Senate Democratic Policy Committee Hearing

"An Oversight Hearing on Providing Relief to Seniors Who Have Fallen into the Prescription Drug 'Donut Hole'"

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Senator Dorgan and members of the DPC, 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. Several months ago the DPC had hearings on Medicare Part D and in that hearing I discussed the "donut hole." Today I would like to emphasize how the donut hole could be eliminated if the prices the Medicare program paid for drugs were lowered and why the private sector will be less successful in lowering drug prices than the Medicare program itself.

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 two-thirds of Medicare spending is by beneficiaries with 5 or more chronic conditions. The next steps I believe Congress should consider in the transformation of the Medicare program are outlined in an article I wrote in the New England Journal of Medicine last 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 multiple chronic conditions, the so called "donut 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 "donut hole." The plans that fill in the "donut hole" are very expensive and are not affordable by most Medicare beneficiaries.

The gap in coverage is especially onerous for the 23 percent 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 impacted by the "donut hole." Today you are hearing from several of these individuals. Unfortunately, many of the beneficiaries with multiple chronic conditions are too sick to testify today.

What my colleagues and I wondered was whether the "donut 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 than the mount that people in Canada, the United Kingdom, or France pay for these same 25 drugs.

In July 2005, the Congressional Budget Office (CBO) published a comparison of the rates different federal programs are paying for brand-name 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. The CBO report also showed that Medicare beneficiaries are paying much higher rates than the VA or DOD was paying.

One issue therefore is whether the Medicare program could negotiate as good a deal with the pharmaceutical companies as Canada, the United Kingdom, France, the VA or the DOD. Economic theory suggests that the Medicare program could negotiate an equally good or even better deal if Medicare negotiated as a single entity instead of having each individual health plan negotiating for a much smaller quantity of drugs. Medicare could get the best discount because it offers the largest volume.

Although I respect theory and believe it is usually a good predictor of behavior, I am more convinced when there is actual experience. We actually have comparable experience in the hospital sector which shows that the Medicare program pays lower rates than the private sector.

In 1982, I was working in the Office of the Secretary of Health and Human Services when the Secretary made the decision to propose the Medicare Prospective Payment System – the DRGs. I helped design the Medicare Prospective payment system when I worked in the Secretary's office. In the 20+ years since the program became operational many things have surprised me. However, perhaps my greatest surprise was the fact that the private sector has continually paid higher rates than the Medicare program for hospital services. The most recent MEDPAC report shows that private insurers are paying between 14 and 30 percent more than the Medicare program has paid for similar services since 2000. I would have expected that the large insurers who operate in a competitive market place would be able to negotiate more effectively with hospitals than they actually have. These are the same private insurers that some have argued will be able to negotiate better rates than Medicare with the pharmaceutical companies. If the private insurers cannot negotiate better rates with hospitals for the past 20+ years, then why should anyone think they will be able to negotiate better rates with pharmaceutical companies?

In the Health Affairs paper we developed a micro simulation model to see if the "donut hole" could be eliminated if the Medicare program paid the same rates as Canada, the United Kingdom, or France. What we found was that the "donut hole" could be completely eliminated if Medicare paid the same rates as Canada, the United Kingdom or France. By paying international prices for drugs, the Medicare would spend the same amount as under current law while completely eliminating the "donut hole." In addition, Medicare beneficiaries and health plans would pay less and utilization of drugs would increase because drug prices were lower. We subsequently ran the model using the CBO analysis of federal drug prices and found that the "donut hole" could also be eliminated if the Medicare program paid the same prices as the VA or DOD. I have sent this data to Senator Bill Nelson of Florida and he has used this information in S. 2354 to propose that the Medicare program be able to negotiate directly with pharmaceutical companies.

We then analyzed the characteristics of Medicare beneficiaries who were most likely to benefit from the elimination of the "donut hole". These were primarily beneficiaries with multiple chronic conditions – beneficiaries with various combinations of diabetes, congestive heart failure, COPD, Alzheimer's disease, depression, and other chronic conditions. These are the types of individuals who are appearing before the Committee today.

I understand that Congress is facing a difficult choice. Maintaining the "status quo" and paying higher drug prices might result in the drug companies spending more on research and development. This could lead to the discovery of the next big drug. However, currently only 14 percent of drug company revenues are spent on research and development. On the other hand, lowering the drug prices and eliminating the "donut hole" is likely to immediately improve the health status of millions of Medicare beneficiaries because they will have better access to needed drugs.

For me it is unclear why the Medicare beneficiary should have to pay much higher rates for drugs than seniors in Canada, the United Kingdom, or France. This is especially a concern when Medicare beneficiaries are having gaps in coverage that adversely affects their health status and their pocketbook.

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. This would allow the market place to operate.