

This dilemma is worsened by a phenomenon known as price discrimination, or the practice of setting different prices for consumers in different markets. The pharmaceutical industry's pricing practices leave seniors holding the short end of the stick. Analyses prepared by House Government Reform Committee's Democratic staff in more than 90 Congressional districts have found in each case older Americans with no drug coverage pay almost twice as much as enrollees in large group health plans for some of the most commonly prescribed medications. A separate series of Government Reform studies concluded that drugs sold in Canada and Mexico are generally half the price of the same drugs sold to U.S. consumers.

These trends -- eroding coverage and rising prices -- are making it increasingly difficult for seniors to purchase the medications they need to control chronic conditions. An estimated 16% of Medicare beneficiaries are enrolled in Medicare HMOs today, and 70% of those plans offer drug coverage. But it is not guaranteed -- and during the last two years, Medicare managed care plans have withdrawn from many regions -- stranding tens of thousands of seniors many of whom only signed up to get pharmaceutical coverage in the first place. Moreover, 21% of Medicare HMOs are limiting drug coverage to $500 or less per year. By next year, 32% of Medicare managed care plans are expected to have such limits. This suggests that absent fundamental change, more and more seniors who can't afford the drugs they need will wind up in hospitals and nursing homes.

WHILE PHARMACEUTICAL MANUFACTURERS WATCH PROFITS GROW...

Twelve Fortune 500 pharmaceutical companies earned more in profits ($26.2 billion in 1998) than the entire industry spent on research ($21 billion). *Fortune* magazine rates pharmaceutical manufacturers as the most profitable businesses in America: number one in return on revenues (18.5 percent), assets (16.6 percent), and equity (39.4 percent). The profits of other industries that rely heavily on research pale in comparison: telecommunications, 11.5 percent; computer and data services, 5 percent; and electronics, 3.6 percent.

LEADING MEMBERS OF CONGRESS AND THE ADMINISTRATION PROPOSE PLANS FOR AFFORDABLE MEDICARE DRUG COVERAGE...

This year, several members of Congress and President Clinton introduced comprehensive plans to add an outpatient drug benefit to Medicare. Others are backing legislation that would ensure fairer prescription drug prices. The pharmaceutical industry's response has been to mount a campaign designed to minimize the chances of enacting any proposal that would result in universal access to affordable prescription drugs for the nation's seniors.

Drug makers say they oppose proposals introduced to date because they will harm pharmaceutical research and development efforts. But legislative history suggests that this assertion is untrue. For example, following enactment of the Hatch-Waxman Act in 1984 -- which lengthened patents for certain brand-name drugs while making changes in patent laws that allow generic drug companies to get products to market sooner -- pharmaceutical R&D accelerated. And since 1990, R&D expenditures have grown from $8.4 billion per year to $21 billion last year.

PhRMA IS TRYING TO DEFEAT MEANINGFUL PROPOSALS WITH A SILLY, SLEAZY MULTI-MILLION DOLLAR AD CAMPAIGN AND ANALYSES DESIGNED TO SCARE AND MISLEAD SENIORS...

The Pharmaceutical Research and Manufacturers of America (PhRMA) and other special interest groups can delay -- but not defeat -- the needs of millions of seniors for Medicare drug coverage by creating fake groups such as "Citizens for Better Medicare" and "Alliance to Improve Medicare." A quick look at the membership and financing of these groups shows that they serve industry -- not consumer -- interests. And as PhRMA's "Flo" ads continue to fade from the public's memory, it is becoming clear that real seniors in real cities and towns across the country don't care what the fictional character Flo thinks. What they want is assurance that the federal government will help provide the means to fill their medicine cabinet with lifesaving medications.

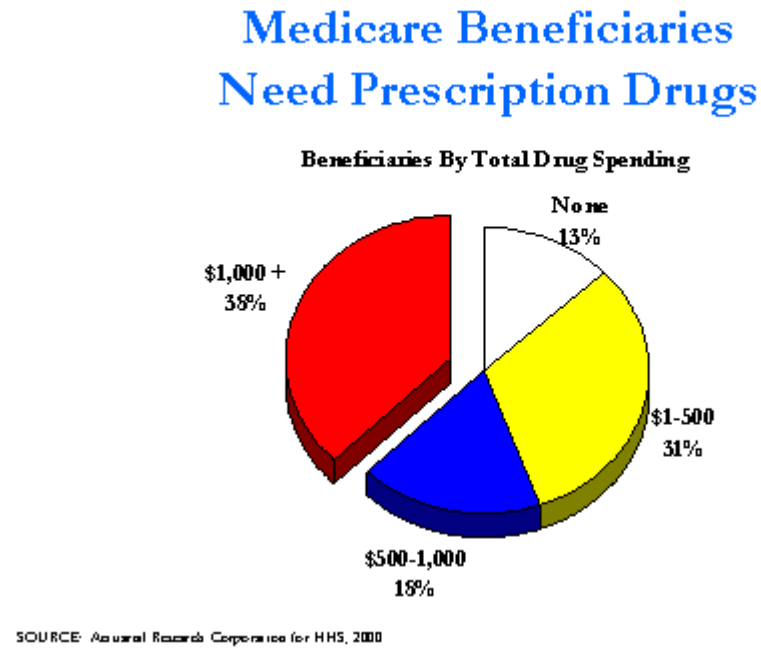
Like HMO reform, Congress will be talking about universal Medicare drug coverage until the day it becomes law. The reason for this is simple: public pressure for affordable drug insurance is being fueled by the aging of our population and its growing health needs -- at the very point scientific research is beginning to provide remedies and cures for diseases that until recently were thought to be unbeatable.

RISING PRESCRIPTION DRUG COSTS

After Medicaid, the Veterans Administration, the managed care plans and big insurers, hospitals, and other parties with some bargaining power win their discounts, manufacturers raise prices for the people without bargaining power—people without insurance and therefore without anyone to negotiate for them. It is particularly unjust that our poorest patients—and many of our sickest patients—are burdened with the world's highest prices.[1]

! Drugs are the fastest growing component of health care costs in the U.S.[2]

! People age 65 and older are 12% of the U.S. population, but they consume almost 35% of all prescription drugs. Excluding insurance premiums, drugs account for 34% of seniors total healthcare bill, more than doctor visits (31%) and hospital admissions (14%).[3]



! From 1981 to 1999, prescription drug prices increased by 306% while the Consumer Price Index rose only 99%.[4]

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[1] Alan Sager and Deborah Socolar, *Affordable Medications for All, Access and Affordability Monitoring Project*, Boston University, (July 1999).

[2] Ibid.

[3] David Gross, American Association of Retired Persons, (November 1998).

