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THE MEDICARE DRUG BENEFIT:

ARE PRIVATE INSURERS GETTING

GOOD DISCOUNTS FOR THE TAXPAYER?

Thursday, July 24, 2008

House of Representatives,

Committee on Oversight and

Government Reform,

Washington, D.C.

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Committee Hearings

of the

U.S. HOUSE OF REPRESENTATIVES

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Committee on Oversight and
Government Reform,
Washington, D.C.

The committee met, pursuant to call, at 10:10 a.m., in Room 2154, Rayburn House Office Building, Hon. Henry A. Waxman [chairman of the committee] presiding.

Present: Representatives Waxman, Cummings, Kucinich, Tierney, Watson, Higgins, Yarmuth, Braley, Van Hollen, Murphy of Connecticut, Sarbanes, Speier, Davis, Burton, Shays, Platts, Issa, Marchant, McHenry, Foxx, Bilbray, and Jordan.

18 Staff Present: Kristin Amerling, General Counsel; Caren
19 Auchman, Press Assistant; Phil Barnett, Staff Director and
20 Chief Counsel; Jen Berenholz, Deputy Clerk; Brian Cohen,
21 Senior Investigator & Policy Advisor; Miriam Edelman, Special
22 Assistant; Earley Green, Chief Clerk; Ella Hoffman, Press
23 Assistant, Karen Lightfoot, Communications Director and
24 Senior Policy Advisor; Karen Nelson, Health Policy Director;
25 Jennifer Owens, Special Assistant; Andy Schneider, Chief
26 Health Counsel; Leneal Scott, Information Systems Manager;
27 Mitch Smiley, Special Assistant; John Williams, Deputy Chief
28 Investigative Counsel; Lawrence Halloran, Minority Staff
29 Director; Jennifer Safavian, Minority Chief Counsel for
30 Oversight and Investigations; Ali Ahmad, Minority Deputy
31 Press Secretary; Larry Brady, Minority Senior Investigator &
32 Policy Advisor; Patrick Lyden, Minority Parliamentarian &
33 Member Services Coordinator; Brian McNicoll, Minority
34 Communications Director; John Ohly, Minority Professional
35 Staff Member; Jill Schmaltz, Minority Senior Professional
36 Staff Member; and Molly Boyl, Minority Professional Staff
37 Member.

38 Chairman WAXMAN. Good morning. The committee will
39 please come to order.
40 Today, the committee is holding another hearing in our
41 series of how to make government work better. Our subject is
42 the Medicare Part D program that provides a prescription drug
43 benefit to seniors and individuals with disabilities.
44 Providing drug coverage to seniors and disabled is
45 essential, but it is also expensive. Over the next decade,
46 the benefit will cost taxpayers hundreds of billions of
47 dollars. We need to make sure this money is spent
48 responsibly and with good value for the taxpayers.
49 This committee has been investigating Medicare Part D
50 for 18 months. During our investigation, we have conducted
51 the only in-depth oversight of the Part D program. GAO and
52 the Congressional Budget Office have been unable to review
53 how well the program is working because the Centers for
54 Medicare and Medicaid Services won't give them the data; and
55 CMS, which does have access to data, refuses to acknowledge
56 fundamental flaws in the program.
57 Last October, I and other members of the committee
58 released the staff report that examined the administrative
59 costs of Medicare Part D. We found that the private insurers
60 that delivered the Medicare benefit are charging taxpayers
61 and beneficiaries $4.6 billion in administrative costs
62 annually. In percentage terms, that is over six times more

63 than it costs to run traditional Medicare. And we found that
64 the Part D program is exceptionally lucrative for private
65 health insurers. They made a billion dollars in profit last
66 year alone.

67 Today, I am joining with 10 members of the committee to
68 release a new staff report, which I ask to be made part of
69 today's hearing record. Without objection.

70 [The information follows:]

71 ******** INSERT 1-1 ********

72 Chairman WAXMAN. Last year's report looked at the
73 profits of the private insurers. Today's report examines the
74 windfall revenues of the drug manufacturers. In this report,
75 we compare the prices that the drug companies charge the new
76 Medicare Part D program with the prices that the companies
77 charged the Medicaid program.

78 What we discovered is that the taxpayers are paying far
79 more for drugs under Medicare Part D than they do under
80 Medicaid. In effect, Medicare Part D has given the major
81 drug companies a taxpayer-funded windfall worth billions of
82 dollars.

83 Our report focuses on the cost to the taxpayer of
84 providing drugs to the 6 million beneficiaries who are
85 enrolled in both Medicare and Medicaid. These are Americans
86 who are old or disabled enough to qualify to be on Medicare,
87 and they are poor enough also to qualify for Medicaid. They
88 are often the oldest and sickest Medicare beneficiaries and
89 their drug coverage is almost fully subsidized by Federal
90 taxpayers. These--"dual eligibles" is what they are called,
91 these dual-eligible beneficiaries account for about half of
92 all drug spending in Medicare Part D.

93 The multibillion-dollar windfall is a result of a
94 provision in the Medicare Part D law that switched drug
95 coverage for the dual eligibles from Medicaid to Medicare
96 Part D. The transfer took effect 2 years ago. Since then,

97 the drug manufacturers have been paid billions more for the
98 drugs used by the dual-eligible beneficiaries than they would
99 have been paid if the dual eligibles had continued to receive
100 their drug coverage through Medicaid.

101 Under Medicare Part D, the 6 million dual-eligible
102 beneficiaries can take the same drugs they got under
103 Medicaid; the only difference is that the Federal taxpayer is
104 now paying 30 percent more. Add it up and it amounts to a
105 drug manufacturer windfall worth at least $3.7 billion in
106 just the first 2 years of the Medicare Part D program. In
107 fact, the actual windfall could be worth billions more if all
108 drugs used by dual-eligible beneficiaries were taken into
109 account.

110 Let me describe some examples. Johnson & Johnson earned
111 over $500 million in additional profits, much of it from just
112 one drug, the antipsychotic medication Risperdal. Bristol
113 Myers earned a windfall of almost $400 million thanks to the
114 higher prices for the stroke medication Plavix. This is an
115 enormous giveaway, and it--it has absolutely no
116 justification. The drug companies are making the same drugs,
117 they are being used by the same beneficiaries, yet because
118 the drugs are being bought through Medicare Part D instead of
119 Medicaid, the prices paid by the taxpayers have ballooned by
120 billions of dollars.

121 The privatization of Medicare Part D is a great deal for

122 the drug companies, And it is a great deal for the private
123 insurers. It is the taxpayers who are taking it on the chin.
124 The circumstances that led to passage of the Medicare
125 Part D were controversial. The chairman of the House
126 committee that wrote the Part D law now runs PhRMA, the drug
127 manufacturers trade association. The administration's top
128 negotiator left the government to lobby for health insurers
129 and drug companies.
130 There are allegations of threats and arm-twisting on the
131 House floor, but that is not the focus of today's hearing.
132 The Medicare drug benefit is providing real help to seniors
133 and the disabled, and it is going to be part of our health
134 care landscape for years to come.
135 The key question for us is, how we can fix the program
136 so that more of the benefit goes to seniors and the disabled
137 and less winds up in the pockets of the drug companies and
138 insurers.
139 Medicaid is one proven model for how the government can
140 use its purchasing power to ensure that it gets low prices.
141 Medicaid is a voluntary program. No drug manufacturers are
142 required to participate. Medicaid gets its low prices by
143 making discounts a condition of manufacturers participating.
144 The program says that if a manufacturer wants to sell their
145 drugs to Medicaid beneficiaries, they have to offer Medicaid
146 their lowest prices. The manufacturers also have to agree to

147 protect the taxpayers from price increases that exceed the
148 rate of inflation.
149 We have well over a decade of operational experience
150 with the Medicaid rebate. It works. It delivers $10 billion
151 annually in savings to the Federal and State governments. In
152 many ways, this is the exact opposite of what is going on
153 under Medicare Part D. Under Part D, the drug manufacturers
154 can charge essentially what they want. Despite their high
155 administrative costs and billion dollar profits, the private
156 insurers have been unable to stand up for the interest of the
157 taxpayers.
158 Now, many of our hearings on waste, fraud and abuse
159 identify problems that the executive branch can fix
160 administratively; that is not the case with Medicare Part D.
161 The waste in this program is the direct result of the
162 statutory design of the law. Congress wrote this law and
163 must lead the way to a solution. To start this process, I
164 will soon be introducing legislation that will protect the
165 taxpayer by bringing down the high price--high drug prices in
166 Medicare Part D. This bill will guarantee that Federal
167 taxpayers cannot be charged higher prices for the
168 dual-eligible beneficiaries under Medicare Part D than under
169 Medicaid.
170 The potential savings to Medicare and the Federal
171 taxpayers are enormous. Passage of reform legislation could

172 save the taxpayer almost $90 billion over the next 10 years;
173 even more could be saved if the Federal Government were to
174 authorize to negotiate prices on behalf of all Medicare
175 beneficiaries.

176 I am looking forward to hearing more about this issue
177 today and working together with the members of this committee
178 to improve the Part D program. I will be introducing our
179 witnesses, who I'm grateful are here today. All of them are
180 here voluntarily.

181 But before we do that, I want to recognize Mr. Davis for
182 an opening statement.

183 [Prepared statement of Chairman Waxman follows:]

184 ******** INSERT 1-X ********

185 Mr. DAVIS OF VIRGINIA. Well, thank you, Mr. Chairman.
186 The Medicare prescription drug program, known as Part D,
187 has successfully provided needed medicines to millions of
188 American seniors. The proof is in the pudding: Overwhelming
189 number of seniors have opted into this program. It is an
190 optional program that speaks for its success. While only in
191 its third year of operation, Part D continues to come in
192 below initial budget projections.
193 Nevertheless, even with all of its successes, Medicare
194 Part D, like any Federal program, could benefit from
195 thoughtful, evenhanded oversight; and I hope that is our goal
196 here today. But I'm not convinced there is much constructive
197 to be learned simply by comparing controlled prices under
198 Medicaid and market prices under Part D and labeling the
199 entire difference a windfall.
200 The majority staff analysis released this morning
201 focuses on dual eligibles, seniors eligible for both Medicare
202 and Medicaid. Before 2006, they received prescription drug
203 insurance through Medicaid which uses statutory price
204 controls. At the request of States and many senior citizen
205 advocates, dual eligibles were included under Part D. Not
206 surprisingly, market-negotiated drug prices for this special
207 population were found to be higher than the legally mandated,
208 below-market Medicaid rates.
209 But any alleged windfall, however large, tells really

210 less than half the story. That difference buys dual-eligible
211 seniors access to drugs not available under Medicaid's more
212 restrictive pharmacy rules, and capturing the alleged savings
213 would be short lived and painful. It would come at a very,
214 very high cost as other segments of the health care delivery
215 system, nongovernment segments--we are talking about employer
216 plans, union plans--payments for the uninsured would then
217 absorb the cost shifts that are inevitably generated by price
218 controls.

219 This is not just a theoretical argument about how free
220 markets work. The Federal Government does have almost 20
221 years of experience with the implications of prescription
222 drug price controls. The Congressional Budget Office and the
223 Government Accountability Office both have repeatedly found
224 that Medicaid price controls increase prescription drug
225 prices to every other purchaser.

226 Transplanting Medicaid price controls onto Part D could
227 have other unwanted implications. We should be very
228 concerned about a Federal Government process to set Part D
229 prices that would turn into a political exercise. There
230 would be enormous political pressure to pick winners and
231 losers.

232 Elsewhere in Medicare, relentless lobbying shifts and
233 shapes reimbursement policies for some services or
234 specialties over others; and it is not a very pretty process.

235 Just a couple of weeks ago, Medicare physicians almost took
236 a 10 percent reimbursement cut at the hands of a
237 government-run pricing system.
238 Given the critical role of Medicare in caring for
239 seniors as they age, we should conduct oversight of the
240 program, but it strikes me that this committee's discussion
241 of Part D is stuck in a rut. With every new report and each
242 successive hearing, I understand Yogi Berra's concept of
243 "deja vu all over again." Repeatedly making economically and
244 plausible arguments about the efficiency of government-run
245 drug pricing or plucking artificial windfalls from thin air
246 won't make Part D, a good program, work any better.
247 It is running well under the original 2003 budget
248 projections, due largely to lower-than-anticipated bids from
249 prescription drug plans. That is what happens in the free,
250 competitive market. And most importantly, opinion surveys
251 report that 85 percent of Part D beneficiaries are happy with
252 the program, the 15 percent obviously on the other side of
253 the aisle here, with the satisfaction rate even higher among
254 the dual eligibles.
255 Meanwhile, other aspects of the program urgently need
256 scrutiny. We could be talking about Medicare payments for
257 durable medical equipment prescribed by physicians or the
258 serious financial trouble facing Part A, Medicare hospital
259 insurance, which is due to go bankrupt in 11 years.

260 The bedrock of the program, Part A, is in dismal shape.
261 The Medicare trustees reported this year the Hospital
262 Insurance Trust Fund will be insolvent in 2019. When that
263 happens, payments can no longer be made to cover seniors'
264 hospital care. There is no authority in current law to allow
265 general revenue funding of that shortfall. We obviously--we
266 fund Part B.

267 I look forward to our oversight hearings on these
268 pressing issues today. Mr. Chairman, I would also ask
269 unanimous consent that the minority staff analysis be
270 submitted for the record.

271 Chairman WAXMAN. Without objection, that will be the
272 order.

273 [The information follows:]

274 ******** COMMITTEE INSERT ********

275 Chairman WAXMAN. We are pleased to welcome for our
276 first panel, Dr. Stephen Schondelmeyer, who is a Ph.D. And
277 Professor and Head of the Department of Pharmaceutical Care
278 and Health Systems at the University of Minnesota; Dr. Gerard
279 Anderson, Ph.D., Professor and Director for the Center for
280 Hospital Finance and Management, Bloomberg School of Public
281 Health at Johns Hopkins University; Fiona M. Scott Morton,
282 Ph.D., Professor of Economics, Yale School of Management,
283 Yale University.

284 We are pleased to have the three of you here today. It
285 is the practice of this committee that all witnesses testify
286 under oath. So if you would please stand.

287 Mr. DAVIS OF VIRGINIA. Mr. Chairman, could I just note
288 for the record, Dr. Schondelmeyer is the majority's witness
289 who, 2 weeks ago, was given notice of this; and we have not
290 yet received written testimony from him.

291 Our minority witness has submitted his for the record
292 ahead of time for scrutiny. Thank you.

293 Chairman WAXMAN. Thank you, Mr. Davis. If the three of
294 you would please stand and raise your right hand.

295 [Witnesses sworn.]

296 Chairman WAXMAN. The record will indicate that each of
297 the witnesses answered in the affirmative.

298 STATEMENTS OF DR. STEPHEN SCHONDELMEYER, PHARM.D., Ph.D.,
299 PROFESSOR AND HEAD, DEPARTMENT OF PHARMACEUTICAL CARE AND
300 HEALTH SYSTEMS, UNIVERSITY OF MINNESOTA; DR. GERARD ANDERSON,
301 Ph.D., PROFESSOR AND DIRECTOR, CENTER FOR HOSPITAL FINANCE
302 AND MANAGEMENT, BLOOMBERG SCHOOL OF PUBLIC HEALTH, JOHNS
303 HOPKINS UNIVERSITY; AND FIONA M. SCOTT MORTON, Ph.D.,
304 PROFESSOR OF ECONOMICS, YALE SCHOOL OF MANAGEMENT, YALE
305 UNIVERSITY

306 Chairman WAXMAN. Dr. Schondelmeyer, we are going to
307 start with you, but Mr. Davis made a very good point that we
308 expect witnesses to submit their statements in advance under
309 the rules. Please go ahead.
310 Did you submit a statement to us, a written statement?
311 Mr. SCHONDELMEYER. I have not yet. I can after this
312 meeting. I do apologize.
313 Chairman WAXMAN. Turn on the mic. Yes, there is a
314 button on the mic.
315 Mr. SCHONDELMEYER. I do apologize. I accepted this
316 assignment with many other commitments, and this was a very
317 tight schedule for me, given other commitments. But I was
318 pleased to do so and--
319 Chairman WAXMAN. We're happy to have you here anyway.
320 Thanks.

321 We are going to ask each of you, as we will all of our
322 witnesses, to try to keep within 5 minutes. I think you all
323 have been informed of that in advance. And if you have
324 submitted written statements, they will be part of the record
325 in full. We're going to have a clock that will be green for
326 4 minutes, yellow for 1 minute and then when the 5 minutes is
327 up, it will turn red. We're not going to be abrupt in
328 stopping you, but I hope that red will be an indication that
329 it is time to get ready--get ready and to conclude.
330 Thank you. Please go ahead.

331 STATEMENT OF DR. STEPHEN SCHONDELMEYER, PHARM.D., Ph.D.

332 Mr. SCHONDELMEYER. Thank you, Mr. Chairman, for
333 inviting--
334 Chairman WAXMAN. Pull your mic a little closer.
335 Mr. SCHONDELMEYER. Thank you for inviting me and thank
336 you to the rest of the committee. I will skip the normal
337 formalities and broad background descriptions, because you've
338 done that well in your introduction.
339 The dual eligibles, as was noted, however, represent a
340 large share of the expenditures both under the previous
341 Medicaid program and under the current Medicare Part D
342 program. Just to put that in perspective, in the year 2005,
343 total Medicaid drug expenditures were about $43 billion a
344 year. In 2006, after those dual eligibles moved from
345 Medicaid over to Medicare, the Medicaid drug expenditures
346 dropped to less than half of that 43 billion, somewhere
347 around $21 billion. So it is very real that this shift did
348 move dollars from the State-run Medicaid programs to the
349 private, market-run Part D Medicare programs.
350 At the same time that that shift occurred, also the
351 access to the rebates under the State-run Medicaid programs
352 disappeared.
353 Let me put in perspective rebates, briefly, under

354 Medicaid. The Medicaid drug rebate program began back in
355 1991 and continues to this day. There is a Federal component
356 to the Medicaid drug rebate program which mandates 15.1
357 percent rebate for all brand-name drugs, and in addition for
358 brand-name drugs, they are subject to a best-price additional
359 rebate and an inflation adjustment rebate that often adds
360 substantially beyond that 15.1 percent for all brand-name
361 drugs. For generic drugs, all generic drugs must provide an
362 11 percent rebate.

363 Now, notice in both brand-name and generic drugs, all
364 prescription drugs are subject to rebates. That is not
365 necessarily the case today. Under the Medicare Part D
366 program, not all drugs are subject to rebate; and
367 particularly those drugs that are covered under the
368 must-cover categories, the categories where the Part D plans
369 can't negotiate or opt to cross different drug categories,
370 those don't appear to receive as much rebate, although under
371 the Medicaid program they did receive the same amount of
372 rebate--at a minimum at least--as the other brand-name drugs.

373 Second, the amount of rebates from 1991--it took a year
374 or two to get the program stabilized. From 1993 to 2000,
375 about 18 to 19-1/2 percent of total drug spending came back
376 to Medicaid programs as rebates. So about 18 to 19-1/2
377 percent came back.

378 Beginning in 2000-2001, though, the States woke up and

379 realized that the Medicaid legislation also authorized
380 States' supplemental rebate programs. In those State
381 supplemental rebate programs, it said States could negotiate
382 on their own rebates above and beyond the Federal rebate, and
383 that has started to grow.

384 In the early--2000 through 2003, we saw rebates grow to
385 20-21 percent. And then we saw a dramatic growth; in 2004
386 rebates grew to 24 percent of the total drug spend, 2005
387 rebates under Medicaid grew to 28.8 percent of the drug
388 spend.

389 Unfortunately, to the best of my knowledge, CMS has not
390 released the rebate data for the years 2006 and 2007 under
391 Medicaid, so we can't look to see what the total amount is.
392 As best I can tell from talking with various States out
393 there, however, the number is probably somewhere above 30 to
394 31 percent total drug spend returned in rebates.

395 Now, that compares with--this committee did a report a
396 year ago that suggested only about 8 percent of the drug
397 spend under Medicare Part D was coming back as rebates, and
398 that wasn't for all drugs and all classes. So if you compare
399 28.8 or 30 percent rebates on Medicaid to 8 percent on
400 Medicare--and I understand your new report shows that the
401 number has gone up under Medicare Part D, but it is still
402 less than half of what the rebate amount was under the
403 Medicaid program--it is obvious that if these same dual

404 eligibles remained in the Medicaid program, the taxpayers and
405 the beneficiaries themselves would benefit from lower drug
406 spend, as you pointed out, Mr. Chairman, on the same drug,
407 the same people. It--just at a lower price in the
408 marketplace. And those are based on State-negotiated
409 supplemental rebates, not mandated rebates. They are
410 negotiated with the States above and beyond the Federal
411 rebate.

412 So it is also important to realize, under the Medicare
413 Part D program, that the dual eligibles and the people on the
414 private side do not receive the benefit of these rebates in
415 lower drug price for most cases. You can find the odd drug,
416 there may be a handful of 10 or 15 drugs where a lower price
417 is actually passed on to the recipients, but for the most
418 part, lower prices are not passed onto the recipient. And
419 the coverage gap, the person pays the entire cost of the drug
420 without the benefit of any of the rebate. And for specialty
421 drugs, where they may be paying 50 to 75 percent coinsurance,
422 they're paying the entire cost of the drug without the
423 benefit of the rebates.

424 In conclusion, it is not just observations of State
425 accountants and academics like myself that say this was a
426 shift in resources. Also Wall Street and corporate annual
427 reports in both 2006 and 2007 noted that drug companies had
428 substantially increased revenues that heretofore had been

429 unexpected due largely, in part, to volume increases under
430 Medicare Part D and the decreased payment for rebates under
431 Part D versus under Medicaid.
432 Thank you very much, Mr. Chairman.
433 Chairman WAXMAN. Thank you, Mr. Schondelmeyer.
434 [Prepared statement of Mr. Schondelmeyer follows:]

435 ******** COMMITTEE INSERT ********

436 Chairman WAXMAN. Dr. Anderson.

437 STATEMENT OF DR. GERARD ANDERSON, Ph.D.

438 Mr. ANDERSON. Thank you, Chairman Waxman. It is a
439 pleasure to return to this committee to talk about the issue
440 of drug pricing.
441 My testimony can be summarized in two observations and
442 three recommendations.
443 My first observation is that Part D plans paid even
444 higher prices for drugs than Medicaid programs were paying.
445 My second observation is the United States pays significantly
446 higher prices for prescription drugs than other countries and
447 that, in the United States, the private sector pays generally
448 20 percent higher prices than the public sector pays for
449 drugs.
450 These two observations lead me to three recommendations.
451 First, there should be greater price transparency in the
452 pharmaceutical market. Second, drug pricing data should be
453 readily accessible to congressional agencies and academic
454 researchers so they can easily know if Part D plans are
455 paying higher prices than Medicaid. And third of all, all
456 government agencies should be paying the same prices for
457 drugs.

458 The remainder of my testimony will explain in greater
459 detail the rationale behind these observations and
460 recommendations.
461 When the responsibility for providing drug coverage for
462 the dual eligibles was transferred in 2005, the expectation,
463 or even the hope, was that Part D plans would be able to
464 obtain lower prices than the Medicaid programs.
465 Unfortunately, a growing body of data, including the report
466 today, suggest that Part D plans are paying even higher
467 prices than Medicaid programs. Amazingly, all the data seems
468 to confirm that the windfall to the drug companies is about
469 $2 billion a year.
470 The first indication of higher prices came from the
471 disclosures by the pharmaceutical companies themselves in
472 their 10-Ks and 10-Qs filed with the Security and Exchange
473 Commission. My written testimony cites specific documents,
474 showing that the pharmaceutical companies were getting higher
475 prices than Part D. Pfizer alone, for example, estimated in
476 its 10-Q an additional $300 million in profits.
477 Secondly, in my report, I show how CBO-CMS actuary data
478 estimate using that data that Part D plans were paying 22
479 percentage points more than Medicaid was paying for the same
480 drug. This committee says 30 percent; the CMS testimony
481 today says 20 percent. So they are all in pretty much the
482 same range.

483 The third indication was the report by this committee
484 last year. So basically all the different sources--and as a
485 researcher you want to have multiple sources--then, the
486 transfer from the dual eligibles will result in about a $2
487 billion annual windfall to the drug companies; and it is
488 currently in line with the report of this committee.
489 Surprisingly, the Medicare program is not the insurer
490 paying the highest prices for drugs in the United States.
491 Typically, the private sector pays 20 percent more for drugs
492 than the Medicare and Medicaid programs.
493 The fact that Part D plans were unable to obtain
494 substantial discounts from the pharmaceutical companies is
495 surprising to me, given the difficulties that the Medicaid
496 agencies have obtaining actual transaction prices to set
497 their own rates. In a series of recent court decisions,
498 judges and juries have found that this lack of price
499 transparency has made it difficult for the Medicaid agencies
500 to actually set prices.
501 President Bush has argued that there should be greater
502 price transparency in the health care sector. When the
503 Bush--while the Bush administration has promoted major
504 efforts to increase the level of price transparency in the
505 hospital and physician sectors, surprisingly there has been
506 very little emphasis on price transparency in the
507 pharmaceutical sector.

