Senate Special Committee on Aging Hearing:
"A Prescription for Savings: Reducing Drug Costs to Medicare"
July 21, 2011

Options to Cut the Costs of Prescription Drugs and Save Medicare, Taxpayers, and Seniors Money

As prepared by the Majority Staff, Special Committee on Aging

The United States spends more for prescription drugs than other developed nations, and pays more for brand drugs than any other developed country.[1] According to testimony provided to the Special Committee on Aging by the Organization for Economic Cooperation and Development (OECD) in 2009, "the average price of 181 pharmaceutical drugs in the United States in 2005 was 30 percent higher than the average in other OECD countries. Other studies (e.g. McKinsey Global Institute, 2008) suggest that this is an underestimate, and the true difference in price is as much as 50 percent."[2]

The U.S. spent $307 billion on prescription drugs in 2010, according to the IMS Institute for Healthcare Informatics.[3] Cardiac drugs alone cost $29.7 billion.[4] Drug prices have risen 44 percent faster than inflation—averaging 3.6 percent per year between 2000 and 2009 as compared to 2.5 percent for general inflation.[5] Worse, it is projected that under the current policies with a rising aging population, spending on prescription drugs will nearly double in the U.S. over the next 10 years.[6]

Medicare is the largest public payer of prescription drugs, accounting for 60 percent of all the public payments. Medicare spent $61.7 billion on prescription drugs in fiscal year 2010. And, the cost of prescription drugs for the U.S. government is increasing. The Medicare Trustees estimate that Part D costs will increase by 9.7 percent in each of the next nine years.[7]

The following outlines nine options to reduce the costs of prescription drugs without impacting patients' choice or access. Each of these policies would significantly impact prescription drug costs and minimize the financial burden on taxpayers and seniors.

1. **Get generics to the market sooner by ending pay-for-delay settlements.** The bipartisan Preserve Access to Affordable Generic Drugs Act (S. 27) would limit pay-for-delay settlements used to keep lower-cost generic drugs off pharmacy shelves. Under these pay-off agreements, brand name drug companies settle patent disputes by paying generic drug manufacturers for the promise of keeping its product off the market. The Kohl-Grassley bill seeks to stop this anti-consumer practice by presuming these deals illegal and giving the FTC the authority to challenge them in court. CBO estimates that this legislation will save taxpayers $2.68 billion over 10 years. The Administration's FY2012 Budget proposal includes a provision to end pay-for-delay settlements, estimated to save $8 billion over 10

[1] Written Statement to Senate Special Committee on Aging Mark Pearson, Head, Health Division, OECD March 30, 2009. http://www.oecd.org/dataoecd/5/34/43800977.pdf
[2] Ibid.
[3] http://www.imshealth.com/deployedfiles/imshealth/Global/Content/IMS%20Institute/Static%20File/IHII_UseOfMed_report.pdf
[4] http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/drugs/2008/hctcest_totexp2008.shtml
[5] Kaiser Family Foundation: Prescription Drug Trends, May 2010. http://www.kff.org/rxdrugs/upload/3057-08.pdf
[6] Christopher J. Truffer et al., "Health Spending Projections Through 2019: The Recession's Impact Continues," Health Affairs 29, no.3 (March 2010)
[7] Medicare Trustees Report https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf

years. The bill has eight cosponsors, Senators Sherrod Brown, Collins, Durbin, Franken, Grassley, Tim Johnson, Klobuchar, and Sanders. The bill was passed out of the Judiciary committee on July 21, 2011.

2. **Allow Medicare to directly negotiate prices of prescription drugs in Part D.** The Prescription Drug Price Negotiation Act (S.44) would allow the Secretary to negotiate drug prices under Medicare Part D, the Medicare Prescription Drug Program. Senator Klobuchar introduced this legislation that would provide the Secretary of Health and Human Services with negotiation authority. The bill has eight cosponsors, Senators Begich, Blumenthal, Feinstein, Inouye, Johnson, Kohl, Sanders and Shaheen.

3. **Require prescription drug manufacturers to provide discounted medications to low-income Medicare recipients.** The Medicare Drug Savings Act (S. 1206) would increase the discounts Medicare receives on prescription drugs for low-income individuals enrolled in Medicare Part D. This would save Medicare $112 billion over the next ten years, reducing the federal deficit and strengthening Medicare. This legislation was introduced by Senator Rockefeller and Senators, Bingaman, Blumenthal, Boxer, Brown, Franken, Merkley, Stabenow, Leahy, Mikulski, Sanders, Tom Udall, and Kohl are cosponsors.

