COMPARING MEDICARE AND MEDICAID DRUG PRICING:

APPLES, ORANGES AND "WINDFALLS"

Committee on Oversight and Government Reform
Republican Staff Analysis
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EXECUTIVE SUMMARY

The Majority report asks the wrong questions and uses the answers as the basis of a fallacious argument about the efficacy of the current Part D program structure: Do federal price controls for Medicaid result in prices below those available in the free market? And does the difference amount to a "windfall" to drug companies?

Of course a statutory mandate that the Medicaid program pay below-market prices produces below-market acquisition costs for that particular government program. The Majority report then leaps from that obvious answer to the economically naïve conclusion a similar mandate should and would produce the same results in a far larger, more dynamic health finance marketplace. Through this imaginative but wholly unproven device, any difference between static Medicaid prices and market-mediated drug costs in Medicare Part D is seen not as negotiated revenue but as an unearned "windfall."

But the drug price differential mandated in Medicaid would not bear fruit in Medicare any more than apples would grow on orange trees. The Majority's argument ignores one immutable law of the American health care system: the inevitable cost shift. When one payer limits reimbursements, all other payers share in making up the difference.

Part D coverage of the 6.4 million seniors eligible for both Medicare and Medicaid is not, as the Majority argues, an example of what's wrong with the program.[1] Service to "dual-eligibles" is instead a prime example of what's right about the fundamental design and ongoing implementation of the Part D benefit.

Before 2006, dual-eligibles had prescription drug coverage through the Medicaid program. Providing prescription drug benefits to this population had been extremely costly to states, and there was significant pressure on Congress to remove dual-eligibles from Medicaid prescription drug coverage and include them in Part D.[2] The Medicare Modernization Act (MMA) transferred the responsibility of prescription drug insurance for this population from Medicaid to Medicare.

In transferring this population from Medicaid to Medicare, MMA also transferred dual-eligibles from a price control system to a market based insurance system. The Majority contends prescription drug manufacturers made a windfall off this population as a result of the change. They argue the real beneficiaries of Part D were not seniors and taxpayers but pharmaceutical companies. It is a convenient argument, but one that vastly oversimplifies the decisions made in

[1] The Henry J. Kaiser Family Foundation, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries" (Jan., 2004).
[2] Robert Pear, *Subsidies to Poor Pose a Hurdle to Compromise on Medicare Bill*, NY Times (July 20, 2003).

2003, deliberately minimizes the policy implications of designing Part D differently, and completely ignores the success of Part D today.

Congress was quite familiar with alternate prescription drug benefit designs because price controls existed in Medicaid and the Department of Veterans Affairs (VA) utilized a national formulary[3]. Congress also understood the tradeoffs of utilizing either model. Those tradeoffs are significant and the negative impacts of alternative structures – conveniently minimized or overlooked by the Majority - would be amplified exponentially if they were to be inflicted on the much larger Medicare beneficiary population.

The Federal Employee Health Benefits Program (FEHBP) provides health insurance to Members of Congress, their staff, and all other federal employees. FEHBP is a voluntary insurance program with more than 300 plan options that have varying deductibles, copayments, and coinsurance.[4] The federal government pays a portion of the cost of the benefit, enrollees pay a portion through premiums and other cost-sharing requirements, and the plans bear part of the financial risk of covering the 8 million beneficiaries. The federal government does not micromanage the prices paid by plans for hospital or physician services or for prescription drugs. The FEHBP plans contract with Pharmacy Benefit Managers (PBMs) to negotiate price concessions from manufacturers. Many of the plans and PBMs responsible for providing prescription drugs to federal employees and negotiating discounts on their behalf are the same plans and PBMs that participate in Part D. FEHBP is similar in design to the Part D program.[5]

Congress chose the most effective and efficient program design for Part D that would not terribly distort all other markets for prescription drugs or limit seniors' access to medically necessary drugs. Additionally, Congress included the dual-eligible population in Part D at the request of the states and advocates who said it was important not to have a two tier prescription drug insurance with a more limited benefit serving low-income seniors.[6]

