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MEDICARE PART D: DRUG PRICING AND MANUFACTURER WINDFALLS

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EXECUTIVE SUMMARY

This report uses confidential information on drug prices to compare the costs of drugs purchased under the new Medicare Part D program with the costs of drugs purchased under traditional Medicaid. It finds (1) that Medicare Part D pays on average 30% more for drugs than does Medicaid and (2) that this discrepancy in pricing produced a windfall worth over $3.7 billion for drug manufacturers in the first two years of the Medicare Part D program.

Unlike traditional Medicare, which is administered by the federal government, the new Medicare Part D prescription drug program depends on private insurers to provide drug coverage. This reliance on private insurers has sparked a debate about the consequences of privatizing the delivery of Medicare services. A staff report released by Rep. Henry A. Waxman and other members in October 2007 compared the administrative expenses incurred by the private Part D insurers with the administrative expenses incurred under traditional Medicare. That report found that the administrative expenses and profits of the private insurers accounted for nearly 10% of the costs of Medicare Part D, nearly six times as much as the administrative expenses of traditional Medicare.

This new report compares the drug prices negotiated by the private Part D insurers with the drug prices paid by Medicaid, a federal-state program that provides health care to over 60 million low-income Americans. In particular, the report focuses on the cost to the taxpayer of providing drug coverage through Medicare Part D to six million "dual eligible" beneficiaries. These are elderly and disabled individuals who qualify for both Medicare and Medicaid. Prior to enactment of Medicare Part D, dual eligible beneficiaries received prescription drugs through Medicaid. The Medicare Part D law transferred their drug coverage to Medicare starting on January 1, 2006. The drugs used by dual eligible beneficiaries now account for more than half of total prescription drug plan (PDP) drug costs under the Part D program. These costs are paid almost entirely by federal taxpayers.

To compare Medicare Part D and Medicaid drug prices, the Committee obtained confidential information on drug expenditures for dual eligible beneficiaries from the ten largest Part D insurers. The Committee also obtained confidential information on Medicaid drug prices directly from the drug manufacturers. The Committee asked both the Part D insurers and the drug manufacturers to provide pricing information for the 100 prescription drugs used most often by dual eligible beneficiaries. Both the insurers and the drug manufacturers provided this information to the Committee voluntarily.

This report finds that the prices paid for the drugs used by the dual eligible beneficiaries under Medicare Part D are significantly higher than the prices paid by Medicaid for the same drugs. The higher prices for the top 100 drugs produced a windfall of $1.7 billion for drug manufacturers in 2006, the first year of Medicare Part D. The higher prices produced an even larger windfall of $2 billion for the drug manufacturers in 2007.

Comparison of Medicare Part D and Medicaid Drug Prices

In 2006 and 2007, the private Part D insurers spent $18.7 billion to purchase the top 100 drugs for dual eligible beneficiaries. On average, the Part D insurers received rebates and other

discounts from drug manufacturers that reduced these costs by 14%, lowering the total cost of providing these drugs to dual eligible beneficiaries to $16.2 billion.

Medicaid purchases the same drugs for low-income beneficiaries who are not dual eligible and pays significantly lower prices. If the private Part D insurers had paid the same prices as Medicaid, their total cost for the drugs used by the dual eligible beneficiaries would have been $12.4 billion. The higher prices paid by the private Medicare Part D insurers increased the costs to the taxpayer for these drugs by 30%.

The price increases were especially large for the drugs on the "protected list" maintained by the Centers for Medicare and Medicaid Services (CMS). The drugs on the protected list are essential medications, such as anti-depressants, anti-psychotics, and AIDS drugs, that CMS requires all Medicare Part D plans to offer. For the 16 drugs among the top 100 that are on the protected list, the private Medicare Part D insurers obtained rebates and discounts of only 7%. The Medicare Part D insurers paid almost 40% more for these essential medications than Medicaid pays.

The 100 top drugs used by the dual eligible beneficiaries are sold in over 1,200 different strengths and forms. For 97% of these formulations, the private Part D insurers paid more for the drugs than does Medicaid. For 74% of these formulations, the Part D insurers received no rebates or discounts at all from the drug manufacturers.

