



Medicare Rights Center

Medicare Part D Drug Benefit

Testimony before the U.S. House of Representatives

Committee on Oversight and Government Reform

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Medicare Rights Center

July 24, 2008

Thank you Chairman Waxman, Ranking Member Davis, distinguished members of the House Committee on Oversight and Government Reform for this opportunity to testify about the Medicare Part D Prescription Drug Benefit. I am Paul Precht, Director of Policy and Communications for the Medicare Rights Center.

The Medicare Rights Center is a national consumer service organization, with offices in New York and Washington, working to ensure that older and disabled Americans get good, affordable health care. Every year the Medicare Rights Center hears from more than 60,000 Americans with Medicare, who have questions about their Medicare benefits, rights and options and problems accessing critical care. Their greatest problem by far is securing affordable prescription drugs. We thank you for inviting MRC to share with you the consumer perspective on the issue of prescription drug costs for people with Medicare.

Medicare Rights Center caseworkers and hotline volunteers handle a wide variety of consumer complaints related to the Part D drug benefit. Some of the issues include:

- Consumers find that medicines they need are not covered by their Part D plan and the plan is unresponsive to their efforts, or the efforts of their doctor, to obtain coverage on the basis of medical necessity.
- Consumers find themselves in the Part D coverage gap, and are unable to afford the cost of their prescriptions.
- Low-income people with Medicare cannot afford the cost sharing under Part D, but are just above the income or asset levels that would qualify them for premium and cost sharing assistance under the Extra Help program.

- Low income people with Medicare who receive Extra Help find their coverage is unstable and unpredictable, as they are abruptly shifted from a plan with a premium that is too high to qualify for a full subsidy to a plan that is cheaper but has new coverage restrictions.
- Consumers find the annual changes in premiums and coverage, and the more frequent changes in prices, confusing and frustrating and the process of selecting a Part D plan daunting.

Too often the result of these problems is that people stop taking their medicines, skip or split doses, or delay filling prescriptions. When these medicines are used to treat conditions such as heart disease, diabetes, mental illness or HIV-related illnesses, the impact on consumers' health can be serious, even life-threatening.

If I was filling all of my prescriptions monthly perhaps I would be able to better control my multiple health issues. As it is, I have hit the coverage gap early on and have had to stop taking some of the meds because I just cannot afford them. I am one month behind in my premium payments because if I get medicine I can't pay the premium. I never have anything left to help with medical copays so now I owe quite a bit of money to my doctors and have stopped calling and going unless I absolutely must. It is a nightmare for the doctors trying to help me fight these illnesses and for me. When I am not in the coverage gap, I pay my premium and roughly \$800 for medication and copays. My disability check is only \$1250. In my state the amount of the check disqualifies me from receiving help from the senior food program. I have no family to help. I have a Master's Degree in Education and thought I would always be able to work—an illusion. No savings, no retirement—all long gone trying to stay alive. I am living now in HUD project that takes my medical into consideration and adjusts my monthly rental. Were it not for that I would be homeless.

Person with Medicare, Baton Rouge, LA

All of these consumer problems are rooted in the continuing high cost of prescription drugs under a benefit run exclusively by insurance companies and pharmacy benefit

managers (PBMs). There is no option to obtain coverage through Original Medicare and the administration is barred from any role in negotiating lower drug prices.

The high drug prices consumers pay at the pharmacy counter are a direct consequence of the decision by Congress to turn administration of the benefit over to private companies. These prices are also symptomatic of an opaque, unfair, unstable and inefficient pricing system that exists in the private market and that has been adopted with all its flaws by Part D.

Part D plans have been unable to negotiate discounts from drug manufacturers on par with the prices that the Veterans Administration, state Medicaid programs or the Canadian government have been able to secure.¹ Plans have also failed to pass through, in the form of lower prices, the manufacturer rebates they do receive. The failure to deliver lower prices impacts consumers in four principal ways:

- Consumers pay higher prices during the deductible and coverage gap, the phases of the benefit when they pay the full price of the drug.
- More consumers fall into the coverage gap, or are pushed into the gap earlier in the year, because the spending that determines the start of the coverage gap, and the end of the initial benefit period, is based on these high drug prices.
- Copayments and coinsurance rates during the initial benefit period are higher, since these payments must, on average, equal 25 percent of the price of covered drugs. The higher the price, the more money it takes to equal an average coinsurance rate of 25 percent.

