
Big Dollars, Little Sense:

*Rising
Medicare
Prescription Drug
Prices*

A REPORT BY
Families USA

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**Big Dollars, Little Sense:
Rising Medicare Prescription Drug Prices**

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INTRODUCTION

“This approach is expected to provide the best discounts on drugs—discounts as good or better than could be achieved through direct government negotiation”
– CMS Administrator Mark McClellan¹

“The market has very clearly driven the prices down.”
– HHS Secretary Michael Leavitt²

When the Medicare prescription drug legislation was being developed by Congress and the Bush Administration, a controversial decision was made about how to cope with the problem of high drug prices. Specifically, the legislation *prohibited* the Medicare program from bargaining with the pharmaceutical companies to secure lower drug prices, a process that the Department of Veterans Affairs (VA) has used quite successfully for many years. The legislation took the responsibility for moderating drug prices out of the hands of the Medicare program and, instead, placed it in the hands of private plans. This decision was based on the presumption that private plans—through marketplace competition—would secure cheaper drug prices.

The results of this approach are critically important both to America’s seniors and to taxpayers. Drug prices set by the plans that participate in the Medicare prescription drug program, known as Part D, significantly affect the size of the premiums and how much a beneficiary will end up paying out of pocket overall. These drug prices also have a direct effect on the burden borne by taxpayers, who pay approximately three-fourths of the costs of the program.

For this reason, Families USA periodically analyzes the drug prices that Part D plans charge for the 20 drugs most frequently prescribed to seniors. This study analyzes price information reported by Part D plans for those drugs. We collected prices from the week of November 15, 2005 (when enrollment in Part D plans began) and the week of April 17, 2006.

The report asks two key questions: 1) What has happened to Part D prices for the most frequently prescribed drugs from November 2005 to April 2006?; and 2) How do Part D drug prices now compare to the prices secured by the VA?

The answers to these questions are both clear and disappointing: 1) Virtually all of the Part D plans raised their prices for the majority of the top 20 drugs in this study. From November 2005 to April 2006, the median price increase among Part D plans for the top 20 drugs prescribed to seniors was 3.7 percent. 2) For *all* of the top 20 drugs prescribed to seniors, VA prices in April were lower than the lowest prices charged by Part D plans. The median price difference was 46 percent. In other words, for half of the 20 drugs, the lowest price charged by any Part D plan was at least 46 percent higher than the lowest price secured by the V A.

METHODOLOGY

In this report, Families USA compared the prices that Part D plans reported to the Centers for Medicare and Medicaid Services (CMS) in November 2005 and April 2006 for the 20 drugs most frequently prescribed to seniors. For those same drugs, we also compared Part D prices with the publicly reported prices negotiated through the VA. This analysis did not include Medicare Advantage Plans that provide a drug benefit because those plans do not report the base prices they charge for drugs.

We obtained price data for Part D plans through Medicare’s “Prescription Drug Plan Finder,” located online at www.medicare.gov. All Part D plan price data were collected through this Web site. Families USA evaluated prices for both mail order and retail purchases; mail order prices were always lower. Therefore, for all plans, we tracked changes only for mail order prices, unless the plan did not offer a mail order option or unless prices for the mail order option were not reported in both months. Only drugs that were on a Part D plan’s formulary—drugs for which the plan would have actively negotiated prices—were included in this analysis.

We obtained VA drug price information from the multiple price schedules that the VA negotiates, including the Federal Supply Schedule, the Restricted Federal Supply Schedule, the Big4 Pricing Schedule, and the National Contracts for the Veterans Administration. The Appendix provides a more complete discussion of the study methodology and the VA pricing schedules.

KEY FINDINGS

- **From November 2005 to April 2006, virtually all Part D plans raised their prices for *most* of the top 20 drugs prescribed to seniors (Table 1).**
 - For Zocor (40 mg), all Part D plans raised their prices. Almost all (98.5 percent) Part D plans also raised their prices for the lower-strength version of Zocor (20 mg).
 - For Fosamax (70 mg), almost 99 percent of Part D plans raised their prices.
 - For Lipitor (10 mg), over 97 percent of Part D plans raised their prices. A smaller—but still sizable—share of Part D plans (88.9 percent) raised their prices for the higher-strength version of Lipitor (20 mg).
 - For Actonel (35 mg), Toprol XL (50 mg and 100 mg), and Xalatan (0.005%), more than 96 percent of Part D plans raised their prices.
 - For Celebrex (200 mg), Nexium (40 mg), and Norvasc (5 mg), more than 94 percent of Part D plans raised their prices.
 - Only the prices for two generic drugs, furosemide (40 mg) and metoprolol tartrate (50 mg), and the brand-name drug Zolofit (50 mg) were not raised by a majority of Part D plans.
 - However, even for furosemide and Zolofit, a plurality of Part D plans raised their prices. Taking furosemide as an example, 42.5 percent of plans raised their prices, 31.5 percent of plans lowered their prices, and 26.0 percent left prices unchanged.
- **From November 2005 to April 2006, the median price increases among Part D plans for half of the top 20 drugs prescribed to seniors were at least 4 percent (Table 1).**
 - The median price increases for Aricept (10 mg), Celebrex (200 mg), and Lipitor (10 mg) were at least 6 percent.
 - The median price increase for both dosages of Zocor (20 mg and 40 mg) was 5.7 percent.