508 In order to make greater price transparency, I believe
509 the Secretary of Health and Human Services should determine
510 in the markets are actually working for pharmaceuticals. One
511 way to determine this is to compare the lowest prices that
512 any of the Part D plans are obtaining and compare to the
513 prices that the Medicaid programs, the VA or even Canada are
514 obtaining.
515 Unfortunately, provisions in the MMA limit disclosure of
516 information on drug prices and drug utilization. This data
517 should be given to CBO, CRS, MedPac and other government
518 agencies to analyze the effectiveness of the Part D program.
519 It should also be given to academic researchers.
520 My third and final recommendation is that all government
521 programs should pay the same rate for each drug. I cannot
522 think of a compelling reason, either economically or
523 ethically, why one government program, save the VA, should
524 pay a higher price or a lower price through the Medicare
525 program; all the money comes from the taxpayers. Governments
526 in other countries manage to pay one price for drugs. Why
527 not the United States?
528 Thank you for the opportunity to testify this morning.
529 Chairman WAXMAN. Thank you very much, Dr. Anderson.
530 [Prepared statement of Dr. Anderson follows:]

531 ******** INSERT 1-2 ********

532 Chairman WAXMAN. Dr. Morton.

533 STATEMENT OF FIONA M. SCOTT MORTON

534 Ms. MORTON. Good morning to the chairman and members of
535 the committee. Thank you very much for inviting me to
536 testify. I just have some short remarks.
537 The report that was released this morning repeatedly
538 says that manufacturers charge more to Part D than they
539 charge to Medicaid. I just would like everyone to keep in
540 mind that the manufacturers--under Medicaid, they sell to
541 drugstores in the normal way, and then they are required to
542 give a rebate back to the government. And that is how we get
543 a net price; it is not a charged price.
544 And the size of that rebate is set in law; and the
545 important thing, I think, that we see today, that we didn't
546 see in the early 1990s, was the size of the inflation
547 component of that. And that is not something that Part D can
548 negotiate for. That inflation component is big, and it is
549 mandated under Medicaid.
550 So I would say that the findings of the report are
551 completely predictable in the sense that we knew that
552 Medicaid was required to get the lowest price, and we knew it
553 had these big rebates. And so, of course, that is going to

554 be, as Mr. Davis said, the place where you've got the lowest
555 prices, and we wouldn't expect Part D to be able to do as
556 well as that.

557 So I think if Congress is concerned about just the cost
558 of covering duals, then you should move them back into
559 Medicaid. I mean, that is where you're going to get the
560 lowest prices for these people. It would also reduce
561 confusion for them and plan shifting as the plan they are in
562 becomes too high cost and they're moved to another plan
563 that--I believe that kind of transition is difficult.

564 Secondly, the report finds that the protected classes in
565 Part D get small discounts. Again, I'm going to take this
566 opportunity to say that when I testified for the Senate in
567 January 2007, I predicted this, because you can't move market
568 share in these groups. The formularies are restricted and
569 the Part D plans have to cover all drugs, essentially; and if
570 you can't bargain with the manufacturer, saying, I'm going to
571 move market share to Drug A from Drug B, you can't get a
572 discount. And I think it is very reasonable then to see that
573 you're not getting discounts in these protected classes.

574 Again, this is something you could change with respect
575 to the regulation. You could have fewer protected classes,
576 you could loosen the formulary restrictions so that plans can
577 do a bit more shifting of market share from one drug to
578 another; and then you'd expect to see bigger discounts.

579 Thirdly, we have talked a lot about the windfall that
580 has arisen from moving guys from Medicaid into Medicare. I
581 have some research looking at the opposite effect, which is
582 the movement of the uninsured from paying cash to having
583 coverage under Medicare, and there the windfall appears to
584 have gone in the opposite direction. So the prices that an
585 uninsured, cash-paying person pays are a lot higher
586 than--now, I don't have the same access to information as you
587 do, Mr. Waxman, so I'm inferring it from some less-good data,
588 but it looks like the prices are going down quite
589 drastically.

590 So we do have success of the program in helping the
591 uninsured get access to drugs at lower prices. But--so I
592 just would like to point that out, since we have the windfall
593 going the other way as well.

594 Then two--just points that are longer run. First of
595 all, I think this committee might want to return to this
596 question next year because the way the negotiations work is,
597 they happen in February for prices to set in November for the
598 next year. So when you think about the experience with the
599 program, it wasn't until February of 2007 that plans and
600 everybody could watch a whole year of operation of this
601 program. And so it wasn't, therefore, until prices were set
602 for 2008 that you see kind of informed outcomes, as opposed
603 to just guessing what are people going to do and where are

604 they going to enroll. So I think we can learn more going
605 forward.

606 And then, lastly, it seems messy and costly to me to try
607 to have a Medicaid rebate applied to some purchases inside
608 Medicare. It seems just--because you get those rebates. The
609 supplemental rebates come from shifting, having a preferred
610 drug; the Medicare Part D rebates come from having a
611 preferred drug. So trying to get a plan to have a Medicaid
612 rebate for a guy who is in their Medicare plan that they are
613 trying to negotiate over with the manufacturers, that seems
614 very complex to me. I think it would be just easier to move
615 them, for the plan.

616 And I think that--oh, the last thing about the Medicaid
617 rebates is, they are large and they really reduce the
618 profitability, of course, of selling to the Medicaid program.
619 I think that works partly because the Medicaid program is
620 small, so if it is 12, 15, 18 percent of the Nation's drug
621 spending, the manufacturers can afford and should be
622 interested in providing medications at low cost to those poor
623 people who are also sick.

624 But when you think about Medicare, 40 percent of all
625 prescriptions are doled out to people who are eligible for
626 Medicare. I mean, by the time you add on Medicaid--that's
627 half the market--you're then talking about a very serious
628 change in the market structure of the pharmaceutical

629 industry.

630 Thank you. That's all.

631 Chairman WAXMAN. Thank you very much.

632 [Prepared statement of Ms. Morton follows:]

633 ******** INSERT 1-3 ********

634 Chairman WAXMAN. I'll start off the question--5 minutes
635 of questions.
636 That was an interesting point you just raised about the
637 Medicaid population being so much smaller than the Medicare
638 population, but when we talk about dual eligibles, we are
639 talking about half the budget for pharmaceuticals under Part
640 D.
641 You're shaking your head. You acknowledge that fact?
642 Ms. MORTON. Yes, I think not everybody who is Medicare
643 eligible is enrolled in Part D. So the current proportion of
644 duals is quite high relative to all the people who could be
645 signing up for Part D going forward.
646 Chairman WAXMAN. If we paid the Medicaid price for
647 those dual eligibles, there would be a tremendous savings.
648 Do you agree?
649 Ms. MORTON. Oh, there would. Because we used to have
650 them in Medicaid where these regulated prices were below
651 market level. Absolutely.
652 Chairman WAXMAN. Do you think that did any harm to the
653 ability of the prescription drug industry to do their
654 research, market their products?
655 Or your statements seem to be, it is a small amount so
656 that the controls on those prices, requirements of
657 discounts--it did not have an adverse effect?
658 Ms. MORTON. It is hard to know what the ideal amount of

659 research and development is, so I won't tread in that area.
660 But in terms of where we were before with kind of 18 percent
661 of spending in Medicaid, seemed like, you know--if you take
662 that as a benchmark, you know, it seemed not so terrible to
663 me; whereas I feel like half of all spending being subject to
664 these rules is really pretty drastically different and moves
665 us a lot more toward a single payer--you know, national
666 health almost.

667 Chairman WAXMAN. As I hear the testimony of the three
668 of you, you all seem to agree that our report is accurate.
669 Is that a fair statement?

670 Start with Dr. Schondelmeyer.

671 Mr. SCHONDELMEYER. Yes, it is. I think it is quite
672 accurate. And I'm not sure it takes fully into account the
673 effect of State supplemental rebates.

674 I would point out that your own State of California gets
675 about 40 percent of their total drug spend back in rebates.
676 And those State supplemental rebates are negotiated, not
677 government-set prices. They are negotiated with the drug
678 companies based on movement of market share and the same
679 tools that the private Part D plans have available.

680 So why is it that States can negotiate up to a 40
681 percent rebate, an additional 20 percent on top of what the
682 Federal rebate is, and the private Part D plans can only get
683 8 to 14 percent rebates? I don't know.

684 Chairman WAXMAN. And, of course, our report was only on
685 the 100 most-prescribed drugs. There are other drugs beyond
686 that, as well, for which there could be a greater savings or
687 that we are paying far more for than we otherwise might have
688 to.
689 Mr. SCHONDELMEYER. Could--but given what I know about
690 the market and how rebates work, I would be willing to wager
691 that there are even smaller rebates on the rest of the drugs
692 in the market than the 100 you looked at.
693 Chairman WAXMAN. I see. Okay.
694 Dr. Anderson, what is your view?
695 Mr. ANDERSON. I agree that these numbers are quite
696 accurate.
697 I think you have to look at it from a variety of
698 different perspectives. One is from the 10-Ks and the 10-Qs,
699 and you add up those that they report, you'll get to about $2
700 billion. Then you sort of look at the differential in the
701 prices between Medicare and Medicaid, and it is about a 20-25
702 percent differential. You do those and you get about a $2
703 billion number.
704 So I think, from a variety of sources, we are seeing
705 that your numbers are quite accurate; and I wish we had
706 access, actually, to your numbers so we could look at them.
707 As researchers, I think it is really important.
708 Chairman WAXMAN. And, Dr. Morton, as I heard your

709 testimony, you confirmed the committeestaff's findings? You
710 can't tell us exactly that we are correct because you don't
711 have the same data, but you confirmed the fact that we're
712 paying far more under Part D for these dual eligibles?
713 Ms. MORTON. That's consistent with what I know.
714 The States get supplemental--can negotiate for
715 supplemental rebates. They get the best price on a brand and
716 there is the inflation component, and Part D can't mimic
717 those latter two. They can mimic the supplemental, but they
718 can't get the inflation piece, for example.
719 And then, secondly, looking outside the drugs that you
720 examined, I would actually think the rebates would be bigger
721 for Part D. And the reason is--
722 Chairman WAXMAN. You would agree with Dr. Anderson?
723 Ms. MORTON. Yes. Because the big drugs for the duals
724 are largely in the protected classes where, as I said, there
725 is less ability to negotiate.
726 Outside the protected classes, you would expect more
727 negotiation, more market share shifting and bigger rebates.
728 Chairman WAXMAN. These are protected classes because
729 they are drugs that--there is no other alternative to those
730 drugs and they are life saving; is that basically right?
731 Ms. MORTON. I think there is also a second factor,
732 which is that you're trying to stop Part D plans from
733 engaging in adverse selection, from cream-skimming in taking

734 healthy people. And if you offer only one HIV drug on your
735 formulary, you're not going to attract the sick people.
736 Chairman WAXMAN. So we protect those classes of drugs,
737 and it is important that we do so for the well-being of the
738 people.
739 Ms. MORTON. That's right.
740 So in some sense that is why I suggest moving these guys
741 back into Medicaid, given--if you're concerned, for this
742 reason, about having a restrictive formulary, then, you know,
743 that going to cost you.
744 Chairman WAXMAN. Thank you.
745 Mr. Davis.
746 Mr. DAVIS OF VIRGINIA. Thank you.
747 Of course, the problem is, these folks don't want to go
748 back into Medicaid. But that is a political issue the other
749 side will have to deal with.
750 Dr. Scott, let me ask you. We keep referring to private
751 sector price controls that would result from Medicaid price
752 regulation being extended to Part D. Can you elaborate on
753 the expected impact of extending price controls to the Part D
754 program on the following groups: employers, employees,
755 unions and uninsured?
756 Ms. MORTON. Certainly. If you have--the best price
757 provision of the Medicaid rebate rules is the critical thing.
758 So if I, as a manufacturer, offer a low price to any

759 private-sector buyer, I have to offer that same--effectively,
760 the way the rebate works--I have to offer that same low price
761 to Medicaid. So the bigger--so that gets expensive as the
762 group that gets that forced rebate gets bigger.

763 So as that group getting bigger and bigger, which it
764 would be if you put in duals or all of Medicare or whatever,
765 then I don't want to give a discount anymore, as a
766 manufacturer, because if I give a discount to even one party,
767 I have to give to the entire portion of the market covered by
768 that best price. And that causes discounts for
769 private-sector employers, for everybody else.

770 Mr. DAVIS OF VIRGINIA. The extension of the philosophy
771 over there is just, why not just fix prices for everybody;
772 that at the end of the day, if you fix prices, that somehow
773 the drug companies are going to go along and just take it?

774 What you are arguing is, they make it up somewhere else
775 along the way.

776 Ms. MORTON. Well, they are going to have an incentive
777 to eliminate those discounts elsewhere in the economy and
778 will move toward a more uniform pricing where everybody pays
779 the same price and nobody can negotiate for a discount.

780 And that is dangerous, I believe, because the way we run
781 our intellectual property is that these brands have patent
782 protection, and the way to create price competition when two
783 molecules have patent protection is to threaten to substitute

784 one for the other and get a discount. If you can't do that
785 because of the best price regulation, then you undermine
786 price competition.
787 Mr. DAVIS OF VIRGINIA. One of the problems with
788 Medicaid is that you don't get the same breadth of offerings,
789 isn't that right, that you would get Medicare Part D?
790 Ms. MORTON. Technically, it is supposed to be an open
791 formulary, but I believe the supplemental rebate States are
792 negotiating for depend most now on having a preferred drug
793 and then a list where the physician has to get prior
794 authorization to prescribe the drug, so that effectively
795 you're getting a narrow formulary. That's right.
796 Mr. DAVIS OF VIRGINIA. Dr. Anderson, do you want to
797 comment?
798 Mr. ANDERSON. I would say, if you would compare the
799 formularies between Medicaid and any of the private-sector
800 plans, you would see that Medicaid has a much broader
801 formulary than most of the private-sector plans.
802 Mr. SCHONDELMEYER. I would agree with that.
803 Mr. DAVIS OF VIRGINIA. But they limit the number of
804 prescriptions that can be filled at any one time, right?
805 Mr. ANDERSON. Some of the States do have those as ways
806 to control expenditures, yes. But the formularies are quite
807 extensive.
808 Congress essentially mandated that in OBRA '90 and

809 essentially said that all State Medicaid programs had to
810 offer all drugs and have access provisions in there to make
811 sure that they are available to all communities, all
812 beneficiaries.
813 So it is quite an open program.
814 Mr. DAVIS OF VIRGINIA. But does a large formulary
815 matter if you can't fill the prescription?
816 Mr. ANDERSON. Essentially, that is the problem of the
817 States having not enough money in their Medicaid programs,
818 and so they are making choices here as to how to save money;
819 and I would not do that, but that's the choices that they
820 have, given limited resources.
821 Mr. DAVIS OF VIRGINIA. Well, I know in Virginia we have
822 gone from Medicaid, 10 years ago, being zero percent of the
823 State budget to, now, 17 percent of the State budget. It has
824 crowded out education and everything else. It is a huge--I
825 wouldn't say completely unfunded Federal--but it is a Federal
826 mandate that carries with it a lot of costs.
827 And, of course, States have to balance their budgets.
828 We don't. There is just, I think, a huge problem.
829 Let me ask, long term on price controls; I'll ask each
830 of you. Are you surprised to learn that in the first 4 years
831 after the government mandated Medicaid price controls in
832 order to control prescription drugs spending, that spending
833 actually increased by 40 percent? Does that surprise

834 anybody?

835 Dr. Morton.

836 Ms. MORTON. I think spending on drugs--it doesn't
837 surprise me, but it might be due partially to the best-price
838 legislation that was passed in 1991, but it also might be due
839 to technological change. We invent new drugs, people want to
840 consume them. The population is aging, more people are on
841 the disability rolls; we're just consuming more health care.

842 Mr. DAVIS OF VIRGINIA. Do prescription drug price
843 controls hold down spending over time? I mean, immediately,
844 obviously, price controls, we know they have an immediate
845 effect; but over time, how does the marketplace reflect that?

846 Ms. MORTON. One of the things you have to realize when
847 you're engaging in this kind of price regulation is that the
848 manufacturer will have some kind of optimal response. So
849 they will raise prices or alter their mix of drugs or change
850 their forms or whatever, if that is going to get them bigger
851 reimbursement. So that is one thing to keep in mind.

852 Then the second thing to keep in mind is just the
853 research and development consequences. If we cut by half our
854 spending on pharmaceuticals, then, you know, that's going to
855 help us today, but it has consequences for future generations
856 because we have privately funded R&D. And unless we're
857 willing to think of some other way to do R&D, I think we have
858 to make sure there is some money to be earned for somebody

859 who develops a novel therapy.

860 Mr. DAVIS OF VIRGINIA. Of course.

861 Mr. SCHONDELMEYER. Earlier, you asked all three of us
862 to respond to the question, are we surprised that 40 percent
863 expenditure increase occurred in the first 4 years. That is
864 expenditure increase, not price increase; and the number of
865 recipients increased in that time and a number of other
866 factors unrelated to price.

867 Also I point out, you ask, do price controls result in
868 lower prices or higher prices over time. I would point out,
869 the other major governments around the world that do have
870 price controls--I'm not saying we have to do that--but do
871 have price controls, do pay lower prices than we do. So
872 price controls for many markets in many governments seem to
873 work.

874 The last thing I'd point out is, the United
875 States--today, our government pays for 50 to 60 percent of
876 all drugs in the U.S. We have become the largest buyer in
877 the marketplace. Whether you act as a regulator of price or
878 a prudent buyer in the marketplace, you're going to have an
879 impact in the marketplace. But I would say our government is
880 not working as a prudent buyer in a market--in a marketplace.
881 And there are behaviors that they can undertake that do
882 facilitate markets, but use the power of a 50-to-60 percent
883 player in a marketplace.

884 Mr. DAVIS OF VIRGINIA. Governments are rarely prudent
885 buyers is my observation.
886 Mr. SCHONDELMEYER. You guys can change that.
887 Mr. DAVIS OF VIRGINIA. I don't think you want Congress
888 to get involved.
889 Chairman WAXMAN. Thank you, Mr. Davis.
890 Mr. Cummings.
891 Mr. CUMMINGS. I have sat here and I have listened to
892 all of you; and I have got to tell you, I'm confused.
893 Because the bottom line, Dr. Anderson and Dr. Schondelmeyer,
894 as I understand it, is that the government is spending more
895 money now, in moving these folks to Medicare Part D, than
896 they were before. Is that the bottom line?
897 Mr. ANDERSON. That's $2 billion more per year.
898 Mr. SCHONDELMEYER. True.
899 Mr. CUMMINGS. Okay.
900 Now, maybe I'm missing something, but Mr. Davis, whom I
901 have tremendous admiration for, talked about "deja vu, here
902 we go again." But the fact is that Americans, hardworking
903 taxpayers that are watching this right now, are probably
904 sitting there scratching their heads and saying, Okay, what
905 does all this mean?
906 Now, Dr. Morton has given us a few suggestions. And as
907 I sat here and I listened to the suggestions, this is what I
908 asked myself. I asked myself, what is the problem with her

909 suggestions? And I want you all to answer.

910 One of the things she says, we should move the folks
911 that are now on Medicare Part D--correct me if I'm
912 wrong--back to Medicaid. Is that right?

913 Ms. MORTON. Just the duals. I mean, my understanding
914 is, Mr. Waxman's concern is just the duals.

915 Mr. CUMMINGS. So that we won't be confused and the
916 public won't be confused--see, what happens here in
917 Washington is, people talk past each other, and so then--but
918 when the bottom-line clears, we are still in the same
919 predicament. And we'll be in the same predicament 10 years
920 from now, but it will be far worse.

921 Is there something wrong with what she said? Is there
922 an issue with that?

923 Mr. ANDERSON. Well, I think you could do that. The
924 problem is that you want to have one program really be in
925 charge for the person's health care, and that should be
926 through the Medicare program or the Medicaid program. And by
927 putting--in the past, they have been separate, so drugs have
928 been part of the Medicaid program, and lots of other things
929 have been part of the Medicare program; and that makes it
930 much more difficult to get good, quality care.

931 So there are pricing reasons why you should follow her
932 ideas, but there are clinical reasons why you might not want
933 to.

934 Ms. MORTON. Now, can I say, the clinical side is not
935 represented so well by our current system of a PDP and then a
936 set of doctors who aren't part of the same organization.
937 I agree with you, but I think we could fix it for
938 everybody.
939 Mr. ANDERSON. We should fix this for everybody, and
940 essentially, potentially having separate payment systems
941 makes it more difficult to solve it, because you want to have
942 one system, one insurer really being responsible for the care
943 of an individual.
944 Mr. SCHONDELMEYER. I agree that could work, to shift
945 them back to Medicaid; but a downside of that is, markets
946 work also based on the principle of volume, and larger volume
947 should get lower price.
948 But here we have the government paying 50 to 60 percent
949 of the drugs on the market, and paying a higher price and
950 moving the dual eligibles from Medicare Part D back to
951 Medicaid means that the government is dividing up their pie
952 again to lots of smaller pieces, and essentially Medicare
953 Part D does that. Instead of the government saying, we're
954 going to pay for all Medicare Part D under one pricing
955 system, we're going to let each plan and hundreds of these
956 plans across the country negotiate prices. So we want a
957 whole bunch of small people negotiating instead of one big
958 party negotiating. So we structurally built into Medicare

959 Part D principles that fight against markets working well in
960 ways that do derive better prices in the marketplace.
961 So we need to ask, should we keep them in Medicare Part
962 D and find ways to better use the government's role in the
963 marketplace.
964 Mr. CUMMINGS. Dr. Morton, I'm running out of time.
965 What was your second most powerful suggestion?
966 Ms. MORTON. I think that we need to study the protected
967 classes quite carefully. I think what Mr. Waxman said about
968 how these are vulnerable populations that are very sick and
969 need access to correct drugs is absolutely right. However,
970 when you give the plans no tools to shift market share or
971 weak tools, then you are going to have expensive prices.
972 Mr. CUMMINGS. Dr. Anderson, would you react to that,
973 please?
974 Mr. ANDERSON. Sure.
975 Essentially what we did when we passed OBRA '90 was, we
976 said everybody in the Medicaid program had--for all the
977 drugs, and so essentially you took out the ability to do
978 formularies. But then you gave them the ability to do
979 rebates.
980 So essentially what you'd want to do in these protected
981 classes is to institute either the best price or the rebate
982 system, so that when there is no competition, the Federal
983 Government or the dual eligibles get the best prices.

984 Mr. CUMMINGS. Thank you, Mr. Chairman.

985 Chairman WAXMAN. Mr. Marchant.

986 Mr. MARCHANT. Thank you, Mr. Chairman.

987 Dr. Morton, in your testimony, you explained that
988 expanding Medicaid, the Medicaid best-price requirement, to
989 Part D would make prices more uniform across the board. Dr.
990 Anderson seems to advocate uniform prices.

991 What would be the implication of a uniform prescription
992 price policy?

993 Ms. MORTON. The implications are twofold. One is that
994 because the production cost of these drugs is quite low
995 relative to the research and development costs, it is worth
996 giving them--it is worth selling at low prices to people who
997 are poor or who can't pay, because you're still covering your
998 manufacturing costs and you're extending the benefit of the
999 drugs to those people. If you have to charge a uniform price
1000 to everybody, then those people can't afford it, they don't
1001 buy and you don't get as many people being helped. So it is
1002 useful to be able to sell at different prices to different
1003 consumers.

1004 Secondly, plans--PBMs and insurers and HMOs--in this
1005 country have invested a lot in changing their organizations
1006 to be able to shift market share from one molecule to
1007 another, and that requires education of doctors and a lot of
1008 organizational effort. And that ability to shift market

1009 shares is what drives prices down, because it creates price
1010 competition between drugs. I buy A and you buy B. A and B
1011 compete. I get a good price on B; that is why I bought it.
1012 You get a good price on A; that is why you bought it.

1013 So your price on A is low and mine is high because we've
1014 engaged in this kind of bargaining. And if you make
1015 everything uniform, then all of that system of extracting
1016 price concessions is no longer worth doing.

1017 Mr. MARCHANT. Thank you.

1018 Dr. Anderson, you seemed to express surprise that Part D
1019 prices are higher than Medicaid. Does any other payer in the
1020 United States get Medicaid prices?

1021 Mr. ANDERSON. Sure. The VA actually gets lower prices,
1022 DOD gets lower prices than Medicaid does in most cases.

1023 Mr. MARCHANT. Does GM get Medicaid prices despite
1024 their--the fact that they are a very large purchaser?

1025 Mr. ANDERSON. I haven't--I don't have access to it.
1026 That's where we need price transparency to know whether or
1027 not GM gets the same prices at Medicaid. We don't, as
1028 researchers, have access. My guess is that they do not,
1029 which is what I'm concerned about, that the marketplace for
1030 drugs does not seem to be working.

