

**Testimony of William Vaughan
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Consumers Union
before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
June 24, 2009**

on

The Tri-Committee Draft Proposal for Health Care Reform: Pharmaceutical Provisions

Mr. Chairman, Members of the Committee:

Thank you for inviting Consumers Union to testify on the pharmaceutical aspects of the Tri-Committee Draft health care reform proposal.

Consumers Union is the independent, non-profit publisher of *Consumer Reports*.¹ We not only test consumer products like cars and toasters, we evaluate various health products, and we apply comparative effectiveness research that can save consumers hundreds and even thousands of dollars in purchasing the safest, most effective brand and generic drugs.²

--Since 1939 we have been advocating for an affordable, secure, quality health insurance system for everyone. That year, Congressman Dingell, we endorsed your father's bill, the Wagner-Dingell Act.

--Our May 2009 issue features an article on "hazardous health plans," and points out that many policies are "junk insurance" with coverage gaps that leave you with a financial disaster. One of the most prevalent stories we have heard from our readers is that they thought they had good insurance—until they had a major health problem, and then it was too late.

--Our about-to-be-released August issue includes a 10-page special editorial feature, using examples of families across the country, on why American

¹ Consumers Union, the nonprofit publisher of *Consumer Reports*, is an expert, independent organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. To achieve this mission, we test, inform, and protect. To maintain our independence and impartiality, Consumers Union accepts no outside advertising, no free test samples, and has no agenda other than the interests of consumers. Consumers Union supports itself through the sale of our information products and services, individual contributions, and a few noncommercial grants.

² See www.ConsumerReportsHealth.org/BBD

consumers so desperately need comprehensive reform. We've attached a copy of this special issue.

Tri-Committee Draft

Therefore, we strongly endorse the approach taken in the Tri-Committee draft, assuming that additional cost containment or progressive financing will be added to ensure that it is budget neutral.

We believe the Draft is a plan that would at long last ensure access to affordable, quality, "peace of mind" health insurance for every American.

The Draft has too many major improvements to list separately. In Attachment I, we provide a table that lays out our health reform principles from our August magazine issue, and how the Draft would dramatically advance these key consumer issues. Attachment II includes a few suggestions to make the Draft even better, but these are minor suggestions compared to the important reforms proposed in the bill.

The Need for More Savings

The American people are desperately worried about the high—and rapidly inflating—cost of health care. Our national polls have frequently shown that the high cost of health care is one of the greatest concerns for consumers, and many fear they would be bankrupted if a major medical problem hit their family. Climbing health costs threaten our national future. Last week The Economist (June 13-19) editorialized the issue well:

“America has the most wasteful [health] system on the planet. [America's] fiscal future would be transformed if Congress passed reforms that emphasized control of costs as much as the expansion of coverage that Barack Obama rightly wants.”

The Draft bill has done an excellent job in identifying big and small savings, but more needs to be done in this bill.

Why?

--The Draft includes the vital reform of requiring private insurance to be guaranteed issue with no pre-existing conditions;

--These needed reforms will only work for private insurers if everyone has to buy health insurance (and can't just wait till they are sick, and then buy it);

--We can't mandate that people buy insurance unless it is a good product and is affordable;

--Many unemployed, lower-income, and working Americans will need subsidies at least to the 400% level for the mandated insurance to be affordable;

--The subsidies cost money, and in a budget neutral bill, that means finding savings or finding taxes.

--The documentation is overwhelming that our health care 'system' is very inefficient and that enormous savings are possible. Thus we hope you will make savings a priority.

Pharmaceuticals in the Draft

We endorse the pharmaceutical changes you have proposed, but many additional savings have been left on the table and should be re-considered. We especially urge you to consider reforms that will answer the industry's favorite lobbying technique—that if you question our profits, we won't do any more research. The fact is that the drug industry is not doing enough efficient, effective research on breakthrough life-saving medicines.³ Congress can achieve savings that also focus more resources on important breakthroughs.

PhRMA's Pledge

We note the recent reports that PhRMA has agreed to find \$80 billion in savings over the next decade in drug discounts, largely to fill in the Medicare Part D donut hole. If true, that is good news. It is a major step forward and we congratulate PhRMA.

But as Ronald Reagan said so often, 'trust but verify.'

