

PRESCRIPTION DRUG IMPORTATION BEYOND CANADA

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ABSTRACT

Obtaining access to safe and affordable medicines is a critical goal. AARP has long favored a system of prescription drug coverage for the vulnerable. However, until recently, there was no public coverage for medicines. With Medicare Part D, the issue becomes even more important. Although not perfect, Medicare Part D provides us with a start to addressing the problem of safe and affordable medicines in the United States. Part of the discussion in improving Medicare Part D includes allowing cheaper drugs from other countries, such as Canada, which has a strict regulatory structure. On the basis of AARP trips and assessments, Canada is a good choice. Because of its regulatory structure and the good experiences of patients who buy their medications there, it is an available alternative for getting cheaper drugs. The Dorgan-Snowe Bill, which would allow importation, is supported by AARP, because it allows importation from Canada with safeguards to ensure legitimate drugs are being sold. However, overall, we need to improve the policy available for access to prescription drugs, because of the increasing need for prescription drugs as additional people face the high costs of health care.

INTRODUCTION

Good morning, and first of all, I want to thank you for the kind invitation to speak on importation of medicines, and particularly, on importation from beyond Canada.

Importation discussions are not new at AARP. When you look back to 1966, our founder, Ethel Andres, went before Congress and demanded some kind of a prescription drug benefit coverage for seniors in this country. So, beginning forty-one years ago, we have had

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both Republican and Democratic administrations, with nothing being done on this topic until last year.

THE MEDICARE PRESCRIPTION DRUG BENEFIT AND AARP

We at AARP were the 800-pound gorilla at the table for the Medicare Part D prescription drug benefit. But believe me, we were only at the table. In fact, it would have been better if we sat outside because we had no say in the details of the prescription drug benefit. Hence, we had to compromise and accept the package given, because we needed to have something. I will get into that later, but we felt that it was, at least, a start. There were other details that made it difficult, such as the initial \$400 billion available for this benefit, and now we know the true cost is somewhere around \$800 billion. There will be some discussion about that information later.

As I noted, we did not have much opportunity to change or to improve the current legislation that was signed into law. We at AARP noted that it was a good beginning, and we are now working with the prescription drug Medicare Part D rollout. But we know, and you know, there are problems. For example, Medicare beneficiary prescription drug costs will not be covered between roughly \$2500 and \$5000 annually. In addition, there are many people in the middle class who will suffer the brunt of the costs associated with Part D in terms of premiums, co-pays, and providers. The Centers for Medicare and Medicaid Services have not contemplated the regulations for the final rollout. In fact, these regulations probably will not be completed until after the law goes into effect in January 2006. So, there is a lot of work to be done.

CANADIAN IMPORTATION

Prescription drug coverage is a huge issue at AARP. Our members tell us their most pressing health care concern is the price of their prescription drugs. They want affordable, meaningful, and safe prescription drugs.

As you heard yesterday and today, we have gone to Canada. We, with California Senator Debra Ortiz, took a delegation to Canada, because of many of the assertions you have made here today and yesterday with respect to the safety of importation. I am pleased this conference got it right in terms of importation, because forever some have been saying "reimportation," implying these drugs are made here in this country.

In fact, the bulk of the drugs we receive in this country are not made in this country. And soon, most will be packaged outside of the country and sent back to the United States. Therefore, it is not “reimportation;” it is “importation.”

COSTS AND IMPORTATION

We are talking about importation because we are concerned about costs. A survey we conducted revealed that, on average, prices for 195 brand name drugs most widely used by older Americans increased at more than double the rate of general inflation from 2000 to 2004. But the average annual increase in manufacturer’s prices charged to wholesalers and other direct purchasers increased from 4.1% in 2000 to 7.1% in 2004. For 153 brand name drugs on the market for the entire five-year period, this translated into a cumulative average price increase of over 35%, compared with the general inflation rate of 13.5% over the same period.

We know profits have gone up. To get a better handle on what should be charged, we need to know how much it costs drug manufacturers to make these drugs. We do not know that answer. The reason we do not know the actual costs is due to secret agreements. There are agreements made with HMOs. There are agreements made with the government. But we, as the general public, have never been able to find out the true costs of these medications. This situation is something we have been fighting for years, because when you know what the true cost is, then you have a point to start negotiating.

PERSONAL IMPORTATION

Another issue in regulation relates to the FDA. It is illegal to import prescription medications from Canada and Mexico. But when you look at the reality—that hundreds of thousands of people go to Arizona and California to escape the snow—their number one priority is to walk across the border to Mexico and get a ninety-day supply of medicines.

That is what the people want. For example, my brother-in-law is a chief border patrol inspector for the Yuma sector. With respect to personal importation, the border patrol turn their backs on this issue, because they know if they try to stop individuals from purchasing medications over the border, they will have a revolution on their hands. The FDA also has not aggressively pursued these individuals,

nor stopped these individuals from coming across the border from Mexico with medicines.

COUNTERFEIT DRUGS

We talk about phony drugs. We talk about fraud. But when you look at the number of reports of people actually dying from medications they purchased from Mexico or Canada because they are not the right dosage, the medications are fraudulent, or they are not the medications they should be, where is the fire in the theater? There has been no testimony about this before any Congressional committees. There have been no such reports and no evidence presented. We do need to regulate. We at AARP do not support the importation from Mexico because they do not have a regulatory system similar to Canada's.

