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Finance and Management**

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Mr. Chairman, members of the Committee; my name is Dr. Gerard Anderson. I am a professor of Health Policy and Management and a professor of International Health at the Bloomberg School of Public Health and professor of Medicine in the School of Medicine at Johns Hopkins University.

Today, I would like begin by making two observations and then make three recommendations regarding the high prices that are being paid by the Medicare Part D prescription drug plans.

My first observation is that after Medicare assumed responsibility from Medicaid for providing drug coverage for dual eligibles, ***Part D plans paid even higher prices than Medicaid programs were paying for the same drugs.***

My second observation is that the ***United States pays significantly higher prices for prescription drugs than other countries.***

These two observations about drug pricing in Part D plans lead me to make three recommendations for this Committee to consider.

First, there should be ***greater price transparency in the pharmaceutical market.***

Second, de identified ***drug-pricing data should be readily accessible to Congressional agencies and academic researchers.***

Third, ***all federal governmental agencies should be paying the same price for drugs,*** rather than having each federal agency pay a different price for the same drug.

The remainder of my testimony will explain in greater detail the rationale behind each of these observations and recommendations.

Its Prices Stupid; Medicare Part D Prices Are Even Higher Than Medicaid Prices

When the responsibility for providing drug coverage for the dual eligibles was transferred from Medicaid to Medicare in 2005, the expectation, or perhaps the hope, was that the Part D plans would obtain lower drugs than the Medicaid programs obtained.

Unfortunately, a growing body of data including the Report issued today suggests that the Medicare Part D plans are paying even higher prices than Medicaid was paying. This can be seen from several perspectives including from the data presented today.

The first indication that the Medicare Part D plans were paying more than the Medicaid programs were paying comes from disclosures made by pharmaceutical companies. Pharmaceutical companies are required to file 10Ks and 10Qs with the Securities and Exchange Commission whenever a major event occurs that could influence the stock price. There are indications in some of the 10Ks and 10Qs filed by the pharmaceutical companies that suggest that the pharmaceutical companies are getting higher prices from Medicare Part D plans than they did from Medicaid. For example, in its 10Q report dated October 1st 2006, Pfizer acknowledged that Pfizer paid fewer rebates, price concessions and gave fewer discounts due “to the impact of the Medicare Act”. On page 34 of their report, Pfizer states that “Our accruals for Medicaid rebates, Medicare rebates, contract rebates and charge backs totaled \$1.5 billion as of October 1, 2006, a decrease from \$1.8 billion as of December 31, 2005, due primarily to the impact of the Medicare Act”. This represents an additional \$300 million to one drug company for one year.

In a report for the Brookings Institution, Richard Frank and Joseph Newhouse examine the cost implications of the transfer of responsibility of drug coverage for the dual eligibles from Medicaid to Medicare. In their report, they reach a similar conclusion. “Manufacturers have realized significant gains simply from the change in responsibility for purchasing from Medicaid to Medicare.”

The second indication that Part D plans are paying high prices is a comparison of the prices that the Medicare Part D plans were paying to the prices that state Medicaid programs. This is based on CBO and CMS actuary data. CBO compares the rates that Medicaid and the private sector pay for “brand name” drugs. According to a 2005 CBO report, the average manufacturer price (AMP) is 79% of the average wholesale price (AWP). The average manufacturer price is the “average price paid to a manufacturer for drugs distributed through retail and mail-order pharmacies”. The CMS actuaries’ then subtract an additional 6% discount for rebates. This suggests that the private sector pays 73% of average wholesale price (AWP). However, according to the same CBO report, the Medicaid programs pay only 51% of average wholesale price (AWP). This suggests that Medicare Part D plans are paying 22 percentage points more than Medicaid was paying for the same drugs for the same dual eligibles.

The third indication was the report by this committee that was published last year. In this report, the committee was able to obtain administrative expenses, sales costs, profits and drug rebates from 12 of the leading insurers in the Medicare Part D program. This report showed that the Medicaid program received rebates that were three times greater than the

Medicare Part D program obtained. The estimate according to this report is that pharmaceutical companies received an additional \$2.8 Billion in 2007 as a result of the transfer from Medicaid to Medicare. This corresponds to the estimates obtained from the disclosures by the drug companies in their 10K's and 10Q's.

The most persuasive evidence, however, is what this Committee uncovered and is being released today.