¹ See *The Best Medicine: A Drug Coverage Option under Original Medicare*, Medicare Rights Center, October 2007, available at <http://www.medicarerights.org/TheBestMedicine.pdf>

- Coverage is more restricted, since plans want to discourage use of high-cost medicines.

Basic Part D Plan in 2008:

- The first \$275 of their drug costs for covered drugs each year (deductible);
- Coinsurance or copayments worth on average 25% of the cost of covered drugs between \$276 and \$2,510;
- 100% of the cost of covered drugs between \$2,511 and \$5,726.25 (coverage gap or doughnut hole); and
- 5% of the cost of covered drugs above \$5,726.25—catastrophic coverage (or a copayment of \$2.25 for covered generics/preferred drugs and \$5.60 for covered brand name drugs, whichever is greater).

Under this plan, consumers will have to reach \$4,050 in out-of-pocket costs in 2008 before you can receive catastrophic coverage.

Policy Implications

The high prices also impact people with Medicare because they constrain the policy options available to Congress to improve coverage.

The very existence of the doughnut hole under Part D is attributable to the high prices paid under the benefit. Congress could not provide a benefit without a coverage gap for the \$400 billion budgeted for a Medicare drug coverage. If the Part D plans could secure prices similar to those provided by the health systems in other industrialized countries, the savings would be sufficient to eliminate the doughnut hole.² The high prices under Part D make it expensive to enact even incremental improvements to the drug benefit, such as expanding access to Extra Help by removing the asset test. This would allow low income older adults and people with disabilities with modest nest eggs to qualify for lower copayments and coverage through the doughnut hole.

² See *The Best Medicine: A Drug Coverage Option under Original Medicare*, Medicare Rights Center, October 2007, available at <http://www.medicarerights.org/TheBestMedicine.pdf>

A System Without Transparency

The prices charged by Part D plans are available to the public on medicare.gov, the on-line plan finder developed by the Centers for Medicare & Medicaid Services (CMS). The availability of these prices, however, provides only the illusion of transparency.

The retail price used by Part D plans is typically based on a percentage of the list price set by the manufacturer, known as the Average Wholesale Price. As a result, consumer prices rise whenever the manufacturers raise the list price. The price that is listed one month, when a consumer consults the plan finder to select the plan, may be completely different the following month, after they have chosen their plan and are locked in for the year.

My 91 year old mother-in-law hit donut hole last year so I went to Medicare drug plan website to use drug plan finder (I have power of attorney). Switched plans and realized in January that the drug pricing information placed on website by insurance company was erroneous and therefore the drug plan finder recommended the wrong plan. This plan will cost several thousand dollars more than plans we could have switched to. It is also amazing to realize how different the price is that these big insurance companies pay for the same drug.

Caretaker for person with Medicare, Atlanta, GA

Lock-In Pricing Model

The price listed on the plan finder, and the monthly Explanation of Benefits received by Part D enrollees, may, or may not reflect the price received by the pharmacy. A number of the major Part D and Medicare Advantage plans, with over 3.5 million enrollees, charge their members prices that are well above the prices received by the

pharmacy. The difference, known as the spread, is pocketed by the pharmacy benefit manager (PBM) administering the benefit for the Part D plan, or, in cases where the PBM and the Part D plan are the same, by the Part D plan itself. Part D plans who adopt this pricing scheme, which is common also in the private market, are said to use a “lock-in” pricing model.

In our experience, the use of the so-called “lock-in” pricing model, in which the prices plan sponsors pay the PBMs are used to calculate spending and coinsurance rates, results in substantially higher prices for consumers, particularly for many widely prescribed generic drugs. These prices are substantially higher than the reimbursement rates established for network pharmacies and often higher than widely available retail prices, indicating that the PBM is keeping the “spread” between the price it receives from the Part D sponsor and what it pays network pharmacies. Whether this spread is a disguised payment for administrative services, or simply a hidden revenue source for the PBM is irrelevant. It is a cost shift to the consumer that is not related to the cost of the drug.