[4] Bureau of Labor Statistics, (1999)

- Studies comparing drug prices charged to uninsured seniors versus drug prices charged to most favored customers such as the federal government or big HMOs prepared by the House Government Reform staff for over 90 congressional districts have consistently demonstrated price discrimination on the part of drug manufacturers. Uninsured seniors often pay twice as much for their prescription drugs than most favored customers.

- Spending on outpatient pharmaceuticals in 1999 is estimated to average $942 per senior citizen.[5]

Growth in Prescription Drug Expenditures, 1992-1998						
Year	**1993**	**1994**	**1995**	**1996**	**1997**	**1998e**
Dollar Amount (billions)	$50.6	$55.2	$61.1	$69.1	$78.9	$93.4
Percent Increase Over Prior Year	8.7%	9.0%	10.6%	13.2%	14.1%	18.4%
Source: Health Care Financing Administration, 1997 National Health Expenditure Estimates (for 1993-1997), Estimate for 1998 from Scott-Levin Source Prescription Audi						

- Spending for prescription drugs rose 14.1% in 1997, compared to a 4.8% increase for health services overall.[6]

- Spending is higher for women. Because of their greater likelihood of living longer and having chronic illness, women on Medicare spend nearly 20 percent more on prescription drugs than men.[7]

- Americans who pay for all or part of their prescriptions out of pocket are charged far more than either insurance companies or HMOs.[8]

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[5] National Academy of Social Insurance, *A Medicare Prescription Drug Benefit*, http://www.nasi.org/Medicare/Briefs/medbr1.htm, (April 1999).

[6] Healthcare Financing Administration data

[7] National Economic Council, Domestic Policy Council, *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage*, (July 22, 1999).

[8] Deborah Amos, ABC News, *ABC World News Tonight*, (April 15, 1999).

! In 1996, a federal judge approved a settlement between some of the drug companies and retail pharmacies that included a $350 million cash settlement and an agreement by these companies to refrain from setting discriminatory prices against retail pharmacies that demonstrate the same ability as HMOs to alter prescription drug market shares.[9]

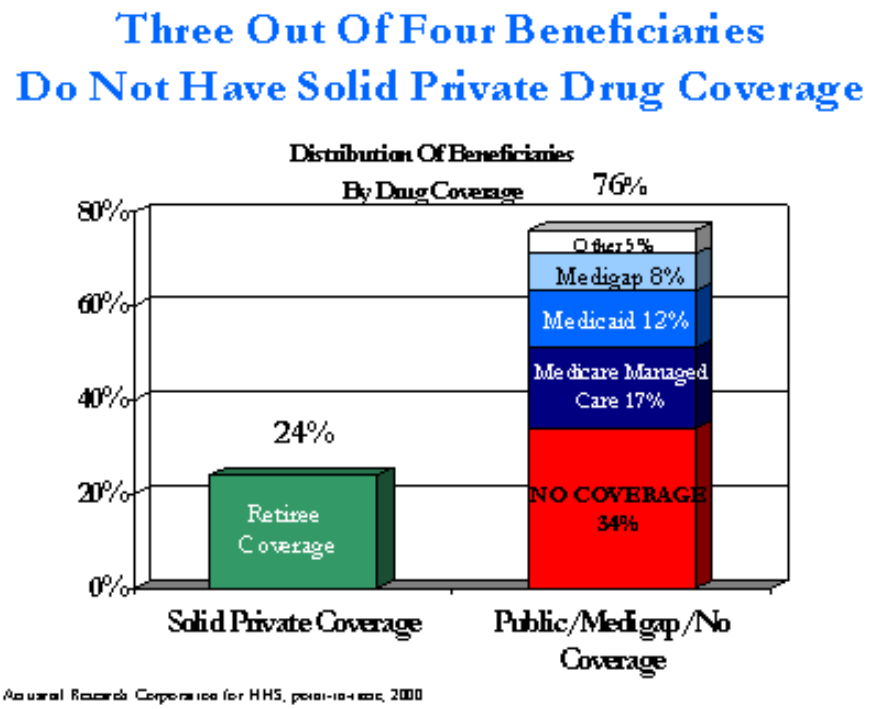
National Health Expenditures: Annual Percentage Growth, 1992-1997							
	1992	1993	1994	1995	1996	1997	5-Year Average
Total	**9.1%**	**7.4%**	**5.5%**	**4.9%**	**4.9%**	**4.8%**	**5.5%**
Hospital Care	8.20	5.80	3.90	3.40	3.90	2.90	4.00
Physician Services	8.50	5.70	3.80	4.60	3.30	4.40	4.30
Nursing Home	9.00	6.70	7.00	6.20	5.20	4.30	5.80
Prescription Drugs	10.60	8.70	9.00	10.60	13.20	14.10	**11.10**
Source: Barents Group LLC analysis of HCFA National Health Expenditure data, 1997.							

[9] *In re Brand Name Prescription Drugs Antitrust Litigatio*n, 1996-2 Trade Cas. (CCH) ¶ 71,449 (N.D. Ill. June 21, 1996).

ERODING PRESCRIPTION DRUG COVERAGE

! Unlike most major insurers, Medicare does not generally cover the costs of outpatient prescription drugs. Because of this gap, Medicare beneficiaries must either pay out-of-pocket or rely on other sources to assist in purchasing medicines. Yet supplemental sources of prescription drug coverage for millions of seniors are inadequate, unaffordable -- or both. As a result, more than one-third of Medicare beneficiaries have no coverage for outpatient prescription drugs.

! Most other beneficiaries rely on drug coverage provided through Medigap plans (8%), employer-sponsored insurance (24%) and some HMOs that offer prescription drugs as an incentive to attract enrollees (17%). But the cost of prescription drug coverage under Medigap is out of reach for many seniors living on modest, fixed incomes. And, as drug prices continue to skyrocket and the number of new, effective medicines increase, Medicare HMOs and private employer sponsored insurance plans have begun -- and are expected to continue -- cutting back or eliminating their prescription drug benefits.



SOURCE: Actuarial Research Corporation for HHS, preliminary estimates, 2000

Medigap Coverage is Limited

- Three of the standardized Medigap plans offer prescription drug coverage (Plans H, I and J). All three plans impose a $250 deductible. Plans H and I cover 50% of the charges up to a maximum benefit of $1,250. Plan J covers 50% of the charges up to a maximum benefit of $3,000. According to a recent analysis, 28.4% of Medicare beneficiaries were enrolled in Medigap plans in 1996.[10] But only approximately 12% of seniors have limited drug coverage under a Medigap plan.

