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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Ron Pollack
Executive Director, Families USA

On behalf of Families USA I would like to thank the Democratic Policy Committee for the opportunity to present testimony on Medicare's prescription drug program and how to provide relief to seniors who experience coverage gaps. This statement focuses on rising drug prices charged by participating Part D plans and their effect on the donut hole.

Seniors Face Rising Drug Prices

When the Medicare prescription drug legislation was being developed by Congress and the Bush Administration, a controversial decision was made about how to cope with the problem of high drug prices. Specifically, the legislation prohibited the Medicare program from bargaining with the pharmaceutical companies to secure lower drug prices – a process that the Department of Veterans Affairs (VA) has used quite successfully for many years.

The legislation took the responsibility for moderating drug prices out of the hands of the Medicare program and, instead, placed it in the hands of private plans. This decision was based on the presumption that private plans—through marketplace competition—would secure cheaper drug prices.

The results of this approach are critically important both to America's seniors and to taxpayers. Drug prices set by the plans that participate in the Medicare prescription drug program, known as Part D, significantly affect the size of the premiums and how much a beneficiary will end up paying out of pocket overall. These drug prices also have a direct effect on the burden borne by taxpayers, who pay approximately three-fourths of the costs of the program.

For this reason, Families USA periodically analyzes the drug prices that Part D plans charge for the 20 drugs most frequently prescribed to seniors. Families USA recently released a report that analyzes price information reported by Part D plans over the past five months for those drugs. We collected prices from the week of November 15, 2005 (when enrollment in Part D plans began) and the week of April 17, 2006.

The report ("Big Dollars, Little Sense"[i]) asks two key questions: 1) What has happened to Part D prices for the most frequently prescribed drugs from November 2005 to April 2006?; and 2) How do Part D drug prices now compare to the prices secured by the VA?

The answers to these questions are both clear and disappointing. 1) Virtually all of the Part D plans raised their prices for the majority of the top 20 drugs in this study. From November 2005 to April 2006, the median price increase among Part D plans for the top 20 drugs prescribed to seniors was 3.7 percent. 2) For all of the top 20 drugs prescribed to seniors, VA prices in April were lower than the lowest prices charged by Part D plans. The median price difference was 46 percent. In other words, for half of the 20 drugs, the lowest price charged by any Part D plan was at least 46 percent higher than the lowest price secured by the VA.

According to the report, only the prices for the generic drugs furosemide (40 mg) (a diuretic) and metoprolol tartrate (50 mg) (a drug for high blood pressure), and the brand-name drug Zoloft (50 mg) (an antidepressant) were not raised by a majority of the Part D plans.

One of the most significant findings in the report is that, for 19 of the top 20 drugs, changes in the median Part D plan prices were virtually identical to the changes in Average Wholesale Price (AWP) established by the drug manufacturers. This means that Part D plans are doing essentially nothing to contain the drug industry's fast-rising prices.

Among the biggest variations between prices negotiated by the VA and those established by Medicare plans were the following drugs:

- For Zocor (20 mg), the lowest annual VA price in mid-April was $127.44, while the lowest Part D plan price was $1,275.36, a $1,147.92 difference, or 901 percent.
- For Protonix (40 mg), a gastrointestinal agent, the lowest annual VA price was $214.45, while the lowest Part D plan price was $1,110.96, a $896.51 difference, or 418 percent.
- For Fosamax (70 mg), the lowest annual VA price was $265.32, while the lowest Part D plan price was $727.92, a $462.60 difference, or 174 percent.
- For Xalatan (0.005% sol.), the lowest annual VA price was $279.84, while the lowest Part D plan price was $555.96, a $276.12 difference, or 99 percent.

When Congress prohibited Medicare from bargaining for cheaper drug prices, it created a huge windfall for the drug companies and unaffordable prices for America's seniors.

Rising Drug Prices Worsens the Problems of the Donut Hole

The higher drug prices charged by Medicare drug plans means seniors – and America's taxpayers – will pay more and more. Because the federal government is barred from negotiating directly with drug manufacturers to obtain lower drug prices, each part D plan that participates in the program negotiates separately with drug manufacturers to obtain price concessions. The law requires these drug plans to pass along a share of their price discounts – the exact percent is not specified – to consumers in the form of lower prices for the drugs the plan covers.

The prices that plans charge for the drugs they cover are used to calculate when an individual has met the annual deductible and the initial coverage limit. Individuals who reach their initial coverage limit – when they are in the coverage gap or "donut hole" – must also pay the prices plans charge for drugs. Plans with lower drug prices can offer better value to people in Medicare. Lower prices also offer a better value to taxpayers, who are subsidizing nearly three-quarters of the cost of the drug benefit.

To understand how Part D plans' drug prices make a difference to beneficiaries, consider the following example. The table below illustrates two Part D plans with the exact same benefit structure:

- both have a $250 deductible;
- both cover 75 percent of drug costs (based on the plan's price for the drugs) until costs reach the initial coverage limit of $2,250, and;
- both require enrollees to pay the full cost of drugs (based on the plan's price) after reaching the initial coverage limit, until drug costs reach $5,100 and catastrophic coverage begins.