Drug Manufacturer Windfalls

The transfer of drug coverage for the dual eligible beneficiaries from Medicaid to Medicare Part D has resulted in large windfalls for the drug manufacturers. There are 29 large drug manufacturers who produce the 100 drugs used most often by dual eligible beneficiaries. In total, these manufacturers received $3.7 billion more from the Medicare Part D insurers in 2006 and 2007 than they would have received if the dual eligible beneficiaries had obtained the drugs through Medicaid.

Johnson & Johnson received the largest windfall: $615 million in 2006 and 2007, including over $500 million in additional revenue from sales of just one drug, the anti-psychotic Risperdal. Bristol-Myers Squib received a windfall of $400 million, including over $200 million in additional revenue from sales of its heart-attack and stroke medication Plavix. Over 13 drug manufacturers had windfall revenues of over $100 million in 2006 and 2007 as a result of the switch in coverage for the dual eligible beneficiaries.

Nine drugs each generated over $100 million more in revenues under the Medicare Part D program than they would have generated had Medicare Part D insurers been able to get the same discounts that Medicaid gets. For these nine drugs, the manufacturers charged the private Medicare Part D insurers 46% more than they charged Medicaid.

The actual windfall for drug manufacturers is probably larger than $3.7 billion because dual eligible beneficiaries use many drugs that are not included in the list of the top 100 drugs. If the price discrepancy between Medicare Part D and Medicaid is the same for these other drugs as it is for the top 100 drugs, the manufacturer windfall could be worth billions of dollars more.

Estimates of Potential Cost Savings

Because dual eligible beneficiaries have low-incomes, the federal taxpayer pays over 98% of their drug costs under Medicare Part D. Over the next ten years, dual eligible beneficiaries are expected to use $432 billion worth of drugs. If drug manufacturers provided the Medicare Part D program with the same prices that Medicaid receives, these drug costs could be reduced by as much as $86 billion, a large savings for taxpayers.

The dual eligible beneficiaries account for over half of drug spending under Medicare Part D. The costs of providing drugs to other Medicare Part D beneficiaries are shared by the federal taxpayers and the beneficiaries. If Medicare Part D paid the same price as Medicaid for all drug purchases, the total savings to the taxpayer over the next ten years could be as much as $156 billion. Beneficiaries could also save up to $27 billion.

I. INTRODUCTION

The legislation creating the Medicare Part D drug program was signed into law by President Bush in November 2003. The program went into effect on January 1, 2006, and is now in its third year of operation. In 2006 and 2007, the Medicare Part D program cost the federal government $47 billion and $49 billion, respectively. Over the next decade, Medicare Part D coverage is estimated to cost the federal government $900 billion.[1]

The new Medicare Part D program differs significantly from Medicare Part A, which covers hospital expenses, and Medicare Part B, which covers outpatient care. Unlike Part A and Part B, the Part D program is not administered directly through the federal government. Instead, private insurers contract with Medicare to deliver Part D coverage. Medicare Part D allows the insurers to offer multiple plans with different premiums, copays, and formularies.

The new Medicare Part D program also differs significantly from Medicaid, which is a federal-state partnership that provides health care to 61 million low-income Americans, primarily children, mothers with young children, seniors, and individuals with disabilities. Prior to 2006, low-income seniors and individuals with disabilities who were eligible for both Medicaid and Medicare typically received their health care and drug coverage through Medicaid. The law creating Medicare Part D, however, required these "dual eligible" beneficiaries to obtain their drug coverage exclusively through Medicare Part D, effective January 1, 2006.[2]

The use of private insurance companies to provide the Medicare Part D benefit has been the subject of a vigorous debate. This debate, which started during congressional consideration of the Medicare drug law, continues today. On one side, President Bush, other senior administration officials, Republican leaders in Congress, and the insurance and pharmaceutical industries argue that competition among many private insurers is the most effective way to keep prices low for seniors and taxpayers. In October 2003, as Congress was debating the Medicare legislation, the President claimed:

> The best way to provide our seniors with modern medicine, including prescription drug coverage … is to give them better choices under Medicare. If seniors have choices, health plans will compete for their business by offering better coverage at more affordable prices.[3]

Republicans on the House Ways and Means Committee maintained that the Part D structure "will allow competitive forces in the private market to generate the best savings for seniors."[4]

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[1] Department of Health and Human Services, 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds (2008).