- The premiums for Medigap plans providing drug coverage are higher than those for the other seven Medigap plans mostly due to the drug coverage component. Adverse selection tends to drive up the per capita cost of coverage under these three Medigap plans as only those persons who expect to actually utilize a significant quantity of prescriptions purchase drug coverage.[11]

- In September 1998, Consumer Reports evaluated Medigap plans, focusing on two plans (C & I) that are virtually identical, except that plan I provides a $1,250 prescription drug benefit. The analysis showed that a 75 year-old senior would typically pay a premium of $1,437 for Plan C and $3,284 for Plan I. That means that seniors are today paying $1,847 for a prescription drug benefit of $1,250--or $597 more in premiums than the actual value of the prescription drug benefit.

HMO Coverage is Decreasing

- Medicare HMOs are projected to reduce prescription drug benefits substantially in the future. Already, nearly three-fifths of plans say they will cap prescription drug benefits at $1,000 next year, while the proportion of plans with a $500 (or lower) benefit cap will increase by over 50%. Other plans have said they will begin charging monthly premiums, or increasing existing premiums that seniors pay to receive a drug benefit.

- The announcement in July 1999 of the withdrawal of HMOs from the Medicare program - dropping almost 400,000 beneficiaries -- means that these seniors will lose their drug coverage and be forced to purchase supplemental drug insurance or pay out-of-pocket for their medications.

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[10] Congressional Research Service, *Medicare: Prescription Drug Coverage for Beneficiaries*, (April 19, 1999).

[11] *Health News Daily*, (8/23/99).

! A recent Kaiser Family Foundation survey of Medicare HMOs warned that the rapid increases in prescription drug costs coupled with reductions in the growth of Medicare payments to plans "jeopardize the availability of relatively generous affordable drug coverage under Medicare HMOs in the future."[12]

Employer-Sponsored Coverage is Declining

! Employers may offer their retirees health benefits. However, the number of employers offering coverage has declined in recent years. A 1997 survey of retiree health plans found that over a 5-year period (1993-1997) the number of employers providing health insurance to Medicare-eligible retirees fell from 40% to 31%. Over the same time period, coverage by large employers (over 5,000 employees) of Medicare-eligible retirees dropped from 63% to 48%. Such diminishing employer-sponsored coverage is another reason for Medicare beneficiaries' reduced access to drug coverage.[13]

! The scope of benefits offered to retirees varies by plan. Of those employers offering retiree medical coverage for Medicare-eligible enrollees in 1997, two-thirds provided some drug coverage. The percentage increases to approximately 90% for large employers, while two-fifths of employers offered a mail-order plan.

! The Employee Benefit Research Institute theorizes that prescription drug benefit plans offered by employers are likely to undergo changes to ensure that only the most efficacious drugs are covered - e.g., increased copayments, inclusion of drug costs in health plan capitated payments to physicians, and more aggressive use of formularies.[14]

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[12] Barents Group LLC, The Henry J. Kaiser family Foundation, *Analysis of Benefits Offered By Medicare HMOs*, 1999: Complexities and Implications, (August 1999).

[13] Mercer/Foster/Higgins, *National Survey of Employer-Sponsored Health Plans*, (1997).

[14] EBRI Issue Brief Number 208, *Prescription Drugs: Issues of Cost and Quality*, (April 1999).

U.S. DRUG PRICES ARE THE HIGHEST IN THE WORLD

! A 1991 General Accounting Office report found that prescription drugs in the U.S. were priced 34% higher than the same products in Canada. Of the 121 prescription drugs surveyed, 99 had higher prices in the United States than in Canada (in 21 cases, the price differentials exceeded 100%; in 8 cases, the price differentials exceeded 200%).

! A similar report by GAO in 1994 comparing the prices for prescription drugs in the UK and the US determined that 66 of the 77 drugs surveyed were priced higher in the United States. For 47 of these drugs the price differentials exceeded 100%. Twelve of the drugs evaluated had a markup of more than 500%. Furthermore, four of the five most commonly dispensed drugs in the United States cost anywhere from 58%-278% more in the U.S. than in the United Kingdom:

Premarin	197% more	Lanoxin	169% more
Xanax	278% more	Zantac	58% more

! A 1991 Senate Aging Committee report concluded that if Medicaid had access to prices that the pharmaceutical industry makes available in Canada (and other countries) state Medicaid agencies and American taxpayers would pay an estimated $474 million less per year for brand-name drugs in the Medicaid program alone.[15]

! How Much Citizens of Other Countries Pay for every $1.00 an American Spends for Prescription Drugs:

United States	$1.00	Canada	$0.64
Germany	$0.71	France	$0.57
Sweden	$0.68	Italy	$0.51
United Kingdom	$0.65		

[15] Special Committee on Aging, United States Senate, Staff Report, Serial No. 102-F, (September 1991).

PRESCRIPTION DRUG COVERAGE FOR SENIOR CITIZENS IN OTHER DEVELOPED COUNTRIES

- An analysis of eight industrialized nations highlights the disturbing fact that the U.S. is the only country lacking government-sponsored prescription drug coverage for its senior citizens.

- Canada, the United Kingdom, Germany, Japan, France, Sweden and the Netherlands all provide universal prescription drug coverage for the elderly. The UK and France fully exempt the elderly from copayments for certain prescription drugs. Sweden charges seniors a $10 copayment for prescription drugs, and caps annual out-of-pocket expenses at $200.

- The chart on the following page clearly illustrates our government's failure to provide pharmaceutical coverage for seniors who need it most.

Government Sponsored Prescription Drug Coverage for Senior Citizens								
Country	**United States**	**Canada**	**United Kingdom**	**Germany**	**Japan**	**Netherlands**	**France**	**Sweden**
National Policy	No outpatient prescription drug coverage for seniors under Medicare. Medicaid provides prescription drug coverage for some low-income seniors; policies vary by state.	All provinces provide prescription drug plans for senior citizens, with copayments that vary by province.	Prescription drug coverage with co-payments; exemptions from some copayments for people over age 60.	Copayments range from $5 to $7, depending on the prescription. Patients also pay the difference between government reimbursed price and the market price (typically the difference between generic and name brand).	Free medical care for all individuals over age 70 (over 65, if bedridden), with nominal co-payments. Free care includes "supply of medications" Additional nominal co-payment for individuals taking more than one, two to three, or six or more prescription drugs per day.	Patient cost sharing of 20 percent, up to a maximum level. In addition, patients pay difference between maximum reimbursed price and the market price, similar to Germany.	"Essential drugs" (e.g., cancer treatment) require no cost sharing; "Normal prescriptions" (e.g., antibiotics) require 30% cost sharing; "comfort" drugs (e.g., tranquilizers) require 60% cost sharing. Elderly individuals with a need for multiple drugs are reimbursed for all costs.	No charge for pharmaceuticals for treatment of chronic diseases. $10 co-payment for all other prescription drugs. Annual copayments capped at $200, for combination of prescription drugs, physician consultations, physical therapy, and hospital inpatient care.
Does This Coverage Exist for non-elderly?	No. Low-income individuals may be covered under Medicaid. Varies by state.	No. Extent of coverage varies by province.	Yes. However, coverage for elderly is more generous.	Yes.	Yes. However, coverage for the elderly is more generous.	Yes.	Yes. However, coverage for elderly needing multiple drugs is more generous.	Yes.