Its Prices Stupid: United States Pays Too Much for Prescription Drugs

The Medicare program is not insurer paying high prices for drugs in the US. The data shows that the US pays higher prices for drugs than any other country and typically the private sector pays higher prices than Medicare and Medicaid,

In a paper that I coauthored in Health Affairs in 2004, I compared the prices for the 30 most commonly sold drugs in the United States to the same drugs in Canada, the United Kingdom and France. We observed that the US pays 52% more than people in the UK, 67% more than those in Canada and 92% more than the people in France for the market basket of these 30 drugs.

We also noted that the higher prices the United States paid for drugs were not uniform across all 30 drugs. Table 1 compares the drug prices for each drug. For example the psychiatric medication, Zoloft, cost 27% more in Canada, 96% more in the UK and 62% more in France compared to the US. One interesting statistic to note is that the United States does pay the lowest price for one of these 30 medications - Viagra.

Senator Nelson from Florida asked me to perform the same comparison using the prices paid by the VA as the comparison group. The empirical results were remarkably similar to the earlier findings in the Health Affairs article. It appears that the VA is paying approximately the same prices as Canada, France and the United Kingdom.

Richard Frank, a professor at the Harvard Medical School, published a perspective in the New England Journal of Medicine showing that the prices of brand name prescription drugs are 35-55% lower in other industrialized countries compared to the United States. Another paper in the New England Journal of Medicine by Scherer compared the drug price differences between the United States and Canada and found similar differences. Price differentials are one reason why many US citizens want to go to Canada to purchase drugs that are produced by American drug manufacturers.

My review of peer reviewed articles and other studies shows that the United States consumer pays significantly higher prices than consumers in other countries. The data also suggests that both the private and public sectors pay high prices for drugs compared to the prices in other countries.

The fact that Part D plans were unable to obtain substantial discounts for the pharmaceutical companies is surprising given the difficulties Medicaid agencies were already having obtaining information of actual transaction prices. In a series of recent court decisions, judges and juries have found that this lack of price transparency has made it difficult for Medicaid agencies to estimate the prices that pharmacies are paying for drugs. This was discussed in testimony I presented to this committee in January 2007.

Recently, I have been asked by several state Medicaid agencies to serve as an expert witness in their court challenges against the pharmaceutical companies concerning the reporting of prices by the pharmaceutical companies. This year, I have already testified in two cases regarding the pharmaceutical pricing of drugs in the Medicaid program. In the first case, \$215 million was awarded to the Alabama Medicaid program against the drug company Astra Zeneca. In the second case, \$114 million was awarded to the Alabama Medicaid program against Glaxo Smith Kline and Novartis.

Solving the Problem: Greater Price Transparency is Needed

The data showing that (1) Medicare Part D plans pay higher prices than Medicaid, (2) that Medicaid was already paying higher prices than necessary because of false prices, and (3) the U.S. pays higher prices for drugs than other countries leads me to make three recommendations.

President Bush has argued that there should be greater price transparency in the health care sector. The Bush Administration has promoted major efforts to increase the level of price transparency in the hospital and physicians sectors. Surprisingly, there has not been the same emphasis on price transparency in the pharmaceutical sector.

I find that the lack of policy focus on price transparency in the pharmaceutical sector quite puzzling. It is much more difficult to compare prices in the hospital and physician sectors than it is in the pharmaceutical sector because there is more variation in the hospital and physician products than there is in pharmaceutical products. Each drug has exactly the same chemical compound every time it is administered. In contrast, there are differences across hospitals, doctors and patients making each hospitalization and doctor visit different. Price comparisons for drugs should be much easier than price comparisons for hospital or physician services.

The question is how could we get greater price transparency for pharmaceuticals? I believe that there is a need for government reporting of drug prices when there is market failure.

Let me begin by stating that I believe in markets. Now let me qualify that statement. I believe in markets when there is price transparency and markets operate efficiently. The higher prices paid by Part D plans for drugs than the Medicaid programs suggest market failure.

In the case of pharmaceuticals, I believe the Secretary of Health and Human Services should determine if markets are actually working for pharmaceuticals. One way to determine if markets are working is for the Secretary of Health and Human Services to identify the lowest price that any of the Part D plans were able to obtain from the pharmaceutical companies. It is likely that one Part D Plan will have obtained the lowest price for drug A, while another Part D plan will have obtained the lowest price for drug B. All that should be included in the Secretary's report is the lowest price that any Part D Plan was able to obtain for each drug. The Secretary's report would not disclose the price that each Part D plan paid or the name of the Part D plan that paid the lowest price. It represents the lowest price the market place could obtain. The price should include all discounts, chargebacks, price concessions and rebates.

This information is currently not available on www.Medicare.gov. The prices on <http://www.medicare.gov> reflect the prices that Medicare beneficiaries pay for the drugs and not the purchase prices of the Part D plan.