4. **Allow Medicare to negotiate drug prices in Medicare Part B when it is the majority purchaser.** Current law bars the Centers for Medicare and Medicaid Services (CMS) from negotiating the prices for physician-administered drugs within the Medicare Part B program, even when the government pays for the vast majority of a specific drug—sometimes over 90%. This policy would allow the federal government to negotiate with a pharmaceutical company when Medicare is the majority purchaser of their drug. This would prevent the federal government from being forced to accept any price set by a pharmaceutical company.

5. **Allow CMS to pay the same price for drugs that are similar.** For 15 years, Medicare used an authority called "least costly alternative" (LCA) to ensure that CMS, beneficiaries and taxpayers did not pay more for a drug when a similar, cheaper drug produced the same result. Unfortunately, a recent court case ruled that CMS did not have the authority from Congress to exercise LCA. This policy would give CMS the explicit authority to use the LCA policy for purchasing similar drugs in Medicare. A report by the HHS OIG estimated a savings of $40 million per year with the institution of an LCA for just two drugs used to treat prostate cancer -- Lupron and Zoladex. When expanded to include more drug classes, the LCA policy can save even more money -- without limiting access to the same life-saving drugs Medicare beneficiaries receive now.

6. **Reduce incentives for doctors to prescribe high cost drugs over safe, effective, and cheaper generic drugs.** Currently, doctors receive a payment of 6% of the price of a drug they administer to a patient under Medicare Part B. This provides a strong incentive to use the most expensive, brand name drug available instead of the less expensive generic drug and raises the cost of drugs for Medicare recipients, taxpayers, and the federal government. This policy would create a more equitable payment structure for the drugs so that there is not a disincentive to prescribe lower-cost drugs that are equally efficacious to a more expensive equivalent.

7. **Give more tools to the government and employers to better manage drug costs.** By acting as the middlemen between insurers and drug companies, Pharmacy Benefit Managers (PBMs) manage drug benefits for the federal government and most employers. PBMs negotiate drug prices, formularies and pharmacy payments for health plans. Drug companies often pay PBMs to promote their drugs on formularies and increase the utilization of a drug—but PBMs don't always have to disclose these payments to their clients. This policy would boost transparency, requiring that PBMs disclose payments received from drug companies to employers or the federal government. These payments can lead to

higher drug costs for taxpayers and consumers. For example, Wisconsin saved over $150 million after switching to a more transparent PBM.[8] In 2006, South Dakota estimated that its state employee plan would save 7 to 8 percent on drug costs by implementing these transparency changes.[9] One Illinois report estimated a savings of up to $140 million per year.[10]

8. **Reduce the needless prescription of dangerous drugs for nursing home residents.** This policy would require physicians to complete a written form before they prescribe atypical antipsychotics for nursing home residents certifying it is appropriate. In April 2005, the Food and Drug Administration (FDA) issued "black box" warnings against prescribing atypical antipsychotic drugs for patients with dementia, cautioning that the drugs increased dementia patients' mortality. According to a 2011 Office of Inspector General (OIG) report, nearly 1.4 million Medicare claims for atypical antipsychotic drugs were prescribed off-label for elderly nursing home residents costing taxpayers hundreds of millions of dollars for these drugs over a six-month period.

9. **Expand a current drug discount program (340B) to long term care programs and safety net hospitals.** This policy would allow the federal integrated care program for dually eligible beneficiaries, PACE (Program of All-Inclusive Care for the Elderly) and small safety net hospitals to be able to directly purchase pharmaceuticals through the "340B" program. This is the same program that Community Health Centers use to buy drugs. It provides drugs at a much lower cost than Medicare and sometimes at a cost lower than Medicaid. This policy is structured so that a portion of the savings that are realized would be returned to Medicare and to state Medicaid programs, therefore helping to add revenues to these programs.

[8] Statement of Rep. Sharon Anglin Treat. House Oversight and Government Reform Hearing on H.R. 4489, FEHBP Prescription Drug Integrity, Transparency & Cost Savings Act. February 10, 2010. http://www.reducedrugprices.org/av.asp?na=594
[9] http://www.consumersunion.org/campaigns//learn_more/001812indiv.html
[10] http://www.ilga.gov/commission/cgfa2006/Upload/PharmacyBenefitCost0406.pdf