Sources:

The Boston Consulting Group, Inc., *Ensuring Cost-Effective Access to Innovative Pharmaceuticals: Do Market Interventions Work?*, (April 1999).

Graig, Laurene A., *Health of Nations: An International Perspective of U.S. Health Care Reform*. (Congressional Quarterly Inc. Washington, DC: 1999).

Lassey, Marie L., Lassey, William, R., and Martin J. Jinks. *Health Care Systems Around the World: Characteristics, Issues, Reforms.* (Prentice Hall, New Jersey: 1997).

DIRECT TO CONSUMER (DTC) ADVERTISING

- Revisions to FDA policies in 1985 and 1997 have resulted in unprecedented increases in marketing directly to consumers. Spending on DTC advertising increased more than 20-fold from $55.3 million in 1991 to over $1.3 billion in 1998.[16]

- In 1998, pharmaceutical manufacturers spent $8.3 billion, all of which is tax deductible, promoting their products in the United States. About $1.3 billion was spent on direct-to-consumer (DTC) advertising and $7.0 billion on advertising and detailing to health care professionals.[17]

- The Pharmaceutical Research and Manufacturers of America (PhRMA) projects 1999 R&D spending to grow by 17 percent from 1998, while spending on DTC advertising is expected to grow 54 percent over 1998 levels.[18]

- More than one-third (35.2 percent) of the entire 1993-98 increase in drug spending was attributable to just five categories of drugs: antidepressants, cholesterol reducers, anti-ulcerants, oral antihistamines, and antihypertension drugs. The top four categories include seven of the ten drugs with the greatest spending on direct-to-consumer (DTC) advertising in 1998.[19]

- The 10 most heavily promoted drugs in 1998 (measured by DTC advertising outlays) accounted for over a fifth (about 22 percent) of the total growth in prescription drug expenditures between 1993 and 1998.[20]

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[16] Dr. Morris B. Mellion, Testimony of the Blue Cross and Blue Shield Association on Prescription Drug Benefits and the Medicare Program for the Committee on Finance, U.S. Senate, (June 23, 1999).

[17] Scott-Levin, *The Pharmaceutical Industry: More Reps and More Promotion Fuel New Launches*, press release, (June 18, 1999).

[18] Pharmaceutical Research and Manufacturers of America, *Pharmaceutical Industry Profile 1999*, Figure 2-1, (1999).

[19] National Institute for Health Care Management, *Factors Affecting the Growth of Prescription Drug Expenditures*, Barents Group LLC, (July 1999).

[20] Ibid.

CALLING THE RESEARCH AND DEVELOPMENT (R&D) SCARE CARD

- Pharmaceutical research was only 0.97% of U.S. health spending in 1990 – 1994, compared to an average of 1.53% for the U.K., Japan, France, Italy, Germany and Canada.[21]

- Twelve Fortune 500 pharmaceutical companies made more in profits ($26.2 billion in 1998) than the entire pharmaceutical industry spent on R&D ($21 billion in 1998).[22] Fortune magazine rates pharmaceuticals as the nation's most profitable industry: number one in return on revenues (18.5%), assets (16.6%), and equity (39.4%). The return on revenues of other industries that rely heavily on research pale in comparison: telecommunications, 11.5%; computer and data services, 5%; and electronics, 3.6%.[23]

- Drug makers and the Pharmaceutical Research and Manufacturers of America (PhRMA) argue that if Americans do not pay high prices to "bear the world's research burden," many new drugs will not be developed. However experts say:

  - Lower U.S. pharmaceutical prices need not mean lower revenue and profit for drug makers if they cut costs, boost volume, or raise prices in other wealthy nations.

  - Drug makers all face the same pricing policies worldwide. A more plausible engine of U.S. pharmaceutical innovation is public funding for biomedical research through NIH.[24]

- The brand name pharmaceutical industry said that increasing the availability of generic drugs, part of the 1984 Waxman-Hatch Act, threatened R&D. But over the five year period following passage of the legislation, pharmaceutical companies more than doubled their investment in research and development, from $4.1 billion to $8.4 billion.[25]

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[21] Alan Sager and Deborah Socolar, *Affordable Medications for All, Access and Affordability Monitoring Project, Boston University*, (July 1999).

[22] Pharmaceutical Research and Manufacturers of America, *PhRMA Annua Survey*, http://www.phrma.org/pdf/publications/industry/pdf99/tables.pdf, (1999).

[23] Fortune Magazine, Fortune 500, http://www.pathfinder.com/fortune/fortune500/index.html, (1999).

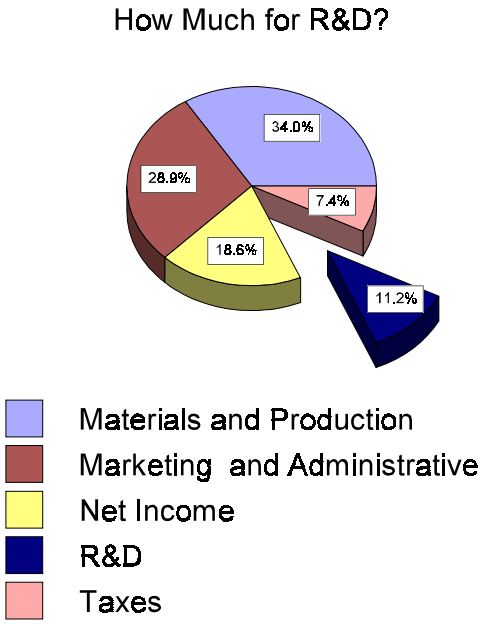
[24] Alan Sager and Deborah Socolar, *Affordable Medications for All, Access and Affordability Monitoring Project, Boston University*, (July 1999).

[25] Pharmaceutical Research and Manufacturers of America (PhRMA), *Leading the Way in the Search for Cures*, http://www.phrma.org/publications/brochure/leading/index.html, (1998).

! In 1990, PhRMA opposed legislation enacted into law to reduce Medicaid drug prices because "[i]ncentives for pharmaceutical research will be reduced."[26] But between 1990 and 1997, pharmaceutical companies again more than tripled their spending on research and development, from $8.4 billion in 1990 to $24 billion in 1998.

! Drug company profits are derived principally from the patents they hold. Enacting policies which ensure fair prescription drug prices will cease drug companies profiteering from charging excessively high prices, and increase their incentive to increase revenues by working to bring newer and better products to market.

! Revenue breakdown for Merck & Pfizer:[27]



! Pharmaceutical companies benefit more than any other industry from the R&D tax credit.[28]

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[26] Letter from the Pharmaceutical Manufacturers Association , (May 22, 1990).