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[3] The Minority is not alone in rejecting both price controls and creating a national formulary in Part D. As Congress debated the merits of repealing the non-interference clause from Part D supporters of that effort often defended it by making clear such that repealing this clause was not price controls or a national formulary, which assumedly they would not have supported. "It is important to note what striking the clause does not mean. It does not mean the Secretary can impose price controls or set drug prices. It does not mean the Secretary can create a national formulary." Chairman Max Baucus (D-MT) Markup Statement Regarding Medicare Drug Price Negotiation, (April 12, 2007) (available online at http://www.senate.gov/~finance/hearings/statements/041207mb%20a.pdf).

[4] Congressional Research Service, "Federal Employees Health Benefit Program: Available Health Insurance Options" (Nov. 26, 2007).

[5] GAO, "Testimony in front of the Committee on Oversight and Government Reform, Oversight of Drug Pricing in Federal Programs" (Feb. 9, 2007).

[6] Robert Pear, *Subsidies to Poor Pose a Hurdle to Compromise on Medicare Bill*, NY Times (July 20, 2003).

Could these two decisions have resulted in increased revenue for reimbursement for the drugs sold to this population in the short run? Yes, that is a possible side effect. Does that mean Congress made the wrong decision? Absolutely not, because instituting price controls or a national formulary will degrade the quality of Part D and inflate prescription drug prices for other patient populations.

Of course the other option available to Congress is to return the dual-eligible population to the Medicaid program for the purposes of providing prescription drug coverage. If Congress agreed, this population would have access to Medicaid price controls and pharmaceutical manufacturers no longer would be benefiting from the purported windfall profits. However, that change would likely be opposed by advocates of low-income seniors, dual-eligible seniors, and states. While the Medicaid program is required to cover a broad array of drugs, states have responded to budgetary concerns by using a number of tools that effectively limit access to certain prescription drugs or quantities of drugs. The Congressional Research Service (CRS) found that "Most states limit coverage of prescription drugs through, for example, the number of refills, or the number of prescriptions in a given time period."[7]

Despite the definitive success of Part D, the Majority report argues Congress made the wrong choice. But critics fail to provide any persuasive or even cogent analysis of the paths not taken. Of course, Congress was familiar with alternate drug benefit structures already in use by the federal government. The Medicaid drug benefit uses statute-based price controls and the VA operates on the basis of a strict centralized formulary, without private pharmacy delivery. Congress rejected those options because the Medicaid model – mandated rebates and discounts – inevitably shifts costs to other payers, and the VA model arbitrarily limits access to new and innovative therapies.[8]

The Majority report offers simplistic criticism of the structure of Part D without accounting for the implications of the alternative structures being advocated. In effect, the Majority report contends that the benefit could be altered to reduce costs without any significant tradeoffs. Employers, employees, and the uninsured will bear the cost of Part D price controls. Such promises of something for nothing, particularly in the health care finance arena, have to be viewed with far more economic realism than the Majority appears willing to confront.

[7] Congressional Research Service, "Implications of the Medicare Prescription Drug Benefit for Dual Eligibles and State Medicaid Programs" (Feb. 25, 2005).
8 *See supra* note 3.

BACKGROUND: FEDERAL ACQUISITION OF PRESCRIPTION DRUGS IN MEDICARE, MEDICAID AND THE DEPARTMENT OF VETERANS AFFAIRS

PART D

The Medicare Modernization Act, enacted in 2003, created the largest prescription drug benefit in American history and the largest expansion of Medicare since its enactment in 1965. In designing Part D, the Medicare prescription drug benefit, Congress rejected Medicaid-style government price controls and a national formulary. Congress chose a market-oriented approach, replicating the basic structure of the Federal Employees Health Benefit Plan, in order to provide choice to seniors and encourage competition and innovation.

In 2003, there was much weeping and gnashing of teeth over Part D's structure by those who don't trust market mechanisms and who demonize pharmaceutical manufacturers in particular. Yet many of the concerns proved to be misplaced.