1031 All the discussion that Fiona Scott Morton talks about
1032 in terms of the marketplace is resulting in the private
1033 sector paying 20 percent more than the public sector. And

1034 why would I want to emulate a system where you're paying 20
1035 percent more?

1036 Mr. MARCHANT. Well, it seems to me that someone in
1037 their 20s or 30, that had a disease that they felt like there
1038 was a time horizon available to them for that disease or
1039 that--to be cured with some kind of a medicine, would hope
1040 that the drug companies would not just flatten their product
1041 line to a price point, but would build something into the
1042 product line for profit and R&D, so that there would be some
1043 hope later. And, of course, the government would have that
1044 hope, too.

1045 Mr. ANDERSON. And I would share in that hope. Right
1046 now, however, the pharmaceutical industry is spending
1047 anywhere from 14 to 18 percent of its revenues on R&D. It is
1048 spending 30 percent on marketing and spending 25 percent on
1049 profits.

1050 So I would love them to increase the
1051 percentage--certainly as a researcher, certainly as a
1052 professor at Johns Hopkins--to increase them from 14 percent
1053 to 20 percent or 25 percent. But that is not what has
1054 happened, and as the profits have increased, the percentage
1055 has remained absolutely stable.

1056 Mr. MARCHANT. Ms. Morton, do you see a danger in that
1057 theory?

1058 Ms. MORTON. The marketing expenses of a pharmaceutical

1059 firm are all driven toward getting more revenue, which--and
1060 those expenses wouldn't be spent if they weren't worthwhile
1061 in bringing in more revenue, so that increases the incentive
1062 to invent something. The more revenue you can collect from
1063 it, then the more incentive you have to invent it.

1064 So the marketing, per se, is not a disaster.
1065 Profitability is very difficult to calculate here because the
1066 percent profit has to be calculated on something--percent of
1067 sale, percent of assets, percent of whatever--and typically
1068 we would do it as percent of assets. And R&D is an asset for
1069 these firms, but it is not counted as such when the
1070 accountants look at assets. So pharmaceutical companies look
1071 like they have tiny assets and few factories when, in fact,
1072 they spend millions on R&D.

1073 So I'm just always leery of profit numbers, because they
1074 can--you can calculate them so many different ways.

1075 Mr. MARCHANT. Thank you, Mr. Chairman.

1076 Chairman WAXMAN. Mr. Yarmuth.

1077 Mr. YARMUTH. Thank you, Mr. Chairman. I want to thank
1078 all the witnesses for their testimony.

1079 I think we are in general agreement that the treatment
1080 of dual eligibles through Medicare Part D is costing the
1081 government and the taxpayers more money than it otherwise
1082 would. And the staff report estimates that the savings to
1083 the taxpayer down the road, or the additional cost to the

1084 taxpayer for failure to do something different, would be in
1085 the neighborhood of $85 billion over that 10-year period.
1086 Dr. Schondelmeyer and Dr. Anderson, does that seem like
1087 a reasonable estimate to you? Is that possible? Is that
1088 understating it?
1089 Mr. SCHONDELMEYER. I think if the program continues as
1090 designed, that is a reasonable estimate. But I would point
1091 out that it is probably even more than that because the
1092 States have gained even more in their supplemental rebates in
1093 the last year or two, and I think the savings could be even
1094 greater than what that represents.
1095 So it is probably a reasonably accurate estimate if not
1096 an underestimate.
1097 Mr. ANDERSON. And I would agree.
1098 Mr. YARMUTH. And it is possible, because the States
1099 have the protection of the inflation cap, essentially, it
1100 could be more than that in terms of savings if the inflation
1101 rate ended up being significantly higher as it has been in
1102 many years.
1103 Mr. ANDERSON. I think in OBRA '90, that was a very
1104 smart thing to include in there, to put it in, because when
1105 the drug companies increase the prices, then essentially the
1106 Medicaid programs gets the advantage of that. And that
1107 doesn't exist in Medicare Part D.
1108 Mr. YARMUTH. Dr. Morton, you said in your testimony

1109 that the result of the study, the staff study, the staff
1110 report was predictable given what we're talking about.
1111 Would you say that the impact that we've seen over the
1112 last few years was predictable when the legislation was
1113 passed to create Medicare Part D?
1114 Ms. MORTON. Certainly, the magnitude, I wouldn't have
1115 wanted to speculate on. But the fact that Medicaid has a
1116 required best-price provision for brands and then the
1117 inflation component on top of that makes me think that it
1118 would be extremely difficult for a private sector--I mean, it
1119 would be impossible if the Part D plans were included in the
1120 best-price provision.
1121 But actually they are exempted, so you could give Part D
1122 a low price, and it wouldn't trigger a Medicaid rebate.
1123 But having said that, I still think it would be very
1124 difficult to match the Medicaid price.
1125 Mr. CUMMINGS. [presiding.] Mr. Bilbray.
1126 Mr. BILBRAY. Mr. Chairman, with your condolence--I
1127 mean, your support, I'd like to yield my time to the ranking
1128 member.
1129 Mr. DAVIS OF VIRGINIA. He is always happy to give you
1130 his condolences.
1131 Dr. Schondelmeyer, let me ask you. Prior to 2006,
1132 dual-eligible seniors who qualify for both Medicare and
1133 Medicaid had prescription drug coverage through Medicaid. Of

1134 course, now they're moved into the Part D.

1135 The majority report argues that by moving dual-eligible
1136 seniors from Medicaid price controls to Part D market prices,
1137 prescription drug companies receive a financial windfall.

1138 Do you disagree with CBO's assessment that mandating
1139 Medicaid price controls in Part D would increase the cost of
1140 drugs to all other private payers?

1141 Mr. SCHONDELMEYER. I haven't looked recently at CBO's
1142 assessment or quantification of that.

1143 I would point out that the Medicaid rebate is partly
1144 based on the best price, which comes from a price negotiated
1145 in the marketplace. And it means that there are at least
1146 one--

1147 Mr. DAVIS OF VIRGINIA. The total marketplace or a
1148 restricted marketplace?

1149 Mr. SCHONDELMEYER. In various buyers in the private
1150 marketplace.

1151 So there is at least one other buyer in the marketplace
1152 that is smaller than Medicaid and smaller than Part D plans
1153 that have negotiated a better price. And I find it
1154 contradictory that the larger Part D plans can't negotiate
1155 similar prices in the private marketplace that the best-price
1156 buyer--so I would argue that not all of the prices are
1157 regulated.

1158 I would give you that the mandated rebate amounts are

1159 set by government law or regulated, but any rebate above and
1160 beyond that is affected by the best price of negotiations in
1161 the marketplace.

1162 Mr. DAVIS OF VIRGINIA. Well, I'm going to ask unanimous
1163 consent that the Congressional Budget Office's letter to
1164 Senator Stabenow, stating that including a best-price
1165 requirement in Part D would put upward pressure on prices
1166 paid by the VA, Medicaid and private purchasers, be included
1167 in the record.

1168 RPTS COCHRAN

1169 DCMN MAYER

1170 [11:10 a.m.]

1171 Mr. CUMMINGS. So ordered.

1172 [The information follows:]

1173 ******** COMMITTEE INSERT ********

1174 Mr. DAVIS OF VIRGINIA. Dr. Scott Morton, let me just
1175 ask you. You have to look at the marketplace as a whole;
1176 isn't that right? When you are cutting in one place, don't
1177 costs somehow rise--the drug companies, or whoever, in their
1178 marketplace are going to make allowances for that?
1179 Ms. MORTON. Yes.
1180 I think we have a problem in our country because, for
1181 our government purchases, we tend not to like to say we will
1182 pay $2.43 for that pill. We like to say we are going to pay
1183 as much as the private sector pays, or 15 percent less than
1184 the private sector, or we are going to pay as much as Canada
1185 pays.
1186 And then the problem for all those sorts of reference
1187 prices is that industry then would like--if they can move the
1188 reference price, they can shift how much Medicaid and
1189 Medicare pay for their drugs.
1190 So if we say "average prices," then the private sector
1191 prices are going to go up, because that is what triggers--
1192 Mr. DAVIS OF VIRGINIA. It is kind of like everybody
1193 taking the lowest seat price on the airplane. If everybody
1194 paid the lowest price that somebody pays on an airplane, they
1195 would be in worse shape than they are.
1196 Ms. MORTON. They would raise the lowest price. That
1197 lowest price price wouldn't be where it was before.
1198 Mr. DAVIS OF VIRGINIA. And that is basically the

1199 argument here, as I understand. It is economics that I took.

1200 Mr. ANDERSON. But I am not sure why the Federal

1201 Government should pay the highest price.

1202 Mr. DAVIS OF VIRGINIA. Well, they don't in many cases.

1203 Mr. ANDERSON. They don't. But essentially--

1204 Mr. DAVIS OF VIRGINIA. Dr. Morton, do you think the

1205 government is paying the highest prices?

1206 They don't pay the highest prices. In fact, Medicare,

1207 Part D, the increases are way below what was initially

1208 estimated as we bring some marketplace into health care. One

1209 of the problems today is the Federal Government is such a

1210 large buyer, you don't have basically a market in some of

1211 these places.

1212 Dr. Morton, would you react to that?

1213 Ms. MORTON. I think you said it correctly before,

1214 Gerry, when you said that Medicaid pays the lowest and then

1215 Medicare and then the private sector. So I think the private

1216 sector is paying the highest prices, and the danger of having

1217 a best-price provision that extends to a large group of

1218 consumers is that those prices go up.

1219 Mr. DAVIS OF VIRGINIA. So are senior taxpayers paying

1220 unfairly high prices for prescription drugs in Part D?

1221 Ms. MORTON. I think--since I am an economist, I am not

1222 going to comment on the "unfair" part. I think my own

1223 research shows there is a huge benefit to moving the

1224 cash-paying uninsured into a plan, okay, because then you
1225 have someone larger working on your behalf.
1226 Mr. DAVIS OF VIRGINIA. They are the ones that took the
1227 brunt of it, aren't they, before this?
1228 Ms. MORTON. Our data show that is a big effect. Moving
1229 into a plan, having been uninsured, means you get access to
1230 much better prices, and of course, your utilization goes up.
1231 Mr. DAVIS OF VIRGINIA. You would agree with that,
1232 wouldn't you, that the biggest beneficiaries of this are the
1233 uninsured, the poor, in terms of moving them into Part D,
1234 that they get a great reduction?
1235 Mr. ANDERSON. Oh, absolutely, the same thing as, we
1236 should try to cover the uninsured in the United States. I
1237 mean, we want to cover as many people as possible. So
1238 absolutely you want to do that; you just don't want to pay
1239 more than you need to pay for services. And I think that is
1240 what this committee's report shows, that you are paying too
1241 much for services. And $2 billion is $2 billion.
1242 Mr. DAVIS OF VIRGINIA. Are they saying too much, or are
1243 they saying they are not paying what Medicaid pays, which is
1244 clearly the lowest? I think there is a difference between
1245 "too much" versus what Medicaid pays.
1246 If you argue that everything over Medicaid prices is too
1247 much and you put Medicaid prices across the board, it
1248 couldn't happen, could it, economically? Wouldn't it raise

1249 Medicaid prices?

1250 Mr. ANDERSON. I don't think it would raise Medicaid

1251 prices.

1252 Mr. DAVIS OF VIRGINIA. So if you think the drug

1253 companies, across the board, charged everybody at Medicaid

1254 rates, that life would just go on and there would be no

1255 ramifications throughout the system?

1256 If that is your opinion, that is fine.

1257 Mr. ANDERSON. They still would be paying more, the

1258 United States would still be paying more than Canada would be

1259 paying. You would have to bring the rates down to VA in

1260 ordered to get down to Canada or U.K. or French rates.

1261 Mr. DAVIS OF VIRGINIA. One thing we have with the U.K.

1262 is you do not have--and a lot of veterans have complained

1263 about this--you don't have the choices in VA because not

1264 everybody is bring their costs down to those levels.

1265 They can't afford to sell their drugs at that level,

1266 isn't that correct?

1267 Mr. ANDERSON. Well, they essentially have a formulary,

1268 and within a therapeutic class they will have a one-drug,

1269 which is exactly the same thing that the Part D plans have;

1270 they don't offer every drug. It is Medicaid that offers

1271 every drug.

1272 Mr. DAVIS OF VIRGINIA. I have one more question.

1273 Dr. Scott, when proponents of a national formulary are

1274 confronted with the counterargument that a structure would
1275 limit seniors' ability to get drugs, their response is often
1276 that seniors can just appeal the decision.
1277 I would ask, are the lower prices on formularies only
1278 achieved by the ability to move market share?
1279 Ms. MORTON. My understanding is, that is the main
1280 reason why you get a low price, that you can promise to move
1281 market share. And if you are a senior and you look at
1282 PlanFinder, for example, in the Part D context, you can see
1283 which plans have a preferred--have a good price on the drug
1284 you are interested in. If it is A versus B, you can see
1285 that, and then you can join the plan that has the low price
1286 on the one you want.
1287 Mr. DAVIS OF VIRGINIA. On the one you want, you get
1288 more choice. Thanks.
1289 Mr. CUMMINGS. Mr. Sarbanes.
1290 Mr. SARBANES. Thank you, Mr. Chairman.
1291 Whenever we have a hearing on the pharmaceutical
1292 industry or drug pricing, I feel like I am in a magic show
1293 because it is all sleight of hand. I mean, it is incredible,
1294 the questions.
1295 When you say, well, if the price is this much higher
1296 than you would get in another way, isn't it really lower
1297 because of X, Y and Z? I mean, people see that the prices
1298 are higher. The report makes it clear that we have spent $2

1299 billion or $3 billion more as taxpayers than we needed to.

1300 By the way, yesterday we were considering trying to get
1301 full funding for the LIHEAP program, which is the Low Income
1302 Home Energy Assistance Program. The cost of that is about $2
1303 billion to $3 billion. Just so people understand, when you
1304 lose that much money that the taxpayers have put forward, you
1305 can't do other things that we ought to be doing to help
1306 people.

1307 To me, this is a classic case of, if it's not broken,
1308 why would you fix it? Not only is it a chief criticism of
1309 the Medicare Part D program that you didn't take advantage of
1310 the opportunity to create a beneficiary pool that could
1311 negotiate in a significant way with the pharmaceutical
1312 industry directly, but in fact with the dual eligibles, what
1313 you did was, you took 6 million people out of a pool that was
1314 in a position to negotiate directly with the pharmaceutical
1315 industry and you put them into a place where they couldn't.

1316 Not only that, you took a system where you had PhRMA on
1317 this side, the pharmaceutical industry on this side, the
1318 beneficiaries on the other side, and you interposed the
1319 insurance companies and the insurance plans and insurance
1320 industry in the middle, which is notoriously inefficient in
1321 terms of its administrative costs.

1322 So you took a situation where you were paying 3 to 5
1323 percent overhead administrative costs through the Medicaid

1324 program; you put in the middle of the stream, the dollar
1325 stream, a system that has got overhead costs of about 17 to
1326 20 percent, right--which is very inefficient--which is a
1327 great result for both the pharmaceutical companies who now
1328 get all this interference run between them on the pricing,
1329 right, so you can hide the ball very easily, and it is good
1330 for the insurance companies, who get to come in here and
1331 charge these huge overhead costs.

1332 It is absolutely madness.

1333 So my first question is, what was the reasoning? What
1334 possible rationale was offered up to justify taking the dual
1335 eligibles and moving them from Medicaid as the payer to
1336 Medicare as the payer?

1337 Mr. ANDERSON. Well, I think it was, as I explained to
1338 Mr. Cummings, that essentially you wanted to have them in one
1339 system, and that would be the Medicare system as being the
1340 controlling system for insurance. And what it meant,
1341 unfortunately, is a $2 billion windfall to the pharmaceutical
1342 companies.

1343 Mr. SARBANES. That is a neat idea to get them into one
1344 system, but you could move them into one system that works or
1345 you can move them into one system that doesn't work. So what
1346 they did was, they moved them into one system that they made
1347 sure wasn't going to work by setting them up in a way that we
1348 couldn't negotiate.

1349 Mr. ANDERSON. Well, essentially, you put them into a
1350 system with 20 percent higher administrative costs and paying
1351 20 percent higher prices, and then trying to say "provide
1352 good care." And that is really hard, because you are down at
1353 40 percent already.

1354 Mr. SARBANES. Isn't central to this the fact that the
1355 Medicare Part D program is not a directly administered
1356 program? You have Medicare Part A, which is directly
1357 administered for hospital benefits. You have Medicare Part
1358 B, which is directly administered for physician services.
1359 You have got Part C, which is a managed care program, which
1360 isn't working so well.

1361 But Part D was not designed that way. Part D is not
1362 directly administered. Part D is a subsidy to the commercial
1363 industry, which has all of these inefficiencies in it. So
1364 why you would want to set it up that way, who can imagine?

1365 Now, on the price control thing, we keep talking about
1366 price controls, but you put it better. This is really just
1367 about a customer called the U.S. Government that goes into
1368 the marketplace and has a lot of bargaining power,
1369 presumably.

1370 Do people have to sell? Do insurance plans that provide
1371 drugs and prescription drugs, do they have to sell to the
1372 government, are they required to sell to the government? Or
1373 do they want to sell to them because it is a big pool of

1374 beneficiaries that they can make money on?

1375 Mr. SCHONDELMEYER. They don't have to sell to the
1376 government. And I would point out, when we talk about using
1377 market share movement under State supplemental rebates or VA,
1378 we call it "price controls." When we talk about using market
1379 share movement under Part D private plans, we call it "the
1380 market." It is the same mechanism.

1381 So you can't call VA's--VA gets a lower price largely
1382 because it is a closed system and a very tightly controlled
1383 market share movement formulary, and that works. And
1384 Medicaid did that because they could do that much better than
1385 the Part D plans are right now.

1386 Mr. SARBANES. If we are going to pray at the altar of
1387 market economics, we ought to at least bring the basic
1388 principles of how you negotiate in the market to the table,
1389 right?

1390 Thank you.

1391 Mr. CUMMINGS. Mr. Issa.

1392 Mr. ISSA. Thank you, Mr. Chairman.

1393 Market distortion is a serious concern, and I think for
1394 all three of you, you have been trying to deal with
1395 it--perhaps in different ways.

1396 Because, Dr. Morton, none of you are here to make a
1397 political statements, I will make a short, simple one to open
1398 this up. I come from California, where we mandate prevailing

1399 wage. I come to Congress where we vote back and forth and
1400 debate and argue, over partisan lines, prevailing wage.
1401 Now, prevailing wage, in at least this Congressman's
1402 opinion, is distorted, so we pay a lot more to build our
1403 homes--not our homes, but our schools and our roads, at least
1404 in California, than we would pay if the large buyer, this
1405 $150 billion entity called California, went out and went to
1406 the low bidder and said, you know, You don't have to pay
1407 higher wages to build roads just to please the State of
1408 California. So I want to be sensitive here that we don't
1409 send that message from the government.
1410 Dr. Morton, I will start with you. VA is a
1411 buyer-seller, we want a good price, and we may not buy every
1412 drug if it isn't the best price, or we may not dispense two
1413 competing drugs as often, if it is more expensive. Would you
1414 say that that was, as an buyer, as a government buyer, a fair
1415 market relationship as an economist?
1416 Ms. MORTON. Yes, I think it is, and I think it is
1417 something that most Americans think that they don't want,
1418 that they would like something better than that, because it
1419 is a very tight formulary.
1420 Also, there is no retail component. So the VA pulls its
1421 truck up to the factory, gets the drugs and brings them to VA
1422 hospitals. You can't go down to your local pharmacy and get
1423 a VA-dispensed drug.

1424 Mr. ISSA. Dr. Morton, I happen to have Indian health
1425 care in my district, quite a bit of it, and they get that
1426 rate, and they are thrilled to get it. And my centers, my
1427 Native Americans, take advantage of it. And by the way, they
1428 also look, in some cases, to buy outside those formularies,
1429 and they pay a lot more, but they do it with discretion
1430 because of the obvious price advantages.

1431 When we are looking at Medicare Part D, as we are here
1432 today, is it fair to say from a pure economic standpoint that
1433 if you take VA's advantage of single buying, low
1434 administration, back-up-the-truck-to-the-dock, that in fact
1435 you're going to spend more when you offer people individual,
1436 broad formulary choices and you add the administrative
1437 burden, that it is essentially where you are, not where we
1438 are? And have you ever calculated that cost?

1439 In other words, if we were to take--because I want to do
1440 a reality check on whether or not we are distorting and
1441 whether or not we are paying too much. If you take the VA
1442 rate and you take those elements, where should you end up as
1443 a hypothetical for Medicare Part D and where do you end up?

1444 Ms. MORTON. That is a really good question. I haven't
1445 done that calculation, but that is exactly the right way to
1446 think about it. And part of what makes this difficult is
1447 that I know that there are some components; most of these
1448 Federal agencies have some component of mandated discounts

1449 and some component of "we negotiated it because we have a
1450 tight formulary." And you would want to just look at the
1451 cases where it is negotiated, as opposed to mandated.
1452 Mr. ISSA. Let me ask a question I think for all three
1453 of you, because this is of interest to me.
1454 Obviously, when we deal with seniors and we deal with
1455 drugs developed only for seniors in America, we are dealing
1456 under Medicare Part D, Medicare in general, that is the
1457 market.
1458 So my question is, how does the United States
1459 Government, in each of your opinions, ensure that drugs which
1460 are geriatric in nature only are fairly priced if there is
1461 very little alternative way of buying it, other than our VA
1462 seniors? Except for that group for the most part, some of
1463 these things have no other market in the U.S.
1464 So each of you, have you thought about how we get the
1465 fair interpretation? Because I am here today believing that
1466 I can't use Medicaid because it is a distorted market. I can
1467 use VA, but I have to add those costs that I mentioned with
1468 Dr. Morton. So if that is all true, when I have a drug that
1469 is limited in its reach. Other than seniors in VA and Native
1470 Americans, how do I fairly make sure that the price is
1471 achieved?
1472 Mr. SCHONDELMEYER. Actually, we have at least one drug
1473 that falls into the category you described. There is a drug

1474 called Epogen that 80 to 90 percent of the market is the
1475 government, and the government is the only payer. So there
1476 really is no such thing as a market-based price, because the
1477 government is the monopolistic buyer in that market; and the
1478 government does set and establish the payment rates for that
1479 drug, and they come up with the value of, here is what it is
1480 worth.

1481 I think Dr. Morton earlier said the government is afraid
1482 to say, here is what we will pay for a drug. But on the one
1483 hand, they do try to do that, but any time they do that, we
1484 call it "control" rather than "market behavior."

1485 I think we have to look for the line between price
1486 regulation and prudent market behavior for government. Let's
1487 focus on the prudent market behaviors and try to avoid the
1488 regulation that drives up the price. But I think you can do
1489 prudent buying as a large buyer government and keep some
1490 element of market in place.

1491 Mr. ANDERSON. We have done that. Just to explain in a
1492 little more in detail, for SRD and renal disease drugs, I
1493 think we have gotten good value for those, and we have
1494 essentially with a government-administered price.

1495 The other thing, Mr. Issa, I would suggest, is the
1496 United States is not the only place where there are seniors.
1497 There are millions, billions of them around--a billion of
1498 them around the world, and pharmaceutical companies are not

1499 just selling to the United States, but they are selling to
1500 the U.K. and Canada and other places as well; and we have to
1501 recognize that.

1502 Mr. ISSA. Dr. Morton, quickly.

1503 Ms. MORTON. I would say, one of the things that you
1504 will get in Part D is this same substituting and bargaining,
1505 and I can shift share from A to B. So if your drug for
1506 seniors has substitutes, therapeutic substitutes, then I
1507 think you can trust to a PBM or a Part D plan to be able to
1508 extract discounts on that drug.

1509 I think the very difficult question, which we aren't
1510 facing at the moment so hugely, is what happens if somebody
1511 invents a pill that cures Alzheimer's, and it is the only
1512 one, or something like that? Then really the government
1513 becomes the only buyer, and there is no good substitute, and
1514 how are you ever going to get a discount in that
1515 circumstance?

1516 But as long as there are therapeutic substitutes, they
1517 buy like everybody else buys.

1518 Mr. ISSA. Thank you, Mr. Chairman, for your indulgence.
1519 Hopefully the follow-up will be how government gets better
1520 if we are going to set prices. Obviously, it hasn't been one
1521 of our strengths, but I look forward to working with you on
1522 that.

1523 Chairman WAXMAN. [Presiding.] Thank you, Mr. Issa.

1524 Ms. Watson.

1525 Ms. WATSON. Thank you very much, Mr. Chairman, for this
1526 hearing. I want the witnesses to know we value your input.
1527 I am concerned too about the real cost of these drugs and the
1528 increases, so--I have heard you allude to a way we should
1529 really model this. Can the three of you explain more how the
1530 government can model the Part D drug program so that it
1531 really works for seniors?

1532 A big smile there. What does that mean?

1533 Mr. SCHONDELMEYER. Well, first, the point that was
1534 brought up by Dr. Anderson: price transparency in the
1535 marketplace. The basic issue, that we don't see how much
1536 rebates are flowing without having a congressional
1537 investigation in the Part D program, to me, tells us that is
1538 not a market. We are going to hide behind the black box and
1539 do what we want, and you guys pay the bills.