Table 1

Percent of Part D Plans That Changed Prices, November 2005 to April 2006

Drug Name	Strength	Dose Form	Increased Prices	Decreased Prices	Made No Change	Median Percent Change in Prices
Actonel	35 mg	tab	96.1%	3.9%	0.0%	4.9%
Aricept	10 mg	tab	92.4%	7.6%	0.0%	6.0%
Celebrex	200 mg	tab	94.8%	5.2%	0.0%	6.5%
Fosamax	70 mg	tab	98.7%	1.3%	0.0%	4.9%
furosemide	40 mg	tab	42.5%	31.5%	26.0%	0.0%
Lipitor	10 mg	tab	97.3%	2.7%	0.0%	6.5%
Lipitor	20 mg	tab	88.9%	11.1%	0.0%	4.7%
metoprolol tartrate	50 mg	cap	27.8%	50.6%	21.5%	-0.1%
Nexium	40 mg	tab	94.3%	5.7%	0.0%	3.5%
Norvasc	5 mg	tab	94.6%	5.4%	0.0%	3.2%
Norvasc	10 mg	tab	90.3%	9.7%	0.0%	3.2%
Plavix	75 mg	tab	89.0%	11.0%	0.0%	4.0%
Prevacid	30 mg	tab	58.3%	12.5%	29.2%	0.0%
Protonix	40 mg	tab	55.8%	21.2%	23.1%	0.0%
Toprol XL	50 mg	tab	96.2%	3.8%	0.0%	3.0%
Toprol XL	100 mg	tab	96.1%	3.9%	0.0%	3.0%
Xalatan	0.005 %	sol	96.8%	3.2%	0.0%	4.9%
Zocor	20 mg	tab	98.5%	1.5%	0.0%	5.7%
Zocor	40 mg	tab	100.0%	0.0%	0.0%	5.7%
Zoloft	50 mg	tab	35.9%	32.1%	32.1%	0.0%
Percent, All Prices			88.2%	7.6%	4.1%	
Median Percent Change						3.7%

Source: Changes in Part D plan prices are based on changes in plan prices available online through the Medicare Prescription Drug Plan Finder during the weeks of November 15, 2005 and April 17, 2006.

Only formulary drugs are included in the analysis, because those are presumably the only drugs for which the plans actively negotiate prices.

- The median drug prices did not rise for only five of the top 20 drugs: furosemide (40 mg), metoprolol tartrate (50 mg), Prevacid (30 mg), Protonix (40 mg), and Zoloft (50 mg).
- **From November 2005 to April 2006, for 19 of the top 20 drugs prescribed to seniors, the median Part D plan price changes were virtually identical to changes in manufacturer prices as measured by Average Wholesale Price—AWP (Table 2).**
 - The median AWP for the top 20 drugs prescribed to seniors rose by 3.8 percent, while the median Part D plan price change for those drugs was 3.7 percent. This means that Part D plans are not effectively reducing drug price inflation (as measured by AWP) for the seniors they are serving.
- **As of April 2006, there were large differences in the prices charged by Part D plans compared to the prices secured by the VA (Table 3).**
 - For each of the top 20 drugs prescribed to seniors, the lowest price charged by any Part D plan was higher than the lowest price secured by the VA.
 - Among those top 20 drugs, the median difference between the lowest Part D plan price and the lowest VA price was 46 percent. In other words, for half of the 20 drugs, the lowest price charged by any Part D plan was at least 46 percent higher than the lowest price secured by the VA.
 - For Zocor (20 mg), the lowest VA price for a year's treatment was \$127.44, while the lowest Part D plan price was \$1,275.36, a difference of \$1,147.92 or 901 percent. For Zocor (40 mg), the lowest VA price for a year's treatment was \$190.76, while the lowest Part D plan price was \$1,275.36, a difference of \$1,084.60 or 569 percent.
 - For Protonix (40 mg), the lowest VA price for a year's treatment was \$214.45, while the lowest Part D plan price was \$1,110.96, a difference of \$896.51 or 418 percent.

Table 2

Price Changes by Part D Plans and Manufacturers, November 2005 to April 2006

Drug Name	Strength	Dose Form	Median Percent Change	
			Part D Plans	Manufacturer Average Wholesale Price (AWP)
Actonel	35 mg	tab	4.9%	4.9%
Aricept	10 mg	tab	6.0%	6.0%
Celebrex	200 mg	tab	6.5%	6.5%
Fosamax	70 mg	tab	4.9%	4.9%
furosemide	40 mg	tab	0.0%	0.0%
Lipitor	10 mg	tab	6.5%	6.5%
Lipitor	20 mg	tab	4.7%	4.7%
metoprolol tartrate	50 mg	cap	-0.1%	0.0%
Nexium	40 mg	tab	3.5%	3.5%
Norvasc	5 mg	tab	3.2%	3.2%
Norvasc	10 mg	tab	3.2%	3.2%
Plavix	75 mg	tab	4.0%	4.0%
Prevacid	30 mg	tab	0.0%	0.0%
Protonix	40 mg	tab	0.0%	3.4%
Toprol XL	50 mg	tab	3.0%	3.0%
Toprol XL	100 mg	tab	3.0%	3.0%
Xalatan	0.005 %	sol	4.9%	4.9%
Zocor	20 mg	tab	5.7%	5.7%
Zocor	40 mg	tab	5.7%	5.7%
Zoloff	50 mg	tab	0.0%	0.0%
All Drugs			3.7%	3.8%

Sources: Changes in Part D plan prices are based on changes in plan prices available online through the Medicare Prescription Drug Plan Finder the weeks of November 15, 2005 and April 17, 2006.

Only formulary drugs are included in the analysis, because those are presumably the only drugs for which the plans actively negotiate prices.

Manufacturer changes in Average Wholesale Price (AWP) were tracked the weeks of November 15, 2005 and April 17, 2006. Average Wholesale Price changes are from *MDDB-Select*, published by Medi-Span (Indianapolis, IN: Wolters Kluwer Health, Inc., April 2006).