[27] Alan Sager and Deborah Socolar, *Affordable Medications for All, Access and Affordability Monitoring Project*, Boston University, (July 1999).

[28] New Democrat Coalition, The R&D Tax Credit Benefits All Industries, fact sheet, (1999).

! In FY 99, public funding of biomedical research in U.S. – much of which research supports development of new drugs -- is much greater in the U.S. than in other countries.

FY 99 Public R & D Funding (In Billions)	
U.S. National Institutes of Health	$15.6
Canadian government research	$0.7
U.K. National Health Service and Medical Research Council	$1.2
Source: Alan Sager and Deborah Socolar, Affordable Medications for All, Access and Affordability Monitoring Project, Boston University, July 1999	

PHARMACEUTICAL LOBBYING AND POLITICAL CONTRIBUTIONS

! Pharmaceutical and medical supply companies have given $2,172,520 in political soft money during the first half of 1999, more than double the $1,014,000 they gave during the first half of 1995.[29] This increased spending to influence public policy has occurred while Congress debates how to provide seniors with Medicare coverage for prescription drugs and the Federal Trade Commission (FTC) is investigating prescription drug prices and efforts by brand-name drug companies to stifle generic competition. For example, the FTC is examining the circumstances under which one brand-name drug paid a generic competitor up to $100 million per year to keep consumers from benefitting from the introduction of low-cost generic alternatives.[30]

! In 1997 and 1998, pharmaceutical manufacturers spent $148.5 million to lobby federal officials.[31]

Top 10 Pharmaceutical Companies Buying Influence

Company	1997-98 Pol. Contrib.	1997 Lobby	1998 Lobby	1997-98 Lobbying and Contrib.
Pfizer Inc.	$1,103,180	$10,000,000	$8,000,000	**$19,103,180**
Merck & Co.	$351,228	$5,140,000	$5,000,000	**$10,491,228**
Eli Lilly & Co.	$712,173	$3,836,442	$5,160,000	**$9,708,615**
Glaxo Wellcome Inc.	$687,751	$3,774,000	$3,120,000	**$7,581,751**
Schering-Plough Corp.	$486,919	$2,682,508	$4,268,000	**$7,437,427**
Bristol-Myers Squibb	$827,324	$3,780,000	$2,820,529	**$7,427,853**
American Home Products	$301,225	$2,500,000	$2,210,000	**$5,011,225**
Novartis Corp.	$638,592	$1,560,000	$1,160,000	**$3,358,592**
Rhone-Poulenc Inc.	$467,575	$1,640,000	$1,220,000	**$3,327,575**
Abbott Laboratories	$312,971	$893,300	$1,743,785	**$2,950,056**

Source: Citizens for Responsive Politics, Political Contributions Include Soft Money Contributions

[29] Common Cause, *Follow the Dollar Reports, Legislative Battles and Soft Money*, http://www.commoncause.org/publications/aug99/083099_legbattles.htm, (August 30, 1999).

[30] Ralph King, *Wall Street Journal*, (October 1, 1999).

[31] The Center for Responsive Politics, http://www.opensecrets.org/lobbyists/98catorders/H04.htm, information processed from lobbying disclosure forms, (downloaded October 11, 1999).

EXECUTIVE COMPENSATION

- The 25 highest paid executives in the 12 companies studied made **$545.5 million** in annual compensation, excluding unexercised stock options in 1998. The average compensation for the 25 executives was **$21.8 million**. The median compensation for these executives was **$15.1 million**.

- The 25 executives with the largest unexercised stock option packages in 1998 had stock options valued at **$2.1 Billion** in 1998. The average value of unexercised stock options for these 25 executives was **$84.7 million**. The median unexercised stock option package for these executives was **$58.3 million**.

- The highest paid executive in each of the 12 companies received average compensation, exclusive of unexercised stock options, of **$28.0 million** in 1998. The median compensation for these 12 executives was **$32.9 million**. Taken together these executives received a total of **$335.6** million in compensation in 1998.

- The executive with the largest valued unexercised stock options in each of the 12 companies had stock options worth, on average, **$103.1** million in 1998. The median value of unexercised stock options was **$91.2 million**. Taken together, these 12 executives held stock options valued at **$1.2 billion**.

- The 63 executives from the 12 companies received, exclusive of unexercised stock options, **$660.5 million** in 1998, and an average compensation of **$10.5 million**.

- The value of unexercised stock options for these 63 executives was **$2.7 billion** and averaged **$43.1 million** per executive.

***Unless otherwise noted, statistics in this section were obtained from analyzing information available on public Securities and Exchange Commission filings for publicly trade corporations.*

Cross-Industry Comparison of Executive Salaries

Company	Executive Total Direct Compensation (Realized)
Coca-Cola Company	$57,321,900
Bristol-Myers Squibb	$56,279,300
Colgate-Palmolive	$52,703,500
Abbott Labs	$45,175,500
Texaco	$6,146,100
AT & T	$3,300,200
Delta Airlines	$2,097,800
Pennzoil-Quaker State	$1,216,400

Source: Wall Street Journal Reports, survey by New York compensation consultants: William M. Mercer Inc., "Executive Pay," April 8, 1999, p. R1.

Salaries Paid to 12 Pharmaceutical Executives in 1998		
1.	C.A. Heimbold, Jr., Chairman and Chief Executive Officer, Bristol-Myers Squibb	56,337,553
2.	Robert P. Luciano, Retired Chairman of the Board, Schering Plough Corporation	54,289,354
3.	Duane L. Burnham, Chairman of the Board and Director, Abbott Laboratories	46,030,441
4.	Randall L. Tobias, Chairman of the Board and Chief Executive Officer, Eli Lilly &Company	41,759,339
5.	Gordon M. Binder, Chief Executive Officer and Chairman of the Board, Amgen	39,538,895
6.	Mr. Steere, Chairman/CEO, Pfizer	38,401,457
7.	Lodewijk J. R. de Vink, President and Chief Operating Officer, Wamer-Lambert	27,455,125
8.	John R. Stafford, Chairman of the Board, President and Chief Executive Officer, AmericanHome Products Corporation	15,205,002
9.	Ralph S. Larsen, Chairman/CEO, Johnson & Johnson	7,215,347
10.	G. A. Ando, Executive Vice President and President, Research and Development,Pharmacia & Upjohn, Inc.	3,282,102
11.	David E. I. Pyott, President and CEO, Allergan	3,112,210
12.	Judy C. Lewent, Senior Vice President and Chief Financial Officer, Merck & Company,Inc.	3,006,884
AVERAGE COMPENSATION FOR TOP PAID EXEC FROM EACH COMPANY		27,969,476
TOTAL COMPENSATION FOR TOP PAID EXEC FROM EACH COMPANY		335,633,709