Congress should then require the Secretary to prepare a semi-annual report that compares the lowest price that any of the Part D plans obtain to the prices obtained by the VA, Medicaid program, and Canada for each drug. The report will show where the market is working and where there is market failure. It is likely that Part D plans are getting good prices for some drugs and not others. The VA is one appropriate comparison point because the VA Secretary negotiates prices with the pharmaceutical industry. Medicaid prices are a second comparison point because the Medicaid is a government program that has been paying for drugs for many years. Canada is an appropriate third comparison point because it is a government entity that pays for drugs. More important, if the price differential between US and Canadian prices is large, then millions of Americans will go to Canada to obtain drugs.

It is important to compare the prices at the individual drug level since the market place will be more competitive for certain drugs than for other drugs. With this information, the Secretary of Health and Human Services will be able to compare the lowest prices that the market place can obtain. This will give the Secretary and the Congress the necessary information to determine where the market place is effective and where there is market failure.

Unfortunately, the prices that the Part D plans are paying for individual drugs remains confidential. CMS collects the data on prices, price concessions, rebates, and discounts but is prohibited by the MMA from sharing this data or even analyzing it internally. As a result, no one knows the rebates, price concessions or discounts that the Part D plans receive. The MMA prevents CBO, GAO, CRS and university researchers from obtaining this data. The data obtained by this committee is beginning to lift the veil of secrecy and increase the level of price transparency. This leads to my second observation.

Solving The Problem: Expanding Access to Information

When the MMA legislation was passed, there were provisions that kept much of drug pricing data private. The rationale was to allow the Part D plans and the pharmaceutical manufacturers to be able to negotiate lower prices under confidential arrangements. However, as the report issued today suggests, the Part D plans are paying substantially higher prices than Medicaid programs were paying. All of this suggests that the confidentiality agreements have not resulted in lower prices.

The limitations in the MMA have had a major deleterious impact on the ability of the CBO, CRS, GAO, MedPAC, and other government agencies to analyze effectiveness of the Part D program. It has also limited the ability of academic researchers to analyze the data. There are long run benefits to making information accessible to government officials and academic researchers. Congress should consider the tradeoffs in making more data available.

The Medicare drug data provides multiple opportunities for government officials and independent researchers to examine important policy, economics and clinical questions. There are many possible studies that could be done with the data. Let me suggest two. First, it is important to compare the cost impact of one drug compared to another drug. Without data on the actual prices of either drug, it is impossible to compare the cost effectiveness of alternative drug regimens. Secondly, often, drugs can often replace medical or surgical treatments. While we know the cost of the medical or surgical treatment from Medicare data, without data on the cost of the drug, it is impossible to perform a rigorous study comparing the cost of drug treatment to the cost of medical or surgical treatment. These are just two of many examples of studies that the GAO, CBO, MedPAC and CRS and academic researchers would like to do if the drug data were available.

There is some movement towards the release of data by the CMS. However, the preliminary information we have received from the CMS suggests that there will be severe restrictions on what data will be released, to whom, and under what circumstances. Given that public money and public beneficiaries are involved, it is unclear why there needs to be such level of secrecy. The level of secrecy is much lower for hospital and physician services. My fellow researchers and I have had access to hospital and physician data from the Medicare program for many years and no one has suggested that it has resulted in higher prices.

Solving the Problem: Paying One Price for Drugs

Because of numerous laws and regulations, different federal healthcare entities pay different prices for each drug. The VA pays different prices for drugs than DOD, PHS, federal prisons, VA, and all other government agencies that purchase drugs. Each Medicaid program pays different prices for drugs. The availability of formularies in some programs, rebates and discounts in other programs contributes to the different prices that different government agencies pay for exactly the same drugs.

My third and final recommendation is to create an environment where all federal healthcare programs pay the same rate for each drug. I am unable to identify any compelling economic or ethical reason why one government program should get or deserves lower drug prices than another government program. Governments in other countries manage to pay one price for drugs. I realize that this would require a major change to how the federal government would pay for drugs. It should be so considered a long run objective.