[2] Medicare Prescription Drug, Improvement, and Modernization Act, § 103 (PL 108-173) (2003).

[3] The White House, President Calls on Congress to Complete Work on Medicare Bill (Oct. 29, 2003).

[4] Committee on Ways and Means, Hearing on Negotiating Lower Prices for America's Seniors, 108th Cong. (Dec. 11, 2003).

Senate Majority Leader Bill Frist argued that "competition through the private sector, through bulk purchasing and negotiation, is a more effective means to hold down prices."[5]

Pharmaceutical and insurance industry representatives have consistently made similar assertions. According to representatives of the drug industry, "low Part D bids have largely been driven by plans' ability to secure substantial price discounts and rebates on drugs furnished to Medicare beneficiaries."[6] The industry organization representing many Part D insurers has claimed that the insurers are providing "deeper than expected discounts"[7] and "tremendous savings."[8]

On the other side of the debate, Democratic members of Congress and public health groups have raised questions about the cost and effectiveness of the private Part D insurers. In 2006, analyses of Medicare drug plan prices released by Rep. Henry A. Waxman indicated that the Part D insurers were failing to provide seniors with significant price discounts at the pharmacy counter and were unable to control rapid increases in drug costs.[9]

In October 2007, Rep. Waxman and other members of the Committee on Oversight and Government Reform released an analysis of the administrative costs of the Medicare Part D program. This analysis found that the administrative expenses, sales costs, and profits of the private insurers offering Medicare Part D coverage would cost taxpayers and beneficiaries $4.6 billion in 2007, nearly 10% of total program and beneficiary costs. These administrative expenses are almost six times greater than the administrative costs of traditional Medicare.[10]

The October 2007 report also examined the drug pricing data submitted by the private Part D insurers to CMS. This data provided indications that the private insurers were not successful in obtaining large discounts from drug manufacturers.[11]

II. OBJECTIVE AND METHODOLOGY

The debate over the effect of privatizing the delivery of Medicare Part D coverage has been largely theoretical. Answering the questions about the performance of the private Part D insurers requires access to the actual cost and pricing data of the insurers and drug manufacturers. These data are propriety and closely guarded. This has often left Congress and the public without

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[5] *Does Medicare or Private Insurance Do a Better Job of Controlling Health Care Costs?,* The New York Times (Nov. 27, 2003).

[6] Biotechnology Industry Organization, Medicare Part D Plans Deliver Significant Savings on Innovative Breakthrough Medicines (2007).

[7] Pharmaceutical Care Management Association (PCMA), *PCMA Statement on U.S. House Approval of H.R. 4* (Jan. 4, 2007).

[8] Pharmaceutical Care Management Association (PCMA), Beneficiaries in Part D Enjoying Broad Savings and Broad Access on Their Prescription Drugs (May 2, 2007).

[9] See, e.g., Minority Staff, Special Investigations Division, House Committee on Government Reform, *New Medicare Drug Plans Fail to Provide Meaningful Drug Price Discounts* (Nov. 2005); Minority Staff, Special Investigations Division, House Committee on Government Reform, *Medicare Drug Plan Prices Are Increasing Rapidly* (Nov. 2005).

[10] Committee on Oversight and Government Reform, Majority Staff, Private Medicare Drug Plans: High Expenses and Low Rebates Increase the Costs of Medicare Drug Coverage (Oct. 2007).

[11] *Id.*

access to the information needed to assess the performance of the Part D private insurers and to compare their performance with traditional Medicare.

To provide insight into the effectiveness of the Part D program, this report uses confidential information on drug prices to compare the costs of drugs purchased through the new Medicare Part D program with the costs of drugs purchased through Medicaid. Under Medicare Part D, drug prices are established through negotiations between the private Part D insurers and the drug manufacturers. By contrast, drug prices in the Medicaid program are regulated by the 1990 Medicaid drug rebate law.[12]

Under the Medicaid law, drug manufacturers are required to provide Medicaid significant price discounts as a condition for their participation in the program. For brand-name drugs used by Medicaid beneficiaries, manufacturers are required to provide the drug to Medicaid at the lower of (1) their "best price," which is defined as the lowest price at which they sell the drug to private purchasers, or (2) 15% below their "average manufacturer price," which is defined as "the average unit price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade."[13] For generic drugs, manufacturers are required to provide a discount of 11% off of their average manufacturer price.[14] In the case of brand-name drugs, the Medicaid drug rebate law also protects the program from rapid price increases, requiring additional manufacturer price concessions if a drug's cost increases faster than the overall inflation rate.[15]