Table 3

Lowest Department of Veterans Affairs (VA) Prices and Lowest Part D Plan Prices for the Top 20 Drugs Prescribed to Seniors, April 2006

Drug Name	Strength	Dose Form	Lowest VA Price Per Year	Lowest Part D Plan Price Per Year	Price Difference Per Year	Percent Difference
Actonel	35 mg	tab	\$ 372.24	\$ 703.32	\$ 331.08	88.9%
Aricept	10 mg	tab	\$ 1,058.69	\$ 1,553.40	\$ 494.71	46.7%
Celebrex	200 mg	tab	\$ 632.09	\$ 902.64	\$ 270.55	42.8%
Fosamax	70 mg	tab	\$ 265.32	\$ 727.92	\$ 462.60	174.4%
furosemide	40 mg	tab	\$ 8.56	\$ 13.44	\$ 4.88	57.0%
Lipitor	10 mg	tab	\$ 520.44	\$ 748.92	\$ 228.48	43.9%
Lipitor	20 mg	tab	\$ 782.44	\$ 1,068.36	\$ 285.92	36.5%
metoprolol tartrate	50 mg	cap	\$ 7.20	\$ 12.00	\$ 4.80	66.7%
Nexium	40 mg	tab	\$ 848.45	\$ 850.44	\$ 1.99	0.2%
Norvasc	5 mg	tab	\$ 315.84	\$ 463.20	\$ 147.36	46.7%
Norvasc	10 mg	tab	\$ 490.44	\$ 636.60	\$ 146.16	29.8%
Plavix	75 mg	tab	\$ 989.36	\$ 1,283.76	\$ 294.40	29.8%
Prevacid	30 mg	tab	\$ 657.48	\$ 862.20	\$ 204.72	31.1%
Protonix	40 mg	tab	\$ 214.45	\$ 1,110.96	\$ 896.51	418.0%
Toprol XL	50 mg	tab	\$ 162.65	\$ 224.52	\$ 61.87	38.0%
Toprol XL	100 mg	tab	\$ 250.06	\$ 336.00	\$ 85.94	34.4%
Xalatan	0.005 %	sol	\$ 279.84	\$ 555.96	\$ 276.12	98.7%
Zocor	20 mg	tab	\$ 127.44	\$ 1,275.36	\$ 1,147.92	900.8%
Zocor	40 mg	tab	\$ 190.76	\$ 1,275.36	\$ 1,084.60	568.6%
Zolof	50 mg	tab	\$ 542.12	\$ 786.96	\$ 244.84	45.2%
Median Difference					\$ 257.69	45.9%

Note: Annual price is calculated based on the price posted by the Part D plans and the Department of Veterans Affairs in April 2006.

Sources: VA prices are from the VA pharmacy benefit manager (PBM) and the VA's list of national contracts. These prices were collected online through www.pbm.va.gov during the last two weeks of April 2006, as well as through conversations with VA staff. For each drug, the VA price shown is the lowest price for that drug on any one of several price schedules negotiated and maintained by the Department of Veterans Affairs (the Federal Supply Schedule, the Restricted Federal Supply Schedule, the Big4 pricing schedule, or the VA National Contracts).

Part D plan prices are from the Medicare Prescription Drug Plan Finder, located online at www.medicare.gov, accessed the week of April 17, 2006.

Prices shown are the lowest prices reported by any Part D plan in Region 5 (DC/DE/MD), where we used zip code 20906 for the Washington/Baltimore metro area, and for Region 14 (Ohio), where we used zip code 45206 for Cincinnati. The lowest price was the mail order price.

The drugs are the 20 drugs most frequently prescribed to seniors in the Pennsylvania PACE program in 2004.

- For Fosamax (70 mg), the lowest VA price for a year's treatment was \$265.32, while the lowest Part D plan price was \$727.92, a difference of \$462.60 or 174 percent.
- For Xalatan (0.005%), the lowest VA price for a year's treatment was \$279.84, while the lowest Part D plan price was \$555.96, a difference of \$276.12 or 99 percent.
- **As of April 2006, the gap between the lowest and highest prices that different Part D plans charged for the same drug was sizable (Table 4).**
 - Among the top 20 drugs prescribed to seniors, the median difference between the lowest and highest prices that Part D plans charged for the same drug was 36 percent, a difference of \$202.02 for a year's treatment. In other words, for half of the 20 drugs, the highest price charged by any Part D plan was at least 36 percent higher than the lowest price charged by a Part D plan.
 - For 18 of the drugs, the difference between the lowest and highest price charged by a Part D plan for a year's treatment was more than \$100.
 - For three of the top 20 drugs, Nexium (40 mg), Prevacid (30 mg), and Zocor (20 mg), the difference between the lowest and highest Part D plan price for a year's treatment was more than \$500.
 - For Nexium (40 mg), the difference between the lowest and highest Part D plan prices was \$801.60 for a year's treatment.
 - For Prevacid (30 mg), the difference between the lowest and highest Part D plan prices was \$787.80 for a year's treatment.
 - For Zocor (20 mg), the difference between the lowest and highest Part D plan prices was \$500.64 for a year's treatment.

Table 4

Variations in Part D Plan Prices, April 2006

Drug Name	Strength	Dose Form	Annual Cost			
			Lowest Part D Plan Price	Highest Part D Plan Price	Price Difference	Percent Difference
Actonel	35 mg	tab	\$ 703.32	\$ 902.64	\$ 199.32	28.3%
Aricept	10 mg	tab	\$ 1,553.40	\$ 1,795.56	\$ 242.16	15.6%
Celebrex	200 mg	tab	\$ 902.64	\$ 1,107.36	\$ 204.72	22.7%
Fosamax	70 mg	tab	\$ 727.92	\$ 902.64	\$ 174.72	24.0%
furosemide	40 mg	tab	\$ 13.44	\$ 88.92	\$ 75.48	561.6%
Lipitor	10 mg	tab	\$ 748.92	\$ 927.00	\$ 178.08	23.8%
Lipitor	20 mg	tab	\$ 1,068.36	\$ 1,301.88	\$ 233.52	21.9%
metoprolol tartrate	50 mg	cap	\$ 12.00	\$ 89.88	\$ 77.88	649.0%
Nexium	40 mg	tab	\$ 850.44	\$ 1,652.04	\$ 801.60	94.3%
Norvasc	5 mg	tab	\$ 463.20	\$ 592.56	\$ 129.36	27.9%
Norvasc	10 mg	tab	\$ 636.60	\$ 795.24	\$ 158.64	24.9%
Plavix	75 mg	tab	\$ 1,283.76	\$ 1,529.16	\$ 245.40	19.1%
Prevacid	30 mg	tab	\$ 862.20	\$ 1,650.00	\$ 787.80	91.4%
Protonix	40 mg	tab	\$ 1,110.96	\$ 1,528.68	\$ 417.72	37.6%
Toprol XL	50 mg	tab	\$ 224.52	\$ 342.60	\$ 118.08	52.6%
Toprol XL	100 mg	tab	\$ 336.00	\$ 490.56	\$ 154.56	46.0%
Xalatan	0.005 %	sol	\$ 555.96	\$ 700.56	\$ 144.60	26.0%
Zocor	20 mg	tab	\$ 1,275.36	\$ 1,776.00	\$ 500.64	39.3%
Zocor	40 mg	tab	\$ 1,275.36	\$ 1,711.08	\$ 435.72	34.2%
Zolofl	50 mg	tab	\$ 786.96	\$ 1,169.52	\$ 382.56	48.6%
Median Difference					\$ 202.02	35.9%