CANADA

As I mentioned previously, we traveled to Canada with Senator Ortiz. We went to Winnipeg and Vancouver, and we saw the process. We took a state pharmacist with us and individuals who directly looked at the process in their health departments and county health departments. We went to Canada, and we saw that process. We saw that they do receive faxed prescriptions from the United States. Canada has a large organization called CIPA: Canadian International Pharmacy Association. And, as its guest, we visited mail order pharmacy sites, looked at them, and saw how they processed orders and medicines.

When they receive a prescription by fax, they contact the doctor in the United States. They verify all of the information on the prescription and verify that it is the right individual who is getting the medication. They have the information translated into English, or in some cases Spanish; and, on the 800-number that you call to order, if you do not speak English, they have people who speak many languages, including Chinese, Japanese, Spanish, and English. When we looked at their system and their process, we saw that if you do it right, if you have regulations in place, if the packaging information is there, including the DIN number, you can process prescription medications in Canada and in this country with that same DIN number.

VULNERABLE PATIENTS

People who invested in 401(k)s and many companies that crashed financially in 1999 are now living on fixed incomes. People who previously used their social security checks for golfing fees now use them to help them maintain a standard of living above the poverty level. In combination with state legislation, such as Medi-Cal (which is an insured, subsidized health program for the disabled and elderly who live on fixed incomes and who meet the poverty level guidelines to receive totally subsidized healthcare), federal budget cuts, and the California budget deficit, these people are going to have to start paying premiums, paying co-pays, and sharing the cost of their care. If they cannot pay for their medical care, providers are going to refuse or deny them care. Now there are some legal problems with some of these cuts. For example, federal law says that the elderly and disabled are guaranteed subsidized healthcare; therefore, there may be many lawsuits if the state proposal passes in this state. While there are people who abuse the Medicare or Medi-Cal services, there are far more people who do not abuse the system. We owe them an obligation.

What is our obligation? We have an obligation to a person who is thirty-five years old, working hard, who gets injured on the job and has no medical benefits. If the employer has dropped or reduced the benefit or capped the expenditures for care, who is going to pay for that care? It is not limited to one kind of employer. Even when I was with the United Farm Workers, our own health insurance was underinsured; I was underinsured. For example, I had to have an MRI. They paid \$35 and I had to pay \$4600. We had women with children who were still paying for childbirth fees three years after they had their babies. There are farm workers who, through no fault of their own, came in contact with pesticides. Farm workers generally do not have medical insurance, are paid minimum wage, and, in some cases, are paid less than minimum wage. They pay into the social security system, but they receive no benefit, because most of them are illegal. Thus, they have little ability to pay for their health care costs.

We had legislation in California that was signed and passed, SB2, which would require employers with over 100 employees to provide some form of health care for their workers. The state would work with them, partner with them, and help pay for some of the care. A new governor was elected in California because of a recall. He put an initiative on the ballot and SB2 was defeated, so now we do not even have that protection.

We have in-home support services that are partly subsidized by the federal government and the state of California. The state wants to cut back the collective bargaining agreements that were made for people who care for their own family members, who give up careers, and who give up their jobs. These collective bargaining agreements provide some form of health care. The agreements were repealed, and their health care was taken away. What is the result? They gave up their careers and are caring for loved ones.

The stories go on and on. We at AARP put a face on this, because those are the people we represent: the frail, the disabled, the vulnerable. We represent them in every aspect, whether it is health care or consumer representation. There are always predators out there, just like there are predators in the prescription drug business.

IMPORTATION FOR SAFE AND AFFORDABLE MEDICINE

We are looking for the most safe and effective way of getting two things: (1) safe medicines and (2) less costly medicines. Those are the two things our members are concerned about, more than anything else we do for them.

We support the Dorgan-Snowe Bill, because it goes beyond Canada and provides some safeguards. The legislation will at least start the process for us to negotiate prescription drug medication costs. The problem for us is that we cannot get that bill to a floor vote because the leadership will not allow that to happen. We have got to work together.

We are open to dialogue. There is the phone number for our federal affairs department. It is important that if you agree or disagree with our position, that you let us know what you think and feel. This is all part of the bigger picture. If there is real abuse and fraud out there—and we talked about Canada and India and other countries—we want to know. And yes, we know that Canada cannot begin to meet the medication demand of California. That is why Canada cannot be the sole source of prescription drugs. We have chosen Canada because it is close, and we know Canadians get up to 70% discount compared to what we pay domestically. But there are other countries where these drugs are manufactured, and there is a process in the Dorgan-Snowe Bill that will allow us to feel better about bringing these medications into the United States.

CONCLUSION

So, in conclusion, we can attack the fraud in medicine sales and we can attack the abuse. But as Dr. Rene Rodriguez said, we have got to do something. We have got to start, just like we started on the Medicare bill, to include medications. We are trying to improve the access to prescription drugs and to address the higher cost of prescriptions.

In conclusion, we ask for your help as people who are a brain trust, who are creative, and who are very intelligent in terms of the pros and cons of the importation issue. We need that dialogue; we need that discussion and invite it. Thank you.