> "The most glaring problem of the plan was reliance on private insurers to provide a drug-only benefit, despite being told that insurers would not enter the market." (Energy and Commerce Committee, Democratic dissenting views on H.R. 2473)[9]

> "Relying on a private insurance system will increase the costs to the beneficiary and the Government…." (Energy and Commerce Committee, Democratic dissenting views on H.R. 2473)[10]

> "Many seniors will find when they get this benefit that they pay more out of pocket than they do now without any coverage." (Gail Shearer, Director of Health Policy, Consumers Union)[11]

> "This legislation will leave millions of older Americans choosing between food and medicine." (Robert Hayes, President, Medicare Rights Center)[12]

Five years later, millions of seniors are enrolled in Part D plans offering low-cost prescription drug insurance and covering a broad array of drugs. The program continues to come in below budget projections.[13]

More than 90 percent of seniors now have access to prescription drug insurance.[14] Despite the doomsday predictions, plans have not been cherry-picking the healthiest

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[9] Online at http://energycommerce.house.gov/legviews/108lvhr2473.shtml.
[10] *Id.*
[11] Lisa Rapaport, "Critics: Consumers Will Have to Hunt for Savings with Medicare Drug Benefit," (Nov. 26, 2003).
[12] Ellen Beck, "Analysis: Medicare law has cost drawbacks," United Press International (Dec. 8, 2003).
[13] CMS Release, "Strong Competition and Beneficiary Choices Contribute to Medicare Drug Coverage with Lower Costs than Predicted" (Aug. 13, 2007).
[14] "Medicare Prescription Drug Benefit's Projected Costs Continue to Drop," Centers for Medicare and Medicaid Services Press Release (January 31, 2008).

seniors. In fact, seniors with the worst health and highest use of prescription drugs have been the most likely to sign up for Part D.[15] Additionally, surveys of seniors participating in Part D report satisfaction rates of between 83 percent to 89 percent.[16] Finally, as a result of competition and innovation, Part D is costing taxpayers and seniors $243.7 billion less or 37 percent less than the original 10-year cost-estimates.[17]

Part D is a voluntary benefit administered through private prescription drug plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs). PDPs must offer a standard benefit or actuarially equivalent set of benefits. Each plan is responsible for designing a formulary structure, within certain requirements, and negotiating discounts and rebates from pharmaceutical manufacturers.

PDPs are required to cover at least two drugs in each category or class of drugs.[18] This requirement guarantees that seniors and their doctors will not be subjected to an overly restrictive formulary and provides sufficient flexibility to plans to design a formulary that leverages significant prescription drug price reductions. PDPs can use those savings to lower the prices of drugs or savings may be used to offset lower premiums, a lower deductible, or to provide enhanced coverage in the coverage gap. Regardless of the application of the savings, seniors directly benefit from lower plan costs.

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[15] "Most Seniors now have drug coverage, University of Michigan study shows" (Aug. 9, 2007) (online at http://www.ns.umich.edu/htdocs/releases/story.php?id=5985).

[16] Medicare "New Survey Released on Seniors Opinion Regarding Medicare Part D Benefit (Nov., 2007); Medicare Rx Education Network "Senior Impressions of Medicare Part D" (Nov., 2007); AARP "Prescription drugs and Medicare Part D: A report on Access, Satisfaction, and Cost" (Nov., 2007); Wall Street Journal Online "Seniors Like Their Medicare Drug Plans" (Dec., 2007).

[17] CMS Actuary Richard Foster, Testimony to the House Ways and Means Subcommittee on Health, "The Financial Outlook for Medicare" (April 1, 2008).