To ensure an accurate comparison between the Medicare Part D program and Medicaid, the report focuses on the drugs used by dual eligible beneficiaries. These are seniors or individuals with disabilities who are eligible for Medicare and are eligible for Medicaid because of their low income and resources. There are approximately six million dual eligible beneficiaries. Compared to other Medicare beneficiaries, dual eligible beneficiaries have a high level of drug use. Dual eligible beneficiaries are generally the oldest and least healthy members of the Medicare population and use significantly more drugs than the average Medicare Part D beneficiary. Although they account for only approximately one-third of Medicare Part D beneficiaries enrolled in Part D Prescription Drug Plans (PDPs), data submitted to the Committee by the Part D insurers indicates that dual eligible beneficiaries account for 57% of the total PDP drug costs.

Prior to 2006, the six million dual eligible beneficiaries received their drug coverage through Medicaid. On January 1, 2006, the coverage for these six million dual eligible beneficiaries was switched from Medicaid to Medicare Part D. Taxpayers continue to subsidize this coverage, which is now provided by the private Part D insurers. The federal government pays an estimated 98% of the drug costs of the dual eligible beneficiaries under Medicare Part D.[16]

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[12] Section 1927 of the Social Security Act, as added by section 4401of the Omnibus Budget Reconciliation Act of 1990, P.L. 101-580.

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] Actuarial Research Corporation and Henry J. Kaiser Family Foundation, *Estimates of Medicare Beneficiaries' Out-of-Pocket Drug Spending in 2006* (Nov. 2004). Dual eligible Part D enrollees who are not

The data used in this report come from two primary sources: (1) the private Part D insurers and (2) the drug manufacturers. From the insurers, the Committee received detailed information on 2006 and 2007 drug utilization, rebates, and discounts. The Committee requested information from the ten leading providers of Medicare Part D PDPs.[17] Combined, these insurers provided Part D coverage to over 14 million beneficiaries, accounting for 82% of all PDP enrollees.[18] Their enrollment in 2007 included 5.8 million dual eligible beneficiaries, approximately 95% of all dual eligible beneficiaries.

The Committee's request asked the insurers to provide information for all strengths and forms — brand and generic — of each of the 100 drugs most frequently prescribed for dual eligible beneficiaries.[19] Combined, these 100 drugs account for 56% of drug expenditures for dual eligible beneficiaries, and account for 57% of all Medicare PDP drug expenditures. The Committee requested drug-by-drug information on the quantity of the drug dispensed, the total cost paid for the drug, and the total value of the rebates and other discounts received for the drug. The insurers were asked to provide this information in the aggregate for all Part D beneficiaries, as well as separately for dual eligible beneficiaries. All ten insurers cooperated with the Committee request voluntarily.[20]

From the drug manufacturers, the Committee received detailed information about sales to the Medicaid program. There are 29 major pharmaceutical manufacturers that produce the top 100 drugs used by dual eligible beneficiaries.[21] For each of these drugs, the Committee asked that the manufacturer provide information on the rebates provided to the Medicaid program in 2006 and 2007. All 29 drug manufacturers cooperated with the Committee request voluntarily.

The analysis in the report compares drug costs paid by the private Medicare Part D insurers for the top 100 drugs with the amounts paid by Medicaid for the same drugs. The data provided by the insurers and the drug manufacturers allow for cost comparisons to be made for over 1,200 formulations of the top 100 drugs.

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residents of a nursing home or medical institution must pay a share of their drug copay, up to $1.05 per prescription for generic drugs and up to $3.10 per prescription for brand-name drugs. *Id.*

[17] The ten insurers are Aetna, CVS/Caremark, Coventry, Humana, Medco, Memberhealth, United, Universal American, Wellcare, and Wellpoint. The analysis did not include information on Medicare Advantage Prescription Drug (MA-PD) Plans because these plans do not provide drug coverage to a significant number of dual eligible beneficiaries.

[18] Centers for Medicare and Medicaid Services, Medicare Prescription Drug Plans (PDPs) by Total Enrollment in Parent Organization (2007).