Some of the Members were here for the Carter-era fights over hospital cost containment. The hospitals defeated containment legislation by pledging to hold costs down. Congress trusted them. The public was betrayed.⁴ The thought of trusting a savings pledge from a for-profit trade association (assuming that PhRMA can get past the anti-trust issues) is like watching Lucy holding the football--you know what's going to happen.

Therefore we hope you will legislate the policies on which the pledge is based in a CBO-score-able way. If the savings off baseline are not achieved, company-specific rebates to Medicare, Medicaid, and the Health Insurance Exchange could be legislated. For companies that fail to meet the savings for ERISA/private sector plans, various tax breaks could be reduced (and the savings placed in a compensation fund for the health plans).

³ FDA data shows that only about 15 percent of new drug approvals are for breakthrough or new molecular entities. The rest are 'me-too' type drugs that bring some competition to the marketplace, but generally little or no medical advance.

⁴ Karen Davis, Commonwealth Fund, May 26, 2009, "Bending the Health Care Cost Curve: Lessons from the Past": "The [hospital] coalition set a 1978 goal of reducing the rate of increase by 2 percentage points below the 1977 rate of increase; that goal of 13.6 percent increase in 1978 was met. All subsequent goals, as well as goals related to holding down increases in the number of beds and employees, as well as increases in capital investment were substantially exceeded...."

Pharmaceutical Provisions in the Draft

Comparative Effectiveness Research (CER)(page 423ff):

We strongly endorse the AHRQ-based CER Trust Fund that, when fully operational, will provide \$375 million a year for this key safety and efficiency research.

Attachment III is a sample of our Best Buy Drug work on proton pump inhibitors (anti-heartburn medicines). The CER data is from the Oregon Health and Science University. As you can see, several of the medicines are very similar. But one is 1/10 the cost of the heavily advertised brand drug. As a consumer, why not prefer the \$20 a month drug rather than the \$200 a month product? If it doesn't work, after talking to your doctor, try one of the others. This is what CER can do to help hold down costs. Clearly, in this example, most of us could save \$180 a month.

Many are worrying that comparative effectiveness research (CER) may lead to limits of what is covered. We believe CER will help us all get the best and safest care. It makes sense to give preference to those items which objective, hard science says are the best, especially if the research takes into consideration relevant differences such as gender, ethnicity, or age. But if a drug, device, or service does not work for an individual, then that individual must be able to try another drug, device, or service without hassle or delay. The key to this is ensuring that the nation's insurers have honest, usable exceptions processes in place. A "model exceptions and appeals"-type legislative effort is where we should be putting our energy to address the otherwise legitimate concern of many people about CER.

Physicians Payments Sunshine Provisions (page 560ff)

Including this anti-fraud type provision in the bill should score for savings and reduce the level of unsavory 'gifting' that is flooding the medical world. In recent years, there has been phenomenal growth in various forms of financial transfers to those doctors and hospitals who are responsible for ordering drugs, devices, and supplies. These financial incentives are given many names and justified in many ways, but we all know 'there is no such thing as a free lunch.' These financial 'gifts' are designed to encourage, subtly and not so subtly, the increased use of the givers' products.

When disc jockeys were given gifts by record companies, it was called payola—and it was a scandal. It should be equally disturbing to patients and health policymakers to see so much money transferred to physicians and hospitals, because it can distort medical judgment and increases utilization of the most expensive products which are not necessarily the best products.

Closing the Doughnut Hole Division B, Section 1182, p. 307):

We strongly support closing the Medicare Part D donut hole. Congress took a major step by enacting a prescription drug benefit. But it can be made better. Beneficiaries in the donut hole—this year a gapping hole of over \$3400—frequently stop taking their medicines or cutback on doses. The health of some of our most vulnerable beneficiaries could be improved by closing this gap. The Draft takes about a decade to achieve this, and with additional resources (ideas described below), we hope you could end this insurance anomaly sooner.

Improving low income access to medications: Division B, Title II, Subtitle A (pages 316ff). These sections which raise asset tests and make it easier to enroll in the low-income subsidy programs will make a major difference in the ability of the most vulnerable to take advantage of the promise of Part D and actually obtain their medications.

