Mr. Chairman, and members of the aging committee, thank you for inviting me here this afternoon. My name is Greg Hamilton and I am a consultant in the healthcare industry in which I have worked for over 35 years. Most of my clients are Qui Tam attorneys working with relators, the DOJ and the States to recover monies lost through fraud. I've been asked to discuss with you the affect on Seniors of the 2008 and 2009 drug price increases as described in articles by the Wall Street Journal and the New York Times.

The WSJ's article on April 15, 2009 quoted one of my former employers, Express Scripts, saying it saw prices rise more than 10-15% over the past 12 months. The NYT article in November 2009 stated that Wholesale Prices for brand name drugs rose by about 9% in the last year. They further noted that this increase was in contrast to a reduction in the Consumer Price Index which had fallen by 1.3%.

Both articles quote Catherine Arnold, a drug industry analyst at Credit Suisse, who said her study of the nations eight biggest pharmaceutical companies showed list prices rising an average of 8.7% in the 12 months ending September 30,2009.

Contributors to both articles believe these unusual increases were the result of anticipated cost containment under healthcare reform and/or a need to maintain profits as patents on many popular brand drugs are set to expire over the next few years. I suspect it is a combination of the two.

In order to see why these price increases will impact seniors (both Part D and others) we need to understand the way in which drug claims are adjudicated i.e. paid. Pharmacies are not paid by insurance companies. Almost all pharmacy claims are paid by a middleman called a Pharmacy Benefit Manager (PBM). Insurance companies, Unions, and other payors hire PBM's to maintain networks of retail pharmacies, create formularies, configure co pay tiers, collect rebates, and adjudicate claims.

PBM's begin the process by first contracting with retail pharmacies. They negotiate reimbursement rates for prescription drugs at some discount off of Average Wholesale Price (AWP). NOTE: Most Medicaid drug reimbursement is also calculated at a discount off of AWP. I'm sure many of us here are familiar with the numerous state and federal lawsuits concerning AWP, but we will have to save that issue for another day.

AWP is directly related to Wholesale Price. It is typically 20% or 25% above Wholesale Price. So when Wholesale Price increases so does the AWP, which in turn drives up the reimbursement to the pharmacy and consequently the patients' co pay.

Price increases, to both Patients and Payors, can, theoretically, be offset through rebates. PBM's combine AWP's with rebates to determine the total cost of a drug to the payor. Lower cost drugs are sometimes placed in a lower co pay category to encourage patient selection and thus reduce their cost and the cost to the payor. The NYT article cites analysts and a 2007 Congressional study as saying these rebates often accrue to the middlemen and not to consumers. My experience in the industry supports this claim.

The NYT article cites PHARMA Senior Vice President Ken Johnson as saying the pricing studies were incomplete by failing to include rebates. I believe he is implying that rebates may erase or mitigate the price increases mentioned. Such an inference is flawed in that it forgets the basic nature of rebates. These rebates are not paid out of generosity or altruism. They are negotiated based on relative prices for drugs within specified therapeutic categories. In this case the articles report that the eight largest pharmaceutical companies had comparable increases. So if all the prices went up at about the same rate there would be no rational for new or additional rebates as the relative prices would remain constant . Payors would have no leverage with which to pit one company against another in order to derive new rebates. The Payors and the patients will just have to pay more for the drugs, seniors included.

THANK YOU.