[19] U.S. Department of Health and Human Services, Office of Inspector General, *Dual Eligibles Transition: Part D Formularies' Inclusion of Commonly Used Drugs* (Table 4) (Jan. 2006).

[20] In some cases, manufacturers provide Part D plans with "differential rebates," with the plans accruing larger rebates for sales to dual eligible beneficiaries than they accrue for sales to other Part D beneficiaries. In these cases, the analysis used the larger differential rebate amounts provided for dual eligibles as the basis of the comparison to the rebates provided to the Medicaid program.

[21] The 29 manufacturers were Abbott, Apotex, AstraZeneca, Barr Pharmaceuticals, Baxter, Boehringer Ingelheim, Bristol Myers, Eisai, Eli Lilly, Forest Pharmaceuticals, Glaxo, HoffmanLaRoche, Johnson & Johnson, King Pharmaceuticals, Merck, Mylan, Novartis, NovoNordisk, Pfizer, Proctor and Gamble, Purdue Pharma, Sandoz, SanofiAventis, Schering Plough, Takeda, TAP, Teva, Watson Pharmaceuticals, and Wyeth.

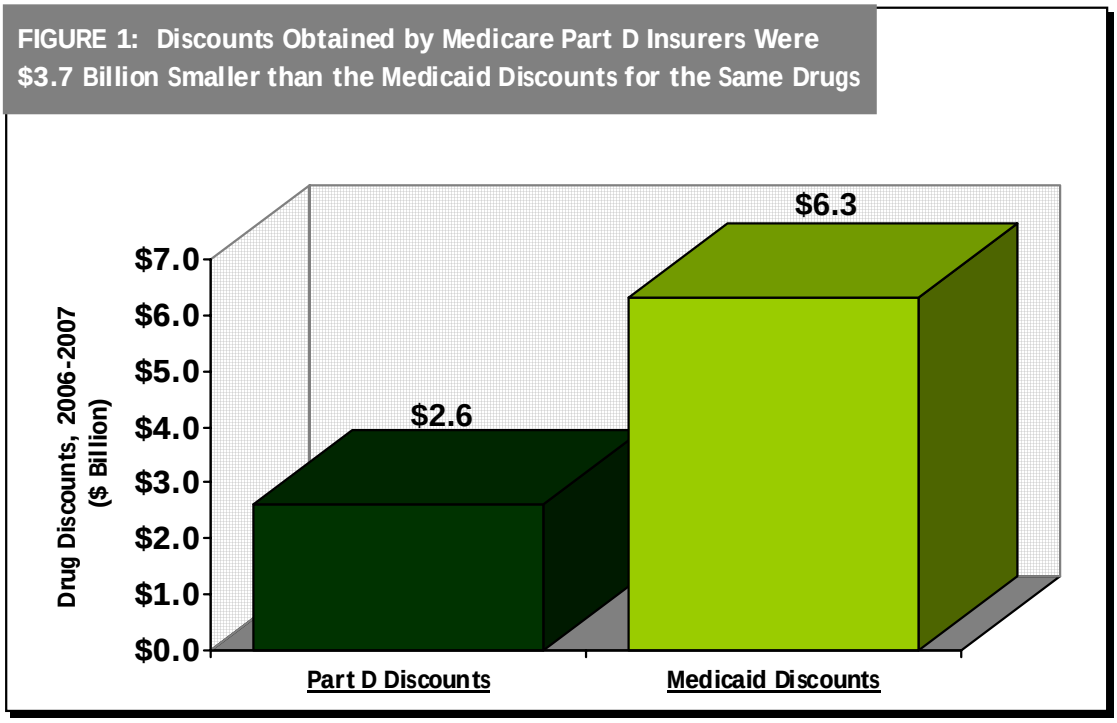
III. FINDINGS

A. Comparison of Medicare Part D and Medicaid Drug Prices

In 2006 and 2007, the private Medicare Part D insurers paid $18.7 billion to purchase the top 100 drugs for dual eligible beneficiaries. They received $2.6 billion in rebates and discounts from the drug manufacturers, reducing their total drug costs by 14% to $16.2 billion.