Protecting Medicare Part D beneficiaries from mid-year formulary changes (Division B, section 1185, pages 312-313): We support this section permitting beneficiaries to switch plans if the plan makes formulary changes that impact the enrollee. In our monitoring of the program, we have found that a much more serious problem is year-long price increases in various drugs that can badly disrupt a senior's budgeting plans. These often dramatic price increases appear to be a form of bait-and-switch. We urge you to consider an amendment that if the price of a drug increases by more than X percent of the advertised price during the open enrollment period, then the beneficiary may switch plans.

Drug rebate reforms in Medicaid and Medicare (Division B, Sections 1842, 1843, and 1181; pages 708ff): These sections achieve major savings of about \$20 billion over ten years in Medicaid and in the Medicare dual eligible programs.⁵ These changes seem very appropriate, particularly closing the loophole whereby a minor change in a drug can cause it to be treated as a new formulation that is exempt from rebates owed because of excessive inflation. Rebates on Medicaid and dual eligibles in Medicare managed care plans will also correct for the fact that Medicaid plans do not seem to be obtaining the same level of savings as the Medicaid program previously obtained directly from the companies.⁶

Additional Savings to Consider

Stop Brand Company payments to Generic Companies to delay entry of generic drugs (reverse payments); Eliminate other Brand-Generic abuses such as 'authorized generics.' CBO should score Congress with billions in savings if the current Hatch-Waxman Act abuses identified by the FTC and independent researchers are stopped. HR 1706 (by Rep. Rush and 7 others on this Committee) should be included in the reform package.

⁵ CBO, Budget Options, Volume I: Health Care, pages 138-143.

⁶ Center for Health Strategies, Inc., "Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Settings," January 2003. Also, the Lewin Group, "Extending the Federal Drug Rebate Program to Medicaid MCOs: An Analysis of Impacts," May, 2003.

Create a pathway for follow-on biologics (FOBs). A way must be found to end the endless monopoly that now exists for biologics. They are an increasingly costly and inflationary part of the health care economy. We have endorsed Chairman Waxman's bill (HR 1427). CBO clearly shows that huge savings are possible in this field.

If agreement cannot be reached on the period of exclusivity, then other ways should be found to help consumers and taxpayers obtain savings. The June 2009 MedPAC report discusses the idea of reference pricing⁷ or payment for results, where a drug's payment is linked to beneficiaries' outcomes through risk-sharing agreements with manufacturers.

We note that the MedPAC report says that the EU's FDA had approved as of last June more than ten FOBs⁸. Medicare could achieve billion dollar-a-year savings if the U.S. FDA certified that these EU biologics were safe and were not causing adverse events and if their importation were permitted.

Promote research while controlling costs: Require drug rebates to Medicare for drug inflation in excess of population and CPI growth, except no rebates would be required on new breakthrough drugs (as defined in the FDA approval process), thus controlling costs while encouraging drug innovation. Under this proposal there would be a cap on growth in spending on pharmaceuticals, but it would reward companies that had the most truly innovative products.

Help consumers and advance comparative effectiveness research: Amend the FDA laws to require that new drugs be tested against the best practice in the field, not just against a placebo;

Re-importation: After ensuring safety, permit the importation of drugs (Berry, et al, HR 1298), including biosimilars;

Permit Medicare to negotiate on drug prices (Berry, et al., HR 684)⁹; special attention should be given to negotiating prices on selected biologics;

For safety and savings, enact a two or three year moratorium on the direct-to-consumer advertising of newly approved prescription drugs (proposals by DeLauro and others); require rebates for the increased high-cost drug utilization caused by such advertising.

Encourage savings for consumers and taxpayers through mail-order pharmacy use of maintenance drugs. There may be data that mail-order pharmacy is safer (fewer errors in

⁷ MedPAC, June, 2009, p. 106. "Set a drug's payment rate no higher than the cost of currently available treatments unless evidence shows that the drug improves beneficiaries' outcomes."

⁸ MedPAC, June, 2009. Page 114.

⁹ This provision receives an amazing 86 percent support in the Kaiser Family Foundation Health Tracking Poll of April, 2009.

refills) and our own data shows savings of up to several hundred dollars on a common package of five drugs through Part D plans.

Encourage generics: Require rebates from the 20 percent of Part D plans that have the lowest generic drug substitutions rates, in cases where a generic is exchangeable with a brand;

Conclusion

We thank you again for this opportunity to testify.

The American health care system must and can be fixed.