Source: Highest and lowest Part D plans prices were collected online through the Medicare Prescription Drug Plan Finder during the week of April 17, 2006. Only formulary drugs are included in the analysis, because those are presumably the only drugs for which the plans actively negotiate prices.

DISCUSSION

Drug price data from the private Medicare Part D plans show that these plans have failed to achieve “the best discounts on drugs,” as touted by CMS Administrator Mark McClellan. Price trends show that the Part D plans are not exerting downward price pressure on drug manufacturers. In fact, since the start of program enrollment, prices for the Part D plans have increased much more frequently than they have decreased or remained constant. What’s more, Part D plans appear to be simply passing manufacturer price increases along to Medicare consumers. In addition, Part D plan prices are significantly higher than the prices available through the VA: For each of the 20 drugs most frequently prescribed to seniors, the lowest price available through any Part D plan was higher than the lowest price negotiated by the VA. This performance hardly demonstrates the strong negotiating leverage the Administration claimed the private plans would exert.

What Difference Do Part D Plans’ Drug Prices Make?

The Medicare Modernization Act (MMA), which authorized the new Medicare drug program, forbids the federal government to negotiate directly with drug manufacturers to obtain lower drug prices for seniors and for the Medicare program. Instead, each Part D plan that participates in the program negotiates separately with drug manufacturers to obtain price concessions. The law requires that these drug plans pass along a share of their price discounts—the exact percent is not specified—to consumers in the form of lower prices for the drugs that the plan covers. The prices that plans charge for the drugs they cover are used to calculate when an individual has met the annual deductible and the initial coverage limit. They are also the prices that individuals pay after reaching their initial coverage limit—when they are in the coverage

gap or “doughnut hole.” Plans with lower drug prices can offer better value to people in Medicare. Lower prices also offer a better value to taxpayers, who are subsidizing nearly three-quarters of the cost of the drug benefit.³

How do Part D plans’ drug prices make a difference to enrollees? Consider the example illustrated in Table 5, which uses two Part D plans with the exact same benefit structure: both have a \$250 deductible; both cover 75 percent of drug costs (based on the plan’s price for the drugs) until costs reach the initial coverage limit of \$2,250; and both require enrollees to pay the full cost of drugs (based on the plan’s price) after reaching the initial coverage limit, until drug costs reach \$5,100 and catastrophic coverage begins. (See Table 5.)

Table 5

Variations in Drug Prices, an Example

Both Plans: \$250 deductible, 25% cost-sharing, \$2,250 initial coverage limit	Plan A Price	Plan B Price
Drug 1	\$100.00	\$50.00
Drug 2	\$100.00	\$50.00
Drug 3	\$50.00	\$50.00
Monthly total drug costs (used to calculate when someone meets the deductible, initial coverage limit, and catastrophic coverage)	\$250.00	\$150.00
Monthly cost-sharing by beneficiary before initial coverage limit	\$62.50	\$37.50
Total amount paid on prescription drugs (not including premiums) in 2006	\$1,500.00	\$637.50
Plan premium paid by beneficiary	\$30/month (\$360/year)	\$15/month (\$180/year)
Total cost to beneficiary enrolled in the plan	\$1,860.00	\$817.50

In our example, the enrollees take three different prescription drugs every day. People enrolled in Plan A would meet the \$250 deductible in the first month, after which they would have to pay 25 percent of the plan's price for their drugs—\$62.50 a month—and the plan would pay the remaining 75 percent, or \$187.50. At the end of nine months, Plan A enrollees' total drug costs would reach the initial coverage limit of \$2,250. Coverage would stop and, from October through December, the enrollees would pay the full price the plan charges—\$250 a month—for the three drugs. At the end of the year, the beneficiaries' total drug spending would be \$1,500.00 (that's the \$250 deductible in the first month, eight months at \$62.50 each, and three more months at \$250 each).

People enrolled in Plan B would meet their deductible later—not until the second month. Once the deductible is met and coverage begins, they would pay less for their prescription drugs each month because Plan B offers lower drug prices. Their 25 percent copayment would amount to

only \$37.50 a month, rather than the \$62.50 they would have to pay in Plan A. Also, because the plan's drug prices are lower, their total drug costs would never reach \$2,250. As a result, they would never hit the initial coverage limit and would have help with drug costs throughout the year. They would pay only \$637.50 on prescription drugs during the year.

Prices matter for taxpayers as well. That's because the government pays for approximately three-quarters of the cost of the drug benefit: Each beneficiary who enrolls in the program pays 25.5 percent of the premium, and Medicare pays the remaining 74.5 percent.⁴ Future increases in drug prices will translate into premium increases, raising the total cost of the program over time.

As we've shown, the prices offered by drug plans matter to everyone who is paying for prescription drugs through Medicare—both the seniors enrolled in the plans and the taxpayers who are bearing a share of the costs.