1540 So we need to have price transparency and transparency
1541 of the flow of dollars in this marketplace. Markets work
1542 with information. When you hide information, markets cease
1543 to work properly. So one is that price transparency.

1544 Second, I think, look to the Medicaid programs and
1545 especially what States are doing in their State supplemental
1546 rebates and obtaining these much larger discounts above the
1547 already-mandated Federal Medicaid rebate and say, How can you
1548 use those mechanisms or apply those to the Medicare Part D

1549 plans; and ask why--the Part D plans, why aren't you
1550 negotiating the same kind of rebate? If this is a market,
1551 why can't you get the same level of rebate out there?

1552 And then look to see, are there reasons, maybe reverse,
1553 perverse incentives, that keep these Part D plans from
1554 wanting to get more rebates from the drug companies.

1555 I would argue that no one in America is really managing
1556 or regulating prices very well, whether it is government
1557 regulated or private regulated. What we do is, we get bigger
1558 discounts and rebates, but the top keeps floating up faster
1559 than inflation by a factor of two to three times the
1560 inflation rate, every year, year after year, no matter what
1561 we do.

1562 So prices keep going up no matter what we have done, and
1563 we fool ourselves into thinking getting more rebate dollars
1564 back is saving us money. It really isn't. It is not
1565 controlling the net we pay overall in the first place.

1566 Rebates are simply a loan to the drug companies for 9 to
1567 12 months, and then we collect the money back and spend a lot
1568 in administrative costs doing so.

1569 Mr. ANDERSON. I think if are going to have a
1570 marketplace, we have to have price transparency. We don't
1571 have price transparency in the pharmaceutical, whereas we are
1572 pushing it in the physician market, we are pushing it in the
1573 hospital market.

1574 But I am not sure that we can ever get good prices when
1575 we have given the drug companies substantial reasons not to
1576 negotiate prices, and that would be the patents that we have
1577 given them for up to 17 years. This essentially takes away
1578 their reason for negotiation.

1579 So I think what we have to do is take a look at what
1580 other countries are doing in this area. They are paying
1581 about half the prices that we are paying for pharmaceuticals,
1582 in other countries, and that is why Americans are going to
1583 Canada and other places for these things. So one of the
1584 things the Medicare program could do--and I know many of you
1585 voted on this a year ago--is to have the Medicare program
1586 negotiate directly with the pharmaceutical industry in order
1587 to get a best price.

1588 The other thing that I would just add to that is, I am
1589 not sure why the VA, the Medicare program, the prisons and
1590 all the other places don't negotiate. I don't understand why
1591 the government pays different prices for exactly the same
1592 drugs, depending on whether it is a prisoner who needs it or
1593 somebody who is part of the community health center or
1594 somebody who is the Medicaid recipient.

1595 The government should be paying one price for drugs.

1596 Ms. MORTON. I am a little less enthusiastic about
1597 transparency than my colleagues, because I think in the
1598 context of Medicare Part D, if I am a plan and I am

1599 negotiating hard in a particular class and I get a good deal
1600 on drug A, I don't really want to publish that for all my
1601 competing plans to see. And they might in fact be
1602 negotiating on drug B and drug C. So there is going to be
1603 differences across us, and the plans are going to be trying
1604 to get that lowest price as a way to lower their costs and
1605 attract more seniors.

1606 So requiring manufacturers to publish that price is
1607 going to lead the manufacturers to be less willing to give
1608 those discounts and less willing to price aggressively. So I
1609 worry about transparency.

1610 Secondly, I completely agree with Dr. Schondelmeyer in
1611 terms of the supplemental rebates the States are getting
1612 through Medicaid being a good model, but that actually is
1613 what Part D is doing. They are negotiating those rebates
1614 based on preferred drugs on a formulary. And what they can't
1615 do, which Medicaid can do, is get a best price or an
1616 inflation component, which are big parts of the discount that
1617 Medicaid gets.

1618 Then, lastly, I would say--Dr. Schondelmeyer said, why
1619 can't Part D do some of these supplemental rebates, negotiate
1620 for lower prices? Part of the reason Part D can't is because
1621 there are protected classes, and in these protected classes,
1622 the plan is restricted from making a drug preferred and
1623 saying, You have to consume this HIV drug instead of that

1624 other one until there is a medical need for you to switch.
1625 And when you have that kind of restriction, then it is not
1626 possible for the plan to negotiate aggressively and get a
1627 discount.

1628 Now, there are good reasons for having those
1629 restrictions, but I am just saying those restrictions are
1630 expensive.

1631 Mr. SCHONDELMEYER. That is exactly when government
1632 needs to step in, is when you have on the one hand, the
1633 market should work by negotiating lower prices and preferring
1634 one drug over another, but on the other hand, it is
1635 clinically not appropriate.

1636 Government has a role in that, and that is why you are
1637 here, and you do have a role in establishing a mechanism to
1638 deal with something the market can't do effectively.

1639 Chairman WAXMAN. Thank you very much, Ms. Watson.

1640 Mr. Shays.

1641 Mr. SHAYS. Thank you, Mr. Chairman, for having this
1642 hearing.

1643 I am struck by the fact that Medicare Part D is about
1644 $40 billion and Medicare Part A is about $220 billion; and we
1645 want to save money, but we are having a hearing on the
1646 Medicare Part D program. I think we should, and I think we
1647 should because I think it has worked, frankly, phenomenally
1648 well.

1649 For years, politicians talked about having a
1650 prescription drug program, and in 2003 a Republican Congress,
1651 believe it or not, passes a prescription drug program. The
1652 program they wanted was going to cost about $400 billion over
1653 a certain period of time, and the Democratic program was
1654 going to cost $800 billion. I chose the less expensive plan
1655 because I thought it would cost twice as much when we finally
1656 adopted it, because most programs that we pass under Medicare
1657 turn out to be twice as much as the estimate.
1658 And, believe it or not, it is like one-third less than
1659 it was going to be, not twice as much.
1660 Dr. Anderson, when you come in with a beaming face as
1661 though you have made this great discovery that those products
1662 that are controlled may be less expensive, I say, Whoopie,
1663 you are exactly right.
1664 I would like to make a proposal. Do you ever get any
1665 Federal grants?
1666 Mr. ANDERSON. I do.
1667 Mr. SHAYS. I want to save the government money. How
1668 much do you get paid as a salary?
1669 Mr. ANDERSON. $175,000.
1670 Mr. SHAYS. I want you to only accept $50,000. I am
1671 going to tell you that is what you get for that grant. I
1672 want to save the Federal Government money. But we don't do
1673 that, because we want you to have your talents and we want

1674 you to have your creativity. But we don't control what you
1675 get, at least I don't think we do.
1676 We do it with doctors. That is not negotiation; that
1677 is, take it or leave it. They are underpaid; our doctors get
1678 less for the service than it costs them, but we act like
1679 somehow this is a great program because we have price
1680 controls.
1681 Tell me why I shouldn't be grateful that this program
1682 costs less than it was supposed to cost, that the seniors who
1683 are in it have nine out of ten--excuse me, 85 percent
1684 satisfactory rate--and nine out of ten who are part of the
1685 dually eligible don't want to go back into the old system nor
1686 do the States want them to go back into the old system.
1687 Nobody wants to go back into the old system, But you are
1688 using that as a price comparison.
1689 Mr. ANDERSON. First of all, you said the $400 billion.
1690 If you look at Kerry Weems' testimony that he is going to
1691 give today and you add up the numbers of the expenditures
1692 that are projected, you will see it is $400 billion. So
1693 essentially you talk about a 30 percent reduction; but
1694 essentially when you voted on the bill, it was $400 billion--
1695 Mr. SHAYS. You are talking about a shifting 10-year
1696 time frame. Let's talk about the same numbers we were using
1697 when we did it, compare apples to apples.
1698 Mr. ANDERSON. Right, I think that is what we have got.

1699 Mr. SHAYS. Sir, you are not.

1700 Mr. ANDERSON. We will take a look at that.

1701 Mr. SHAYS. Dr. Morton, what is your comment?

1702 Ms. MORTON. I just wanted to say that underlying all of
1703 this discussion, we should remember that pharmaceuticals are
1704 really unusual, because the research and development that was
1705 used to produce the drugs we are consuming today occurred 15
1706 or 20 years ago.

1707 So part of the problem is, if you say to a doctor, We
1708 are going to reduce your salary from $200,000 to $100,000,
1709 they can take it or they can drive a taxi. And if they go to
1710 drive a taxi, then we have no more doctors left. And that
1711 constrains what you do as a body for paying for physicians.

1712 Mr. SHAYS. I know how we can build twice as many
1713 bridges. We will just pay the construction workers half the
1714 price. But I don't believe in that, and I am for the
1715 prevailing wage. But here we have a competitive model that
1716 is working.

1717 Ms. MORTON. I am sorry. I just want to say one thing.

1718 So the thing about the drugs is that if I say today, as
1719 Congress, I am going to pay half as much as I was paying
1720 yesterday, that drug is already invented. It costs a tiny
1721 amount to manufacture, so, of course, the drug company is
1722 going to sell it at half the price.

1723 Mr. SHAYS. Let me ask you about price controls. I went

1724 to California about 15 years ago, and a company was
1725 developing something to slow the beginning stages of
1726 Alzheimer's. They spent $800 million.
1727 I checked 2 years later, they had spent about $200
1728 million more and it failed; they lost $1 billion. But they
1729 told me at the time they wouldn't have spent a darn penny if
1730 they had price controls.
1731 And it seems to me this is really a debate on whether we
1732 with we have price controls or not; that is what it is really
1733 about. And I don't buy into price controls. I think what we
1734 will have is less discovery. I think we won't have the drugs
1735 that we see today.
1736 And if you disagree, either one, tell me why.
1737 Mr. SCHONDELMEYER. First of all, your statement, or the
1738 framing of the issue, isn't exactly correct, because price
1739 controls were in effect. If you call Medicaid rebates
1740 pricing controls, then they were in effect and they did spend
1741 the money, and VA price controls were in effect and they did
1742 spend the money.
1743 So I find the statement that if price controls were in
1744 place, we wouldn't have spent the money to be a little bit
1745 specious of an argument, because there were price controls,
1746 by your definition.
1747 Mr. SHAYS. Excuse me, you don't believe that when we
1748 tell doctors, this is the payment, that is not a price

1749 control? Do you really think we negotiate with our doctors?
1750 Mr. SCHONDELMEYER. No, and the same with pharmacists
1751 and others in California. The States cut the fees.
1752 Mr. SHAYS. Do you think we negotiate with our doctors,
1753 or do you think we basically say, this is it?
1754 Mr. SCHONDELMEYER. No, it is take it or leave it.
1755 Mr. SHAYS. Yes, it is price controls.
1756 Mr. SCHONDELMEYER. But it is different. I would point
1757 out, there is not a best-price provision for doctors like
1758 there is in the Medicaid State rebate programs, and there are
1759 not State supplemental rebates like there are.
1760 So there are some aspects of this that are market based
1761 in terms of the prices Medicaid pays. It is not all just to
1762 fix, we will only pay this.
1763 Chairman WAXMAN. The gentleman's time has expired.
1764 Ms. Speier.
1765 Ms. SPEIER. Thank you, Mr. Chairman.
1766 This lively debate is interesting to me because I
1767 believe that California is a great example. The Medicaid
1768 system in California is one in which we have historically
1769 negotiated rebates and discounts in the Medicaid system, and
1770 they have been healthy discounts. And the pharmaceutical
1771 companies have flocked to California because it is a great
1772 universe from which to sell their product, and there has been
1773 great competition there.

1774 So, I guess my question is--and I would disagree a
1775 little bit with what my colleague has just said--if you look
1776 at how many dollars are actually spent on R&D, at least
1777 historically, the majority of those dollars have come from
1778 the taxpayers of this country and NIH grants, if I am not
1779 mistaken. So it is the government that funds the lion's
1780 share of this research that goes on.
1781 All the other industrialized countries in the world have
1782 price controls in effect, and we end up subsidizing the
1783 prices of pharmaceuticals in these other countries.
1784 So, I guess my question is, you have spoken a lot about
1785 transparency. But in trying to identify which is more
1786 important, just lifting the language in the bill that was
1787 passed by Congress, it says that the Federal Government can't
1788 negotiate.
1789 Isn't that the most important thing we can do in terms
1790 of trying to bring the costs of these drugs down?
1791 Mr. ANDERSON. I think it is, in fact, the most
1792 important thing, and I would strongly support that as an
1793 idea. I mean, it is very close to what the other countries
1794 are doing, as you suggest; and I don't understand why we want
1795 to be spending twice as much for drugs as other countries are
1796 spending.
1797 Mr. SCHONDELMEYER. Also, we can look at both the market
1798 and other things that have worked. State supplemental

1799 rebates are negotiated and operated by States on behalf of
1800 the entire Medicaid program within the State.
1801 Somebody earlier referred to General Motors or large
1802 corporations and their behaviors. I don't see General Motors
1803 turning over their drug benefit to each local plant and
1804 telling each local plant, you go out and negotiate drug
1805 prices on your own.
1806 Hey, centralize it and do it centrally.
1807 The equivalent of that in terms of Medicare would be for
1808 the Federal Government to use State supplemental rebate
1809 negotiation tactics on behalf of all Medicare Part D programs
1810 and then pass the benefit on to those local Part D plans out
1811 there.
1812 So we see in the private market centralized behavior,
1813 large prudent buyer behavior and using the market to work.
1814 And I think the government can do that and be a prudent buyer
1815 and not be a price regulator, per se.
1816 Ms. MORTON. The problem I see with that is, if Health
1817 and Human Services negotiates directly with pharmaceutical
1818 companies, it depends on your interpretation of the word
1819 "negotiate."
1820 If you are going to say, I am a large buyer, I am the
1821 Secretary, I mandate you give me 20 percent less, of course,
1822 that is going to work. If you say, I would like you to give
1823 me 20 percent less, then the question is, why?

1824 A regular plan says, I want you to give me 20 percent
1825 less because I am going to consume your competitor if you
1826 don't. I am going to consume drug A if you don't give me a
1827 price cut on drug B.
1828 The Secretary presumably wants to include all drugs,
1829 doesn't want to tell American seniors, you can only have drug
1830 A and you can't have drug B. So if the Secretary can't
1831 exclude somebody, then I don't quite understand how they
1832 negotiate a lower price. I understand how they instruct, you
1833 will give us a lower price.
1834 Ms. SPEIER. Well, California has a MediCal medical
1835 formulary, and drugs get on or off the formulary, and, you
1836 know what? They do make those decisions.
1837 Furthermore, these drug companies want to make sure
1838 their drug is on the formulary. So it is not like it is so
1839 much an exclusion as much as it is, we want to be on your
1840 formulary and we will give you this.
1841 Ms. MORTON. Right.
1842 But California Medicaid is excluding some drugs, and the
1843 people in California Medicaid are getting this benefit for
1844 free, and they don't really have the ability to complain and
1845 say, "I would like a choice of all cholesterol drugs,"
1846 whereas I think seniors and employed people expect to have
1847 more choice in their formulary or choice of cost plans.
1848 Ms. SPEIER. I have a mother on 15 drugs right now. She

1849 doesn't know which cholesterol-busting drug is the best. She
1850 is on three or four of them.

1851 So I think it is kind of--it doesn't make a lot of sense
1852 to say that these seniors want these drugs. They tend to
1853 want the drug that they have been on, as opposed to wanting
1854 some drug. And if we didn't have direct-to-consumer
1855 marketing, we would have a whole lot better system in this
1856 country to start off with.

1857 Mr. SCOTT MORTON. So suppose you have a national
1858 formulary. They have been on drug A all the time; they
1859 arrive at Medicare, and the Secretary has negotiated a good
1860 price on B, and that is it. The question is, what does the
1861 person do at that point?

1862 That is a system we could have. That is what the
1863 Government of France does.

1864 Ms. SPEIER. You know what it is called? It is called
1865 prior authorization. We have done it in California, and it
1866 has worked. For that individual who does better on the drug
1867 that is no longer on the formulary, you can still have that
1868 drug, it just needs prior authorization.

1869 Frankly, that is what we should be doing on the Federal
1870 level. It is not like it hasn't already been done. It is
1871 done, it is done effectively, and it saves a lot of money.

1872 Ms. MORTON. And Part D plans do that.

1873 Chairman WAXMAN. The gentlewoman's time has expired.

1874 Mr. Burton.

1875 Mr. BURTON. My first wife, who died 6 years ago, was
1876 taking chemotherapy in Indianapolis. And there were two
1877 women sitting there next to her, they all had the needle in
1878 their arms taking their chemotherapy. And one of the women
1879 was saying--she was actually complaining because, she said,
1880 My Tamoxifen costs so much, I can't afford it; it is $325 a
1881 month.

1882 And the other lady said, I am getting mine for $50 a
1883 month.

1884 And she says, No, that can't be right. And I am sitting
1885 there as a legislator, and I said, No, that can't be right.

1886 And the lady said, No, I am getting it from Canada for
1887 with about one-sixth the cost of what it was in America.

1888 I held hearings on this when I was chairman of the
1889 committee, and I couldn't figure out why, right at the border
1890 between Canada and the United States, you can go across the
1891 border and get the same pharmaceutical product for one-fifth,
1892 one-fourth, one-third, one-half. So I started being
1893 supportive of a process called reimportation, and that was
1894 because I couldn't figure out why Americans should pay more
1895 for pharmaceutical products than people in other parts of the
1896 world.

1897 I found out, along with my colleagues, that in Spain,
1898 France, Germany, all over the world, the price is one-half,

1899 one-third, one-fourth, one-fifth or one-sixth of what it is
1900 in the United States.

1901 The argument was, well, in the United States we have to
1902 do research and development, we have to do advertising and
1903 all that other sort of thing.

1904 My problem is, why isn't the rest of the world paying
1905 for part of that? Why in the world should the American
1906 people have the burden of advertising, research and
1907 development and everything, and then pay five or six times
1908 what it costs for the same pharmaceutical product someplace
1909 else?

1910 So we supported the reimportation program. The
1911 pharmaceutical companies went to the FDA and started talking
1912 about purity and whether or not there could be tampering and
1913 all that sort of thing, and they, in effect, have been able
1914 to block reimportation. They have been very effective, so
1915 they can protect their margins here and protect their market
1916 share. I don't understand that, and I don't think anybody in
1917 America who really thinks about it understands that.

1918 We should not be paying more for pharmaceutical products
1919 than the rest of the world simply because, you know, we can
1920 afford the R&D, and we can afford that and load it on the
1921 back of the American people.

1922 So we passed the prescription drug benefit, and we
1923 guaranteed in there that there would be no control whatsoever

1924 by the Federal Government in the price of the pharmaceutical
1925 products that the government is going to be involved in. So
1926 they, once again, are able to block and say, It is going to
1927 cost a lot more here in America; and they have been
1928 successful in blocking pharmaceuticals from the rest of the
1929 world.

1930 We can, with the new technologies, guarantee that drugs
1931 coming in are the product that we say they are. We can
1932 encapsulate them in plastic. We can put microchips or those
1933 mini, very small chips in there, to make sure that the
1934 product is the same as it is here in the United States, to
1935 guarantee the purity and everything. And yet we can't do
1936 that. And we can't do that because the pharmaceutical
1937 industry wants to keep the prices at a certain level here
1938 while they are able to give discounts way, way down the line,
1939 much lower costs, in other parts of the world.

1940 I would like for somebody to explain to me why we can't
1941 have a process where the pharmaceutical companies can say,
1942 Okay, since you in the United States are going to make sure
1943 you are going to get comparable prices, we are going to go
1944 out and negotiate or tell the other countries in the world we
1945 are not going to allow you to charge this much less.

1946 I sat down with the president of Eli Lilly, a company in
1947 my State. I sat down with people from Merck, vice presidents
1948 and presidents. And I said, why don't you come up to the

1949 Hill and sit down with us, Members of Congress, and let's try
1950 to negotiate some type of solution to this problem so
1951 Americans aren't burdened with a huge price while the rest of
1952 the world is getting off relatively scot-free. And they
1953 wouldn't do it.
1954 Rather than doing that, they had PhRMA, their
1955 organization here in Washington that has tons of lobbyists,
1956 some of whom I am sure are here today--they had PhRMA go to
1957 the FDA and say, Oh, my gosh, these pharmaceutical products
1958 coming in from the rest of the world may not be pure; they
1959 may be tampered with, while at the same time they knew full
1960 well there were mechanisms we could use to protect those
1961 products coming into the country.
1962 In addition, many of the products they are talking about
1963 are made in India and other parts of the world and coming in
1964 here in bulk anyhow--Viagra being one of them, which is used
1965 very widely here in the United States and, I understand in
1966 India, which really doesn't need it. It is only costing them
1967 about 10 or 12 cents a pill, whereas here, it is costing over
1968 10 bucks.
1969 Anyhow, I would like for you to give me an answer to
1970 that problem. Why do Americans pay three, four, five, six
1971 times what they are paying in Canada and elsewhere? Why
1972 can't we do something about negotiating? And why do we pass
1973 a Medicare prescription drug benefit that protects the

1974 pharmaceutical companies from negotiation with our
1975 government? I mean, it just seems to me there ought to be a
1976 question of fairness here.

1977 I want the pharmaceutical industry to make a lot of
1978 money. I want them to be very profitable. I am for the free
1979 enterprise system. But while I say that, I say, why should
1980 Americans bear the burden of all this, while the rest of the
1981 world is, in effect, getting off scot-free?

1982 Thank you, Mr. Chairman, for giving me the time.

1983 Chairman WAXMAN. The gentleman's time has expired.

1984 We will give a short opportunity for an answer. I think
1985 you answered a question there.

1986 Ms. MORTON. I have a short answer. So, one, I like the
1987 way you phrase the question, which is, Why doesn't everybody
1988 else pay more?

1989 I mean, we have two choices: One, there is too much
1990 R&D, we should pay less, pay the same as France, and we have
1991 a new industry that responds to that. Or we think the amount
1992 of R&D we want is good right now, or it should be more, in
1993 which case everybody else is free riding. They are as rich
1994 as we are, and they are not contributing to the cost of R&D.

1995 I think that is a very good question. Designing a
1996 regulation to get that to happen, I have some thoughts which
1997 I would be happy to share with you. But I think it is quite
1998 tricky.

1999 Mr. ANDERSON. Fourteen percent R&D, 30 percent
2000 marketing.
2001 Mr. SCHONDELMEYER. And they don't spend as much on
2002 marketing in other countries because their systems aren't as
2003 open.
2004 Others today have commented, if you do this, if you do
2005 that, it will raise prices in the rest of the market. But I
2006 would bet most of those people who made that comment weren't
2007 talking about prices in the rest of the world.
2008 I think we need to take actions and communicate to drug
2009 companies we expect them not only to look at raising prices
2010 in the rest of the U.S. market, but the rest of the world
2011 market; and they do need to look at other countries also to
2012 get back the money for R&D and to subsidize their
2013 development.
2014 I would also point out that the drug that was involved
2015 in many cancer drugs was actually discovered by the National
2016 Institutes of Health. One of the leading cancer companies
2017 that has more products I think on the market than any other
2018 company, the last time I looked, 3 or 4 years ago, had about
2019 21 cancer drug entities. And how many of those had that
2020 company discovered in their own R&D? Zero. The largest
2021 company that sells cancer drugs, at least 3 or 4 years ago,
2022 hadn't discovered a one; they had come from Federal
2023 Government funding.

2024 Chairman WAXMAN. Thank you, Mr. Burton. Your time has
2025 expired.
2026 Mr. Tierney.
2027 Mr. TIERNEY. Thank you, Mr. Chairman.
2028 I am always amused when Mr. Burton and I come down on
2029 the same side of an issue here. I was sort of hoping that he
2030 had made that passionate plea to his caucus a few years back,
2031 and maybe we wouldn't be here discussing what we are
2032 discussing today.
2033 Look, I think the manufacturers have a hard time
2034 justifying the high prices. I think they have gotten a bit
2035 of a windfall out of it. But I know one of the arguments we
2036 are going to hear back is just what we are talking about
2037 right there, that if you do anything about this, research is
2038 going to stop and everybody is going to go to hell and die.
2039 So I really want to knock that out of the box right now.
2040 It is nonsense and foolishness, as far as I am concerned.
2041 They reported, what, about $90 billion of profits last
2042 year, up $20 billion previous to that, or whatever, and I
2043 don't for a moment think that a change in the price situation
2044 here is going to stop them from doing research.
2045 So let me start with Dr. Anderson, if you would. Would
2046 reducing the high prices that they are now charging on the
2047 Part D program have an impact on the industry's research and
2048 development?