The Tri-Committee proposal will bring us to the goal of affordable, quality, dependable health care for all, and we hope you give consumers even more tools to help drive the system toward quality and cost savings. The proposals in the pharmaceutical sector make important improvements and savings. Even more savings are possible and can be directed toward spurring breakthrough research.

Appendix I

Consumer Union Goals in Health Reform	Tri-Committee Draft
<p>Ensure health access to every American: Make insurance simple by creating a national health insurance exchange where one can always go—regardless of one’s health or situation in life-- to choose a private or public plan, with sliding scale subsidies based on income to make it affordable.</p> <p>The insurance offered should be comprehensive, bringing financial security and peace of mind.</p> <p>Coverage should be especially good for preventive care.</p>	<p>The Health Insurance Exchange, with reformed private policies (guaranteed issue, no pre-existing conditions) and a public plan option, with premium and cost-sharing subsidies phasing out at 400% of poverty, achieve this goal. Those who have good plans today can keep what they have.</p> <p>The minimum standard benefit package (and at least 2 distinct, more valuable options), with no yearly or life-time limits and with out-of-pocket catastrophic protection at \$5,000 for an individual and \$10,000 for a couple, would achieve this goal. The low-income get even more protection.</p> <p>The packages all include comprehensive preventive services; Medicare is improved to make preventive care more affordable; and a new Wellness and Prevention Trust Fund would help spur community wellness.</p>
<p>Eliminating pre-existing conditions and guaranteeing issue can’t work for insurers, unless everyone has to have insurance. But we can’t force people to buy policies they can’t afford or that are inadequate, so subsidies are needed. And a public plan option working on a level playing field can use competition to minimize the need for subsidies by holding costs down and driving quality up.</p>	<p>The individual mandate to have at least the ‘Essential’ benefit plan, coupled with subsidies, and efforts to control cost, achieve this goal.</p> <p>Cost containment includes the public plan option, medical loss ratio requirements, comparative effectiveness research, form simplification, stepped up anti-fraud, stopping drug and device company ‘gifts’ to providers, new ways for doctors to deliver quality coordinated care, and implementation of MedPAC recommendations.</p> <p>Consumers Union urges even more be done to control costs.</p>

<p>Increase quality and help consumers choose quality, by making error rates public, particularly infection rates (largely preventable infections kill 100,000 Americans per year).</p> <p>Encourage care based on quality, not just quantity, and help spread the use of electronic medical records.</p> <p>Encourage more primary care doctors.</p>	<p>Division B's Section 1151 reduces payments for hospital readmissions due to poor quality and section 1441 establishes a new center to set priorities for quality improvement. State Medicaid plans are rewarded for not paying for poor care such as infections.</p> <p>We hope it is clearer that infection rates are to be public on a facility specific basis, and that more is done to report 'never events,' and require periodic quality recertification of providers, per the recommendations of the IOM.</p> <p>Efforts to develop accountable care organizations and medical homes will help ensure better care coordination. The Stimulus package HIT monies should help productivity over time and improve quality.</p> <p>The Draft's major sections on the workforce, graduate medical education, and increased payments to primary care doctors should all help.</p>
<p>Help small businessmen get affordable health insurance for themselves and their employees.</p>	<p>The Health Insurance Exchange will make policies more affordable; subsidies to small and lower wage firms will make it affordable.</p>

Attachment II

On quality

We urge that you more clearly help consumers encourage quality, by increasing the public reporting of infections and other medical errors. Consumer pressure can inspire providers to focus more on preventing infections and other errors—but first, consumers need to be informed.

Ten years ago, the Institute of Medicine issued its report, To Err is Human, noting that medical errors were killing up to 98,000 people a year and costing the health system tens of billions in unnecessary costs. The CDC now says that 100,000 are dying just from largely preventable infections, which add an extra \$35.7 to \$45 billion per year in treatment costs. No one can say whether anything has really improved over the last decade: the IOM's recommendations have been largely ignored.

We urge you, in addition to the 7 hospital re-admission conditions discussed on page 222 of the Draft, to include public reporting of healthcare-acquired infections such as MRSA and other deadly conditions. We also hope you will take another look at the IOM report, and move to require public reporting of 'never events' (like surgery on the wrong part of the body) the way Minnesota has done. It is way past time to adopt the IOM's proposals for periodic quality re-certification of providers. We retest pilots and others for competency—we should retest providers on a periodic basis. Finally, we urge you to consider some of the excellent language in the Senate HELP bill to improve our nation's failing Emergency Medical Systems.