How Beneficiaries Would Do Better with Lower Drug Prices

The Part D plan prices discussed in the Key Findings represent a best-case scenario: These were the *lowest prices available* for each of the 20 drugs we studied. Using only the lowest prices available paints a much more favorable picture of the Part D plans, because no single drug plan offered the lowest price on all 20 drugs. In practice, a Medicare beneficiary who enrolls in a drug plan might very well be unable to obtain the lowest price on all the drugs he or she takes.

To see what these price differences mean, consider a hypothetical beneficiary taking the five drugs most frequently used by seniors—Plavix (75 mg), Lipitor (10 mg), Fosamax (70 mg), Norvasc (5 mg), and Protonix (40 mg). Would a senior taking these prescription drugs fare any better if Medicare obtained prices comparable to VA prices? The answer is a clear “yes.”

In April 2006, Families USA queried Medicare’s Prescription Drug Plan Finder to determine the least expensive Part D plan for a patient using these five drugs. Using the same benefit plan structure, we then substituted the lowest VA price for the plan’s base price for all five drugs to see how much someone using those drugs might save if private plans could get prices comparable to VA prices (Table 6).

Looking at the lowest-priced plan that Medicare listed—Humana PDP Standard—we found that an enrollee would realize significant savings if he or she could get prices comparable to the lowest VA prices. For that plan, a patient taking the five most frequently prescribed drugs would save \$2,134.78 in annual out-of-pocket costs if the plan negotiated prices as effectively as the VA. If we look at the cost for each drug (purchased by mail order) while the beneficiary is in the coverage gap or “doughnut hole,” we find that, per month, the beneficiary would save \$27.82 for Plavix (75 mg), \$22.08 for Lipitor (10 mg), \$38.55 for Fosamax (70 mg), \$14.22 on Norvasc (5 mg), and \$74.71 for Protonix (40 mg). Overall, the total monthly cost to the beneficiary while in the coverage gap would be reduced from \$369.50 to \$192.12, a difference of \$177.38.

Table 6

Comparing Beneficiary Costs for a Part D Plan and the Department of Veterans Affairs (VA), April 2006

How much difference would it make to a senior if Part D plan prices were equal to the lowest VA prices? This example looks at the least expensive Part D plan (according to the Medicare Prescription Drug Plan Finder) for someone taking the five drugs most frequently prescribed to seniors. Using the same plan benefit structure, VA prices were substituted for the plan's reported base price for each drug. We then calculated when an enrollee would meet the deductible and reach the coverage limit using both the plan's prices and VA prices.

Humana PDP Standard*

	Humana PDP Standard	Same Benefits, VA Lowest Prices	Annual Savings with VA Prices
Total Annual Costs	\$ 3,013.00	\$ 878.22	\$ 2,134.78
Annual Premiums	\$ 77.28	\$ 77.28	
Deductible	\$ 250.00	\$ 250.00	

Monthly drug costs after meeting the deductible but before total drug costs reach \$2,250

(What the patient pays per month after meeting the deductible but before falling into the coverage gap or "doughnut hole")

	Humana PDP Standard**	Same Benefits, VA Lowest Prices	Monthly Savings with VA Prices
Plavix (75 mg)	\$ 27.57	\$ 20.61	\$ 6.96
Lipitor (10 mg)	\$ 16.36	\$ 10.84	\$ 5.52
Fosamax (70 mg)	\$ 15.17	\$ 5.53	\$ 9.64
Norvasc (5 mg)	\$ 10.14	\$ 6.58	\$ 3.56
Protonix (40 mg)	\$ 23.15	\$ 4.47	\$ 18.68
Total Monthly Costs (Mail Order)	\$ 92.38	\$ 48.03	\$ 44.35

Monthly drug costs after total drug costs reach \$2,250 but before total out-of-pocket expenses reach \$3,600

(What the patient pays per month while in the coverage gap or "doughnut hole")

	Humana PDP Standard**	Same Benefits, VA Lowest Prices	Monthly Savings with VA Prices
Plavix (75 mg)	\$ 110.27	\$ 82.45	\$ 27.82
Lipitor (10 mg)	\$ 65.45	\$ 43.37	\$ 22.08
Fosamax (70 mg)	\$ 60.66	\$ 22.11	\$ 38.55
Norvasc (5 mg)	\$ 40.54	\$ 26.32	\$ 14.22
Protonix (40 mg)	\$ 92.58	\$ 17.87	\$ 74.71
Total Monthly Costs (Mail Order)	\$ 369.50	\$ 192.12	\$ 177.38

* In April 2006, the Medicare Prescription Drug Plan Finder recommended Humana PDP Complete as the least costly plan. However, that plan offers complete coverage through the coverage gap, which means that no plan prices are reported. Therefore, the second least costly plan, Humana PDP Standard, was substituted for the purposes of this analysis.

Humana PDP Standard's monthly costs are based on 90-day mail order prices. The benefit for Humana PDP Standard includes a \$250 deductible and 25 percent cost-sharing (based on the plan's price for the drugs) up to \$2,250 in drug costs. After that, there is no coverage until an individual spends \$3,600 on prescription drugs during the year.

** Because monthly costs are based on a percentage of the prices charged by Humana PDP Standard, the numbers for monthly costs may not add due to rounding.

How Plan Price Changes Hurt Beneficiaries

The example shown above illustrates how people in Medicare could save money if the Part D plans negotiated as effectively as the VA. But it isn't just the price differences between Part D plans and the VA that hurt seniors. Part D plan price changes throughout the year can hurt as well. Individual Part D plans can raise the price they charge for a medication at any time during the year without providing any notice to plan enrollees. Yet people in Medicare are not allowed to change plans during the year to respond to such price changes.⁵ Thus, these price changes create financial uncertainty for seniors—as a plan's prices change, someone enrolled in that plan might find that he or she falls into the doughnut hole much sooner than expected, or that the cost per prescription has gone up. In addition, a senior who picked a plan believing it to be a low-cost selection may later find that plan price increases make it a less desirable selection, but the senior cannot change drug plans until the next year.