These price reductions were substantially smaller than the Part D insurers would have obtained had they received the same rebates that the Medicaid program receives. If the Part D insurers had been able to obtain the Medicaid discounts for the top 100 drugs, the Part D insurers would have reduced their total drug costs for the dual eligible beneficiaries by over twice as much, $6.3 billion. Figure 1. This would have cut their total drug costs to $12.4 billion. The higher prices paid by the private Medicare Part D insurers increased the cost to the taxpayer for these drugs by 30%.

FIGURE 1: Discounts Obtained by Medicare Part D Insurers Were $3.7 Billion Smaller than the Medicaid Discounts for the Same Drugs



Almost every drug is more expensive under Medicare Part D than under Medicaid. There are over 1,200 formulations of the top 100 drugs for which a comparison can be made between the discounts obtained by the Medicare Part D insurers and the Medicaid program. For over 95% of these formulations, the Medicaid prices were lower than the Medicare Part D prices. For 74% of these formulations, the Part D insurers received no rebates or discounts at all.

Under Medicare Part D, there are approximately 230 drugs that insurers are required to include on their formulary, including 16 of the top 100 drugs. These drugs are listed on CMS's

"protected list" and fall into six classes: anti-depressants, anticonvulsants, antipsychotics, HIV-AIDS drugs, immunosuppressants, and antineoplastics (drugs used to treat tumors).[22] For these essential medications, the private Medicare Part D insurers consistently paid higher prices than the Medicaid program. For the 16 top 100 drugs on the protected list, the rebates and discounts received by the Part D insurers reduced the drug costs by only 7%. In comparison, Medicaid receives rebates that reduce the costs of these drugs by 33%, over four times as much.

In 2006 and 2007, dual eligible beneficiaries used $6.1 billion worth of the 16 top 100 drugs on the protected list. If the Part D insurers had received the same price for these drugs as Medicaid pays, costs to the taxpayer would have been reduced by over $1.5 billion.

Another subset of drugs for which the Part D insurers have been unable to obtain significant discounts and rebates are generic drugs. The insurers have been successful in encouraging the use of generic drugs, with Part D generic utilization rates that are higher than those achieved under the Medicaid program.[23] However, the inability of the insurers to obtain rebates or discounts on these generic drugs means that significant savings have not been realized.

In 2006 and 2007, dual eligible beneficiaries used $1.7 billion worth of generic drugs that were among the 100 top drugs, representing almost 10% of drug spending for dual eligible beneficiaries. The Part D insurers obtained no rebates or discounts on 98% of the formulations of these generic drugs. Overall, the rebates and discounts received by Part D insurers on these generic drugs decreased their cost by only $261,000. If the Part D insurers had obtained rebates that were the same size as the Medicaid rebates for these drugs, they would have cut these drug costs by $103 million.

The difference between Medicare Part D drug costs and Medicaid drug costs for the top 100 drugs actually increased between 2006 and 2007. In 2006, drugs for dual eligible beneficiaries cost the Part D insurers $1.7 billion more than they would have cost had these insurers been able to obtain the Medicaid drug prices. In 2007, the excess charges increased by almost 20% to $2 billion.

One explanation for the rising gap between Medicare Part D drug costs and Medicaid drug costs is the difference in the vulnerability of the two programs to rapid increases in brand-name drug prices. The Medicare Part D program is susceptible to increases in drug prices because the Part D insurers typically adjust their prices based on the manufacturer's list prices, which are called "average wholesale prices."[24] In contrast, brand-name drug prices cannot increase faster than the inflation rate under the Medicaid program without subjecting the manufacturer to a financial penalty. Under Medicaid law, if drug manufacturers increase prices at a rate that exceeds the

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[22] See Centers for Medicare and Medicaid Services, Q&A Formulary Guidance (2005) (online at www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidanceAllorSubAll.pdf). Congressional Research Service, Drugs Required to be Covered By All Medicare Part D Plans (July 2008).

[23] Committee on Oversight and Government Reform, *supra* note 9.

[24] Committee on Oversight and Government Reform, *supra* note 9.

inflation rate, they are required to pay an additional rebate, known as the inflation rebate, to make up the difference.[25]

This susceptibility to drug price inflation increased the costs of drugs to the Medicare Part D program in 2007. The per-prescription cost of the average brand-name drug used by a beneficiary in a Part D plan increased from $119.52 in 2006 to $127.41 in 2007. This is a 6.6% price increase, over twice the inflation rate in 2006.