Do More to Help the Consumer in the Health Insurance Exchange

The honest, sad truth is that most of us consumers are terrible shoppers when it comes to insurance. The proof is all around you.

--In FEHBP, hundreds of thousands of educated Federal workers spend much more than they should on plans that have no actuarial value over lower-cost plans.¹⁰

--In Medicare Part D, only 9 percent of seniors at most are making the best economic choice (based on their past use of drugs being likely to continue into a new plan year), and most are spending \$360-\$520 or more than the lowest cost plan available covering the same drugs.¹¹

--In Part C, Medicare has reported that 27% of plans have less than 10 enrollees, thus providing nothing but clutter and confusion to the shopping place.¹²

¹⁰ Washington Consumers' Checkbook Guide to Health Plans, 2008 edition, p. 5.

¹¹ Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009.

¹² SeniorJournal.com, March 29, 2009.

The Institute of Medicine reports that 30 percent of us are health illiterate. That is about 90 million people who have a terrible time understanding 6th grade or 8th grade level descriptions of health terms. Only 12 percent of us, using a table, can calculate an employee's share of health insurance costs for a year.¹³ Yet consumers are expected to understand "actuarial value," "co-insurance" versus "co-payment," etc.

If Congress wants an efficient marketplace that can help hold down costs, you need to provide more consumer tools in that marketplace. The Health Choices Administration and Insurance Ombudsman are a good start. We hope you can flesh out their powers and duties as follows:

We believe standard benefit packages (and definitions) are the key to facilitating meaningful competition. The Draft bill provides 3 broad categories of policies, and we appreciate the fact that these broad groupings will be helpful to consumers. But like Medigap policies A-L, we urge you to make the policies sold in each of these broad categories identical, so that consumers can shop on the basis of price and quality, and not on tiny, confusing differences (10 rehab visits v. a plan with 12, etc.). If someone wants to buy extra bells and whistles, they can do that outside of the exchange. To only require these broad groupings to be 'actuarially equivalent' is to invite a Tower of Babel of tiny plan differences, designed by the insurers to attract the healthy and avoid the most expensive—and with the end result of confusing the consumer.

Consumers want choice of doctor and hospital. We do not believe that they are excited by an unlimited choice of middlemen insurers.¹⁴ Fewer offerings of meaningful choices would be appreciated. There are empirical studies showing that there is such a thing as too much choice, and dozens and dozens of choices can paralyze decision-making.¹⁵ The insurance market can be so bewildering and overwhelming that people avoid it. We think that is a major reason so many people having picked a Part D plan, do not review their plan and fail to make rational, advantageous economic changes during the open enrollment period.

√ Require standardization of insurance definitions so consumers can easily compare policies on an "apples-to-apples" basis. This is key. Hospitalization should mean hospitalization. Drug coverage should mean drug coverage, etc. Attached on the last page of this testimony is an article from our May magazine which demonstrates what radically different coverage two similar sounding policies can provide. It is not clear that the

¹³ HHS Office of Disease Prevention and Health Promotion

¹⁴ "Nearly three-fourths (73 percent) of people ages 65 and older felt that the Medicare Prescription drug benefit was too complicated, along with 91 percent of pharmacists and 92 percent of doctors. When asked if they agreed with the statement: "Medicare should select a handful of plans that meet certain standards so seniors have an easier time choosing," 60 percent of seniors answered in the affirmative." Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009. Page 2.

¹⁵ Mechanic, David. Commentary, Health Affairs, "Consumer Choice Among Health Insurance Options," Health Affairs, Spring, 1989, p. 138.

“benefit standards defined” (p. 29, line 11) will guarantee comparability of terms among plans.

√ Require insurers to clearly state (in standardized formats) what’s covered and what’s not in every plan offering, and to estimate out-of-pocket costs under typical treatment scenarios. The Washington Consumers’ Checkbook’s “Guide to Health Plans for Federal Employees (FEHBP)” does a nice job showing what consumers can expect, but even in FEHB policies they find it impossible to provide clear data on all plans.¹⁶ HR 2427 by Rep. DeLauro and Rep. Courtney and 23 others is excellent language on how to design such scenarios.