[18] The exception to this requirement is the six classes of clinical concern. Part D plans are required to cover all, or substantially all of the drugs in the following categories: immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic. The Majority staff report makes brief mention of the impact of the six protected classes of drugs on the ability of Part D plans to negotiate with manufacturers. These protected classes guarantee formulary placement for a drug. This reduces the leverage available to Part D plans to negotiate larger rebates. The Majority staff report reflects the result of this guaranteed formulary placement, finding price increases especially large for the drugs on the "protected list" maintained by the Centers for Medicare and Medicaid Services (CMS). The impact of the six protected classes is also reflected in list of drugs that apparently had the largest Part D net revenue increase from the rebate differential. Of the nine drugs included on the list four are anti-psychotics that are a part of the protected classes. There are indications the dual eligible population has a higher utilization rate for the drugs in the six protected classes than other seniors in Part D. As a result, this population is utilizing more of the drugs that receive some of the smallest price concessions from manufacturers. Therefore, the rebates being achieved on behalf of the dual-eligible population are likely to be smaller than the aggregate rebates being achieved on behalf of other seniors in Part D.

But the recently passed Medicare legislation, H.R. 6331, has the potential to substantially expand the number protected classes. The legislation gives the Secretary of Health and Human Services authority to expand the protected classes to include classes of drugs that have "major or life threatening clinical consequences". This provision runs contrary to a goal of maximizing rebates in Part D.

In order to participate in Part D, plans' pharmacy networks must provide convenient access to pharmacies for all enrollees. Convenient access is defined as 90 percent of urban enrollees living within two miles of a pharmacy; 90 percent of suburban enrollees living within 5 miles of a pharmacy; and 70 percent of rural enrollees living within 15 miles of a pharmacy. The practical effect of these requirements is that most seniors have been able to continue to fill prescriptions at the pharmacy of their choice.

MEDICAID

The Medicaid program is a federal and state partnership in which each state can design a prescription drug benefit within certain federal parameters. The Medicaid program employs a number of statute-based price controls that result in below market prices for drugs. First, there is a Federal Upper Payment limit (FUL), which acts as pricing ceiling in the Medicaid program. In addition to this price control, since 1990 the federal government has mandated manufacturer rebates in exchange for allowing the drug to be furnished through the Medicaid program. The basic rebate is 15.1 percent of the Average Manufacturer's Price (AMP). Those ultimate prices offered to Medicaid must represent the "best price" paid to any other drug purchaser in the market.[19] Additionally, as of 2004, 33 states now require supplementary manufacturer rebates in order for the drug to be placed on a preferred list.[20] As a practical matter, beneficiaries may have difficulty accessing drugs that are not on the state's preferred list.

DEPARTMENT OF VETERANS AFFAIRS

The Department of Veterans Affairs (VA) operates an integrated health system that served 4.4 million people in 2006. Unlike Medicare, which reimburses for care administered by private physicians, hospitals, and other providers, the VA directly provides care to veterans. In terms of market leverage and impact, veterans' utilization of drugs through the VA system is extremely small and only represents 2 percent of overall drug utilization.[21]

The VA purchases prescription drugs directly from manufacturers and veterans fill prescriptions through VA pharmacies and the consolidated mail outpatient pharmacy (CMOP) network. Because the VA does not include community pharmacies in their delivery system, pharmacy expenditures are not reflected in the VA prices. The VA employs a national formulary and drugs included in the formulary are required by statute not to exceed a federal ceiling price.

[19] Congressional Research Service, "Prescription Drug Coverage Under Medicaid" (Feb. 6, 2008).
[20] *Id.*
[21] Fiona M. Scott Morton, Testimony at the Senate Finance Committee, "Prescription Drug Pricing and Negotiation" (Jan. 11, 2007).