B. Drug Manufacturer Windfalls

The higher prices under the Medicare Part D program have created a windfall for drug manufacturers. If the legislation creating the Medicare Part D program had not transferred the dual eligible beneficiaries from Medicaid to the new Medicare Part D program, the manufacturers would have continued to receive the lower Medicaid prices for the drugs used by the six million dual eligible beneficiaries. In 2006 and 2007, the amount of this taxpayer-funded windfall was $3.7 billion for the manufacturers of the top 100 drugs used by dual eligible beneficiaries.

For many drug manufacturers, the windfall revenues were large. Thirteen manufacturers received windfall revenues exceeding $100 million in 2006 and 2007. Johnson & Johnson had the largest windfall of any company, receiving over $600 million in 2006 and 2007 in additional payments for drugs used by dual eligible beneficiaries. Bristol-Myers Squibb had the second largest windfall, receiving over $400 million in additional payments. Abbot had the third largest windfall, receiving nearly $300 million in additional payments. These three manufacturers provided the private Part D insurers with average drug discounts of 5% or less. In contrast, the Medicaid rebates on the drugs offered by these companies would have resulted in discounts of 31% or more. See Table 1.

The drug responsible for the greatest increase in manufacturer revenues was Risperdal, an anti-psychotic manufactured by Johnson & Johnson. In 2006 and 2007, Johnson & Johnson received over $500 million more under the Medicare Part D program for Risperdal prescriptions for dual eligible beneficiaries than the company would have received if Risperdal had been purchased under Medicaid. This windfall for Johnson & Johnson may not continue in the future, however, because a generic version of Risperdal became available in June 2008.

Other drugs that produced significant windfall revenues for their manufacturers are Depakote, an anti-psychotic made by Abbott; Zyprexa, an anti-pyschotic made by Eli Lilly; and Plavix, a heart attack and stroke medication made by Bristol-Myers Squibb. In each case, the manufacturers realized windfall revenues in excess of $200 million in 2006 and 2007. In total, there were nine drugs among the top 100 that generated more than $100 million in increased revenues as a result of the higher prices paid by the Medicare Part D program for drugs used by dual eligible beneficiaries. See Table 2.

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[25] CMS, *supra* note 17.

Table 1: Drug Manufacturer Receiving the Largest Windfalls in 2006 and 2007	
Manufacturer	**Amount of Windfall Revenue (2006-2007)**
Johnson & Johnson	$615,000,000
Bristol-Myers Squibb	$401,000,000
Abbott	$301,000,000
GlaxoSmithKline	$291,000,000
Eli Lilly	$273,000,000
Merck	$262,000,000
Wyeth	$239,000,000
Pfizer	$235,000,000
Boehringer Ingelheim	$157,000,000
Sanofi Aventis	$137,000,000
Novartis	$136,000,000
Eisai	$135,000,000
AstraZeneca	$123,000,000
All Other Manufacturers	$434,000,000
Total Manufacturer	$3,739,000,000

For individual drugs, the differences in the prices under the Medicare Part D program and the Medicaid program can be large. For one common antibiotic, the manufacturer charged Medicare Part D insurers almost $10 more per pill than the manufacturer charged Medicaid. The manufacturer of a frequently used anti-convulsant drug provided the Part D insurers with an average discount of less than 3% compared to a 70% discount for Medicaid. The manufacturer of a popular sleep medication provided the Part D insurers with an average discount of less than 10% compared to a 65% discount for Medicaid.

The total windfall received by the drug manufacturers in 2006 and 2007 is probably larger than $3.7 billion. The $3.7 billion windfall represents the additional revenues that the manufacturers received from sales of the top 100 drugs used by dual eligible beneficiaries. The top 100 drugs account for only 54% of sales for dual eligible beneficiaries. If the price differential between Medicare Part D and Medicaid were the same for the other drugs used by dual eligible beneficiaries, the size of the total windfall would be nearly twice as high, almost $7 billion.