2049 Mr. ANDERSON. It is hard to answer that one
2050 analytically, but I don't think so.
2051 Mr. TIERNEY. All right.
2052 Dr. Schondelmeyer, what do you think? Can we reduce
2053 Part D prices without adversely impact the research?
2054 Mr. SCHONDELMEYER. I think you can certainly go back to
2055 the Medicaid prices that you had and not affect research
2056 dramatically, because we were there and they were accepting
2057 those prices and they were living with that. So I think you
2058 can at least go back to that level, without a major effect on
2059 the market.
2060 Mr. TIERNEY. Dr. Morton, do you want to weigh in?
2061 Ms. MORTON. I would more or less agree with that,
2062 although I will say that a lot of these entities are
2063 discovered by venture-capital-funded small firms that are
2064 then bought by the larger firms, and anybody who is in
2065 venture capital or that kind of finance is investing because
2066 they expect a return. So anytime you alter the return, that
2067 goes into the calculation of whether they are going to spend
2068 money in the biopharma area.
2069 So I don't think you can ever assume no effect. It is
2070 just, are we making a small shift of duals? Or are we making
2071 a big shift of everyone who's eligible for Medicare?
2072 Mr. TIERNEY. Thank you.
2073 Let me ask you--Dr. Schondelmeyer, you can start on

2074 this--what is the difference or what is the variation between
2075 how much research is done from government-funded projects
2076 versus what the industry does? And which drugs are involved,
2077 the more commonly used drugs or the less commonly used drugs,
2078 and all of that?

2079 Mr. SCHONDELMEYER. I haven't examined that
2080 systematically in recent years, but the evidence seems to
2081 suggest that drugs for categories that are most critical,
2082 such as cancer, tend to come more from government-funded
2083 research, and that drugs that come from the pharmaceutical
2084 companies tend to be more the lifestyle drugs, the drugs
2085 that--you know, feel good, live-well-type drugs, come from
2086 the drug companies that have broader populations.

2087 So the government tends to fund more critical,
2088 life-threatening drug discovery and drugs for smaller
2089 populations, while the drug companies tend to fund drugs for
2090 broader populations and maybe for more symptomatic or
2091 feel-good purposes.

2092 Mr. TIERNEY. We have all heard the expression of "me
2093 too" drugs out there and the research on that. Do you want
2094 to comment on that a little bit?

2095 Mr. SCHONDELMEYER. Well, I would be careful. There is
2096 an issue of "me too" drugs; I think it is often
2097 misunderstood, too, though.

2098 I do think for a legitimate disease-state category,

2099 where there is three or four or five companies in the race to
2100 find a drug in that category, among those three, four or
2101 five, for whatever reason, whether it is regulatory or
2102 company performance, one of them is going to come out first.
2103 I wouldn't say that the other four or five that were
2104 legitimately in the race are "me too" drugs because they were
2105 in the race. And, in fact, those other drugs could--if our
2106 market works, which it doesn't work well--could create
2107 competition.
2108 Where "me too's" come in is when the company that first
2109 discovered it or other companies 15 years later come out with
2110 an extended release dosage form, a right-handed or
2111 left-handed molecule, those are "me too" drugs and those are
2112 kind of ways of extending patent pricing without adding a
2113 whole lot of value to the market in most cases.
2114 Mr. ANDERSON. The NIH would suggest that more money is
2115 actually being spent by PhRMA than by NIH right now. We
2116 would have to take a look in terms of what it is spending it
2117 on.
2118 NIH is much more basic research kinds of things. PhRMA
2119 is a lot more drug development kind of things. But I think
2120 overall, the numbers from NIH would suggest that PhRMA is
2121 spending a little more.
2122 Ms. MORTON. I would second that.
2123 I mean, NIH doesn't do the testing. So you can invent a

2124 molecule, but then you have to show that it is safe in
2125 thousands and thousands of people and go through the FDA.
2126 All of that is actually quite expensive, and NIH doesn't do
2127 that.

2128 You can also see why the lifestyle drugs wouldn't be
2129 coming out of the government. I mean, I imagine the grant
2130 application to NIH for Viagra would not get funded.

2131 Mr. TIERNEY. You have more confidence than I do. I
2132 would hope you are right on that.

2133 Thank you, Mr. Chairman. I yield back.

2134 Chairman WAXMAN. Thank you, Mr. Tierney.

2135 Ms. Foxx?

2136 Ms. FOXX. Thank you, Mr. Chairman.

2137 I want to make one brief comment. As I have been
2138 sitting here, listening to the comments that you all have
2139 been making--and I've made this observation on a couple of
2140 other occasions--I grew up in the mountains of North Carolina
2141 in the late 1940s, early 1950s, in the poorest county in
2142 North Carolina when I was growing up.

2143 My family was extraordinarily poor, yet we could afford
2144 health care. Everybody in our county could afford health
2145 care. In fact, I didn't know many people who had any kind of
2146 really big problems with health care. We had a hospital. We
2147 had doctors.

2148 And I have thought a lot about why it was that we could

2149 get health care in those days, and we have such a problem now
2150 with people, who are much better well off than we were, not
2151 getting health care.
2152 My observation is, it is two things: number one,
2153 government involvement, and I think any time you get the
2154 Federal Government involved in just about anything, you get
2155 more of a problem than you get a solution; and the other is
2156 third-party payer, when people are not in charge, I think you
2157 create problems.
2158 I would just say that as a statement, because when I
2159 hear people say, get the government more involved, the
2160 Federal Government, it is just like scraping a fingernail
2161 across a blackboard for me, because I think what you are
2162 doing is simply creating more problems.
2163 But I want to ask a question of Dr. Scott first, and
2164 then I have a general question.
2165 Do you think that pharmacy benefit managers are
2166 sophisticated negotiators on behalf of seniors? We have
2167 heard about the problems with getting prices. Tell me what
2168 you think about that.
2169 Ms. MORTON. Yes, I think they are sophisticated
2170 negotiators. A lot of the Part D plans that have been most
2171 successful in the sense of being taken up by many people are
2172 run by quite large and sophisticated insurance companies.
2173 Ms. FOXX. Then the other question I have, my

2174 understanding is that under Medicare, some drugs are paid for
2175 by federally set prices. They are injectable drugs under
2176 Part B. I would ask each member of the panel--and I know we
2177 have a limited time--do we set the prices for those drugs
2178 well? What is the history of the Federal Government setting
2179 those prices? My understanding is that there is a mixed
2180 history there; sometimes we have done well, sometimes we have
2181 done poorly.

2182 Relate that to what you are recommending now. Those are
2183 the folks on the upper end of the panel who are recommending
2184 that primarily.

2185 Mr. SCHONDELMEYER. First, I would comment on, Are PBMs
2186 a sophisticated buyer? They are, but they don't have a
2187 fiduciary responsibility to act on behalf of the recipient.
2188 They act on behalf of their own stockholders and corporate
2189 entities, and those are different financial decisions that
2190 they make. So they are very sophisticated at taking care of
2191 themselves and meeting the requirements that are made of them
2192 for the recipients, but not acting in the best financial
2193 interest of the recipients.

2194 I would also bet that hospital you had in your area was
2195 government subsidized under the Phil Burton program--

2196 Ms. FOXX. No. Well, it may have gotten some, but it
2197 was primarily supported by the people who used it.

2198 Would you mind answering the question I asked you to

2199 answer?

2200 Mr. SCHONDELMEYER. Yes. And what was that question?

2201 Remind me.

2202 Mr. ANDERSON. Let me answer. I will get it.

2203 Basically, if you take a look the Medicare program, the

2204 seniors in 1964, only about half of them had health insurance

2205 after Medicare. The other half got--

2206 Ms. FOXX. You have just made my point.

2207 Mr. ANDREWS. I did? I thought you said that everybody

2208 had coverage.

2209 Ms. FOXX. I just said I think what created the problems

2210 with our not being able to get health care is third-party

2211 payer and the involvement of the government.

2212 Mr. ANDERSON. Well, I would disagree.

2213 Ms. FOXX. Do you mind answering the question I asked?

2214 Mr. ANDERSON. On the Part B thing, sure, essentially

2215 there was a problem with Part B drugs, that they were

2216 essentially giving serious discounts to doctors, but the

2217 Medicare program did not know those serious discounts, did

2218 not have price transparency, did not know that.

2219 Part of the Medicare Modernization Act of 2003,

2220 hopefully, with the average sales price, solved that problem,

2221 and now the discounts are less.

2222 So I think the Medicare program can learn and solve the

2223 problems.

2224 Ms. FOXX. What kind of learning curve is there for the
2225 people in the program?
2226 Mr. SCHONDELMEYER. Well, I would answer your first
2227 question about the ASP and the government buying.
2228 First of all, Medicare Part B is a very different
2229 market. It is primarily through physicians and a totally
2230 different distribution system, and there were incentives for
2231 doctors to actually prescribe more higher-priced drugs.
2232 I would argue, though, similar incentives are in place
2233 in the Medicare Part D program for the very reasons I stated.
2234 There is no fiduciary responsibility on behalf of PBMs, and
2235 they can make more money by negotiating rebates from drug
2236 companies, but not passing it on in lower costs to the
2237 recipients.
2238 So I think the problems we had and the learning curve we
2239 have hasn't really stuck in Medicare Part D.
2240 Chairman WAXMAN. Mrs. Foxx, your time has expired.
2241 Ms. FOXX. Thank you.
2242 I would like to say for Federal bureaucrats, there is no
2243 fiduciary responsibility either.
2244 Chairman WAXMAN. The last word.
2245 I want to thank the three of you very much for your
2246 participation. I think that all the members on the committee
2247 and all the people in the audience should get college credit
2248 for this discussion. It was a very high-level one, and I

2249 think a very worthwhile one. Certainly you have been helpful
2250 to us.
2251 Mr. DAVIS OF VIRGINIA. Let me just add to that and
2252 thank our panel. It has been very informative.
2253 Chairman WAXMAN. Our next witness is Mr. Kerry Weems.
2254 He is Acting Administrator for the Center for Medicare and
2255 Medicaid Services, Department of Health and Human Services.
2256 I would like to ask him to come forward.
2257 Before you even sit down, it is the policy of this
2258 committee that all witnesses testify under oath. So if you
2259 would please raise your hand.
2260 [witness sworn.]
2261 Chairman WAXMAN. The record will show that the witness
2262 answered in the affirmative.
2263 We have your prepared statement and it will be part of
2264 the record in its entirety. What we would like to ask you to
2265 do is try to stay within 5 minutes for your oral
2266 presentation.
2267 I think you know the routine; it is green, 4 minutes;
2268 yellow for 1 minute, and when it is red, we would like you to
2269 certainly conclude.
2270 Thank you for being here.

2271 STATEMENT OF KERRY WEEMS, ACTING ADMINISTRATOR, CENTER FOR
2272 MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND
2273 HUMAN SERVICES

2274 Mr. WEEMS. Thank you, Mr. Chairman, and thank you,
2275 distinguished members of the committee. It is a pleasure to
2276 appear before you today.
2277 The success of the Medicare prescription drug benefit
2278 provides strong evidence that competition through private
2279 plans has contributed significantly to lowering costs to both
2280 the government and beneficiaries. Through Part D, Medicare
2281 beneficiaries are extremely satisfied with their current
2282 prescription drug coverage and have been given meaningful
2283 choices for drug coverage at a cost much lower than
2284 originally estimated.
2285 Experience with Part D thus far demonstrates that
2286 competition is working for beneficiaries and taxpayers alike.
2287 According to the fiscal year 2009 President's budget, the
2288 necessary cost of the Medicare Part D program is 40 percent
2289 lower than the projections at the time the bill was passed,
2290 and beneficiaries are reaping these savings.
2291 Independent surveys have consistently shown that more
2292 than 85 percent of Medicare beneficiaries and nearly nine out
2293 of ten dual eligibles are satisfied with their Part D

2294 coverage. High satisfaction rates are directly related to
2295 the other successes in the Part D program, including
2296 meaningful and affordable choices, unprecedented information
2297 and transparency for beneficiaries, lower-than-projected
2298 costs from effective private sector negotiation, and
2299 increased generic utilization.
2300 With the overwhelming success and popularity of
2301 Medicare's Part D benefit, we should be vigilant against
2302 attempts to use government mechanisms to intervene in the
2303 market and move to administered government pricing.
2304 When Congress enacted Part D, the decision was made to
2305 move dual eligibles to Part D, which offered the dignity of
2306 choice and a market-based approach to the drug benefit
2307 structure and pricing. Congressional research agencies like
2308 CBO and GAO widely agree that direct government negotiation
2309 of prescription drug pricing in Part D is unlikely to lead to
2310 lower costs. As the chart demonstrates, simply comparing
2311 Medicaid's rebates to Medicare does not capture all the other
2312 efficiencies and savings achieved through Part D by
2313 encouraged use of generic, lower-cost drugs, lower-cost
2314 sharing opportunities for copayments and coinsurance.

2315 RPTS KESTERSON

2316 DCMN MAGMER

2317 [12:06 p.m.]

2318 Mr. WEEMS. What is more, through drug utilization
2319 management, Part D has improved health outcomes by reducing
2320 the possibility of adverse drug events.

2321 The record from implementation of mandatory price
2322 controls and rebates in Medicaid reveals that these
2323 price-setting policies have the potential to increase costs
2324 in the private sector and others not subject to the
2325 government-imposed price controls.

2326 CBO examined the implementation of the Medicaid drug
2327 rebates on the market and found that, while access to rebates
2328 lowered Medicaid's outpatient drug expenditures, spending on
2329 prescription drugs by non-Medicaid patients may have
2330 increased as a result of the Medicaid rebate program.
2331 Further, GAO found that in the first 2 years of the Medicaid
2332 drug pricing program, the average price for medicines
2333 purchased by HMOs and Group Purchasing Organizations
2334 increased.

2335 With Medicare beneficiaries accounting for nearly 40
2336 percent of prescription drug spending in the United States,
2337 it is not at all unreasonable to expect that a change from
2338 market pricing in Part D to a government-mandated rebate
2339 structure could have an even stronger ripple effect on the

2340 cost of prescription drugs for those not subject to
2341 government-imposed price controls.
2342 With a combination of more than 50 percent of the market
2343 subject to a statutorily dictated pricing structure, these
2344 two Federal programs could eliminate the potential rebates
2345 for any other purchasers. More specifically, it could lead
2346 to higher prices at the pharmacy, may compromise incentives
2347 to move enrollees toward low-cost therapeutic equivalents or
2348 generic drugs, or may undermine utilization management
2349 activities that the participating plans use for important
2350 safety protections as well as cost controls.
2351 The Part D Program has been successful beyond
2352 expectations even in its infancy. Beneficiaries have
2353 meaningful choices for drug coverage at a cost that is much
2354 lower than estimated; and, more importantly, they are
2355 satisfied with their coverage.
2356 Thank you for the opportunity to appear before you
2357 today. I look forward to your questions.
2358 Chairman WAXMAN. Thank you very much, Mr. Weems.
2359 [Prepared statement of Mr. Weems follows:]

2360 ******** INSERT 3-1 ********

2361 Chairman WAXMAN. Without objection--I think we've
2362 discussed this with the minority--we want to do an initial 10
2363 minutes on each side, 10 controlled by the Chair and 10
2364 controlled by Mr. Davis. And without objection, that will be
2365 ordered.

2366 I want to start off my questions with you.

2367 Mr. Weems, we are here today because we want to know
2368 whether we can make the Part D program work better for the
2369 taxpayers. You testified that the program is highly
2370 successful. You told us that beneficiaries are satisfied
2371 with the program. They have affordable choices, and they
2372 have good information with which to make choices and that
2373 they have greater, better access to generic medicines. If
2374 that is true, it is good news. And to be honest, after we
2375 have spent almost $100 billion on this program, I would hope
2376 that that would be the case.

2377 The issue for us is whether the taxpayers are getting
2378 the best value for their $100 billion, and that is why the
2379 findings of the report released this morning are so
2380 troubling. The report finds that the prices paid by Part D
2381 insurers for the 100 drugs most used by dual eligibles are a
2382 lot higher than the prices Medicaid pays. On average,
2383 Medicare Part D is paying 30 percent more.

2384 Mr. Weems, the central finding of the report is that
2385 Medicare Part D is paying significantly higher prices for

2386 drugs than Medicaid. Do you agree with this finding?

2387 Mr. WEEMS. Mr. Chairman, I had the opportunity to be
2388 briefed on your report; and I appreciate the opportunity for
2389 that. I have not had the opportunity to examine it in depth,
2390 but I would find that, for those particular drugs, that a
2391 government-enforced price-setting system likely can produce
2392 lower prices, but that does not take into account the cost
2393 that may spread through the rest of the system. Yes, the
2394 prices may be lower in a government-administered pricing
2395 system, but, as a result, they may be higher in the Federal
2396 employees benefits. So I would say that we would need to
2397 perform the rest of the analysis to see where those costs
2398 flow to.

2399 Chairman WAXMAN. Well, we had the Medicaid system in
2400 place for 10 years with pharmaceutical rebates. Do you know
2401 that--if there is any evidence to show that there was a flow
2402 throughout the whole system of higher drug prices?

2403 Mr. WEEMS. Yes. We have evidence that suggests that,
2404 yes, costs were higher in the private sector as a result and
2405 also that there was a--

2406 Chairman WAXMAN. Can you say that those higher prices
2407 were attributed to the Medicaid payment? Or are drugs
2408 getting higher every year?

2409 Mr. WEEMS. Well, I believe there is research that
2410 attributes to that, and it is also no accident that the

2411 amount of rebates that were available under the best price
2412 began to go away under under the--in the private sector.
2413 Chairman WAXMAN. We have looked at all the research on
2414 this subject, and we can't find any studies that substantiate
2415 your position. So we would like you to submit that to us for
2416 the record.
2417 [The information follows:]

2418 ******** COMMITTEE INSERT ********

2419 Chairman WAXMAN. You're in charge of Part D; and what
2420 we see is that, according to this report, taxpayers paid more
2421 than $3.7 billion over the first 2 years of the program as a
2422 result of the dual eligibles not being given the Medicaid
2423 price and now going to the Medicare price. Does that concern
2424 you?

2425 Mr. WEEMS. Again, I think the analysis may be
2426 incomplete. It may be that the prices were--you know, there
2427 could be a lower price there, but it is also likely that
2428 those prices would have shown up higher someplace else,
2429 probably in the non-dual part of the Part D program.

2430 Chairman WAXMAN. You have emphasized that Medicare Part
2431 D is costing less than projected--

2432 Mr. WEEMS. Yes.

2433 Chairman WAXMAN. --and that is true. But the biggest
2434 reason the costs are less is that fewer seniors have enrolled
2435 than projected. It is obvious that if Part D is serving
2436 fewer seniors, it's costs are going to be lower.

2437 On the central issue of drug prices, Part D is
2438 overpaying. Before January, 2006, the 6 million
2439 dual-eligible beneficiaries were getting their drugs through
2440 Medicaid. After January 1, 2006, they started getting their
2441 drugs through Medicare Part D. The only thing that changed
2442 is how much the taxpayers have to pay for these drugs. The
2443 cost for just 100 popular drugs increased by $3.7 billion.

2444 That is indisputable.

2445 Are you putting the interest of the big drug companies
2446 ahead of the interests of the taxpayers when your concern is
2447 not for the extra costs that we are actually paying for these
2448 very same beneficiaries?

2449 Mr. WEEMS. Let me dispute one of your premises, if I
2450 might, that the only thing that changed was that the price
2451 changed. No, something else changed; and that is that the
2452 beneficiaries were moved from a State-run, price-fixing
2453 program--in some cases, of States with restricted
2454 quantities--into a risk-based insurance product, where they
2455 have in many cases, even for the low income, the dignity of
2456 choice, which they didn't have in Medicaid, broader access to
2457 more drugs and no limits on the--

2458 Chairman WAXMAN. That depends on what plan they joined.
2459 Because the plans could restrict the drugs' formulary.

2460 But the Medicaid rebate program, which I helped
2461 design--I was around when we adopted it. It is all
2462 voluntary. The drug company didn't have to participate. And
2463 the drug companies participated on the basis that we would
2464 demand the best price for them that they were charging others
2465 in exchange for adding all their drugs on the formulary. So
2466 the companies benefited by making sure that all their drugs
2467 could be available to Medicaid patients.

2468 This wasn't a price fixing--this wasn't a fixed price or

2469 price fixing. It was a negotiation by the government for a
2470 lower price for that population. Now we have no negotiation;
2471 and, as a result, I believe, we are seeing higher prices. We
2472 are definitely paying higher prices. Would you say it is not
2473 because we don't negotiate it any longer? It is not because
2474 we don't have the Medicaid reimbursement formulary that--for
2475 that same population for those same drugs?

2476 Mr. WEEMS. Again, I would say there is only half the
2477 analysis; and that is the analysis that, you know, the States
2478 pay. You can look at the--you know, the price that is
2479 mandated by the rebate. The analysis that needs to be
2480 complete is what happens on the other side of the equation,
2481 the market equation, when--press down prices here, they are
2482 going to go up someplace else. The Federal employees benefit
2483 program, private insurer, we've seen it happen.

2484 Chairman WAXMAN. We'd have to see if that is the case.
2485 I'm looking forward to see what documentation you have for
2486 that.

2487 If we had lower prices in the United States, it would
2488 probably lead to higher prices in the other countries.
2489 Should we worry about that?

2490 It just seems to me that for the dual eligibles that we
2491 actually provided drugs to under the Medicaid program at a
2492 lower cost and the same drugs at a lower cost we are now
2493 paying for that same population at a much higher cost and for

2494 that group we are paying a lot more money. I don't think--I
2495 don't see what we're getting for that extra money.
2496 Mr. WEEMS. If we were to--let's take one of the
2497 suggestions that one of the academics made here. And that is
2498 if we were to take that dual-eligible population and apply
2499 the rebate, the Medicaid rebate, to that population, the most
2500 likely initial result would be an increase in Part D for
2501 everybody else who is not dually insured. Is that, you know,
2502 the consequence that we would like to have? Is, you know, a
2503 secular increase in Part D that then spread beyond Part D and
2504 other parts of private market?
2505 Chairman WAXMAN. I don't believe that would be an
2506 accurate statement of what would happen. I think the drug
2507 companies are trying to maximize the amount they can get for
2508 their drugs; and if you provide more money for their drugs,
2509 they are going to be happy to take it. So I don't see
2510 evidence for that statement.
2511 I'm going to reserve the balance of my time, which is 1
2512 minute and 37 seconds and yield to--now 10 minutes to Mr.
2513 Davis.
2514 Mr. DAVIS OF VIRGINIA. We just have a fundamental
2515 disagreement between us over if you reduce costs in one area,
2516 does it raise costs in other areas. Somehow I think the
2517 chairman and advocates on that side think that this just
2518 comes out of the drug companies' hides and that is the end of

2519 it and it has no effect on research and development or
2520 anything else. And I don't think that is borne out.
2521 In fact, I would ask unanimous consent, Mr. Chairman,
2522 that we put in--you had asked a question earlier about
2523 overpaying, and there is no effective--on the
2524 overpayment--this is a CBO paper, How the Medicaid Rebate on
2525 Prescription Drugs Affects Pricing in the Pharmaceutical
2526 Industry. This is a Congressional Budget Office report, and
2527 I would unanimous consent that--
2528 Chairman WAXMAN. Without objection, we'll put that in
2529 the record.
2530 Mr. DAVIS OF VIRGINIA. Thank you very much.
2531 [The information follows:]

2532 ******** COMMITTEE INSERT ********

2533 Mr. DAVIS OF VIRGINIA. The majority staff report found
2534 that Part D rebates are smaller than Medicaid rebates.
2535 You're not surprised by that finding, are you?
2536 Mr. WEEMS. Not at all.
2537 Mr. DAVIS OF VIRGINIA. Is this new information?
2538 Mr. WEEMS. No.
2539 Mr. DAVIS OF VIRGINIA. In Congress, we often lobby to
2540 change reimbursement for different services covered by
2541 Medicare or to expand those services all from political
2542 perspectives. The drug company or somebody could be--or a
2543 manufacturer could be from your district and there is
2544 pressure to slip this in here or slip this in there or expand
2545 services to one needy group over another.
2546 At CMS, we are tasked with creating a national formulary
2547 or setting prices. Do you think the process would be open to
2548 meddling by Congress by disease advocates and drug
2549 manufacturers?
2550 Mr. WEEMS. Absolutely. And, you know, we can see the
2551 evidence of this. You know, if you look at the mail that CMS
2552 receives, we receive virtually no mail--I don't think I'm in
2553 a position to say zero--but virtually no mail about the price
2554 of specific drugs under Part D. We receive huge volumes of
2555 mail about those drugs for which we do administer pricing
2556 under Part D. A lot of mail, a lot of pressure and, in some
2557 cases, there is even legislated prices--

2558 Mr. DAVIS OF VIRGINIA. When you say mail, are you
2559 talking about mail from Members of Congress?
2560 Mr. WEEMS. Members of Congress, manufacturers, lobbying
2561 organizations, you name it. We receive virtually none of
2562 that under Part D. One of the great success stories of Part
2563 D is it has depoliticized the price of individual drugs.
2564 Mr. DAVIS OF VIRGINIA. What would be--is that one of
2565 the reasons, you think, that the costs that were projected
2566 originally are far and above what has actually taken place?
2567 Mr. WEEMS. That and the effects of competition.
2568 Mr. DAVIS OF VIRGINIA. I mean, there is a fundamental
2569 difference, that some of us believe competition brings down
2570 costs, some of us think that the government is smart enough
2571 to be able to just negotiate the best cost because of our
2572 buying power. In fact, there are some formularies that have
2573 greater potential buying power than the Federal Government.
2574 Mr. WEEMS. The PBMs, the prescription benefit managers,
2575 the ones that the Part D program use, represent about 240
2576 lives across the Nation. So that is real buying power.
2577 Mr. DAVIS OF VIRGINIA. If CMS--we talk about we are
2578 tasked with creating a national formulary, setting prices.
2579 What impact could that have on seniors in Part D?
2580 Mr. WEEMS. If it is a highly restrictive formulary, it
2581 might mean that they don't get the drugs that they need.
2582 Mr. DAVIS OF VIRGINIA. Mr. Weems, you have been a

2583 career employee, haven't you?