√ Maintain an insurance information and complaint hotline, and compile federal and state data on insurance complaints and report this data publicly on a Web site. The States would continue to regulate and supervise insurers operating in their state, but with the continual merger and growing concentration of insurers, consumers need a simple place where complaints can be lodged and data collected, analyzed, and reported nationally concerning the quality of service offered by insurers. This type of central complaint office may have allowed quicker detection of the UnitedHealth-Ingenuis abuse of underpaying ‘out-of-network’ claims.

√ Institute and operate quality rating programs of insurance products and services. This would be similar to the Medicare Part D website, with its ‘5 star’ system.

√ Manage a greatly expanded State Health Insurance Assistance Program that would provide technical and financial support (through federal grants) to community-based non-profit organizations providing one-on-one insurance counseling to consumers. These programs need to be greatly expanded if you want the HIE connector to work. The SHIPs should be further professionalized, with increased training and testing of the quality of their responses to the public.

√ Require plans to provide year-long benefit, price, and provider network stability. In Medicare Part D, we saw plans advertise certain drug costs during the autumn open enrollment period, and then by February or March increase prices on various drugs so much that the consumer’s effort to pick the most economical plan for their drugs was totally defeated. This type of price change—where the consumer has to sign up for the year and the insurer can change prices anytime—is a type of bait and switch that should be outlawed.

√ Make consumers fully aware of their rights to register complaints about health plan service, coverage denials, balance-billing and co-pay problems, and to appeal coverage denials. We appreciate the requirement in Sec. 132 for ‘fair grievance and appeals mechanisms,’ but urge that the Commissioner, perhaps with the help of the NAIC, develop a **model** system that all participating insurers have to use.

¹⁶Op. cit., p. 68.

Attachment III—Comparative Effectiveness Research Example

Proton pump inhibitors (PPIs) are a class of drugs used to treat heartburn, gastroesophageal reflux disease (GERD), and ulcers. Heartburn and GERD are quite common. Between a quarter and a third of adults in the U.S. will have GERD at some point in their lives. There are five medicines in this class. One is available as a relatively inexpensive nonprescription drug.

To help you and your doctor choose a PPI if you need one, *Consumer Reports* has evaluated the drugs in this category based on their effectiveness, safety and cost. This two-page brief is a summary of a 14-page report you can access on the Internet at www.CRBestBuyDrugs.org. You can also learn about other drugs we've analyzed on this *free* Web site. Our independent evaluations are based on scientific reviews conducted by the Oregon Health and Science University-based Drug Effectiveness Review Project. Grants from the Engelberg Foundation and National Library of Medicine help fund *Consumer Reports Best Buy Drugs*.

DO YOU NEED A PPI?

If you have heartburn only occasionally and have not been diagnosed with GERD, you probably do *not* need a PPI. Over-the-counter antacids and generic prescription drugs will very likely provide relief. See the Our Recommendations box on this page for mention of several such medicines. If you have chronic heartburn or get diagnosed with GERD, your doctor is highly likely to prescribe a PPI.

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Not everyone with heartburn needs a PPI drug. Several of the PPIs have been widely advertised to consumers and heavily promoted to physicians, and this has led to overuse of the drugs in the treatment of “garden variety” heartburn.

If you suffer from only occasional heartburn and have not been diagnosed with GERD, nonprescription antacids such as Maalox, Mylanta, Rolaids, and Tums, or acid-reducing drugs such as cimetidine (Tagamet), famotidine (Pepcid), nizatidine (Axid), and ranitidine (Zantac) will very likely provide relief.

Talk with your doctor about the role that dietary and lifestyle changes can play in alleviating heartburn, too – such as eating smaller meals, weight loss, and avoiding alcohol.

If, however, you experience heartburn twice a week or more for weeks or months on end, have frequent regurgitation of food into your throat or mouth (with or without heartburn), or if your heartburn is not relieved by the drugs mentioned above, you may have GERD and need a PPI. GERD is a condition that makes you prone to acid reflux and can, over time, cause damage to your esophagus. The five available PPI medicines are roughly equal in effectiveness and safety, but differ in cost. One – omeprazole (Prilosec OTC) – is available as both a prescription and nonprescription generic drug.