Table 1 Comparing US Prices to Canada, UK, and France for the 30 Most Commonly Prescribed Drugs in the US in 2003

Product	Dose	US: Canada	US: France	US:UK
Lipitor	10	1.36	1.86	1.65
Lipitor	20	1.64	.	1.49
Lipitor	40	1.63	1.41	2.13
Lipitor	80	1.67	1.89	1.64
Zocor	20	1.42	2.90	1.69
Zocor	40	1.80	1.79	1.75
Zocor	10	1.00	.	1.30
Zocor	80	1.27	.	1.24
Zocor	5	1.46	1.78	.
Prevacid	30	1.59	.	.
Prevacid	15	1.47	.	.
Paxil	20	1.60	2.48	2.07
Paxil	40	.	.	.
Paxil	10	1.62	.	.
Paxil	30	1.52	.	1.21
Zoloft	100	1.45	.	1.21
Zoloft	50	1.27	1.96	1.62
Zoloft	25	3.41	2.56	.
Celebrex	200	2.29	2.06	2.14
Celebrex	100	2.95	2.65	2.75
Celebrex	400	.	.	.
Norvasc	5	0.96	1.58	1.26
Norvasc	10	1.09	2.63	1.46
Norvasc	2.5	.	.	.
Neurontin	300	1.21	1.38	1.08
Neurontin	100	1.29	1.86	1.09
Neurontin	400	1.24	1.42	1.12
Neurontin	600	1.13	1.36	0.89
Neurontin	800	1.03	1.32	0.94
Effexor	75	1.23	.	1.27
Effexor	37.5	1.94	2.75	1.69
Effexor	25	.	4.08	.
Effexor	100	.	.	.
Effexor	50	.	2.76	1.22
Pravachol	40	2.00	1.93	1.93
Pravachol	20	1.45	2.00	1.16
Pravachol	10	1.74	.	2.15
Pravachol	80	.	.	.
Vioxx	25	2.46	1.73	1.76
Vioxx	12.5	2.07	1.60	1.59
Vioxx	50	.	.	.

Table 1 Comparing US Prices to Canada, UK, and France for the 30 Most Commonly Prescribed Drugs in the US in 2003 (Continued)

Fosamax	70	1.68	1.22	1.22
Fosamax	35	.	.	.
Fosamax	10	1.24	1.34	1.25
Fosamax	5	1.62	1.32	1.18
Fosamax	40	1.50	.	.
Wellbutrin	75	.	.	.
Wellbutrin	100	2.39	.	.
Zithromax	250	1.59	2.03	1.61
Zithromax	600	1.40	.	.
Zithromax	500	.	.	1.71
Zithromax	1000	.	.	.
Zithromax	250	.	.	.
Singulair	10	1.32	1.42	1.41
Singulair	5	1.97	1.44	1.43
Singulair	4	2.13	.	1.39
Ambien	10	.	9.62	9.01
Ambien	5	.	.	9.98
Levaquin	500	2.02	.	.
Levaquin	250	2.00	.	.
Levaquin	750	.	.	.
Viagra	100	0.89	0.78	0.78
Viagra	50	0.89	0.93	0.95
Viagra	25	0.93	0.99	1.04
Premarin	0.63	6.27	3.39	3.28
Premarin	1.25	5.16	2.85	3.63
Premarin	0.3	5.36	.	.
Premarin	0.9	4.18	.	.
Premarin	2.5	.	.	5.71
Claritin	10	3.64	5.43	5.37
Augmentin	875	2.95	.	.
Augmentin	500	3.46	4.13	.
Augmentin	250	2.54	3.17	.
Toprol	50	2.99	.	9.10
Toprol	100	2.66	1.21	8.34
Toprol	25	.	0.79	.
Toprol	200	4.29	2.27	5.60
Synthroid	0.08	5.70	.	.
Synthroid	0.1	6.65	.	.
Synthroid	0.05	8.84	.	.
Synthroid	0.13	6.68	.	.
Synthroid	0.15	7.98	.	.
Synthroid	0.03	4.94	.	.
Synthroid	0.11	5.84	.	.

Table 1 Comparing US Prices to Canada, UK, and France for the 30 Most Commonly Prescribed Drugs in the US in 2003 (Continued)				
Synthroid	0.2	8.55	.	.
Synthroid	0.18	6.84	.	.
Synthroid	0.3	6.34	.	.
Ortho-tri-cyclin	0	2.98	3.19	.
Allegra-D	60	3.02	.	.
Glucotrol	10	.	1.61	.
Glucotrol	5	.	1.68	.
Glucotrol	2.5	.	.	.
Zestril	20	2.74	0.99	1.12
Zestril	10	1.11	.	1.22
Zestril	40	.	.	.
Zestril	5	1.41	2.81	1.55
Zestril	30	.	.	.
Zestril	2.5	.	.	1.34
Amoxicillin	500	.	0.72	0.74
Amoxicillin	250	.	.	0.70
Amoxicillin	875	.	.	.
Atenolol	50	.	0.32	0.66
Atenolol	25	.	.	0.74
Atenolol	100	.	0.29	0.99
Flonase	---	2.41	3.90	2.36

