CAPITOL ANALYSTS NETWORK, INC.
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IF CONGRESS HELPS GRANDMA PAY FOR HER MEDS, WHO WINS?

With the tax cut fight behind us, Washington's attention has turned to the pharmaceutical industry. Next Thursday, the Senate Finance Committee is expected to begin public deliberations over how to structure an outpatient pharmaceutical benefit as part of the Medicare program. The House Ways and Means Committee and the House Energy and Commerce Committee also should begin the formal design process a few days later. If all goes as GOP leaders plan, before the month of June is over, both the full House and the full Senate will be debating on the floors of Congress detailed legislation on how to best spend $400 billion or more over ten years to help Medicare beneficiaries with their drug bills. A $400 billion federal subsidy will pay for 20 percent of all projected senior pharmaceutical consumption. It's possible that the total will exceed $400 billion, but only if offsetting spending cuts or tax increases elsewhere are adopted, such as boosting customs fees.

As the Committee drafting process gets underway, the dominant idea significantly expands the private insurance market, with a senior pharmaceutical policy having four design elements:

- Seniors who elect to purchase subsidized insurance would pay modest monthly premiums of $33 to $35 and also pay modest annual deductibles of $250 to $275.
- After breaching the deductibles, private insurers would pick up 50 to 80 percent of additional drug costs until a limit is reached.
- Above the limit, seniors would pay 100 percent until they reach a second, and final, catastrophic ceiling.
- Above the catastrophic ceiling, insurance would again pay 90 to 100 percent.

The federal government would pay insurers to offer this product. Furthermore, the federal government also would pay some or all of the premiums for seniors with incomes up to 175 percent of the poverty line. Those below the poverty line already receive assistance under the Medicaid program.

<u>Who Pays What – and How Big Is the Donut?</u>

Late Thursday, the leaders of the Senate Finance Committee, Chairman Chuck Grassley (R-IA) and Ranking Democrat, Max Baucus (D-MT), announced they had reached agreement on a Medicare reform plan that offer significant outpatient pharmaceutical assistance to seniors. These two Senators wield considerable influence with their Committee colleagues. Consequently, investors can assume that the full Committee will approve their compromise with few modifications. The full Senate can be expected to debate their plan soon thereafter. The following table compares the Finance Committee leaders' plan with what the House passed last

year, which the Ways and Means Committee is considering carefully again this year. As the following table shows, the primary difference in the plans are co-payment rates and the size of the "donut" – the term used to describe the zero coverage range just below the 90 to 100 catastrophic coverage. Since the House plan would require insurers to pay 80 percent of amounts between $251 and $1,000, it has to be less generous above $2,000 to stay within the $400 billion budget.

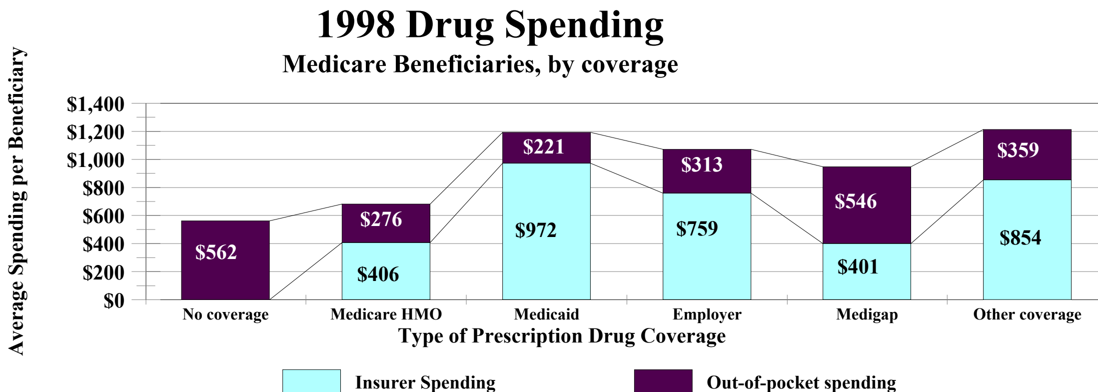
Comparing House and Senate Medicare Drug Proposals

	House-Passed Bill in 2002	Current Senate Finance Plan
Consumer Monthly Premium	$33 per month	$35 per month
Consumer Deductible	$250 per year	$275 per year
Insurance Payments	80% from $251 to $1,000; 50% from $1,001 to $2,000; 0% from $2,001 to $4,800; 100% above $4,800	50% from $276 to $3,450; 0% from $3,451 to $5,300; 90% above $5,301

It is not necessary for aggressive investors to wait any longer before making plans on how to respond. Enough is known. The key question to answer is – how will senior react to these types of plans?