Some argue that allowing plans to change their prices at any time during the year gives seniors the opportunity to benefit when plans lower their prices in response to competition. However, the fact is that plans are raising their prices far more frequently than they are decreasing prices—of the 2,202 Part D plan prices we studied, more than 88 percent went up from November to April. Only 7.6 percent of prices went down during that period. Seniors who want to take their chances that a plan will lower a drug's price are betting against very heavy odds.

Does the VA Keep Prices Down Only by Restricting Access?

Defenders of the current structure of the Medicare drug program contend that the reason the VA obtains such low prices is that the VA formulary—its list of covered drugs—includes fewer drugs than the formularies of most of the Part D plans. While that statement is true, it is also misleading, and it is misleading on two counts:

- The VA negotiates low prices for both formulary and non-formulary drugs. Even for drugs not on the VA formulary, VA prices were still lower than the prices charged by Part D plans. The median price difference for drugs *on* the VA National Formulary was 46.7 percent. For drugs *not on* the VA National Formulary, the difference was 42.8 percent, still quite substantial (Table 7).
- The VA formulary and Part D plan formularies operate differently, and in some ways, the VA system gives broader access to prescription drugs than the Part D plans.

The VA has a National Formulary that, in May 2006, listed 13 of the 20 drugs studied in this report. For nearly all of these drugs, there were no restrictions limiting use.⁶ Those receiving care in the VA system who need drugs not on the VA formulary *do* have access to those drugs through a prior-authorization process.

The Part D plans also have formularies. On average, those plans listed 18 of the 20 drugs we studied. However, for a large number of those drugs, most plans place some type of restriction on use. On average, Part D plans covered only 11 of the 20 drugs without any restrictions. What's more, Part D plans frequently require prior-authorization for formulary drugs. Those needing a drug not on their Part D plan's formulary can go through an exceptions and appeals process, but generally, those drugs are not available through the plan. The only option for patients in this situation is to purchase these drugs at whatever retail prices their pharmacy charges.

Looking at prices negotiated for non-formulary drugs, and comparing the mechanics of formulary access for the VA system and for Part D plans, it seems clear that it isn't the VA formulary alone that results in such low prices. The VA also obtains large discounts simply by using the government's negotiating power.

If the government were able to use the leverage of negotiating on behalf of 43 million Medicare beneficiaries, it would likely be able to obtain prices that are much more in line with those it negotiates for the millions of Americans covered through the VA system.

Table 7

Price Differences between Part D Plans and the Department of Veterans Affairs (VA) Based on Placement on the VA National Formulary

Drugs on the VA National Formulary					
Drug Name	Strength	Dose Form	Lowest Part D Price Per Year	Lowest VA Price Per Year	Percent Difference
Actonel	35 mg	tab	\$ 703.32	\$ 372.24	88.9%
Aricept	10 mg	tab	\$ 1,553.40	\$ 1,058.69	46.7%
Fosamax	70 mg	tab	\$ 727.92	\$ 265.32	174.4%
furosemide	40 mg	tab	\$ 13.44	\$ 8.56	57.0%
metoprolol tartrate	50 mg	cap	\$ 12.00	\$ 7.20	66.7%
Norvasc	5 mg	tab	\$ 463.20	\$ 315.84	46.7%
Norvasc	10 mg	tab	\$ 636.60	\$ 490.44	29.8%
Plavix	75 mg	tab	\$ 1,283.76	\$ 989.36	29.8%
Toprol XL	50 mg	tab	\$ 224.52	\$ 162.65	38.0%
Toprol XL	100 mg	tab	\$ 336.00	\$ 250.06	34.4%
Zocor	20 mg	tab	\$ 1,275.36	\$ 127.44	900.8%
Zocor	40 mg	tab	\$ 1,275.36	\$ 190.76	568.6%
Zolof	50 mg	tab	\$ 786.96	\$ 542.12	45.2%
Median Percent Price Difference					46.7%

Drugs Not on the VA National Formulary					
Drug Name	Strength	Dose Form	Lowest Part D Price Per Year	Lowest VA Price Per Year	Percent Difference
Celebrex	200 mg	tab	\$ 902.64	\$ 632.09	42.8%
Lipitor	10 mg	tab	\$ 748.92	\$ 520.44	43.9%
Lipitor	20 mg	tab	\$ 1,068.36	\$ 782.44	36.5%
Nexium	40 mg	tab	\$ 850.44	\$ 848.45	0.2%
Prevacid	30 mg	tab	\$ 862.20	\$ 657.48	31.1%
Protonix	40 mg	tab	\$ 1,110.96	\$ 214.45	418.1%
Xalatan	0.005 %	sol	\$ 555.96	\$ 279.84	98.7%
Median Percent Price Difference					42.8%

Sources: VA prices are from the VA pharmacy benefit manager (PBM) and the VA's list of national contracts. These prices were collected online through www.pbm.va.gov during the last two weeks of April 2006, as well as through conversations with VA staff.

For each drug, the VA price shown is the lowest price for that drug on either the National Formulary or on any one of the other price schedules negotiated and maintained by the Department of Veterans Affairs (the Federal Supply Schedule, the Restricted Federal Supply Schedule, the Big4 pricing schedule, or the VA National Contracts).

Part D plan prices are from the Medicare Prescription Drug Plan Finder, located online at www.medicare.gov, accessed the week of April 17, 2006.

Prices shown are the lowest prices reported by any Part D plan in Region 5 (DC/DE/MD), where we used zip code 20906 for the Washington/Baltimore metro area, and for Region 14 (Ohio), where we used zip code 45206 for Cincinnati. The lowest price was the mail order price.

The drugs are the 20 drugs most frequently prescribed to seniors in the Pennsylvania PACE program in 2004.

Are Part D Plans Moderating Drug Price Inflation?