Stock Options Paid to 12 Pharmaceutical Executives in 1998		
1.	Melvin R. Goodes, Chairman of the Board and Chief Executive Officer, Warner-Lambert	256,255,631
2.	C.A. Heimbold, Jr., Chairman and Chief Executive Officer, Bristol-Myers Squibb	210,870,381
3.	Mr. Steer,Chairman/CEO, Pfizer	149,780,085
4.	Randall L. Tobias, Chairman of the Board and Chief Executive Officer, Eli Lilly & Company	119,209,665
5.	Raymond V. Gilmartin, Chairman of the Board, President and Chief Executive Officer, Merck & Company, Inc.	115,676,386
6.	Gordon M. Binder, Chief Executive Officer and Chairman of the Board, Amgen	108,772,055
7.	John R. Stafford, Chairman of the Board, President and Chief Executive Officer, American Home Products Corporation	73,616,959
8.	Ralph S. Larsen, Chairman/CEO, Johnson & Johnson	69,776,081
9.	Raul E. Cesan, President and Chief Operating Officer, Schering Plough Corporation	55,463,146
10.	Duane L. Burnham, Chairman of the Board and Director, Abbott Laboratories	50,300,642
11.	F. Hassan, President and Chief Executive Officer, Pharmacia & Upjohn, Inc.	19,966,610
12.	Lester J. Kaplan, Ph.D., Corporate Vice President and President Research & Development and Global BOTOX (R), Allergan	7,088,956
AVERAGE STOCK OPTIONS FOR TOP PAID EXEC FROM EACH COMPANY		103,064,716
TOTAL STOCK OPTIONS FOR TOP PAID EXEC FROM EACH COMPANY		1,236,776,597

Salaries Paid to all Pharmaceutical Executives Examined in 1998		
1.	C. A. Heimbold, Jr., Chairman and Chief Executive Officer, Bristol-Myers Squibb	56,337,553
2.	Robert P. Luciano, Retired Chairman of the Board, Schering Plough Corporation	54,289,354
3.	Duane L. Burnham, Chairman of the Board and Director, Abbott Laboratories	46,030,441
4.	Randall L. Tobias, Chairman of the Board and Chief Executive Officer, Eli Lilly & Company	41,759,339
5.	Gordon M. Binder, Chief Executive Officer and Chairman of the Board, Amgen	39,538,895
6.	Mr. Steere, Chairman/CEO, Pfizer	38,401,457
7.	Richard Jay Kogan, Chairman of the Board and Chief Executive Officer, Schering Plough Corporation	29,316,737
8.	Lodewijk J.R. de Vink, President and Chief Operating Officer, Warner Lambert	27,455,125
9.	Hugh A. D''Andrade, Vice Chairman and Chief Administrative Officer, Schering Plough Corporation	25,285,000
10.	K.E. Weg, Executive Vice President, Bristol-Myers Squibb	18,947,430
11.	Melvin R. Goodes, Chairman of the Board and Chief Executive Officer, Warner Lambert	16,485,819
12.	John R. Stafford, Chairman of the Board, President and Chief Executive Officer, American Home Products Corporation	15,205,002
13.	Dr. Niblack, Executive Vice President, Pfizer	15,099,044
14.	Kevin W. Sharer, President, Chief Operating Officer and Director, Amgen	15,098,053
15.	Dr. McKinnell, Executive Vice President, Pfizer	15,028,686
16.	Anthony H. Wild, Vice President; President, Pharmaceutical Sector, Warner Lambert	12,154,546
17.	Sidney Taurel, Chairman of the Board, President and Chief Executive Officer, Eli Lilly & Company	11,806,379
18.	Ronald M. Cresswell, Senior Vice President and Chief Scientific Officer, Warner Lambert	10,309,881
19.	Thomas R. Hodgson, Retired President and Chief Operating Office, Abbott Laboratories	9,234,748
20.	Robert G. Blount, Senior Executive Vice President, American Home Products Corporation	8,920,611
21.	Ernest J. Larini, Vice President and Chief Financial Officer, Warner Lambert	8,654,836
22.	Mr. Miller, Senior V.P.; General Counsel, Pfizer	8,352,830
23.	Gary P. Coughlan, Senior Vice President and Chief Financial Officer, Abbott Laboratories	7,465,589
24.	Ralph S. Larsen, Chairman/CEO, Johnson & Johnson	7,215,347
25.	Mr. Clemente, Senior V.P. Corporate Affairs; Secretary and General Counsel, Pfizer	7,117,131
AVERAGE FOR TOP 25		21,820,393
TOTAL FOR TOP 25		545,509,833
26.	August M. Watanabe, MD, Executive Vice President, Science and Technology, Eli Lilly & Company	6,909,189
27.	Robert L. Parkinson, Jr., President, Chief Operating Officer and Director, Abbott Laboratories	5,826,743
28.	M. F. Mee, Senior Vice President and Chief Financial Officer, Bristol-Myers Squibb	5,750,294
29.	Miles D. White, Chief Executive Officer and Director, Abbott Laboratories	5,393,656
30.	Raul E. Cesan, President and Chief Qperating Officer, Schering Plough Corporation	4,917,429
31.	Robert N. Wilson, Vice Chairman, Johnson & Johnson	4,696,059
32.	James T. Lenehan, Worldwide Chairman, Consumer Pharmaceuticals & Professional Group, Johnson & Johnson	4,483,852