IMPLICATIONS OF ALTERNATIVE PART D STRUCTURES

APPLYING MEDICAID PRICE CONTROLS TO PART D

As previously discussed, the Medicaid program includes a complex set of rebate rules resulting from the Omnibus Budget Reconciliation Act of 1990. Congress' intention was to establish price controls that would result in the Medicaid program getting the lowest prices for drugs in the market. Based on the premise Medicaid was the payer of last resort, it was thought the program should get the greatest discounts in the market. The Congressional Budget Office (CBO) estimates that in 2003 these price controls resulted in rebates of approximately 31 percent of the average manufacturer price (AMP) for brand-name prescription drugs.[22]

However, the Medicaid price controls implemented in the early 1990's did not occur in a vacuum and have important implications for prescription drug pricing in other patient markets and for drug research and development. For example, in a recent report comparing prescription drug insurance in Medicaid, Medicare and the VA, the Congressional Research Service (CRS) warned that Medicaid-like price controls, "could have indirect effects on beneficiary access to future innovative drug products, and even economic impacts on other payers and providers."[23]

CBO has echoed this concern several times. In a recent letter CBO explained the implications of including Medicaid's "best price" requirement into Medicare.

> Such an approach, however, would put upward pressure on prices paid by the VA, Medicaid, and private purchasers. Medicaid and the VA are required by law to receive price discounts that at least equal the largest private-sector discounts that drug manufacturers provide. Expanding that requirement to the Medicare benefit, which accounts for a larger share of total drug spending, would encourage drug manufacturers to reduce the private-sector discounts on which the VA's and Medicaid's prices are partially based.[24]

In 1996, CBO reported on the implications of the Medicaid drug pricing controls implemented five years earlier. CBO found the price controls Congress implemented had an inflationary effect on pharmaceutical pricing in other markets:

> In particular, the best-price provision has increased the prices paid by some purchasers in the private sector. Since Medicaid constitutes between 10 percent and 15 percent of the market for outpatient prescription drugs, pharmaceutical manufacturers are much less willing to give large private purchasers steep discounts off the wholesale price when they also have to give Medicaid access to the same low price. As a result, the largest

[22] Congressional Budget Office, Letter to Senator Charles Grassley (June 21, 2005).
[23] Congressional Research Service, "Pharmaceutical Costs: A Comparison of the Department of Veterans Affairs (VA), Medicaid and Medicare Policies" (April 13, 2007).
[24] CBO, Letter to Senator Debbie Stabenow, (April 16, 2007).

> discounts that pharmaceutical manufacturers give off the wholesale price—the best-price discounts—have fallen from an average of more than 36 percent in 1991 to 19 percent in 1994.[25]

Essentially, manufacturers recoup the losses resulting from price controls by increasing prices in other markets. CBO found that hospitals, nursing homes, HMOs, mail-order pharmacies, and pharmaceutical benefit management companies (PBMs) were the most affected by this offset effect of Medicaid price controls.[26]

The magnitude of price increases resulting from Medicaid price controls is proportional to the size of the market that Medicaid represents. For example, research has shown that for every 10 percent increase in Medicaid market share pharmaceutical prices increased another 10 percent in 2002.[27] The Part D population represents a far larger proportion of drug utilization, far exceeding the Medicaid utilization rate.

In fact, when Congress was considering how to structure Part D, CBO warned that if the legislation did not exempt prices negotiated in Medicare from being made available to Medicaid through the "best price" requirement it would raise the cost of the program.

> The best-price provision constrains price competition. Manufacturers are less willing to give the same large discounts to Medicaid, which constitutes about 10 percent of the market for outpatient prescription drugs.[28]

The Medicaid price controls also create perverse incentives for certain types of research and development as well as increase the launch price for new prescription drugs. In addition to the previously discussed rebates, Medicaid also demands an additional rebate if the price of a drug increases at a rate exceeding the Consumer Price Index. This price control is an attempt to prevent manufacturers from raising a drug's price in order to offset the impact of required rebates. Yet this rebate has unintended consequences.

First, this type of price control increases launch prices for pharmaceuticals.

> If the optimal price for a drug increases more rapidly than this index, there is an incentive over time to introduce new versions of a drug with different

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[25] Congressional Budget Office Papers, "How the Medicaid Rebate on Prescription Drugs Affects Pricing the Pharmaceutical Industry" (January, 1996).
[26] *Id.*
[27] Mark Duggan and Fiona M. Scott Morton, "The Distortionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing" (Aug., 2005).
[28] Congressional Budget Office, Letter to Chairman William Thomas (July 27, 2002).