Implicit in the argument that increased competition between Part D plans will lower drug prices is the concept that competition will also help contain drug price inflation. One-third of national increases in drug expenditures are attributable to increases in drug prices. The other two-thirds are, in roughly equal shares, due to increased use of drugs (more prescriptions being written) and physicians prescribing higher-cost drugs.⁷ Price trends from November 2005 through April 2006 show that not only are Part D plans not getting the best prices possible, but they are failing to curb drug price inflationary trends.

For the 20 drugs in this study, Families USA compared price increases across the Part D plans with changes in manufacturer list price—the Average Wholesale Price (AWP)—during the same time period. AWP is set by the manufacturer. It is substantially higher than what most purchasers pay, but it is a gauge of drug price inflation.

As noted in the Key Findings, for 19 of the 20 drugs, the median price change across Part D plans from November to April virtually mirrored increases in the manufacturer's AWP (Table 2). During that period, the median price increase across all Part D plans was 3.7 percent, a level consistent with drug price inflation seen in prior years, before the drug plans were supposedly using their market power to negotiate.⁸ Initial indications are that the so-called “market power” exerted by Part D plans is failing to slow the increase in drug prices. Rather, drug price increases remain at the same level, and the Part D plans simply pass along those increases along to Medicare beneficiaries.

Is This the Best That the Part D Plans Can Do?

The prices that Part D plans charge people in Medicare for prescription drugs may not be the prices they negotiate with manufacturers. Part D plans may obtain much deeper discounts—but we have no way of knowing.

Under the law that established the Medicare drug program, the government is prohibited from negotiating directly with manufacturers to get lower drug prices for Medicare beneficiaries. Instead, each of the private plans participating in the program negotiates separately with manufacturers to get discounts. The plans are required to pass some of the discounts they negotiate on to Medicare beneficiaries—but *the proportion of the discount that must be passed on is not specified*. While plans are required to report the prices they are charging Medicare enrollees for particular drugs, they are not required to report the discounts they receive for specific drugs. So, we will never know how much of these discounts lead to savings for people in Medicare and how much the plans retain themselves. What we do know is that the prices that the plans report determine how far the benefit goes for someone in Medicare, and, since the program started, prices have increased far more often than they have decreased or remained stable.

CONCLUSION

Price data from the Part D plans from November 2005 and April 2006 show that these plans are failing to deliver on the promise that competition would bring prices down. The use of “market power,” lauded by Medicare officials and the Administration, has not resulted in drug prices that are comparable to the low prices negotiated by the Department of Veterans Affairs. Not only are Part D plan prices high, but these prices are increasing far more often than they are decreasing, and the plans are not containing drug price inflation. These disturbing price trends do not bode well for either Medicare consumers or taxpayers. The “market power” of the plans has not delivered the low prices promised to Medicare consumers.

The law that established the Medicare prescription drug benefit, in prohibiting Medicare from using the negotiating clout of 43 million seniors and others in Medicare to obtain low drug prices, has given seniors and taxpayers a benefit that costs more than it should. When negotiations are divided among a multitude of plans, none seems to do as well as a single negotiator might. When it comes to reducing and containing drug prices, the Medicare drug program is an opportunity that has been badly squandered.

ENDNOTES

¹ CMS Administrator Mark McClellan, Statement before the Senate Finance Committee, Hearings on the Medicare Prescription Drug Benefit, September 14, 2004.

² Secretary of Health and Human Services (HHS) Michael Leavitt, 2006 National Policy Forum, Day 1, America's Health Insurance Plans, "The 2006 Health Care Agenda: Perspectives from the Bush Administration," Washington, DC, March 7, 2006, transcript available online at http://www.kaisernetwork.org/health_cast/uploaded_files/030706_ahip_perspectives_bush_transcript.pdf.

³ Each Medicare drug plan sets its own premium. When a Medicare beneficiary enrolls in a plan, the beneficiary pays 25.5 percent of the premium, and Medicare pays the remaining 74.5 percent. Section 1860D-13 of the Social Security Act, as added by the MMA (Pub. L. No. 108-173).

⁴ Ibid.

⁵ 42 CFR sec. 423.38(b).

⁶ The VA National Formulary is available online at <http://www.pbm.va.gov/PBM/natform.htm>. Toprol XL was the only drug that the VA National Formulary restricted to a specific diagnosis (congestive heart failure).

⁷ Steven Findlay, *Prescription Drug Expenditures in 2001* (Washington: National Institute for Health Care Management, May 2002); *Prescription Drug Trends* (Washington: The Kaiser Family Foundation, November 2005).

⁸ AARP has been tracking quarterly and annual price increases across brand-name drugs for two years. In 2005, the average prices increased in the first and fourth quarters, a time period comparable to that covered in this report. These increases were 3.3 and 1 percent, respectively. For 2005 overall, the annual price increase was 6 percent. David Gross et al, *Trends in Manufacturer Prices of Brand Name Drugs Used by Older Americans: 2005 Year-End Update* (Washington: AARP Public Policy Institute, April 2006).

⁹ *MDDB Select*, published by Medi-Span (Indianapolis, IN: Wolters Kluwer Health, Inc., April 2006).

APPENDIX: METHODOLOGY

Drug Price Comparisons

Selection of the Drugs Used in the Analysis

The drugs analyzed for this report were the most frequently prescribed drugs in the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program in fiscal year 2004. PACE is the largest and oldest outpatient prescription drug program for older Americans in the United States. In January 2004, there were 190,071 people enrolled in PACE, and PACE filled more than 9.4 million prescriptions during 2004. Because of the program's size and the abundance of claims data, it is commonly used to estimate prescription drug use among older Americans.

Using PACE claims data for 2004, Families USA identified the 20 drugs most frequently prescribed to seniors based on PACE claims volume. Vioxx, which was among the 20 most frequently prescribed drugs in 2004, was excluded from the list because the product was withdrawn from the market.

In December 2005, Families USA used this list of drugs to evaluate Part D plan prices for its report *Falling Short: Medicare Prescription Drug Plans Offer Meager Savings*. Families USA used the same list of drugs for this report in order to track Part D plan price trends over time.