Table 2: Drugs Providing the Largest Windfalls in 2006 and 2007			
Drug	**Manufacturer**	**Drug Use**	**Amount of Windfall Revenue (2006-2007)**
Risperdal	Johnson & Johnson	Anti-psychotic	$510,000,000
Depakote	Abbot	Anti-psychotic	$300,000,000
Zyprexa	Eli Lilly	Anti-psychotic	$225,000,000
Plavix	Bristol-Myers Squibb	Heart Attack, Stroke	$220,000,000
Abilify	Bristol-Myers Squibb	Anti-psychotic	$147,000,000
Ambien	SanofiAventis	Insomnia	$137,000,000
Aricept	Eisai	Alzheimer's Disease	$134,000,000
Advair	GlaxoSmithKline	Asthma, COPD	$133,000,000
Protonix	Wyeth-Ayerst	Reflux	$127,000,000

C. Estimates of Potential Cost Savings

Over the next ten years, dual eligible beneficiaries will use an estimated $432 billion worth of drugs under the Medicare Part D program.[26] In 2006 and 2007, the costs of providing the top 100 drugs to these beneficiaries was 30% higher under Medicare Part D than it would have been if the Medicare Part D insurers had paid Medicaid prices for the drugs. Assuming this cost differential remains constant, the Medicare Part D program would save $86 billion over the next decade if the Part D insurers had access to Medicaid drug prices.

The actual cost savings to the Medicare Part D program from access to Medicaid prices could be even higher because of the impact of the Medicaid inflation rebate, which caps Medicaid brand-name drug price increases at the rate of inflation. Over the last decade, prescription drug prices increased at a faster rate than inflation. Over time, if brand-name drug prices continue to rise faster than the inflation rate, the difference between Medicare Part D prices and Medicaid prices will continue to increase.

In addition to covering the cost of drugs used by dual eligible beneficiaries, the Medicare Part D program provides a "Low Income Subsidy" (LIS) to 3.3 million beneficiaries who are not eligible for Medicaid. Over the next ten years, LIS beneficiaries will use an estimated $202 billion worth of drugs under the Medicare Part D program.[27] Assuming the current cost differential remains constant, the Medicare Part D program would save $40 billion over the next decade if the Part D insurers had access to Medicaid drug prices for these LIS beneficiaries.

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[26] HHS, Office of the Actuary, Summary of Part D Estimates — CY 2008 Trustees Report (2008).

[27] *Id.*

There are proposals in Congress to allow the federal Medicare program to negotiate directly with drug manufacturers for price discounts. If this legislation were enacted and the Medicare program negotiated price discounts equivalent to the Medicaid prices, the additional savings to taxpayers and beneficiaries would be large. Over the next ten years, Medicare beneficiaries in PDP plans who are neither dual eligible nor eligible for the low-income subsidy will use an estimated $275 billion worth of drugs under the Medicare Part D program.[28] The federal government will pay almost one-half of this amount through various forms of payments to the Part D insurers. The beneficiaries will pay the remainder, primarily through premiums, copays, and drug purchases in the Medicare Part D "donut hole." Assuming the current cost differential remains constant, federal taxpayers would save $29 billion and Medicare beneficiaries (other than dual eligibles and LIS individuals) would save $27 billion over the next decade if the Medicare program negotiated prices equivalent to the Medicaid prices.

The potential cumulative cost savings to federal taxpayers if the Medicare Part D program negotiated prices equal the Medicaid prices is the sum of the potential savings for providing drug coverage to dual eligible beneficiaries, LIS beneficiaries, and beneficiaries who are neither dual eligible nor LIS beneficiaries. This total potential savings for taxpayers over ten years is $156 billion.

CONCLUSION

This analysis of confidential data on Medicare Part D and Medicaid drug prices shows that the private Medicare Part D insurers pay significantly higher prices for prescription drugs than does the Medicaid program. In the case of the six million dual eligible beneficiaries, the Medicare Part D insurers paid $3.7 billion more in 2006 and 2007 to purchase the top 100 drugs for dual eligible beneficiaries than they would have paid if they had access to the lower Medicaid drug prices. This increase in costs represents a windfall to drug manufacturers.

Eliminating the drug manufacturer windfall would realize substantial savings to federal taxpayers. Over the next ten years, taxpayers would save $86 billion if the Medicare Part D insurers paid Medicaid prices for drugs used by the dual eligible beneficiaries. If Medicare negotiated directly with drug manufacturers and obtained prices equivalent to the Medicaid prices for all Medicare beneficiaries, the potential savings to taxpayers increases to $156 billion.

[28] *Id.*