2584 Mr. WEEMS. I am a career employee, sir.

2585 Mr. DAVIS. So you are a career employee on there. You
2586 weren't some administration lackey or anything else that they
2587 were able to take because you had given contributions to a
2588 campaign or been active in political causes, right? You're a
2589 career employee, and you have worked at this all your life?

2590 Mr. WEEMS. I started my career in 1983 as a junior
2591 budget analyst with the Social Security Administration.

2592 Mr. DAVIS OF VIRGINIA. How does the financial outlook
2593 for Medicare Part D compare to the Part A program which
2594 covers hospital care?

2595 Mr. WEEMS. They are financed entirely differently.
2596 Part A is financed by FICA taxes. Part D is financed by
2597 premiums and by general fund transfers. So the financing
2598 schemes are different.

2599 Part A, because of its financing schemes and because of
2600 the rising costs in Part A, is going to go broke in 11 years,
2601 according to the trustee's report.

2602 Mr. DAVIS OF VIRGINIA. And you concur with that from
2603 your observations?

2604 Mr. WEEMS. I do.

2605 Mr. DAVIS OF VIRGINIA. And Part D?

2606 Mr. WEEMS. Part D is financed, as I said, from--it is
2607 financed entirely differently, and so it is not subject to

2608 the same sort of constraint that the Part A is.

2609 Mr. DAVIS OF VIRGINIA. But, in fact, the projections on
2610 Part D, are they greater or less than were projected in terms
2611 of the costs to the government?

2612 Mr. WEEMS. In fact, you can see the original cost
2613 estimate is the upper line.

2614 Mr. DAVIS OF VIRGINIA. That is the third chart over?

2615 Mr. WEEMS. That is the third chart over. The lower
2616 line is the most recent cost from the President's budget,
2617 most recent cost estimates.

2618 Mr. DAVIS OF VIRGINIA. So Part A has basically been
2619 overruns and Part D has been underruns in terms of--

2620 Mr. WEEMS. Again, Part A--in fact, this year in Part A,
2621 the expenditures of--in Part A will exceed what we take in in
2622 taxes for Part A.

2623 Mr. DAVIS OF VIRGINIA. Now, in the previous panel we
2624 heard--I think it was Dr. Anderson testified that all Federal
2625 prices for prescription drugs should be uniform. Outside of
2626 prescription drugs, does Medicare, Medicaid, the VA and FEHBP
2627 pay uniform prices for health care services?

2628 Mr. WEEMS. No, they don't. Not as a matter of policy.
2629 There might be times when they--

2630 Mr. DAVIS OF VIRGINIA. Coincidentally.

2631 Mr. WEEMS. Yeah, by coincidence.

2632 Mr. DAVIS OF VIRGINIA. How do you think an effort to

2633 make prices uniform across these programs to the lowest
2634 denominator would be received by physicians or hospitals?
2635 Mr. WEEMS. Well, you know, Mr. Davis, it is an
2636 interesting question. And the question--the answer to that
2637 question depends on your philosophy.
2638 If you were to do it through competitive means, you
2639 would allocate resources correctly. If you were to turn it
2640 over to CMS with my very well-meaning Federal employees who
2641 fix prices every day for A and B, we likely would not get it
2642 right.
2643 Mr. DAVIS OF VIRGINIA. There is sufficient evidence
2644 that Medicaid price controls increase prescription drug
2645 prices to private payers, which in the United States are
2646 generally employers. These are like GM and Ford who are
2647 competing in a global marketplace. Although we may get a
2648 reduction for Medicaid recipients, in effect, I think there
2649 is evidence that drives up the costs to these companies that
2650 has an effect downstream in terms of their ability to
2651 compete.
2652 GM and Ford have both cited higher health care costs as
2653 one of the factors affecting their decline in global
2654 competitiveness. What do you think would be the impact of
2655 requiring Medicaid prices in Part D on Ford or GM?
2656 Mr. WEEMS. For the entirety of Part D?
2657 Mr. DAVIS OF VIRGINIA. And union pension plans I guess

2658 you could throw into that as well.

2659 Mr. WEEMS. Sure, sure. So Part D, together with
2660 Medicaid, represents over half of the pharmaceutical market
2661 in the United States. Applying government cost controls to
2662 more than half the market and pushing down that half of the
2663 market to some specified pricing scheme would definitely--and
2664 I say this without reservation--cause cost increases in the
2665 rest of the market, which specifically would be the private
2666 sector. And, you know, for companies like Ford and GM, it
2667 would substantially increase the pharmaceutical costs in
2668 every vehicle.

2669 Mr. DAVIS OF VIRGINIA. You don't think the
2670 pharmaceutical companies would just say, we're going to
2671 continue the same amount on research and development anyway.
2672 We're just going to take this out of our bottom line, reduce
2673 advertising costs and the like?

2674 Mr. WEEMS. I think that is unlikely, but the next panel
2675 will have somebody from pharmaceutical companies on it, and I
2676 would invite you to ask them.

2677 Mr. DAVIS OF VIRGINIA. Okay. I happen to agree with
2678 you.

2679 Much has been made about the Medicaid coverage of
2680 prescription drugs, but prices are only one factor in
2681 determining the success of any new benefit. How do you think
2682 seniors' access to drugs in Part D compares with Medicaid

2683 recipients' access to drugs?

2684 Mr. WEEMS. They have more access and more choices. The

2685 main feature of Part D is the ability to choose a plan that

2686 works best for the individual.

2687 Mr. DAVIS OF VIRGINIA. You may have a rare disease or

2688 something that is not covered, for example, by Medicaid--

2689 Mr. WEEMS. Correct.

2690 Mr. DAVIS OF VIRGINIA. --that is covered by Part D, and

2691 you can choose that particular--

2692 Mr. WEEMS. A lot of it just has to do with choice. You

2693 know, what is the level of premium that I want to pay each

2694 month? What is the amount of co-pay that I want to be

2695 exposed to? Do I want to use my neighborhood pharmacy?

2696 Those are the kinds of things that seniors find

2697 extremely agreeable about this program, that it is not a

2698 government one-size-fits-all, the government picks winners

2699 and losers. It is that there is choice and a lot of choice,

2700 and their drugs are available to them in a very convenient

2701 way that--where they can get what they want.

2702 When I talk to seniors around this Nation--and I spend a

2703 lot of time talking to them--we hear great satisfaction with

2704 Part D. And what they say over and over again is don't take

2705 this benefit away from us. Make sure you keep this benefit.

2706 This benefit is working for us.

2707 Mr. DAVIS OF VIRGINIA. I think that is why you don't

2708 hear the majority saying let us move these dual eligibles
2709 back to Medicaid. Because it would be politically very, very
2710 unpopular with these groups. And now they'd like to have a
2711 hybrid, it seems to me, of--well, we are going to have
2712 Medicaid pricing in Part D for some items and the like.

2713 Mr. WEEMS. In fact, satisfaction rates for the duals
2714 are higher than those even of the regular population. For
2715 one of the first times, they have been given the dignity of
2716 choice from a government program.

2717 Mr. DAVIS OF VIRGINIA. As opposed to a
2718 one-size-fits-all, take-it-or-leave-it?

2719 Mr. WEEMS. That's correct.

2720 Mr. DAVIS OF VIRGINIA. The purpose of the Medicaid
2721 price regulations was to control the cost to States and the
2722 Federal Government. That is why they put the price controls
2723 in. Since implementing price controls 18 years ago, do you
2724 have any observations on the cost of prescription drugs in
2725 Medicaid? Have they remained flat? Have they gone up? Have
2726 they gone down?

2727 Mr. WEEMS. Well, you know, the best price provisions,
2728 the provisions with respect to rebates, are fixed from a
2729 price. So drug prices continue to go up. You know, they
2730 have been effective in reducing the liability for drugs in
2731 the Medicaid program while increasing the liabilities in
2732 other places and causing market distortions in other places

2733 on the market.

2734 Mr. DAVIS OF VIRGINIA. Okay. My time is up. Thank

2735 you.

2736 Mr. YARMUTH. [presiding.] We have a series of votes, as

2737 you might have noticed. So we'll at this point recess the

2738 hearing and reconvene at 1:00.

2739 [Recess.]

2740 Chairman WAXMAN. [presiding.] The meeting of the

2741 committee will come to order.

2742 The Chair recognizes Mr. Murphy to pursue questions.

2743 Mr. MURPHY. Thank you very much, Mr. Chairman.

2744 I wanted to make a brief comment off of the chairman's

2745 concern, Mr. Weems, over the terminology you used regarding

2746 the Medicaid rebate program and that is peppered in your

2747 testimony, both written and oral, is the idea that this is

2748 price control, that this is price fixing. When it seems to

2749 us that it is merely using the market leverage and market

2750 power of the Federal Government to do exactly what private

2751 industry does, what the HMOs do in negotiating these prices,

2752 which is to say, through a choice of a particular

2753 pharmaceutical company, that this is the price that we're

2754 willing to pay. And if you don't pay it, then you're not

2755 going to be part of our plan, which is essentially what the

2756 Medicaid rebate program does.

2757 Price control strikes me as something very different. I

2758 mean, that is a statutorily imposed price that everyone has
2759 to accept for their product.
2760 This is a voluntary program. I would hope that we'd be
2761 a little careful in mixing what is a voluntary rebate program
2762 that the pharmaceutical companies pay as a means of selling
2763 their drug in a particular plan, the Medicaid plans versus
2764 what is traditionally thought of as price controls.
2765 But my question is a little bit different, and that
2766 is--your testimony, Mr. Weems, as to the disruption in the
2767 delivery of health care that would result from imposing
2768 Medicaid rebates on the dually eligible population. And I
2769 want to just ask you to elaborate a little bit on that as to
2770 what evidence you have that gaining these discounts for
2771 taxpayers would lead to this potentially troublesome
2772 disruption of the health care delivery system.
2773 Mr. WEEMS. Thank you for the question.
2774 And, you know, I don't mean to get into a semantic
2775 battle. But, in my view, a system which fixes a specific
2776 rebate amount and fixes it through statute is very different
2777 than a negotiation. And the 15.1 percent rebate in Medicaid
2778 is fixed and fixed in statute. So I would stand by my terms,
2779 sir.
2780 You know, as for the disruptions--I mean, we can--we can
2781 see this. You know, it was the GAO report that found that,
2782 in the 2 years following the implementation of the Medicaid

2783 best price rebate program, the best price discount for
2784 outpatient drugs purchased by HMOs and PPOs decreased to
2785 about 14 or 15 percent, which is approximately the minimum
2786 required by the statute.

2787 CBO found that the best price rebate program, found that
2788 drug purchasers in the private sector, their discounts
2789 weren't as good. Between 1991 and 1994, the best price
2790 discounts that pharmaceutical manufacturers gave off of
2791 wholesale prices fell from 36 percent to 19 percent.

2792 Mr. MURPHY. For private insurers?

2793 Mr. WEEMS. That's correct.

2794 Mr. MURPHY. So you're suggesting that there is a
2795 movement--there is also testimony that you give about we
2796 would have a discouraging of employers from continuing to
2797 provide prescription drug coverage at the same level they do
2798 today. Is that--

2799 Mr. WEEMS. If it is more costly, we can expect less of
2800 it, yes.

2801 Mr. MURPHY. I guess it strikes me as strange that the
2802 testimony here is that we are essentially going to be--that
2803 today we are, in essence, subsidizing privately held plans
2804 purchased through employers?

2805 Mr. WEEMS. No, not at all.

2806 Mr. MURPHY. Wouldn't that be the converse of suggesting
2807 that--if your suggestion is that by the taxpayers paying less

2808 that you're essentially pushing the bubble in somewhere and
2809 it comes out somewhere else, that private employers are going
2810 to pay more, wouldn't the suggestion be currently today then
2811 we are subsidizing private employers' purchase of--
2812 Mr. WEEMS. Not at all. You need to compare the two
2813 systems. If, in fact--if you had a competitive pricing
2814 system on both sides, then you can make a direct comparison.
2815 But, in fact, on the Medicaid side, there are mandatory
2816 rebates. The simple hydraulics of supply and demand means
2817 that, as you force down those prices, they are going to go up
2818 someplace else. That, in fact, means that the private sector
2819 currently is subsidizing Medicaid.
2820 Mr. MURPHY. And currently, though, currently though,
2821 how does that not lead to an argument that we are currently,
2822 through our inflated prices that we are paying--and you admit
2823 that the prices we are paying today are not commensurate with
2824 what Medicaid is paying--isn't providing a subsidy on the
2825 other side to the private insurers?
2826 Mr. WEEMS. No. The market--the market prices--you're
2827 asking to compare a risk-based market price to a
2828 government-imposed price. They don't compare. Because you
2829 have got the cross subsidy and you're not able to capture the
2830 cost of forcing down the lower price and the cost that that
2831 imposes on the rest of the nongovernment cost-controlled part
2832 of that sector.

2833 Mr. MURPHY. And I know my time has expired, Mr.
2834 Chairman. But to get back to, I think, a fundamental
2835 disagreement, I think that the government rebate program is
2836 not completely risk independent. I mean, we obviously are
2837 setting a price at which we believe that the drug provider
2838 will continue to provide the pharmaceutical product. We are
2839 incorporating risk because we know if we set the rebate price
2840 too high that that pharmaceutical company will no longer sell
2841 the product. So it may be different than the negotiation in
2842 the back and forth that occurs in the private sector, but it
2843 is completely interdependent upon risk. Wouldn't you agree
2844 that that is part of the--
2845 Mr. WEEMS. No. I think we're talking about risk in two
2846 different ways. When I refer to a risk-based insurance
2847 product, that is what we have in Part D where the--the
2848 profit, the equity of the firm is in fact at risk for
2849 achieving a good bid, for lowering drug prices and for
2850 bringing in recipients into their plan. That's the risk.
2851 That's a much different kind of risk than the kind you're
2852 describing.
2853 Mr. MURPHY. You're right. I am mixing terms.
2854 I guess what I'm suggesting is that the fundamentals of
2855 supply and demand that underlie a negotiation between an HMO
2856 and a pharmaceutical company are not absent from the
2857 determination of what the rebate will be under the Medicaid

2858 program. Because if the rebate again is set too high, then
2859 that drug will not be provided as part of the Medicaid
2860 program. So many of the same economic factors that underlie
2861 those negotiations are present in the determination of the--
2862 Chairman WAXMAN. Your time has expired.
2863 If you want to make a comment. Otherwise, we can move
2864 on.
2865 Mr. WEEMS. We can move on, sir.
2866 Chairman WAXMAN. Okay. Mr. Issa.
2867 Mr. ISSA. Thank you.
2868 Are you aware of the history of this best price practice
2869 that Medicaid has where, a year after its implementation, the
2870 Department of Veteran Affairs asked Congress to exempt it
2871 from the calculation of Medicaid's best price because in fact
2872 it was raising their prices? Isn't that true?
2873 Mr. WEEMS. To the best of my knowledge, yes.
2874 Mr. ISSA. So here we have the gold standard to a
2875 certain extent. The Veterans Administration buys selected
2876 drugs at the best possible price, makes decisions, including
2877 formulary decisions, based on the best value for our veterans
2878 and then makes it available to other--certain limited other
2879 government agencies such as Bureau of Indian Affairs and so
2880 on for Indian health, and they choose to always take
2881 advantage of it because the prices are good. And they are
2882 saying, when you mandate a discount, you distort the market

2883 and you distort the likely retail price. Now, isn't that
2884 really what we're really talking about?
2885 Mr. WEEMS. Sure. And we've seen that, since the best
2886 price mandate, that best prices have gone up, unsurprisingly,
2887 I would say.
2888 Mr. ISSA. So a question I asked the economist earlier
2889 today--and I will challenge you on this side some--isn't our
2890 gold standard--the Veterans Administration, it backs up a
2891 truck, takes a whole truckload, reduces reliability,
2892 administration, takes the drugs and makes a good price.
2893 Isn't that the gold standard for pretty much as good as you
2894 would do, assuming you don't simply distort the market and
2895 demand a lower price, regardless of merit?
2896 Mr. WEEMS. Well, I might disagree with that
2897 characterization, because I think it--first of all--and we
2898 are probably trying to get to the same place here. But,
2899 first of all, the Veterans Administration is a government
2900 agency that actually takes custody--
2901 Mr. ISSA. And maybe I can clarify. What I'm saying is,
2902 when you do all of those things, you get the price maybe
2903 lower than any other plan.
2904 Mr. WEEMS. Quite possibly.
2905 Mr. ISSA. But when we're looking for the lowest
2906 possible price, we should not look to Medicaid with a
2907 mandated price, we should look to a bulk buyer buying by

2908 reducing administration and risk to these companies. When
2909 they make a buy, they make a big buy; and you just ship it.
2910 Mr. WEEMS. That's right.
2911 Mr. ISSA. Okay. So, earlier today, I said, when we
2912 want to evaluate Medicare Part D's performance, shouldn't it
2913 be taking, if you will, if possible arithmetically, take the
2914 VA, put back in the administrative cost of not buying from a
2915 single payer but rather allowing people to get drugs where
2916 they want to be, where their doctors and their pharmacies
2917 are, rather than going to a VA facility to pick them up.
2918 Recognizing there is distribution costs, administrative
2919 costs, but that convenience is something our seniors demand
2920 because they want that capability. They're not asking us to
2921 please have 35 locations around the country they can drive to
2922 to get their drugs.
2923 If you add back in those reasonable costs and so on,
2924 isn't that the standard where we would like to see Medicare
2925 Part D close to? And in your estimation are we, when you add
2926 back in those costs, somewhat close?
2927 Because here today it seems like everybody wants to use
2928 Medicaid, which is an artificial mandated price, as the gold
2929 standard, rather than any other comparison. Or they want to
2930 use Canada, where they say if you don't give us a lower
2931 price, we'll simply void your patent and knock it off. So
2932 that is my real question. Can you progress on how you see it

2933 should--

2934 Mr. WEEMS. Sure. That makes the comparison more fair.
2935 But the thing that--that Part D offers that--you know, is
2936 that you need to layer in again here is the choice of plans,
2937 you know, the many, many choices that are available to
2938 seniors and the way that they can, you know, structure their
2939 payments. They can choose, you know, a higher premium level
2940 in return for lower structured co-payments, those kinds of
2941 things. All of that adds to the value of Part D. And, you
2942 know, once you step up from a highly restricted--all the way
2943 up to a program that offers considerable choice--

2944 Mr. ISSA. Right. And, look, I have no question at all
2945 that my seniors want the features of being able to choose
2946 between formularies, to have some choices, to decide sort of
2947 good, better and best.

2948 One of the controversial things by some here on the dais
2949 is, well, why don't we just have one formulary? Why don't we
2950 just have one solution? In a sense, the price that Medicare
2951 Part D gets, which is better than originally forecasted,
2952 isn't one of the most important parts of that. The fact that
2953 independent companies compete based on their formulary and
2954 features and by the way offered to pharmaceuticals, do you
2955 want to be with us, and will you give you a better price for
2956 it, because they are not necessarily taking every therapeutic
2957 solution.

2958 Mr. WEEMS. That's absolutely true.
2959 Mr. ISSA. If we come up with one mandated solution,
2960 although we might get a lower price on that, don't we distort
2961 the market for what the seniors want?
2962 Mr. WEEMS. Yes. And I would say that there are two
2963 aspects to that. First of all, that a restricted formulary
2964 may mean that some people don't get the drugs they need; and,
2965 secondly, it puts the government in the position of choosing
2966 winners and losers in the marketplace.
2967 Chairman WAXMAN. The gentleman's time has expired.
2968 Ms. Foxx, do you have questions?
2969 Ms. FOXX. Thank you, Mr. Chairman.
2970 I think that last point was really important, that we
2971 should not be putting the government in charge of picking
2972 winners and losers, especially when it comes to health care.
2973 I have a couple of questions that I'd like to ask you,
2974 Mr. Weems; and I would say that I'm not always happy with the
2975 way CMS operates. There are things that I disagree with that
2976 you all have done, and so there are lots of things that I
2977 think could be done better over there, And we'll have another
2978 conversation about that sometime after this.
2979 But let me ask you a question. According to the
2980 material that you all have produced, Medicare Part D
2981 enrollees continue to save about--excuse me. I'm asking the
2982 wrong question. You show that Part D costs are lower than

2983 the initial estimates. Can you tell us what accounts for
2984 that?

2985 Mr. WEEMS. Sure. There are a number of things. First
2986 of all, that the degree of competition that occurred in the
2987 system was more robust than originally estimated; secondly,
2988 the price of drugs has not risen as fast as originally
2989 estimated; then, lastly, the total population enrolled is
2990 somewhat lower than originally estimated.

2991 Ms. FOXX. The second question has three parts to it.

2992 You have been around the Department for a long time, and
2993 you probably will remember during the debate about Part D
2994 there were a lot of doomsday predictions. I was not here
2995 during that debate. I didn't vote on Medicare Part D. But
2996 tell me in your opinion which--how these doomsday predictions
2997 have worked out.

2998 Number one, did plans refuse to offer drug-only
2999 insurance? I'll ask all three of the questions, and then you
3000 can respond. Did plans cherry-pick only the healthiest
3001 seniors? And you've already mentioned this about drug prices
3002 not rising exponentially. If we have time, I would like you
3003 to also say something about the price of drugs holding down
3004 the cost of health care in other areas.

3005 Mr. WEEMS. You know, clearly, there was a lot of
3006 concern at the beginning that there wouldn't be marketplace
3007 entry. There has been robust and substantial marketplace

3008 entry. In fact, the complaints are reversed, from nobody is
3009 going to get into this to aren't there too many.
3010 As for cherry-picking, that is something that we still
3011 remain very, very vigilant about in CMS. Every year when the
3012 bids come in, we examine the bids, we examine the formularies
3013 to make sure that there are not discriminatory bids as part
3014 of that.
3015 You know, as for pricing, you know, if you--73 percent
3016 of our enrollees are in plans where the price index did not
3017 increase by more than 3 percent; 50 percent are in plans
3018 where the price index did not increase more than 2; and 14
3019 percent are in plans where the price actually fell. So we
3020 not only see good price stability, we also see that our
3021 seniors are able to protect themselves against the risk of
3022 higher prices in the plans and also during the plan year by
3023 choosing tiered co-payments. Ninety-five percent of our
3024 beneficiaries buffer themselves against the risk of payment
3025 increases by having set co-payments, rather than percentage
3026 co-payments.
3027 Ms. FOXX. Thank you.
3028 Mr. Chairman, I would just like to make a brief comment.
3029 I find it so interesting that, in matters of choice, the
3030 majority party here wants choice when it comes to destroying
3031 life but not choice for citizens when they have the
3032 opportunity to save money and have better health care.

3033 Because it seems to me that one of the things that drives the
3034 majority party so crazy about Medicare Part D is that people
3035 do have choice. We don't want people to have choice about
3036 where to go to school, but, again, we do want them to have
3037 choice to kill babies.

3038 The other thing that I think is not recognized that Mr.
3039 Shays said earlier is Medicare is in deep trouble; and there
3040 is material out all over the place today that the majority
3041 party is going to avoid dealing with the trigger, going to
3042 sweep that under the rug. We don't want to deal with the big
3043 issue of Medicare, but because there is this animus towards
3044 the drug companies, it is easy to pick on drug companies and
3045 pick on the private sector whenever we possibly can and make
3046 them look bad.

3047 So I think we need to be dealing with the real problems
3048 that we have, which is the major Medicare program and what
3049 has come to be called an entitlement, because that is where
3050 our real problems are.

3051 Chairman WAXMAN. The gentlelady's time has expired.

3052 Mr. Weems, I want to ask you some questions. Under the
3053 Medicare Part D, people can choose a plan that will offer
3054 them some drugs. It doesn't have to be every choice of
3055 drugs, but they have their formulary or they can join another
3056 plan that will have its formulary. Isn't that the way it
3057 works?

3058 Mr. WEEMS. That's correct, yes, sir.

3059 Chairman WAXMAN. So they have a choice, but they may
3060 find one drug on one plan but not on that same plan for
3061 another drug so they have to--they really can't pick and
3062 choose. They can't belong to two plans. They can only
3063 belong to one. So they don't really get the choices of all
3064 the drugs they need.

3065 Under the old Medicaid, they had all the drugs on the
3066 list. So I just say that rhetorically when we talk about how
3067 much choice we are actually giving people.