About VA Prices

The Department of Veterans Affairs (VA) administers multiple drug pricing schedules on behalf of the federal government. The price schedules administered by the VA are the best representation of U.S. pharmaceutical prices achievable through government negotiations. For each pricing schedule, the negotiated prices are the prices at which a drug is available to any entity that is eligible to purchase from that schedule.

For the comparisons in this report, we examined the lowest publicly available price negotiated by the VA through several of these pricing schedules as examples of the types of drug prices that can be obtained when the government uses its purchasing clout in negotiations with manufacturers. Some drugs were listed on multiple schedules at different prices. Prices were for 90-day supplies or, if 90-day supplies were not priced, for the listed quantity closest to 90 days. Price data for November 2005 were obtained the week of November 28, 2005. April price data were obtained the week of April 24, 2006. Following is a brief description of each of the pricing schedules used in this report.

- **The Federal Supply Schedule:** The Federal Supply Schedule (FSS) was established in 1949 to facilitate government supply purchases through pricing contracts. The VA is responsible for managing and awarding FSS contracts related to medical products and services, including prescription drugs. FSS prices are based on pricing data that manufacturers submit to the VA. The VA negotiates prices with the goal of obtaining prices that are equal to or better than Most Favored Commercial Customer (MFC) prices. However, on occasion, the Federal Supply Schedule price may be higher than the MFC price. FSS prices are available to all government agencies, including the VA, the Department of Defense, the Bureau of Prisons, the Indian Health Service, the Public Health Service, and some state veterans' homes. Virtually all prescription drug manufacturers participate in the Federal Supply Schedule for all of their products.
- **Big4 Prices:** The VA also administers the Big4 pricing program. This is a discount program that Congress established for the VA, the Department of Defense, the Coast Guard, and the Public Health Service. Under the Big4 program, a price cap is set on what manufacturers can charge purchasers—the price of a drug covered under the Big4 program cannot be more than 76 percent of the Non-Federal Average Manufacturer Price. In some instances, the VA obtains prices that are lower than required. Only brand-name drugs are covered under the Big4 pricing schedule. Sometimes, manufacturers, not wanting to negotiate and administer separate pricing contracts, offer the same pricing to the Big4 and the FSS. The groups that can access Big4 pricing schedules can purchase from either the Federal Supply Schedule or the Big4 pricing schedule, choosing whichever one has the lowest price.
- **Restricted Federal Supply Schedule:** The Restricted Federal Supply Schedule (RFSS) is available to the VA and reflects additional price discounts that the VA has been able to obtain.
- **National Contract Prices:** The VA further negotiates prices with manufacturers for the Veterans Health Administration and the 5 million or so veterans and dependents the program serves annually. National contracts are negotiated through competitive bidding. Low prices are generally obtained in exchange for inclusion on the VA formulary, the list of preferred drugs used by VA providers. National contract prices are generally lower than other pricing schedules, and only VA providers can purchase drugs from this price schedule. VA facilities and providers can purchase from any of these VA price lists, including purchasing non-formulary drugs when necessary.

About Part D Plan Prices

All drug price data for the Part D plans are from the Medicare Prescription Drug Plan Finder located online at www.medicare.gov. All price data for November were obtained the week of November 15, 2005—the first week individuals were able to enroll in a Part D plan. All April price data are from the same source and were obtained the week of April 17, 2006.

■ Determining the Lowest Prices for November and April

We looked at a total of 90 Part D plans comprising all of the plans offered in two regions: Region 5, which covers Washington, DC, Maryland, and Delaware; and Region 14, which covers Ohio. The Prescription Drug Plan Finder requires that all queries be based on a specific zip code. For Region 5, Families USA used zip code 20904, a zip code for the Baltimore/Washington metropolitan area. For Region 14, Families USA used zip code 45206, a zip code for the Cincinnati area. For every plan offered in each of those regions, Families USA recorded all prices—both mail order and retail—for each of the top 20 drugs. The 90 plans included several duplicates—plans that operated in both regions. For those plans, we recorded the mail order and retail prices reported for each region. We included in our analysis only drugs listed on a plan’s formulary, based on the assumption that those are the drugs for which plans actively bargain for lower prices.

The prices we used are the prices posted by each plan for what drugs cost during the plan’s coverage gap (“doughnut hole”), when individuals must pay 100 percent of plan charges. These are the base prices that plans use to calculate when an individual meets the annual deductible and the initial coverage limit (the point at which the gap in coverage begins) and when the individual is eligible for catastrophic coverage. These prices *should* reflect the discounts that plans have been able to negotiate with drug manufacturers. These prices *do* reflect what most in Medicare and taxpayers—who are subsidizing 74.5 percent of program costs—are paying for the drugs these private plans provide.

One plan, Humana PDP Complete, offers coverage through the coverage gap—the only cost to patients is a copayment. Because that plan therefore does not post base prices, we excluded it from the analysis.

■ April and November Prices Compared

To review plan price changes from November 2005 to April 2006, Families USA looked only at plans that appeared on the Medicare Web site during the weeks of November 15, 2005 and April 17, 2006. (A few plans that were listed in April 2006

were not listed in November 2005.) For these plans, we compared prices recorded in April with each plan's prices recorded in November. Price trends were tracked for drugs listed as covered by a plan in both November and April. For two plans, in November, only retail prices were listed, but both retail and mail order prices were listed in April. For those plans only, price trends were tracked using retail prices.

Changes in Manufacturer Prices

To track trends in industry drug prices, Families USA used manufacturer changes for each drug's Average Wholesale Price (AWP) from November 2005 to April 2006. AWP is a retail price set by the manufacturer. Very few payers actually pay AWP. However, AWP trends are a good indicator of price inflation. AWP was obtained from data in Medi-Span's *MDDB Select*.⁹ For the 18 brand-name drugs, Families USA used the AWP listed by the manufacturer. For the two generic drugs, Families USA used an average of multiple manufacturers listed in the database.

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