<u>What's the Best Health Care Somebody Else's Money Can Buy?</u>

Like all consumers, seniors will buy more pharmaceuticals when they pay less out of their own pockets. On April 20,2001 Jack Hoadley, an analyst working for the U.S. Department of Health and Human Services quantified this impact on pharmaceutical purchasing by analyzing official data. He published the following chart.



Source: U.S. Department of Health and Human Services

It shows that seniors without health insurance spent an average of $562 per capita on pharmaceuticals in 1998. Those with insurance consumed between $682 and $1,213, depending on the coverage they held. Seniors who lack insurance now, and who now spend more than $250 on pharmaceuticals, also would buy more when an insurance company is picking up fifty to eighty percent of the tab for purchases above $250.

There is anecdotal evidence that some seniors take less than the optimal amount of medicine prescribed by their doctors to save money. If they are supposed to take hypertension medicine twice a day, they may take it once a day, for example. Sales on hypertension medicine are likely to rise when uninsured seniors become well insured. However, most seniors won't break doctors orders when it comes to medicine that keeps them alive; this phenomenon is unlikely to be common among those suffering from cancer, serious heart disease, or diabetes. What accounts, therefore, for Hoadley's findings that pharmaceutical consumption rises significantly when patients have insurance? It can't be due to soaring cancer medication sales.

It appears that seniors primarily expand their purchases of drugs that improve the quality of life, rather than purchase more life-sustaining drugs, when they become covered by significant insurance. The plans being weighed by the key congressional Committees most resemble Medigap policies. Those plans also have 50 percent copayment requirements. If so, then newly insured seniors may respond similarly, and boost their purchase of pharmaceuticals by a similar percentage, 68 percent.

How Much Will This Buying Surge Help Industry?

According to Congressional testimony submitted by John Poisal, a statistician with the Center for Medicare and Medicaid Services, 54 percent of Medicare beneficiaries already have pharmaceutical insurance coverage; another 19 percent have coverage part of the year, while 27 percent have no coverage http://www.medicaid.com/media/press/testimony.asp?Counter=624 . A lower estimate of the buying surge can be derived by assuming that only the 27 percent without *any* coverage will switch to the new, Medigap-comparable, federally, subsidized plan. If this subpopulation also buys 68 percent more in response to having insurance, then total senior purchases will rise by 18 percent (0.68*0.27). A ceiling can be calculated by assuming that *all* those lacking full-time coverage switch over, or 46 percent of seniors. If this group also buys 68 percent more, then the total increase will be 31 percent (0.68*0.46).

The American Association for Retired People (AARP) estimates that Medicare beneficiaries in 1999 generated 40 percent of U.S. prescription spending. If this group now buys 18 percent to 31 percent more because of federally subsidized insurance, then total national sales to all patients will grow by 7.2 percent (0.40*0.18) to 12.4 percent (0.40*0.31). Perhaps this explains why pharmaceutical companies have been discreetly silent to date as the debate escalates. We are unlikely to see a repeat of the "Harry and Louise" television commercials.

If you want to reconfigure your investments to benefit from the possible seniors buying surge, a good starting point may be to review a list of quality-of-life improvement drugs that are

now sold to them. This CAN analysis includes such a list, sorted by company, and dollar volume, as an appendix. Factories making these drugs may have to put on additional shifts to meet additional demand. Insurance likely will go into effect on January 1, 2006.

O Canada!

There is another little discussed reason why drug companies support the GOP plans. It will put an end to grandma's drug smuggling. On May 8, 2003, the *Washington Post* quoted FDA Commissioner Mark McClellan as stating that unauthorized cross-border sales, mostly done with Canadian counter-parties, amount to 1 to 2 percent of all drug sales. In the same article, a spokesman for The National Association of Chain Drug Stores estimated that such sales are growing at a remarkable 50 percent annual clip.