3068 Secondly, I want to point out you said with pride that a
3069 lot of insurance companies are out there competing and that
3070 just shows us it is wonderful and really working. But it
3071 also might show that they are making a lot of money; and if
3072 they're making a lot of money, why not go into that business?
3073 I just say that rhetorically as well.

3074 Then the other thing I want to ask you is, we had 6
3075 million people on Medicaid, and we paid less for them. Now
3076 they are on Part D Medicare, and we pay more for them. It is
3077 your premise that, if we paid less, the prices would go up in
3078 other areas where government spends on drugs; is that right?

3079 Mr. WEEMS. That's correct. Or in the private sector.
3080 I wouldn't just limit it to government, sir.

3081 Chairman WAXMAN. Okay. Now that we've taken 6 million
3082 people and we have paid less for them, are we seeing a drop

3083 in what is being paid in other government programs or in the
3084 private sector?
3085 Mr. WEEMS. Again, I think that is a question that bears
3086 examination. The question may be--
3087 Chairman WAXMAN. It goes to your argument.
3088 Mr. WEEMS. It bears examination, sir.
3089 Chairman WAXMAN. Have you seen any evidence of the
3090 prices dropping for other government programs?
3091 Mr. WEEMS. One of the reasons that we did not see the
3092 top line on that is prices have not increased in the way or
3093 at the speed that was originally estimated. So I would point
3094 to that as evidence, sir.
3095 Chairman WAXMAN. What prices haven't increased at the
3096 speed of--
3097 Mr. WEEMS. Drug prices.
3098 Chairman WAXMAN. Who estimated them?
3099 Mr. WEEMS. The original estimate from the Office of the
3100 Actuary for the--
3101 Chairman WAXMAN. Is that the one we were never allowed
3102 to see? We still haven't gotten that one, as I understand.
3103 That was--the actuary's life--no, not his life, his job was
3104 threatened if he shared with Congress the cost.
3105 Well, let me go into another question. Let us say we
3106 spent $3.7 billion for 6 million beneficiaries when they're
3107 under Medicaid--$3.7 million less, now we're paying $3.7

3108 million more. Is that the best use of our $3.7 million? The
3109 drug companies like it, but couldn't we use that for other
3110 purposes when we have so many uninsured?

3111 For example, one of the reasons the President said he
3112 vetoed the SCHIP bill was because it cost so much money.
3113 Well, that $3.7 billion would have covered 3.3 million
3114 uninsured children. Which is a better use of that money,
3115 paying it to the drug companies or paying less to the drug
3116 companies and using it for children?

3117 Mr. WEEMS. Again, sir, I think that analysis
3118 ignores--is only half the equation. It ignores the
3119 distortions that the price setting creates in other parts of
3120 the market. You may--

3121 Chairman WAXMAN. We can't be responsible for every
3122 distortion--you have never given us any evidence of that.
3123 But even if you do, there are always distortions.

3124 I want to ask you one question about this issue of
3125 distortion. Do you think if we charge less--let me put it
3126 this way--if we charge more for drugs that the drug companies
3127 say, well, since I'm making so much money under this Medicare
3128 Part D, I'm going to give a break to these other payers of
3129 the private sector?

3130 I can't believe that is the case. They are in business
3131 to make money. If they can sell their drugs at a certain
3132 price to the private sector, they'll do it. If they can sell

3133 their drugs to the government at a higher price, they'll do
3134 it. It is when somebody says, no, we're not going to pay the
3135 higher price that they have to realize that they're not going
3136 to make the money they were making before and then make their
3137 business calculations.

3138 Mr. WEEMS. And I think you perfectly encapsulated the
3139 problem with government-administered pricing. We know that
3140 in Part A and B we overpay in some areas and underpay in
3141 others, and it creates distortions and costs that, frankly,
3142 we're not able to measure.

3143 Chairman WAXMAN. In Part D?

3144 Mr. WEEMS. A and B. In Part A and B. It is a
3145 government-administered prices program. We know that we
3146 overpay.

3147 Chairman WAXMAN. Would you be surprised if you found
3148 that one plan was paying more for the same drug than another
3149 plan under Part D?

3150 Mr. WEEMS. For the same drug, no.

3151 Chairman WAXMAN. You wouldn't be surprised?

3152 Mr. WEEMS. No.

3153 Chairman WAXMAN. Would you be surprised if one plan was
3154 bargaining for lower prices and didn't pass it onto the
3155 consumer but increased their profits?

3156 Mr. WEEMS. If it is a rebate, they have to pass it on
3157 in their premiums, sir.

3158 Chairman WAXMAN. Well, it may not be a rebate. They
3159 just negotiated a better price because they did some deals.
3160 That's what we want in the market, right?
3161 Mr. WEEMS. That's correct.
3162 Chairman WAXMAN. Pass on the lower prices to the
3163 Medicare system or beneficiary or does it just simply make
3164 all those companies that to our surprise decided to go into
3165 the business richer?
3166 Mr. WEEMS. If they are going to compete for
3167 beneficiaries, they're going to have lower premiums, and that
3168 drives down their profits.
3169 Chairman WAXMAN. Do you think that's the only reason
3170 signs up on one plan as opposed to another, the price?
3171 Mr. WEEMS. The price and the coverage of the drugs.
3172 Chairman WAXMAN. Yeah. Okay. Thanks.
3173 The gentleman from North Carolina, Mr. McHenry is
3174 recognized.
3175 Mr. MCHENRY. I appreciate it, and I hope we will still
3176 have the same liberal time policies for me as for you. I
3177 know being chairman has its privileges.
3178 Chairman WAXMAN. I went over 30 seconds. If you want
3179 an extra 30 seconds, I'll give you--
3180 Mr. MCHENRY. That would be great, but I think you
3181 probably just burned it.
3182 So anyway--

3183 Chairman WAXMAN. I can't make you happy any way, huh?

3184 Mr. MCHENRY. Well, actually, you know, your philosophy
3185 is very different and your focus is different here
3186 because--based on the studies--

3187 Chairman WAXMAN. The gentleman's time is just beginning
3188 at 5 minutes.

3189 Mr. MCHENRY. Okay.

3190 Chairman WAXMAN. Take my generosity.

3191 Mr. MCHENRY. I appreciate your generosity.

3192 But in this particular case, I think we do have some
3193 disagreements. Because, based on the studies I have seen,
3194 Mr. Weems--now, you know, Medicare Part D has cost both less
3195 for consumers that are using the program and for the
3196 taxpayers than the original cost estimate; is that correct?

3197 Mr. WEEMS. Forty percent less, yes.

3198 Mr. MCHENRY. Forty percent less?

3199 Mr. WEEMS. Yes, sir.

3200 Mr. MCHENRY. So market forces are--have been much more
3201 powerful in bringing down the cost than the government
3202 setting an arbitrary dollar amount that they will pay for an
3203 arbitrary drug?

3204 Mr. WEEMS. The power of Part D has been to use market
3205 forces to bring prices down well below those that were
3206 originally estimated.

3207 Mr. MCHENRY. Okay. There is an IMS health report in

3208 2007. Generics--and it said, generics account for 13 of the
3209 15 drugs most prescribed by Medicare Part D. All right? And
3210 also according to this study, generics accounted for 68
3211 percent of all medicines prescribed in Part D.
3212 Mr. WEEMS. Generic usage is in the 60 percentile. My
3213 number is about 64 percent.
3214 Mr. MCHENRY. So can you comment on the effect that that
3215 has on the cost for the consumer, the senior and for
3216 taxpayers?
3217 Mr. WEEMS. Sure. And that was one of the points that I
3218 was making earlier. It is not an exact comparison to compare
3219 somebody who is in a price-fixed indemnity program to a
3220 risk-based program that has some additional benefits to it,
3221 you know, such as therapy management, such as therapeutic
3222 interchange. I mean, there can be and, you know, we have
3223 seen scenarios where somebody who was in Medicaid came over
3224 to Medicare, was able to get more of the drugs, would be able
3225 to get more drugs, the ones that they needed and, in many
3226 cases, to be able to get those at a lower price and have
3227 better health outcomes and avoid costs in the A and B part of
3228 the Medicare program.
3229 Mr. MCHENRY. I have got four questions here in
3230 succession. You can answer them just briefly.
3231 Do Medicare and Medicaid programs generally serve the
3232 same type of beneficiaries? Yes or no?

3233 Mr. WEEMS. No.

3234 Mr. MCHENRY. Okay. Are Medicare and Medicaid programs
3235 financed the same way?

3236 Mr. WEEMS. No, they're financed very differently.

3237 Mr. MCHENRY. Okay. So then is it fair to say that
3238 Medicare and Medicaid are two fundamentally different
3239 programs?

3240 Mr. WEEMS. They are.

3241 Mr. MCHENRY. They serve different beneficiaries and
3242 have different benefit structures and are financed in
3243 different ways?

3244 Mr. WEEMS. Yes.

3245 Mr. MCHENRY. So if you and I understand this
3246 correctly--I mean, obviously, by overseeing the program, you
3247 know, you have a depth of knowledge. Do you believe that the
3248 price structure of one program would work for the other
3249 program?

3250 Mr. WEEMS. Well, clearly, it would not be wise to move
3251 the price structure of the Medicaid program into the Medicare
3252 program where there would essentially be an administered
3253 price-fixing arrangement for, you know, more than half of the
3254 pharmaceutical market in the United States. That would have,
3255 at least in my estimation, you know, considerable effects
3256 that would spill over into the private sector in terms of
3257 higher costs. So I would say that would not be particularly

3258 wise.

3259 Mr. MCHENRY. There are some shortcomings with the
3260 program. It is a government program. It is what government
3261 does very well. Inefficiency is what government does very
3262 well. However, because market forces are involved, it has
3263 been better in terms of the cost and the benefits to
3264 consumers.

3265 So we have talked about the negative aspects of the
3266 program. That's what this whole hearing is about, after all.
3267 That is why you have a crowd behind you and the reason why
3268 the chairman had it. But can we talk about some successes,
3269 and, you know, and answer one general question? Has Medicare
3270 Part D shown to improve beneficiary access at a
3271 less-than-expected cost?

3272 Mr. WEEMS. Certainly. And beneficiaries are getting
3273 the drugs that they need. They are getting it in a way that
3274 is convenient to them. It is a real challenge to find any
3275 program that has a satisfaction rate of 85 percent on the
3276 part of the beneficiaries, and that's what the Medicare Part
3277 D program has. Among the low-income beneficiaries, it is 90
3278 percent.

3279 Mr. MCHENRY. Thank you, Mr. Chairman.

3280 Chairman WAXMAN. Thank you, Mr. McHenry.

3281 Mr. Weems, thank you very much for your participation.
3282 I know you're anxious to get back to the work that the

3283 government bureaucracies do so poorly, according to my
3284 friends on the other side of the aisle. But I salute you for
3285 the work that you do, and we want to make laws that will make
3286 sure that we protect the taxpayers and the beneficiaries.
3287 Mr. WEEMS. Thank you for the opportunity to appear,
3288 sir.
3289 Chairman WAXMAN. For our next panel, we want to call
3290 forward Mr. Mark Merritt, President and Chief Executive
3291 Officer of the Pharmaceutical Care Management Association;
3292 Mr. Rick Smith, Senior Vice President for Policy,
3293 Pharmaceutical Research Manufacturers Association, PhRMA; Mr.
3294 Paul Precht, Director of Policy and Communications, Medicare
3295 Rights Center; and Ms. Judith Stein, Executive Director of
3296 the Center For Medicare Advocacy.
3297 We are very grateful for all of you coming to our
3298 hearing today, and we thank you for being here. And I want
3299 to make mention of the fact that we're particularly grateful
3300 that you allow us to share Mr. Merritt's birthday with him
3301 and to have him here on this special occasion. You wouldn't
3302 have wanted to be anywhere else on your birthday.
3303 Mr. MERRITT. It really is a dream come true. Thank
3304 you.
3305 Chairman WAXMAN. Okay. Well, you said that without
3306 being under oath, but the rest of the testimony you all be
3307 asked to give--it is the practice of this committee that it

3308 be done under oath. So I'd like to ask you to all stand.

3309 [Witnesses sworn.]

3310 RPTS COCHRAN

3311 DCMN MAGMER

3312 Chairman WAXMAN. The record will indicate that each of
3313 the witnesses answered in the affirmative.

3314 STATEMENTS OF MARK MERRITT, PRESIDENT AND CHIEF EXECUTIVE
3315 OFFICER, PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION; RICK
3316 SMITH, SENIOR VICE PRESIDENT FOR POLICY, PHARMACEUTICAL
3317 RESEARCH AND MANUFACTURERS ASSOCIATION (PhRMA); PAUL PRECHT,
3318 DIRECTOR OF POLICY AND COMMUNICATIONS, MEDICARE RIGHTS
3319 CENTER; AND JUDITH STEIN, EXECUTIVE DIRECTOR, CENTER FOR
3320 MEDICARE ADVOCACY

3321 Chairman WAXMAN. Mr. Merritt, as a birthday gift to
3322 you, we are going to let you start.

3323 I think you all know the rules. Your prepared
3324 statements will be in the record in their entirety. We would
3325 like to ask you to try to limit the oral presentation to 5
3326 minutes. We have the clock.

3327 STATEMENT OF MARK MERRITT

3328 Mr. MERRITT. Thank you, Mr. Chairman and Ranking Member
3329 Davis, the rest of the members who will be in and out
3330 throughout.

3331 My name is Mark Merritt. I am President of the
3332 Pharmaceutical Care Management Association. PCMA is a
3333 national association representing America's pharmacy benefit
3334 managers. PBMs administer prescription drug benefits for
3335 more than 200 million Americans with health coverage. Our
3336 clients include the Nation's largest public and private
3337 purchasers, including labor unions, Fortune 500 companies,
3338 FEHBP plans, and, of course, Medicare.

3339 First, I would like to thank you, Chairman Waxman, for
3340 your leadership on health care issues. PCMA is appreciative
3341 of the opportunity to work with your staff on generic
3342 biologics legislation and on ensuring generic competition in
3343 the marketplace, and I am pleased to be here today to testify
3344 about Medicare Part D and what we do in it.

3345 To begin, PBMs use a number of tools and strategies to
3346 maximize value in terms of quality, access and convenience
3347 and overall drug spending. First, let's talk about PBMs and
3348 discounts and rebates regarding manufacturers. There, PBMs
3349 pool the purchasing ability of all our clients and consumers

3350 and encourage certain kinds of utilization to obtain
3351 discounts and rebates from brand-name manufacturers.
3352 First, our panels of independent clinical experts,
3353 called P&T committees, or pharmacy and therapeutic
3354 committees, comprised of independent doctors, pharmacists,
3355 academics and others, inform us of which drugs are
3356 appropriate for certain therapeutic classes which address
3357 particular medical conditions. Then we negotiate with
3358 manufacturers who make competing products within that class.
3359 The manufacturer which offers the best discounts and
3360 rebates typically has their drugs placed on formularies at
3361 lower copays than their competitors. That encourages
3362 consumers to choose the more affordable drug, although their
3363 physician can, of course, direct them to another, if
3364 clinically appropriate.
3365 While discounts on individual drugs can vary widely,
3366 overall, manufacturer rebates have decreased drug spending by
3367 up to 9 percent in FEHBP, according to their report. And I
3368 believe your new report, if I read it correctly--and I just
3369 got it, of course--says we save about 14 percent in Part D.
3370 But I am not sure about that.
3371 Extracting manufacturer discounts, however, is only one
3372 way PBMs deliver savings. The majority of our savings that
3373 we generate results from innovative and aggressive management
3374 of other components of drug spending.

3375 First, we create more affordable delivery options, such
3376 as mail service pharmacy, which can save 10 percent for
3377 payors and patients alike. Second, we aggressively negotiate
3378 more economical reimbursement and dispensing fees with
3379 drugstores in our pharmacy networks. Third, we use
3380 formularies, medication, therapy management and other tools
3381 to increase generic utilization and create a more affordable
3382 and often safer drug mix for patients. Four, we employ drug
3383 utilization review programs, or DUR, to inform patients and
3384 doctors when we identify unsafe or unnecessarily expensive
3385 prescribing patterns. And, five, we are constantly
3386 developing new innovative tools, like electronic prescribing,
3387 which improve efficiency, safety and savings across the whole
3388 system.

3389 Today, we are proud of our accomplishments in Part D.
3390 Costs are lower than expected, premiums are as well, generic
3391 utilization is higher and getting better, beneficiaries have
3392 broad access to formularies and drugs and have access to over
3393 60,000 pharmacies.

3394 Overall, our savings are comparable to those we generate
3395 in the private sector and for FEHBP plans. Most importantly,
3396 of course, beneficiaries themselves are highly satisfied with
3397 the program; and, of course, that is our marketplace.

3398 There are, however, additional policy options that would
3399 further enhance our ability to generate savings that I would

3400 offer for the committee's consideration, some of which have
3401 been mentioned already today.

3402 First, we desperately need to create competition among
3403 biologics by pursuing legislation such as your proposal, Mr.
3404 Chairman, the Access to Lifesaving Medicines Act. This is
3405 the fastest-growing component of drug spend and will reach
3406 $100 billion sometime in the next 10 years. We need more
3407 competition in that space.

3408 Second, we would ask policymakers to build on the
3409 groundbreaking new e-prescribing incentives that were just
3410 passed as part of the physician pay package.

3411 Third, we would ask you to take a closer look at the six
3412 classes of clinical concern that have been mentioned earlier
3413 in which all drugs from all drug makers are mandated for
3414 coverage in certain classes, therapeutic classes. These are
3415 specifically important regarding dual eligibles, who are
3416 heavy utilizers of these drugs.

3417 And this policy of mandating coverage, again, for all
3418 drug companies, all drugs in a certain class, we don't
3419 believe it improves access, but it does make it difficult,
3420 more difficult, for PBMs to negotiate rebates for drugs in
3421 those classes. And, again, they account for about 40 percent
3422 or more of the spending of dual-related spending.

3423 In fact, the rebates in the six protected classes, we
3424 are only able to generate about half as much--or half of

3425 significant rebates as we are in other classes. Because when
3426 that leverage is taken away from us, it inhibits our ability
3427 to get the right discounts from the pharmaceutical
3428 manufacturers.

3429 In conclusion, though, I appreciate the opportunity to
3430 share with you our progress on my birthday and also look
3431 forward to answering any questions you might have and any
3432 concerns you might have.

3433 Chairman WAXMAN. Thank very much, Mr. Merritt.

3434 [Prepared statement of Mr. Merritt follows:]

3435 ******** INSERT 4-1 ********

3436 Chairman WAXMAN. Mr. Smith.

3437 STATEMENT OF RICK SMITH

3438 Mr. SMITH. Thank you, Mr. Chairman and members of the
3439 committee. Thank you for the invitation to participate in
3440 today's hearing.

3441 My name is Richard Smith. I am Senior Vice President
3442 for Policy and Research at PhRMA, which represents
3443 pharmaceutical research companies.

3444 Medicare Part D has greatly improved beneficiaries'
3445 access to needed medicines, reduced out-of-pocket costs and
3446 retained broad choice among medicines. This has been
3447 accomplished at much lower than anticipated cost to
3448 beneficiaries and taxpayers, and data show that Part D
3449 enrollees are highly satisfied and they are saving money.

3450 Last week, Congress adopted an important PhRMA support
3451 improvement allowing more low-income beneficiaries to qualify
3452 for enhanced assistance.

3453 The committee requested that I provide information on
3454 the nature of financial arrangements between pharmaceutical
3455 manufacturers and Part D plans, along with the extent of
3456 discounts. As a trade association, PhRMA maintains a strict
3457 antitrust compliance policy, so I can neither obtain nor

3458 discuss our members' proprietary information related to
3459 prices, negotiations or discount strategies. As a result, my
3460 testimony reflects only publicly available information.
3461 Part D was designed to achieve a range of objectives by
3462 carefully balancing affordability, access choice and improved
3463 use of medicines. This careful balance requires assessing
3464 the program on an overall basis, recognizing that its
3465 objectives are interrelated.
3466 Part D saves beneficiaries money. Peer-reviewed
3467 research and government studies report sizeable reductions in
3468 seniors' monthly out-of-pocket costs, and premiums in 2008
3469 are actually below the level initially projected for 2006.
3470 Part D's competitive structure saves taxpayers money.
3471 Both CBO and the Medicare Trustees report costs are far less
3472 than anticipated, largely because of vigorous competition.
3473 CBO concludes plans have "secured rebates somewhat larger
3474 than the average rebates observed in commercial health
3475 plans." And the Trustees report states many brand-name
3476 prescription drugs carry substantial rebates, often as much
3477 as 20 to 30 percent.
3478 I would also note, in the six classes, plans have an
3479 array of tools used to negotiate savings. In these classes,
3480 plans have tiers, utilization management and many generics.
3481 Comparing CBO's 2008 and 2006 baseline shows that
3482 projected total cost for 2007 through 2016 has dropped by

3483 $438 billion, or 37 percent. Actual plan bids, the best
3484 measure of the program's per person cost, are 12.8 percent
3485 lower than they were 2 years ago.
3486 Part D offers beneficiaries choice of medicines through
3487 the medicines covered by individual plans and through choice
3488 among plans. In fact, two of the largest Part D plans report
3489 covering all 100 of the most commonly used drugs; and
3490 beneficiaries are picking plans that combine no deductible,
3491 lower-than-average premium, and a broad choice of medicines.
3492 While access to medicines has improved as intended under
3493 Part D, IMS Health estimates that the program's impact on
3494 retail pharmaceutical sales was an increase of about 1
3495 percent in 2006. And a recent academic study reports that,
3496 overall, Part D reduced average drug prices, and the trustees
3497 have reported that rebates increased in 2008. Moreover, drug
3498 costs growth has slowed since Part D's enactment to 3.8
3499 percent in 2007, the lowest rate since 1961.
3500 In assessing the program's cost savings, it is important
3501 to consider the full range of populations covered and the
3502 full range of cost-saving tools used. For instance, 14
3503 million uninsured or underinsured beneficiaries before Part D
3504 did not have discounts and rebates routinely negotiated on
3505 their behalf. Now, powerful purchasers representing millions
3506 of covered lives each negotiate savings on their behalf.
3507 And plans use a variety of tools, among them discounts,

3508 rebates and incentives, to increase generic use to achieve
3509 savings. As was mentioned previously, 13 of the 15 most
3510 commonly prescribed drugs in Part D are generic. These tools
3511 have produced affordable premiums and are largely responsible
3512 for the overall $438 billion reduction in the program's total
3513 projected cost.

3514 In conclusion, Part D has achieved its objectives for
3515 beneficiaries who clearly recognize its value. Vigorous
3516 competition has driven down costs, both for beneficiaries and
3517 taxpayers. Changing Part D's market-based structure would
3518 undermine the balanced approach which has produced sizeable
3519 cost savings and greatly improved access to needed medicines.

3520 We look forward to working with the committee to enhance
3521 the program by building on its successful foundation, and I
3522 appreciate the opportunity to testify.

3523 Chairman WAXMAN. Thank you very much.

3524 [Prepared statement of Mr. Smith follows:]

3525 ******** INSERT 4-2 ********

3526 Chairman WAXMAN. Mr. Precht.

3527 STATEMENT OF PAUL PRECHT

3528 Mr. PRECHT. Thank you, Chairman Waxman, members of this
3529 committee, for this opportunity to testify.
3530 I am Paul Precht, Director of Policy and Communications
3531 for the Medicare Rights Center.
3532 The Medicare Rights Center is a national consumer
3533 service organization with offices in New York and Washington.
3534 Our hotline volunteers and caseworkers help older and
3535 disabled Americans deal with every conceivable type of
3536 problem standing between them and the health care they need.
3537 Before the Part D benefit started in 2006, the most
3538 frequent call came from people with Medicare who could not
3539 afford to buy the medicines they were prescribed. Today,
3540 despite the billions in subsidies provided to the insurance
3541 companies and pharmacy benefit managers running Part D, it
3542 remains the number one problem we hear.
3543 A typical call comes from someone making less than
3544 $20,000 a year. More than half of the people with Medicare
3545 earn less than that amount. They don't have much to live on,
3546 but it is still too much to qualify for extra help with their
3547 prescription drug costs.

3548 Multiple drugs to treat multiple chronic conditions put
3549 this person in the Part D coverage gap, the donut hole, where
3550 she--and it is often a widow living alone who calls--must pay
3551 both the premiums for her Part D drug coverage and the full
3552 price of her drugs. With a drug bill in excess of $500 per
3553 month for months on end, on top of medical and other bills,
3554 the options are few. She can try to get free samples from
3555 her doctor. She can head for the emergency room. When these
3556 strategies fail, too often, she may go without the medicine
3557 she needs.

3558 Prescription drug prices are just too high, and Part D
3559 plans are not delivering the lower prices that were promised
3560 when this benefit was created. They certainly are not
3561 providing discounts on par with the prices the VA, State
3562 Medicaid programs, or our neighbors in Canada have secured.
3563 That is widely acknowledged.