Taking the evidence for effectiveness, safety, cost, and

other factors into account, **Prilosec OTC** is our choice as a *Consumer Reports Best Buy Drug* if you need a PPI. You could save \$100 to \$200 a month by choosing this medicine over more expensive prescription PPIs.

If you have health insurance, find out if your plan helps pay for Prilosec OTC. If not, talk to your doctor about taking the PPI with the lowest out-of-pocket cost to you.

Safety note: A few studies have linked PPIs to a higher risk of pneumonia and infection with a bacterium called *C. difficile*, and in December 2006 a study found that long-term use of PPIs may be associated with an increased risk of hip fractures. Talk with your doctor about these risks, especially if you must take a PPI over a long period of time. People aged 65 and over, and people with chronic medical conditions, who take a PPI should get vaccinated against pneumonia and get a flu shot every year.

This summary was last updated in January 2007.

Esomeprazole

20mg Nexium NA: 87%
(84%-91%) 87%

Esomeprazole

40mg Nexium 73%
(65%-82%)

90%

(88%-92%) 93%

Lansoprazole

30mg Prevacid 70%
(61%-80%)

86%
 (83%-90%) 91%
 Omeprazole
 20mg Prilosec 65%
 (54%-76%)
 85%
 (81%-88%) 86%-92%
 Pantoprazole
 20mg Protonix 77%
 (70%-84%)
 77%
 (65%-88%) 55%-86%
 Pantoprazole
 40mg Protonix 72%
 (62%-83%)
 89%
 (86% to 92%) 78%
 Rabeprazole
 20mg Aciphex 69%
 (52%-86%)
 82%
 (76%-89%) 89%

1. Effectiveness data presented for PPI dosage strengths that have been studied to date.
2. Data from individual studies. Ranges given reflect multiple studies.
3. NA= Data Not Available

PPI W2 0207

1. "Generic" indicates drug sold by generic name.
2. Monthly cost reflects nationwide retail average prices for September 2006 (except where noted), rounded to nearest dollar.

Information derived by *Consumer Reports Best Buy Drugs* from data provided by Wolters Kluwer Health, Pharmaceutical Audit Suite.

3. This is a nonprescription (over-the-counter) version of omeprazole available at any drug store. The shelf price of this medicine varies widely. It may be least expensive at large discount stores and at Internet pharmacies. The cost for a month's supply given in this table (\$19-\$26) is based on a spot check of prices at Internet online pharmacies on October 30, 2006.
4. Generic omeprazole is generally available at a lower price at large discount stores. In some cases the price may be half of that reflected in this table, which presents nationwide average prices.

UNDERSTANDING GENERICS: A generic drug is a copy of a brand drug whose patent has expired. In this table, only omeprazole is available as a generic. It is also sold under its brand name, Prilosec. A nonprescription version, Prilosec OTC, is also available. The remaining PPIs are sold only as brand name drugs.

Esomeprazole 20mg tablets Nexium No \$193
 Esomeprazole 40mg tablets Nexium No \$181
 Lansoprazole 15mg delayed-release tablets Prevacid No \$145
 Lansoprazole 30mg delayed-release tablets Prevacid No \$131
 Lansoprazole 15mg delayed-release capsules Prevacid No \$184
 Lansoprazole 30mg delayed-release capsules Prevacid No \$186
 Omeprazole 20mg_s tablets Prilosec OTC_s Yes \$19-\$26_s

Omeprazole 10mg sustained-release tablets Prilosec No \$125
Omeprazole 20mg sustained-release tablets Prilosec No \$153
Omeprazole 40mg sustained-release tablets Prilosec No \$265
Omeprazole 10mg, sustained-release tablets Generic Yes \$116.4
Omeprazole 20mg, sustained-release tablets Generic Yes \$89.4
Omeprazole/sodium bicarbonate 20mg/1100mg Zegerid No \$138
Omeprazole/sodium bicarbonate 40mg/1100mg Zegerid No \$146
Omeprazole/sodium bicarbonate 20mg/1680mg Zegerid No \$170
Omeprazole/sodium bicarbonate 40mg/1680mg Zegerid No \$176
Pantoprazole 20mg delayed-release tablets Protonix No \$159
Pantoprazole 40mg delayed-release tablets Protonix No \$146
Rabeprazole 20mg tablets Aciphex No \$189