Grandma smuggles because Canadian prices for pharmaceuticals are an average of 40 percent cheaper there than in the U.S. because of price controls. No doubt grandma would prefer to buy her medicine from local pharmacists rather than risk consuming faulty products from largely unknown Canadian sellers, and she would do so if prices were comparable. If she had GOP-style insurance, this would be the case. Instead of buying hypertension medicine from British Columbia for $100 a month, for example, she could buy it for $180 down the street, and – after a 50 percent copayment – pay only $90. Notice, however, that the price received by the retailer has gone up from $100 to $180. Much of that $80 increase will filter back to the pharmaceutical manufacturers. If one million grandmas change their ways, annual drug profits could grow by $1 billion to $3 billion.

Probability of Congressional Action

CAN estimates there is a 65 percent chance that Congress will pass a Medicare drug benefit this Congress, perhaps as early as this summer.

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Appendix A: Quality-of-Life Drugs that Doctors Often Prescribe for Seniors

Company	Drug (Trade Name)	2000 Sales ($000)	Purpose
Abbott	***Depakote***	854,391	Migraines, mood disorders
Abbott	***Biaxin***	553,963	Anti-ulcer
Abbott	***Hytrin***	181,420	Prostate reduction
Alza	***Ditropan XL***	187,687	Control urinary incontinence
AstraZeneca	***Prilosec***	4,619,525	Acid reflux
Aventis	***Serzone***	345,902	Anti-depressant
Aventis	***Arava***	140,820	Rheumathoid arthritis
Berlex	***Betapace***	159,884	Chest pain
Boehringer Ingelheim	***Flomax***	256,834	Prostate disease
Bristol-Myers	***Buspar***	758,690	Anti-anxiety
Bristol-Myers Onco	***Megace Oral Susp***	156,751	Appetite stimulant
Eisai	***Aricept***	505,909	Alzheimer's disease
Glaxo Wellcome	***Imitrex***	984,771	Migraine relief
Glaxo Wellcome	***Wellbutrin SR***	788,795	Anti-depressant
Glaxo Wellcome	***Zantac***	209,862	Anti-ulcer
Immunex	***Enbrel***	696,449	Rheumathoid arthritis
Janssen	***Risperdal***	1,307,066	Alzheimer's disease
Janssen	***Sporanox***	139,010	Nail fungus
Key	***K-Dur***	302,631	Potassium deficiency
Knoll	***Synthroid***	538,425	Thyroid hormone replacement
Lilly	***Prozac***	2,665,241	Anti-depressant
Lilly	***Zyprexa***	1,905,110	Anti-depressant
McNeil	***Ultram***	554,158	Pain killer
Merck	***Vioxx***	1,518,485	Anti-arthritic
Merck	***Fosamax***	839,534	Osteoporosis
Merck	***Proscar***	216,016	Prostate reduction
Mylan	***Lorazepam***	143,609	Anti-depressant
Novartis	***Aredia***	456,096	Anemia
Novartis	***Neoral***	348,350	Rheumatoid arthritis
Novartis	***Miacalcin***	288,723	Osteoporosis
Parke-Davis	***Neurontin***	1,279,955	Anti-depressant
Pfizer	***Zoloft***	1,980,436	Anti-depressant
Pfizer	***Viagra***	796,084	Sexual dysfunction
Pfizer	***Diflucan***	522,880	Nail fungus
Pharmacia	***Celebrex***	2,154,360	Anti-arthritic
Pharmacia	***Ambien***	750,566	Insomnia
Pharmacia	***Daypro***	168,120	Rheumathoid arthritis
Purdue	***MS-Contin***	144,119	Pain killer
SmithKline Beecham	***Paxil***	1,843,845	Anti-depressant
SmithKline Beecham	***Relafen***	340,899	Anti-arthritic
Tap	***Prevacid***	3,147,258	Anti-ulcer
Wyeth-Ayerst	***Premarin***	1,173,830	female hormone replacement/cancer therapy
Wyeth-Ayerst	***Effexor***	135,249	Anti-depressant

Sources: *Pharmacy Times 2001*; Families USA; Department of Health and Human Services