33.	Ronald G. Geibman, Worldwide Chairman, Health Systems & Diagnostics Group, Johnson & Johnson	4,410,599
34.	Rodolfo C. Bryce, Executive Vice President HealthCare Products, Schering Plough Corporation	4,225,265
35.	David M. Ojivier, Senior Vice President, American Home Products Corporation	4,047,012
36.	Joy A. Amundson, Senior Vice President, Ross Products, Abbott Laboratories	3,923,274
37.	George Morstyn, Vice President, Product Development, and Chief Medical Officer, Amgen	3,874,961
38.	Joseph C. Connors, Executive Vice President and General Counsel, Schering PloughCorporation	3,435,396
39.	N. Kirby Alton, Senior Vice President, Development, Amgen	3,336,237
40.	G. A. Ando, Executive Vice President and President, Research and Development, Pharmacia &Upjohn, Inc.	3,282,102
41.	Charles E. Golden, Executive Vice President and Chief Financial Officer, Eli Lilly & Company	3,115,498
42.	David E. I. Pyott, President and CEO, Allergan	3,112,210
43.	Pedro P. Granadillo, Senior Vice President, Human Resources and Manufacturing, Eli Lilly &Company	3,098,995
44.	Judy C. Lewent, Senior Vice President and Chief Financial Officer, Merck & Company, Inc.	3,006,884
45.	Rebecca 0. Goss, Senior Vice President and General Counsel, Eli Lilly & Company	2,870,931
46.	Robert Essner, Executive Vice President, American Home Products Corporation	2,669,768
47.	Raymond V. Gilmartin, Chairman of the Board, President and Chief Executive Officer, Merck& Company, Inc.	2,557,204
48.	Edward M. Scolnick, Executive Vice President, Science and Technology and President Merck& Company, Inc. Research Laboratories, Merck & Company, Inc.	2,407,114
49.	F. Hassan, President and Chief Executive Officer, Pharmacia & Upjohn, Inc.	2,366,116
50.	T. G. Rothwell, Executive Vice President and President, Pharmaceutical Operations,Pharmacia & Upjohn, Inc.	2,332,154
51.	LesterJ. Kaplan, Ph.D., Corporate Vice President and President Research & Development andGlobal BOTOX (R) Allergan	2,141,015
52.	Robert I. Levy, Senior Vice President, American Home Products Corporation	2,088,249
53.	C.J. Coughlin, Executive Vice President and Chief Financial Officer, Pharmacia & Upjohn,Inc.	2,002,706
54.	Per Wold-Olsen, President, Human Health Europe, Middle East & Africa, Merck &Company, Inc.	1,909,628
55.	Christian A. Koffmann, Worldwide Chairman, Consumer and Personal Care Group, Johnson &Johnson	1,500,307
56.	Francis R. Tunney, Jr., Corporate Vice President Administration, General Counsel andSecretary, Allergan	1,450,844
57.	George A. Vandeman, Senior Vice President, Corporate Development, General Counsel andSecretary, Amgen	1,365,745
58.	F. Michael Ball, Corporate Vice President and President, North America Region and GlobalEye Rx Business, Allergan	1,351,128
59.	J. L McGoldrick, Senior Vice President, General Counsel and President Medical Devices,Bristol-Myers Squibb	1,190,938
60.	James V. Mazzo, Corporate Vice President and President, Europe! Africa! Middle East Regionand Global Lens Care Products, Allergan	1,111,256
61.	Per G.H. Lofberg, President, Merck & Company, Inc.-Medco Managed Care, L.L.C, Merck &Company, Inc.	954,410

62.	P.S. Ringrose, Ph.D., President, Pharmaceutical Research Institute, Bristol-Myers Squibb	933,589
63.	C. Smith Cox, Senior Vice President and Head, Global Business Management, Pharmacia &Upjohn, Inc.	926,428
AVERAGE FOR ALL		10,483,889
TOTAL FOR ALL		660,485,018

Stock Options Paid to all Pharmaceutical Executives Examined in 1998		
1.	Melvin R. Goodes, Chairman of the Board and Chief Executive Officer, Warner Lambert	256,255,631
2.	C. A. Heimbold, Jr., Chairman and Chief Executive Officer, Bristol-Myers Squibb	210,870,381
3.	Mr. Steere, Chairman/CEO, Pfizer	149,780,085
4.	Lodewijk J.R. de Vink, President and Chief Operating Officer, Warner Lambert	142,626,819
5.	Randall L. Tobias, Chairman of the Board and Chief Executive Officer, Eli Lilly & Company	119,209,665
6.	Raymond V. Gilmartin, Chairman of the Board, President and Chief Executive Officer,Merck & Company, Inc.	115,676,386
7.	Gordon M. Binder, Chief Executive Officer and Chairman of the Board, Amgen	108,772,055
8.	Sidney Taurel, Chairman of the Board, President and Chief Executive Officer, Eli Lilly &Company	89,793,434
9.	Dr. McKinnell, Executive Vice President, Pfizer	80,037,446
10.	John R. Stafford, Chairman of the Board, President and Chief Executive Officer, AmericanHome Products Corporation	73,616,959
11.	Ralph S. Larsen, Chairman/CEO, Johnson & Johnson	69,776,081
12.	K. E. Weg, Executive Vice President, Bristol-Myers Squibb	66,907,002
13.	Ernest J. Larini, Vice President and Chief Financial Officer, Warner Lambert	58,330,716
14.	Per G.H. Lofberg, President, Merck & Company, Inc.-Medco Managed Care, L.L.C, Merck& Company, Inc.	56,744,422
15.	Edward M. Scolnick, Executive Vice President, Science and Technology and PresidentMerck &_Company,_Inc._Research_Laboratories, Merck & Company, Inc.	55,799,496
16.	Raul E. Cesan, President and Chief Operating Officer, Schering Plough Corporation	55,463,146
17.	Dr. Niblack, Executive Vice President, Pfizer	52,192,255
18.	Duane L. Burnham, Chairman of the Board and Director, Abbott Laboratories	50,300,642
19.	Thomas R. Hodgson, Retired President and Chief Operating Officer, Abbott Laboratories	49,269,542
20.	Richard Jay Kogan, Chairman of the Board and Chief Executive Officer, Schering PloughCorporation	48,860,156
21.	Judy C. Lewent, Senior Vice President and Chief Financial Officer, Merck & Company, Inc.	47,516,538
22.	Robert N. Wilson, Vice Chairman, Johnson & Johnson	43,770,451
23.	Mr. Clemente, Senior V.P. Corporate Affairs; Secretary and General Counsel, Pfizer	43,450,931
24.	Mr. Miller, Senior V.P.; General Counsel, Pfizer	40,086,792
25.	Joseph C. Connors, Executive Vice President and General Counsel, Schering PloughCorporation	32,895,406
AVERAGE FOR TOP 25		84,720,097
TOTAL FOR TOP 25		2,118,002,437
26.	Robert P. Luciano, Retired Chairman of the Board, Schering Plough Corporation	32,834,982
27.	Ronald M. Cresswell, Senior Vice President and Chief Scientific Officer, Warner Lambert	32,472,149