3564 What is less well-known, however, is that the rebates
3565 and discounts that the Part D plans have been able to obtain
3566 are not passed through to consumers in the form of lower
3567 prices. That means each time a diabetic person with Medicare
3568 scrapes together the money to buy a $400 specialty drug, the
3569 Part D plan pockets a $30 or $40 rebate, based on the
3570 averages that this committee has uncovered. That rebate is
3571 not used to lower the $100 coinsurance she paid during the
3572 initial benefit period, and it does not bring down the $400

3573 price she pays during the donut hole.

3574 Plans argue that rebate revenue is used to keep premiums
3575 down. In effect, under this system, sick people who need
3576 expensive medicine pay a surcharge to keep costs down for
3577 their healthier neighbors. It is the opposite of the way
3578 insurance is supposed to work.

3579 It is not just brand-name drugs that are too expensive
3580 under Part D. People with Medicare are also being
3581 overcharged for generics under some plan D plans. This
3582 scheme was described in the Wall Street Journal this week.
3583 This is how it works.

3584 The Part D plan, an insurance company, pays its pharmacy
3585 benefits manager $60, for example, for each prescription of
3586 generic Zocor that it covers. But the drug really costs only
3587 $20. The pharmacy receives $15 from the PBM and $5 from the
3588 consumer. At the end of the month, the consumer gets a
3589 statement from the PBM saying it spent $55 for the
3590 prescription, and the customer is $60 closer to the donut
3591 hole.

3592 Consumers who take a few generic drugs that are subject
3593 to these inflated prices can be pushed into the donut hole 2
3594 or 3 months earlier in the year. What happens when consumers
3595 hit the donut hole? Do they pay the $20, the reimbursement
3596 rate for the pharmacy? They do not. They pay $60, and the
3597 pharmacy is forced to kick back $40 to the PBM.

3598 PBMs argue this pricing scheme keeps administrative
3599 costs down for the insurance companies. But here is the
3600 twist: Sometimes the Part D plan and the PBM running this
3601 pricing scheme are part of the same company. In our view,
3602 prices are being manipulated to gouge both the consumer and
3603 Medicare, which pays more for the dual eligibles, since they
3604 pay the cost sharing.

3605 We are 2-1/2 years into the Part D drug benefit, and
3606 even if the administration follows through on its promise to
3607 end this scheme--and they backed off last time they proposed
3608 to end it--it will continue through the end of 2009.

3609 When the insurance industry and the PBMs talk about how
3610 Part D has marshaled market forces to lower costs, this is
3611 the market they are talking about. It is untransparent, it
3612 is rigged against consumers, particularly when they fall
3613 sick, and it does not deliver the prices consumers could
3614 receive if Medicare was negotiating with manufacturers and
3615 running the benefit.

3616 People with Medicare should have the choice to receive
3617 drug coverage directly through Medicare. A Medicare plan
3618 that, for example, could encompass the duals, as a start,
3619 would be a good way to deal with these overcharges that we
3620 are facing.

3621 Just one last remark. Everybody talks about the
3622 satisfaction rates with Part D. But those same polls also

3623 show similar percentages of people want a simpler benefit,
3624 they would like the option to have coverage under Medicare,
3625 and they want the government to be able to negotiate lower
3626 prices.

3627 Thank you.

3628 [Prepared statement of Mr. Precht follows:]

3629 ******** INSERT 4-3 ********

3630 Chairman WAXMAN. Ms. Stein.

3631 STATEMENT OF JUDITH STEIN

3632 Ms. STEIN. Good afternoon and thank you, Chairman
3633 Waxman. Thank you for being here, Mr. McHenry and
3634 Congressman Murphy.
3635 I am Judy Stein. I am testifying today on behalf of the
3636 Center for Medicare Advocacy, of which I am the founder and
3637 Executive Director.
3638 Since 1977, first at Connecticut Legal Services and then
3639 when I founded the Center in 1986, I have dedicated my legal
3640 career to representing Medicare beneficiaries. At the Center
3641 for Medicare Advocacy, we have represented thousands of
3642 Medicare beneficiaries and their helpers in Connecticut and
3643 across the country to understand and utilize Part D. We hear
3644 repeatedly from them about problems that arise from the
3645 complexity of the program and its ever-increasing costs.
3646 Unfortunately, problems go beyond just the dually eligible
3647 population.
3648 There are a myriad of plans, each with varying benefit
3649 structures, formularies, out-of-pocket costs, and it makes
3650 comparisons all but impossible. Beneficiaries have
3651 insufficient information to understand formularies,

3652 coinsurance, copayments and coverage gaps. They lack
3653 sufficient information to make sound choices. Indeed, the
3654 Center has hired an experienced advocate who dedicates all of
3655 her time just to handle the Part D problems just in
3656 Connecticut.

3657 I thank you very much, Chairman Waxman for your
3658 leadership in investigating prescription drugs and Part D in
3659 general and Congressman Murphy for all the work he has done
3660 in our home State and now very happily here in Washington to
3661 help Medicare beneficiaries across the country.

3662 Over the past several years, the Center has written
3663 extensively about the effects on our clients of increased
3664 reliance on private insurance plans to provide Medicare
3665 coverage. Those plans lack the stability and uniformity of
3666 the Medicare program, and they have often decreased, not
3667 increased, access to care and increased costs.

3668 Unfortunately, the only way to get Medicare coverage for
3669 outpatient prescription drugs is through private plans. Our
3670 clients must decide each year which plan to choose from among
3671 dozens and dozens with varied cost sharing and coverage
3672 rules.

3673 This is the packet my mother had to look through, and
3674 she is a relatively well woman who takes only three drugs.
3675 It took us hours to go through the decisions for her.

3676 If beneficiaries seek assistance, and if it is

3677 available, they must divulge private information about their
3678 health and medications. I don't think this has been thought
3679 of at all as one the personal expenses of the program. This
3680 information is something that many beneficiaries do not even
3681 want to share with their families. And, frankly, I was not
3682 aware of the drugs my mother took until I had to help her
3683 with Part D; and she would have preferred I didn't. It is
3684 also a step beyond to divulge this information to
3685 1-800-MEDICARE representatives or a plan operator, and many
3686 people don't want to do that.

3687 As a consequence, the vast majority of beneficiaries,
3688 because of these problems and others, do not in fact change
3689 plans from year to year, so the whole issue of choice is
3690 increasingly becoming a red herring. In fact, 17
3691 percent--only 17 percent of people chose to switch plans this
3692 last year, even though it would have been in their best
3693 interests oftentimes to do so.

3694 Our clients are subject to the whims of the companies
3695 that decide to offer drugs to the Medicare program. They
3696 must either bear the increased costs and reduced access to
3697 drugs or go through one or another an onerous process, either
3698 to choose to appeal a decision or to wait until next year
3699 when they may be able to get a better plan. Because if your
3700 health changes or the plan changes the drug's pricing or the
3701 drugs on its formulary, all of which can happen, you cannot

3702 get into a different Part D plan.

3703 According to an ongoing study by AARP, any savings in
3704 drug costs achieved by Part D were achieved through a
3705 reduction in the cost of generic drugs. However, the prices
3706 for 169 brand-name drugs went up 50.4 percent between 2001,
3707 when the first AARP study happened, and 2007.

3708 Higher drug costs mean that beneficiaries reach the
3709 coverage gap, or donut hole, sooner. Increased costs are
3710 causing a terrible impact on our beneficiaries, especially
3711 those who cannot take a generic equivalent, and that includes
3712 people with cancer, cardiac problems and other very
3713 significant illnesses. No stand-alone drug program offers
3714 brand-name drug coverage during the gap.

3715 This week, a woman from California e-mailed us telling
3716 us, "I am having terrible problems trying to find a way to
3717 pick the medication for my father's chronic illness. He is
3718 diabetic, needs chemotherapy for bladder cancer, and has
3719 cardiac arrhythmia. Between him and my mother, they have
3720 only $1,900 per month, and my father is already in the donut
3721 hole." That was in July. There are 6 more months ahead.

3722 One of our clients in Connecticut, a 52-year-old woman,
3723 pays $6,000 a month for her medications, if she could afford
3724 them, which she cannot. She is on Social Security Disability
3725 because of her sickle cell anemia. Her prescription drug
3726 plan refused to provide coverage for the dose needed by this

3727 woman, even though it was ordered by her physicians, who
3728 referred her to the Center, and we appealed outside the plan
3729 finally and got coverage.

3730 One woman in Tennessee wrote she can't afford and is
3731 therefore not taking her drugs.

3732 In conclusion, the program has untold expenses for
3733 beneficiaries, for States who, like Connecticut, are wrapping
3734 around and paying for Medicaid beneficiaries and people on
3735 their State pharmaceutical assistance plans, and are putting
3736 ever-increasing costs of prescription drugs into the prices
3737 that taxpayers must pay for Medicare in general.

3738 In summary, we urge the Congress to take the following
3739 steps: Include a prescription drug benefit in the
3740 traditional Medicare program and authorize the Secretary to
3741 negotiate the cost of drugs within that program at least;
3742 require drug plans to pass along the fullest extent of their
3743 rebates and include beneficiaries while they are--and include
3744 those rebates when beneficiaries are paying themselves in the
3745 gap; increase transparency by requiring drug plans to make
3746 available information about their pricing and rebates;
3747 increase oversight of the Medicare Web page, which is often
3748 very different from the information given on the plan's Web
3749 pages themselves; and require CMS to provide greater
3750 oversight of the Part D plans in their oversight.

3751 Chairman WAXMAN. Thank you very much, Ms. Stein. We

3752 are going to put that whole statement in the record and all

3753 of those recommendations, which we very much appreciate.

3754 [Prepared statement of Ms. Stein follows:]

3755 ******** INSERT 4-4 ********

3756 Chairman WAXMAN. I am going to start off the questions.
3757 Our committee for the first time was able to analyze the
3758 drug and insurance proprietary data on drug pricing and
3759 compare the prices charged to the Medicare Part D program and
3760 the prices charged to Medicaid, and the findings reveal that
3761 the private Medicare Part D insurers are paying 30 percent
3762 more for drugs than the Medicaid program. This has resulted
3763 in a windfall of over $3.7 billion for the drug manufacturers
3764 on the sale of drugs to dual-eligible enrollees.
3765 These elderly and disabled individuals used to get their
3766 drugs from Medicaid. They have switched to Medicare Part D,
3767 and now their higher drug prices are costing taxpayers
3768 billions of dollars.
3769 Mr. Weems argued that if Medicare Part D got the same
3770 discounts for drugs that the dual eligibles that Medicaid
3771 gets, there would be a negative consequence for other
3772 Medicare beneficiaries. Specifically, he said this could
3773 lead to higher prices at the pharmacy, compromised incentives
3774 to move enrollees to generic drugs, undermine utilization
3775 management activities that plans for important safety
3776 protections as well as cost controls.
3777 Ms. Stein, what do you think about what Mr. Weems'
3778 concerns are that he expressed to us about this issue?
3779 Ms. STEIN. Thank you, Chairman.
3780 Well, one of the things I think is that I added one of

3781 the economists who spoke this morning, the figures on the
3782 bottom line on Mr. Weems' chart, and they came to, I believe,
3783 $400 billion, which I believe was also the original estimate
3784 of what the program would cost. So it seems to me that I
3785 don't understand where the savings are in that explanation
3786 that was given. I think one of the things we often find is
3787 that one has to add up the numbers and question where they
3788 are coming from.

3789 What I know is that we have 6,500 calls and thousands of
3790 e-mails every year at this Center. I sit in the real world
3791 listening to real people. They cannot afford these drugs.
3792 They are in the donut hole way earlier than was anticipated,
3793 and it is a problem with them. They cannot afford the drugs,
3794 and they are not getting the rebate in price when they are in
3795 the donut hole. Also, the plans don't cover their drugs,
3796 more often than not.

3797 Chairman WAXMAN. Thank you very much.

3798 Mr. Precht, what do you think of the argument that we
3799 are really doing a favor for the rest of the Medicare
3800 beneficiaries by paying a higher price for the dual
3801 eligibles?

3802 Mr. PRECHT. I am not an economist, but it doesn't make
3803 any sense to me. It seems that there is money that is going
3804 into the pharmaceutical manufacturers, rather than into
3805 providing coverage for people with Medicare; and it certainly

3806 seems we could use that money to get more people into the
3807 extra health program, for example, so they wouldn't have to
3808 pay full price in the donut hole.

3809 It seems to me that if there were competition between
3810 the private plans and a Medicare option that negotiated its
3811 rates that that would provide some price discipline and it
3812 could result in lower prices, both in the Medicare option as
3813 well as the private option.

3814 Chairman WAXMAN. Mr. Merritt and Mr. Smith, do you
3815 disagree with the report's findings that the manufacturers
3816 are charging more for drugs under Medicare Part D for dual
3817 eligibles than they are under Medicaid?

3818 Mr. SMITH. Mr. Chairman, I haven't had an opportunity
3819 to review the report. It certainly wouldn't surprise me if
3820 the type of market-based system we have, with very powerful
3821 large purchasers, lots of tools at their disposal--Mr.
3822 Merritt described those--negotiated a price that was
3823 different than the price that was previously set through the
3824 administered pricing system of Medicaid.

3825 I think it is important to recognize that the--

3826 Chairman WAXMAN. You say because of all the strong
3827 tools they have they negotiated a price that is higher than
3828 Medicaid?

3829 Mr. SMITH. I am saying there might be a valuation in
3830 the marketplace that is different than the valuation through

3831 the administered pricing system of Medicaid.

3832 Chairman WAXMAN. So you think Medicaid is lower priced,
3833 and we have moved to a higher price system under Part D
3834 through the private plans?

3835 Mr. SMITH. Mr. Chairman, without having had an
3836 opportunity to review the report, I am simply saying that I
3837 can imagine that private purchasers with lots of tools
3838 negotiating come up with different valuations than does an
3839 administered pricing system.

3840 And when we look at the entire population, including the
3841 14 million individuals who previously weren't typically
3842 having discounts and rebates negotiated on their behalf, I
3843 think that we see that there is considerable price pressure.

3844 Chairman WAXMAN. How about just the 6 million that are
3845 dual eligibles? With all these tools that the private plans
3846 have for negotiating better prices, why are we paying more
3847 for that distinct population for their drugs than we were
3848 under Medicaid?

3849 Mr. SMITH. Well, I believe, first, that private plans
3850 negotiate for entire populations, so average rebates for
3851 entire populations may differ than average rebates for a
3852 segment of the population. They may also use a different mix
3853 of savings mechanisms. They may use more than rebates of
3854 savings mechanisms. And, ultimately, I think it is difficult
3855 to pull the one population out, look at it separately from

3856 the entirety the population being covered and for which
3857 savings is being negotiated.
3858 Chairman WAXMAN. Would you include the private-sector
3859 coverage for non-Medicare? Would you put them in the overall
3860 picture?
3861 Mr. SMITH. I am not quite sure I understand the
3862 question, Mr. Chairman.
3863 Chairman WAXMAN. I will send you a letter about it
3864 afterwards.
3865 Mr. McHenry.
3866 Mr. MCHENRY. Thank you, Mr. Chairman.
3867 You know, this committee is trying to find efficiency in
3868 government, and I appreciate it. It has taken us a while to
3869 actually get to hearings that get to that during this
3870 Congress, but I am glad that we can actually have this
3871 discussion.
3872 I do have a question. Mr. Precht, we are speaking about
3873 Medicare Part D today. But, admittedly, Medicare is a larger
3874 issue that we are concerned about.
3875 Ms. Stein, I appreciate your advocacy and help in this
3876 process and helping American seniors get the information they
3877 need to make good decisions about this. But, you know, I
3878 would like to know, because you are concerned about Medicare
3879 rights, Mr. Precht, are you concerned about the financial
3880 adequacy of Medicare Part A?

3881 Mr. PRECHT. Yes, sir, very much.

3882 Mr. MCHENRY. In terms of the amount of money the
3883 government spends, isn't it far greater in Medicare Part A?

3884 Mr. PRECHT. That is correct. There is more money spent
3885 on hospital care than on prescription drugs.

3886 Mr. MCHENRY. Do you think we should be looking at that
3887 as a Congress?

3888 Mr. PRECHT. Absolutely.

3889 Mr. MCHENRY. Okay. I mean, the price differential
3890 between the two is significant. It is--what--about $200
3891 billion--$220 billion for Medicare Part A and about $50
3892 billion for Medicare Part D. Is that roughly correct? I am
3893 not trying to put you on the spot.

3894 Mr. PRECHT. I will take your word for it.

3895 I mean, there is certainly more spending. I guess I
3896 don't know. I am not as familiar as I should be with
3897 research that looks at the spending under Part A and whether
3898 we could be saving money. But I think probably there are
3899 ways to save money there as well.

3900 Mr. MCHENRY. Ms. Stein, to your comment that
3901 beneficiaries are struggling with ever-increasing
3902 prices--and, generally speaking, in this time right now of
3903 inflation, we are all struggling with high prices--gas
3904 prices, food prices and everything else. It is putting a
3905 pinch on seniors, especially. But in terms of the Medicare

3906 Part D beneficiaries and what they pay in premiums, has that
3907 gone up?
3908 Ms. STEIN. Yes, sir. In fact, my--for instance, Humana
3909 has gone up three times what it was in the first year of the
3910 program.
3911 And, by the way, with regard to Part A, the Center for
3912 Medicare Advocacy is extremely concerned about the cost of
3913 Medicare in general, and we do a great deal of work with
3914 regard to those issues.
3915 Mr. MCHENRY. Sure. Back to the point of what the
3916 beneficiaries are paying, according to the CBO, the cost
3917 estimate at the beginning of this program was, I believe, $37
3918 or $35, and CMS estimated about the same at the beginning of
3919 the program. I think CMS estimated $37. CBO said $35. In
3920 fact, the Democrats had an amendment in committee to set the
3921 price of premiums for seniors at $35. Well, premiums are
3922 under $25 right now across the population for all
3923 beneficiaries, is that not correct?
3924 Ms. STEIN. For all beneficiaries, the premiums went
3925 down. For plans that people were in, they often went up, and
3926 they didn't switch. So that people were in a plan in the
3927 first year, their premium went up three times in the second
3928 year for one of the entities that has the largest population.
3929 Mr. MCHENRY. Sure. But there are other entities by
3930 which they can say, I am done with Humana. I am going over

3931 here. There are enough forces out there--

3932 Ms. STEIN. Because of the structure of the program--

3933 Mr. MCHENRY. Ma'am, let me finish asking the question.

3934 There are enough in the way of choices out there that

3935 seniors can make an informed decision; and if on average the

3936 premiums have gone down, isn't that a good thing?

3937 Ms. STEIN. It depends, sir. In my mother's case, for

3938 instance, yes, she takes two drugs. She decided to stay in

3939 her plan because it was a lower premium, she thought. But it

3940 didn't cover one of her drugs. So you could choose a premium

3941 that is lower this year but not get your drug coverage. It

3942 is as not as simple as that.

3943 Mr. MCHENRY. Because an individual makes a mistake

3944 doesn't mean it is a bad policy or bad program. Mistakes are

3945 made every day. After all, look at the United States

3946 Congress. We have made mistakes. We are all human.

3947 Ms. STEIN. With all due respect, sir, just let me say

3948 this. There is only 17 percent of people that switched

3949 plans. So the fact is that people, for whatever reason--I

3950 believe the design of the program--are not utilizing the

3951 choice option because it is so complex. And the fact is

3952 that, if they do choose based on the lowest-cost premium,

3953 they may well find themselves in the wrong plan.

3954 Mr. MCHENRY. Okay. Thank you. I appreciate your

3955 testimony.

3956 I have one final question for Mr. Smith, if I may, Mr.
3957 Chairman.
3958 Overall, we are talking about price negotiation. That
3959 is a part of this. And the majority report, the Democrat
3960 report from this committee, expresses that there will be a
3961 windfall--quote-unquote, windfall to the pharmaceutical
3962 industry unless government negotiated the price. Even though
3963 what they failed to mention is that private entities, all
3964 these different insurers, are negotiating for the price of
3965 drugs. So, therefore, they want the government to step in
3966 and say all these different insurers have to accept this
3967 price.
3968 Okay. If there is a windfall for the pharmaceutical
3969 industry, how much has your business gone up? Because the
3970 statistic I have, in your testimony, is that prescription
3971 drug sales have increased by only 1 percent since Medicare
3972 Part D was implemented. Where is the windfall?
3973 Mr. SMITH. Yes, sir. I would, of course, view prices
3974 that are set by very powerful purchasers negotiating very
3975 aggressively for prices and the resulting prices as not
3976 generating a windfall. The basic result has been that, in
3977 2008, prescription drug costs in the United States went up by
3978 the lowest rate since 1961, 3.8 percent, and the slowdown in
3979 growth continues. IMS Health reports, for the 12 months
3980 ended May of this year, the growth rate for prescription

3981 medicines in the United States, the entire cost for the whole
3982 country, was 1 percent.
3983 Mr. MCHENRY. Thank you, Mr. Chairman.
3984 Mr. MURPHY [Presiding.] Thank you, Mr. McHenry.
3985 Mr. Smith, I want to get back to follow up on a few of
3986 Chairman Waxman's questions. I know he may follow up with
3987 you in written correspondence.
3988 But with regard to the differences between the
3989 negotiations that happened with private plans and the
3990 Medicaid rebate system, your ultimate leverage in a
3991 negotiation with a particular health care plan is to not sell
3992 that drug to that plan, to not be part of their formulary, is
3993 that correct?
3994 Mr. SMITH. Without suggesting proprietary information
3995 about business practices, I think that would generally
3996 accurately characterize the market.
3997 Mr. MURPHY. With regard to the Medicare rebate system,
3998 your ultimate leverage with the Medicaid rebate system is to
3999 voluntarily not sell your drug as a part of the Medicaid
4000 system?
4001 Mr. SMITH. That is correct. On a one-size-fits-all
4002 basis, you are really excluded from a very large portion of
4003 the market entirely, very different from the private sector.
4004 Mr. MURPHY. Because the purchasing pool is so large
4005 from the Medicaid side, because, as you say, it is a

4006 one-size-fits-all, the decision is much harder to not sell
4007 the drug to the Medicaid system.
4008 Mr. SMITH. Well, there is no real opportunity to
4009 reflect value, because there is that statutory formula that
4010 sets the price. So I think that one of the challenges is
4011 that there really is no negotiation in that respect because
4012 it is a decision that is generated by a statutory pricing
4013 formula.
4014 Mr. MURPHY. But you are not compelled to sell the drug?
4015 Mr. SMITH. It is either sell at that statutory formula
4016 or be excluded from the entire Medicaid market.
4017 Mr. MURPHY. Ms. Stein, the report that is released
4018 today details a 6.6 percent increase in the average cost of a
4019 drug from 2006 to 2007, which is about twice the rate of
4020 inflation. You suggested some of the impacts of this in your
4021 testimony.
4022 But I just wanted to ask you, what is the impact of that
4023 6.6 percent increase in the price of the drug to an average
4024 health care consumer in the Part D system, given I think the
4025 testimony that you have given about the number of people
4026 falling into the donut hole earlier than expected or earlier
4027 than people had hoped for?
4028 Ms. STEIN. Sir, they are very often in the donut hole
4029 earlier. Once they are there, they are paying the full cost
4030 of the drug, not with the rebate. People, as you will see in

4031 my written testimony, are taking less than the full
4032 prescription which has been given by their physician, as
4033 someone is quoted in my testimony. Particularly people on
4034 psychotropic drugs we find are not taking their medications.
4035 Many of them don't like to take them in the first place.

4036 So we have a lot of problems with the fact that people
4037 aren't taking the medications or taking less than has been
4038 prescribed, and they are falling into the donut hole earlier.

4039 I would also like to suggest there are tremendous costs
4040 to the States as a consequence, which, as you know in
4041 Connecticut, we are also paying--when the people fall into
4042 the donut hole, we are paying those coinsurances. And on
4043 specialty drugs that can be for the individual as well as for
4044 the State up to 33 percent of the cost of that special
4045 brand-name drug.

4046 Mr. MURPHY. The last question, just to make this point
4047 clear, when an individual falls into the donut hole, when
4048 they come to pay for the price at the retail pharmacy, they
4049 are not getting the benefit, certainly not of Medicaid, but
4050 they are not getting the benefit of the potential discount
4051 negotiated by the HMO they were covered which?

4052 Ms. STEIN. That is correct. That is included and helps
4053 them get into the donut hole sooner. Once they are in the
4054 donut hole, they don't have the benefit of that; and they pay
4055 more, therefore.

4056 Mr. MURPHY. Thank you, Ms. Stein.

4057 Thank you very much to the entire panel. We will keep
4058 the record open for further comments and statements.

4059 I would like to add without objection for the record a
4060 statement for today's hearing submitted by America's Health
4061 Insurance Plans.

4062 Without objection, that is entered into the record.

4063 [The information follows:]

4064 ******** COMMITTEE INSERT ********

4065 Mr. MURPHY. Again, thank you to this panel. Thank you
4066 to our previous two panels.
4067 This hearing is adjourned.
4068 [Whereupon, at 2:26 p.m., the committee was adjourned.]