> dosage amounts or route types (e.g. capsule, liquid, tablet) that would have unrestricted base prices…Our evidence indicates that the manufacturers of these drugs find the benefit of a new version outweighs the fixed cost required; these drugs proliferate more new NDCs than would otherwise be expected during our study period.[29]

These higher launch prices reduce the effectiveness of Medicaid rebates to control prescription drug spending over time. Additionally, all other payers are subject to the higher launch prices.

In addition to this side effect, Medicaid price controls also influence the type of research and development pursued by manufacturers. A factor in allocating research and development resources between competing products is the potential return on investment. The Medicaid price controls financially reward investment in research to modify the dosage amounts and routes of existing products on the market.[30] The opportunity cost of this incentive can result in a shift of resources away from more innovative research and development.

Should Congress enact measures to mandate Medicaid prices in Part D, the result will be substantial prescription drug price increases for every other purchaser. In the United States, 62 percent of non-elderly population is enrolled in employer-sponsored health insurance.[31] As a result, employers would bear the largest financial burden of price controls in Part D. That increased cost of prescription drugs will also impact employees due to cost-sharing in health insurance. Additionally, 17 percent of the non-elderly population is uninsured.[32] The uninsured are the most sensitive to price increases because their cost are not shared by an insurer or benefit from the lower prices negotiated by the insurer.

APPLYING VA NATIONAL FORMULARY TO PART D

The VA provides prescription drug coverage to veterans that represent about 2 percent of drug utilization in the United States. The VA employs price ceilings, a national formulary, and a closed delivery system to manage prescription drug prices.[33]

Since 1997, the VA has used its own PBM and a national formulary in order to control drug spending. Proponents of the VA formulary often simply

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[29] Mark Duggan and Fiona M. Scott Morton, "The Distortionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing" (Aug., 2005).
[30] *Id.*
[31] Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey" (Oct., 2007).
[32] *Id.*
[33] United States Government Accountability Office, "Prescription Drugs An Overview of Approaches to Negotiate Drug Prices Used by Other Countries and U.S. Private Payers and Federal Programs" (Jan. 11, 2007).

compare the number of chemical compounds covered by the VA to the number of chemical compounds covered by a Part D plan. Unfortunately, that comparison does not recognize the VA formulary covers over-the-counter (OTC) drugs, which Part D plans are prohibited from covering, and injectable drugs, which are not covered under Part D but instead provided through Medicare Part B. A more appropriate comparison is the number of unique chemical compounds requiring a prescription. A recent study found that the VA national formulary includes 581 unique chemical compounds. By comparison the Part D plan with the highest enrollment includes 1,003 such compounds, or 73 percent more than the VA.[34] If used by Part D, a VA-style formulary would restrict seniors' ability to access drugs prescribed by their physicians.

Some have argued that regardless of restrictions that may be imposed by a national formulary, seniors would not necessarily lose access to medically necessary drugs because their physicians could appeal the coverage decisions. However, it is important to note that a formulary's ability to extract savings is directly related to the plan's ability to change beneficiary utilization.[35] For example, when the VA closed the proton pump inhibitors (PPI) class of drugs in 1997 it took approximately 6 months for that health system to shift almost all of the veterans off of the closed out drug to the new covered drug. Prior to this formulary change, 84 percent of veterans taking this class of drugs were prescribed Prilosec and the remaining 16 percent received Prevacid. After the formulary change almost 95 percent of veterans using this class of drugs were switched from Prilosec and began taking Prevacid.[36] A national formulary that is effective at reducing prices will have to move market share and will not be flexible.