Both Plans: **$250 deductible, 25% cost-sharing, $2,250 initial coverage limit**	**Plan A Price**	**Plan B Price**
Drug 1 Drug 2 Drug 3	$100 $100 $50	$50 $50 $50
Monthly total drug costs (used to calculate when someone meets the deductible, initial coverage limit, and catastrophic coverage)	$250	$150
Monthly cost-sharing by beneficiary before initial coverage limit	$62.50	$37.50
Total amount paid on prescription drugs (not including premiums) in 2006	$1,500	$637.50
Plan premium paid by beneficiary	$30/month	$15/month

	$360/year	$180/year
Total cost to beneficiary enrolled in the plan	**$1,860**	**$817.50**

In the above example, the enrollees take three different prescription drugs every day. People enrolled in Plan A would meet the $250 deductible in the first month, after which they would have to pay 25 percent of the plan's price for their drugs - $62.50 a month. At the end of nine months, Plan A enrollees' total drug costs would reach the initial coverage limit of $2,250. Coverage would stop, and from October to December, the enrollees would pay the full price of the plan charges. At the end of the year, the beneficiaries' total drug spending would be $1,500.

People enrolled in Plan B would meet their deductible later – not until the second month. Once the deductible is met and coverage begins, they would pay less for their drugs each month. Their 25 percent co-payment would amount to $37.50 per month. Because their plan's drug prices are lower, their total drug costs would never reach $2,250 and they would never hit the donut hole. They would pay only $637.50 on prescription drugs during the year.

Drug prices matter for taxpayers as well. That's because the government pays for approximately three-quarters of the cost of the drug benefit. Each beneficiary who enrolls in the program pays 25.5 percent of the premium, and Medicare pays the remaining 74.5 percent. Future increases in drug prices will translate into premium increases, raising the total cost of the program over time.

Finally, the problem of increasing drug prices will drive Part D costs higher and create a widening donut hole in future years. The Congressional Budget Office estimates that the deductible, initial costs, and the donut hole that beneficiaries pay will all grow substantially. By 2013, the CBO projects that the donut hole will grow to $5,066. Catastrophic coverage will not begin until total spending for a beneficiary has reached $9,066, compared to $5,100 today.[ii] Beneficiaries will be paying out of their own pockets for $6,400 of their first $9,066 in drug expenses. Bringing drug prices under control now is essential to protecting our seniors from ever-increasing out-of-pocket costs.

The Need for Transparency

As noted above, the drug prices cited in our report are the prices charged to beneficiaries in the donut hole. These may not be the actual price paid by the plan, however. Under current law, every Part D plan negotiates its own price for the drugs it covers with the pharmaceutical manufacturer. Although the plans are required by regulation to pass a portion of the discounts they receive on to beneficiaries, the proportion of that discount is not specified. Moreover, the plans are not required to report publicly the discounts they receive for specific drugs, although this information is provided to the Centers for Medicare and Medicaid Services (CMS). The plans only publish the prices they charge consumers. Part D plans could in fact be negotiating substantial discounts on the drugs they cover, but retain these savings for themselves.

Making information about these discounts publicly available would provide more complete information about the relationship of competition and prices for prescription drugs. This would be a good first step in obtaining real value in the Medicare drug benefit.

Consumers Need Help Now with Ongoing Challenges

During the first months of Part D implementation, information about the program from Medicare has been at times incomplete or confusing. A recent report from the GAO, for example, found that call centers run by drug plans give seniors accurate and complete information only one-third of the time.[iii]

Millions of seniors are now making their way through the often-byzantine rules of their plans. In addition, as we have reported, prices can and do change throughout the year. Of particular interest to this panel, each month, more beneficiaries will enter the donut hole and be faced with paying their Part D premium while at the same time paying full price for their drugs.

In the long term, Congress can help by giving Medicare the authority to negotiate for drug prices, and using the savings to close the donut hole. In the immediate term, however, seniors do not have to navigate these various challenges on their own. The State Health Insurance and Assistance Programs (SHIPs) exist in each state to help Medicare beneficiaries resolve problems with their health coverage. These agencies, primarily staffed by volunteers, have been on the front lines during the first months of Part D implementation, helping confused seniors sort out the details of Part D. SHIPs have been deluged with requests for help since Part D began. In California, for example, the SHIP served more than three times the number of beneficiaries in January 2006 than it did in all of 2005. Nationwide, call volume to SHIPs has more than doubled through the first few months of the year. Moreover, SHIPs will continue to serve Medicare beneficiaries long after the initial rush of enrollment is over, and they need additional support. At the least, SHIPs should be funded at $1 per Medicare beneficiary – a minimal amount given the vital services they provide and the overwhelming demands on their resources.

Conclusion

Price data from Part D plans reveal that these plans are failing to deliver on the promise that competition would bring prices down. The “market power” lauded by the Medicare officials and the Administration has not resulted in drug prices that are comparable to the low prices negotiated by the Department of Veterans Affairs. Allowing CMS to negotiate directly with drug manufacturers would result in lower prices, save taxpayers money and would partially alleviate the pain of the coverage gap experienced by seniors with expensive drug bills. Providing more funding for SHIPs will provide additional help to seniors. I look forward to continuing to work with this Committee and other leaders in the Senate to ensure seniors get all the assistance they need with their prescription medications.

[i] Dee Mahan, *Big Dollars, Little Sense:Rising Medicare Prescription Drug Prices* (Washington: Families USA, June 2006).
[ii] Congressional Budget Office, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit* (Washington: July 2004) p. 9.
[iii] Government Accountability Office, *Prescription Drug Plan Sponsor Call Center Responses Were Prompt, But Not Consistently Accurate* (Washington: June 2006) p. 6