28.	Pedro P. Granadillo, Senior Vice President, Human Resources and Manufacturing, Eli Lilly& Company	30,008,884
29.	J. L McGoldrick, Senior Vice President, General Counsel and President Medical Devices,Bristol-Myers Squibb	29,551,849
30.	Per Wold-Olsen, President, Human Health Europe, Middle East & Africa, Merck &Company, Inc.	29,314,491
31.	Anthony H. Wild, Vice President; President, Pharmaceutical Sector, Warner Lambert	28,284,211
32.	Rodolfo C. Bryce, Executive Vice President HealthCare Products, Schering PloughCorporation	27,495,462
33.	George A. Vandeman, Senior Vice President, Corporate Development, General Counsel andSecretary, Amgeii	22,738,978
34.	Rebecca O. Goss, Senior Vice President and General Counsel, Eli Lilly & Company	20,197,098
35.	August M. Watanabe, MD, Executive Vice President, Science and Technology, Eli Lilly &Company	20,190,966
36.	F. Hassan, President and Chief Executive Officer, Pharmacia & Upjohn, Inc.	19,966,610
37.	Hugh A. D''Andrade, Vice Chairman and Chief Administrative Officer, Schering PloughCorporation	19,947,213
38.	Christian A. Koffman, Worldwide Chairman, Consumer and Personal Care Group, Johnson& Johnson	19,554,940
39.	Kevin W. Sharer, President, Chief Operating Officer and Director, Amgen	19,119,134
40.	Miles D. White, Chief Executive Officer and Director, Abbott Laboratories	17,997,224
41.	Robert Essner, Executive Vice President, American Home Products Corporation	17,430,030
42.	Ronald G. Gelbman, Worldwide Chairman, Health Systems & Diagnostics Group, Johnson& Johnson	17,065,353
43.	M.F. Mee, Senior Vice President and Chief Financial Officer, Bristol-Myers Squibb	16,783,570
44.	Robert G. Blount, Senior Executive Vice President, American Home Products Corporation	16,754,717
45.	James T. Lenehan, Worldwide Chairman, Consumer Pharmaceuticals & Professional Group,Johnson & Johnson	16,716,124
46.	Robert L. Parkinson, Jr., President, Chief Operating Officer and Director, AbbottLaboratories	16,044,843
47.	Charles E. Golden, Executive Vice President and Chief Financial Officer, Eli Lilly &Company	15,500,488
48.	Robert I. Levy, Senior Viëëe President, American Home Products Corporation	15,190,689
49.	P.S. Ringrose, Ph.D., President, Pharmaceutical Research Institute, Bristol-Myers Squibb	12,174,983
50.	George Morstyn, Vice President, Product Development, and Chief Medical Officer, Arngen	9,827,989
51.	N. Kirby Alton, Senior Vice President, Development, Amgen	9,347,552
52.	Joy A. Amundson, Senior Vice President, Ross Products, Abbott Laboratories	9,171,487
53.	Gary P. Coughlan, Senior Vice President and Chief Financial Officer, Abbott Laboratories	7,173,638
54.	Lester J. Kaplan, Ph.D., Corporate Vice President and President Research & Developmentand Global BOTOX (R) , Allergan	7,088,956
55.	G. A. Ando, Executive Vice President and President, Research and Development, Pharmacia& Upjohn, Inc.	6,378,425
56.	Francis R. Tunney, Jr., Corporate Vice President Administration, General Counsel andSecretary, Allergan	6,266,316
57.	T. G. Rothwell, Executive Vice President and President, Pharmaceutical Operations,Pharmacia & Upjohn, Inc.	5,946,770
58.	David M. Olivier, Senior Vice President, American Home Products Corporation	5,358,265

59.	C. Smith Cox, Senior Vice President and Head, Global Business Management, Pharmacia &Upjohn, Inc.	5,232,277
60.	David E. I. Pyott, President and CEO, Allergan	4,722,960
61.	C. J. Coughlin, Executive Vice President and Chief Financial Officer, Pharmacia & Upjohn,Inc.	4,379,829
62.	James V. Mazzo, Corporate Vice President and President, Europe! Africa/Middle EastRegion and Global Lens Care Products, Allergan	3,228,861
63.	F. Michael Ball, Corporate Vice President and President, North America Region and Global Eye Rx Business, Allergan	2,180,876
AVERAGE FOR ALL		43,137,169
TOTAL FOR ALL		2,717,641,626

BOGUS "CONSUMER" GROUP FACADES

! The Pharmaceutical and Research Manufacturers of America (PhRMA) is running a well-funded and well-organized campaign against providing senior citizens with affordable access to prescription drug or prescription drug coverage under Medicare. They've enlisted a number of healthcare groups, including the Seniors Coalition, Healthcare Leadership Council, National Kidney Cancer Association, National Kidney Foundation, and the Cancer Research Foundation of America, to participate. But it is important to note that these groups have a conflict of interest: they all receive funding from the pharmaceutical industry.[32]

Citizens for Better Medicare

! Under the guise of "Citizens for Better Medicare," the pharmaceutical industry association (PhRMA) is spending approximately $30 million dollars on ads in an attempt to kill the President's Medicare drug plan.

! PhRMA's radio and tv commercials have brought you a fictitious "Flo" – the senior citizen who adamantly states that she doesn't want "big government in her medicine cabinet."

! Flo may not want big government in her medicine cabinet, but it is clear that PhRMA wants "big government" around when it comes to national funding for medical research and protecting the patents for drugs so that they can keep overcharging uninsured seniors.

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[32] Public Citizen, *Pharmaceutical Industry's Propaganda Campaign, Against the Prescription Drug Fairness for Seniors Act*, http://www.citizen.org/congress/drugs/industrycampaign.htm, (1999).

Members of Citizens for Better Medicare, PAC Contributions, 1/1/99 to 6/30/99*	
Glaxo Wellcome Inc	$161,700
Pfizer Inc	$157,850
Merck & Co	$96,132
Cigna Corp	$92,950
Bristol-Myers Squibb	$86,000
Eli Lilly & Co	$78,850
Prudential Insurance	$63,500
Schering-Plough Corp	$59,500
Abbott Laboratories	$57,000
Hoffmann-La Roche	$31,000
Johnson & Johnson	$30,000
Baxter Healthcare	$27,850
Amgen Inc	$20,832
Pharmaceutical Rsrch & Mfrs of America	$19,037
Tenet Healthcare	$16,500
CVS Corp	$8,925
Mallinckrodt Inc	$6,400
Guidant Corp	$6,000
United States Surgical Corp	$5,000
United Seniors Assn	$3,000
American Home Products	$2,750
Source: Center for Responsive Politics, http://www.opensecrets.org/alerts/v5/alertv5_28.htm.. *Based on data downloaded from the FEC 9/1/99. CBM members include members of the Healthcare Leadership Council.	

Alliance to Improve Medicare (AIM) – A Wolf in Grandma's Clothing

- A new phony "consumer" coalition appeared in Washington on September 30, 1999 -- but at least this one is being honest with its acronym if not its name. This group of business, pharmaceutical companies and for profit health care industries, have all joined together to take 'AIM' at efforts to protect and improve Medicare for beneficiaries.

- AIM members include the Pharmaceutical Research and Manufacturers of America, the National Association of Manufacturers, and the American Association of Health Plans, among others.

- Seniors had better beware of AIM's claims. AIM is just another wolf in grandma's clothing and seniors need to know what the wolf is really up to – the group doesn't represent senior citizens, it represents very profitable industry interested in maintaining the status quo -- no outpatient drug coverage under Medicare.

- Drug company coalitions do not want Medicare to purchase drugs because this would put an end to their practice of double-charging seniors without drug coverage for their prescription medicines.