Translated to the Medicare program, this means that in order to achieve VA savings in Part D, not only would a singular formulary have to be established but compliance with that formulary would have to be very high if not almost universal. Seniors, who typically use several medications, would have to be switched by their physicians from one drug to another. Without moving the market share, the same savings could not be achieved. This should give pause to those who advocate using the VA system in Medicare given that seniors have complicated drug regimes that require close management of side effects and drug interactions in order to prevent harm. For example, the VA does not cover Lipitor, the most often prescribed drug in the United States. And, Part D would also have to limit the number of pharmacies where the new prescriptions could be filled. Presumably, Part D could set up Medicare specific pharmacies, similar to

[34] The Lewin Group; "Comparison of VA National Formulary and Formularies of the Highest Enrollment Plans in Medicare Part D and the Federal Employee Health Benefits Program" (Jan. 12, 2007).
[35] Haiden A. Huskamp, Arnold M. Epstein and David Blumenthal, Health Affairs, "The Impact Of A National Prescription Drug Formulary on Prices, Market Share, and Spending: Lessons for Medicare?" (2003).
[36] *Id.*

the VA's closed system that seniors would be required to use. This scenario is unlikely to be welcomed by seniors or their local pharmacists.

CONCLUSION

The Part D benefit was designed to offer choice in prescription drug insurance, value for seniors through low negotiated prices, and overall low program costs for taxpayers. It is achieving those goals and exceeding expectations.[37] The Majority report fails to recognize these benefits and instead makes inappropriate and unrealistic price comparisons. Politically appealing but substantively flawed changes like those advocated by the Majority would have serious implications for the prices paid by employers, unions, health care providers, and the uninsured. Likewise, changing the financial incentives in Part D could have a negative impact in the type of drug research and development that is conducted.

Finally, it is worth noting that the Majority has written eight reports on Part D and the program is only in its third year.[38] This represents a significant level of oversight. Without a doubt Medicare requires substantial oversight given its importance to seniors and its uncertain long-term financial prospects. However, the Majority's criticisms of Part D seem misplaced. Part D costs substantially less than Part A (which primarily pays for hospital based care) and Part B (which primarily pays for physician services). The Hospital Insurance trust fund, Part A's revenue source, is not adequately financed in the short-term and will be exhausted in 2019.[39] This looming financial crisis has received scant oversight from the Majority.

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[37] CMS Release, "Strong Competition and Beneficiary Choices Contribute to Medicare Drug Coverage with Lower Costs than Predicted" (Aug. 13, 2007); "Medicare Prescription Drug Benefit's Projected Costs Continue to Drop", Centers for Medicare and Medicaid Services Press Release (January 31, 2008); "Most Seniors now have drug coverage, University of Michigan study shows" (Aug. 9, 2007) (online at http://www.ns.umich.edu/htdocs/releases/story.php?id=5985); Medicare "New Survey Released on Seniors Opinion Regarding Medicare Part D Benefit (Nov., 2007); Medicare Rx Education Network "Senior Impressions of Medicare Part D" (Nov., 2007); AARP "Prescription drugs and Medicare Part D: A report on Access, Satisfaction, and Cost" (Nov., 2007); Wall Street Journal Online "Seniors Like Their Medicare Drug Plans" (Dec., 2007);CMS Actuary Richard Foster, Testimony to the House Ways and Means Subcommittee on Health, "The Financial Outlook for Medicare" (April 1, 2008).

[38] Full Report: Medicare Drug Plans (Oct. 15, 2007); Benefits of Proposed Democratic Drug Plan Reforms (Oct. 26, 2006); Analysis: Pharmaceutical Industry Profits Increase by Over $8 Billion After Medicare Drug Plan Goes Into Effect (Sept. 9, 2006); Government Paperwork Burdens Have Increased Substantially Under the Bush Administration (July 18, 2006); Case Studies: The Impact of Medicare Drug Plan Restrictions on Seniors (May 23, 2006); Report: Medicare Drug Plans: Restrictions on Access to Formulary Drugs (March, 2006); Report: Medicare Drug Plan Prices Are Higher Than Medicare Drug Card Prices, (Feb., 21, 2006); Report: Medicare Drug Plan Prices Are Increasing Rapidly (Feb., 2006); Report on Medicare Drug Pricing, (Nov., 22, 2005).

[39] 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal supplementary Medical Insurance Trust Funds.