Senate Democratic Policy Committee Hearing

"An Oversight Hearing on the Implementation of the Medicare Prescription Drug Benefit"

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Chairman Dorgan and members of the Democratic Policy Committee, thank you for inviting me to testify today. I am Gerard Anderson, a professor of Public Health and Medicine at Johns Hopkins University and Director of the Johns Hopkins Center for Hospital Finance and Management.

With the passage of the Medicare Modernization Act, Congress began the long overdue transformation of the Medicare program from one oriented around providing acute, episodic care to one oriented towards providing ongoing, chronic care. This transformation of the Medicare program is critical because 2/3rds of Medicare spending is by beneficiaries with 5 or more chronic conditions such as diabetes, congestive heart failure, or Alzheimer's disease.

The transformation of the Medicare program is just beginning and additional steps will be required. The next steps I believe Congress should consider are outlined in an article I wrote in the New England Journal of Medicine this summer. I have attached a copy to my testimony.

Today, I would like to talk about one aspect of the Medicare Modernization Act that is especially important for Medicare beneficiaries with chronic conditions – the so called "doughnut hole" or large gap in coverage in the current Medicare Part D benefit. As you know, Medicare covers 75% of the cost of prescription drug spending from $ 0 to $2,250, there is no real Part D coverage from $ 2,250 to $5,100, and then there is 95% coverage when prescription drug expenditures exceed $ 5,100. According to data from Tricia Neuman of the Kaiser Family Foundation, nearly 95% of all prescription drug plans approved by Medicare have a "doughnut hole."

The gap in coverage is especially onerous for the 23% of Medicare beneficiaries with 5 or more chronic conditions because they fill an average of 50 prescriptions during the year and nearly all of them will be affected by the "doughnut hole."

What my colleagues and I wondered was whether the "doughnut hole" could be filled if the Medicare program paid the same prices for pharmaceuticals as people in Canada, the United Kingdom, or France. We published an article in the journal *Health Affairs* which examined this

issue. A full version of the article is attached to my testimony. In the article, we calculated the amount that Medicare would pay for a market basket of the 25 most commonly prescribed brand name and generic drugs in the United States. We then calculated the price that people in Canada, the United Kingdom, or France would pay for the same market basket of 25 drugs. What we found was that even with the discounts the Medicare plans are receiving from the drug companies; Medicare beneficiaries will be paying 52 to 92 percent more that the people in Canada, the United Kingdom or France for these 25 drugs.

In July 2005, the Congressional Budget Office published a comparison of the rates different federal programs are paying for brand-name drugs. We compared the rates Medicare beneficiaries will pay for prescription drugs to the rates that the Veterans Administration and the Department of Defense pay for drugs. What the study shows is that the discounts the VA and DOD receive are similar to the discounts that people in Canada, the United Kingdom and France are receiving.

One issue therefore is whether the Medicare program could negotiate as good a deal with the pharmaceutical companies as Canada, the United Kingdom, France, VA or the DOD. Economic theory would suggest that the Medicare program could negotiate an equally good or better deal if Medicare negotiated as a single entity instead of each individual health plan negotiating for a much smaller quantity of drugs. This would suggest that Medicare would pay equal or lower prices than these other entities.

We then developed a micro simulation model to see if the "doughnut hole" could be eliminated if the Medicare program paid the same rates as Canada, the United Kingdom, or France. A description of the model is included in our paper. What we found was that the "doughnut hole" could be completely eliminated if Medicare paid the same rates as Canada, the United Kingdom or France. Paying these lower rates the Medicare would spend the same amount as under current law while eliminating the "doughnut hole." In addition, Medicare beneficiaries and health plans would pay less and utilization of drugs would increase because drug prices were lower. We have subsequently ran the model using the CBO analysis of federal drug prices and found that the "doughnut hole" could also be eliminated if the Medicare program paid the same prices as the VA or DOD.

We then analyzed the characteristics of Medicare beneficiaries who were most likely to benefit from the elimination of the "doughnut hole". These were beneficiaries with multiple chronic conditions – beneficiaries with various combinations of diabetes, congestive heart failure, chronic obstructive pulmonary disease, Alzheimer's disease, depression and other chronic conditions.

The choice the Congress faces is difficult. Maintaining the "status quo" and paying higher drug prices could result in the drug companies spending more on research and development which could lead to the next big drug. Currently 14 percent of drug company revenues are spent on research and development. Lowering the drug prices and eliminating the "doughnut hole" is likely to improve the health status of millions of Medicare beneficiaries because they will have better access to needed drugs.

One possibility is to have the federal government negotiate a maximum they will pay for a particular drug and allow the health plans to negotiate with the drug companies for an even lower price.

I would be happy to answer any questions.