These higher prices can have the effect of pushing consumers into the coverage gap earlier in the year than would occur if drug spending were calculated on the basis of the price negotiated with the pharmacy. These higher “lock-in” prices are used to calculate coinsurance rates as well as to calculate copayment rates. In effect, plans that use these inflated prices do not provide the minimum standard benefit required under the statute. Average beneficiary cost-sharing between the deductible and the initial coverage limit is no longer equivalent to 25 percent of the cost of drugs, the cost sharing established by statute for a standard benefit. By inflating the drug price to include the

“spread” retained by the PBM, the benefit is diluted and consumers effectively pay more than an average of 25 percent.

Similarly, because the initial coverage limit is based on prices that are inflated to include the PBM spread, enrollees in plans using this pricing model have an initial coverage limit that is based not only on total drug spending, but on total drug spending plus PBM “spread” revenue. Once the PBM spread is subtracted from total drug spending, the initial coverage limit can be substantially lower than the amount established by statute.

It is deeply troubling that the lock-in pricing model tends to substantially raise prices for commonly prescribed generics. Consumers generally have switched to a generic because of coverage restrictions imposed on brand name drugs in the same therapeutic class, to reduce out-of-pocket spending and to avoid falling in the Part D coverage gap. It is unfair that these consumers, after taking action they thought would lower their costs, should be subject to a pricing model that not only fails to deliver the full savings benefit of generic substitution but could also push them into the coverage gap earlier in the year.

The lack of transparency in the “lock-in” pricing model puts consumers at a disadvantage. In our experience, consumers selecting Part D plans tend to focus primarily on the monthly premium and, to a lesser extent, the coverage and copayments associated with classes of drugs, such as generics. Consumers may be attracted to a Part D plan because it offers low premiums, low copayments and/or gap coverage for generic drugs, yet be unaware that these lower costs are financed by the use of inflated prices for these generics. Moreover, these inflated prices can push them into the coverage gap earlier in

the year and raise their costs once they are in the gap. Our comparison of Part D plans on the plan finder shows that plans charging the highest prices for generic drugs most subject to a “spread” between pharmacy and PBM reimbursement can cost consumers hundreds of dollars more per year, even though they charge premiums and provide coverage and copayments for generics that would seem to provide consumers with a cost advantage.

The “lock-in” pricing model also results in higher prices for consumers when they are in the deductible or coverage gap phases of the benefit. Sometimes, these prices are higher than what pharmacies charge their cash customers. Congress’ intent in guaranteeing access to negotiated prices in all phases of the benefit was surely meant to ensure access to prices that are lower than those charged cash customers. As presently construed, however, a Part D plan can meet the requirement to provide access to negotiated prices by charging prices that are higher than the price paid by consumers with no drug coverage.

Besides consumers, state pharmaceutical assistance programs (SPAPs) that coordinate with Part D also pay higher prices when pick up cost-sharing for SPAP members enrolled in Part D plans that use “lock-in” pricing. This makes it more expensive for states to provide wrap-around coverage for Part D and more expensive to extend such coverage to other people in need not currently eligible for SPAP coverage, such as people with disabilities. Similarly, the use of inflated “lock-in” prices raises the cost to the government of paying cost-sharing for low income recipients of Extra Help. The government also pays more in reinsurance subsidies when plans use lock-in pricing.

CMS has proposed new regulations that would eventually bar Part D plans from using “lock-in” prices under Part D. We support those regulations and trust that the administration will stick to its proposal, notwithstanding pressure from the PBM lobby to weaken it. It is a shame that this anti-consumer practice has been allowed to continue for this long.

Even if CMS follows through on its proposed regulation, however, we are concerned that it will not prevent consumers from being charged inflated prices because the negotiation between the Part sponsor (or its PBM) allows certain network pharmacies, including mail order pharmacies, to pocket the “spread” on certain generic drugs. This practice is especially pernicious when Part D plans use lower copayments to steer beneficiaries to pharmacies that use higher drug prices than other network pharmacies.

There is at least one major Part D plan which sets substantially higher prices for certain generic drugs purchased through a mail order service offered by a national pharmacy chain than it charges to enrollees who use “brick-and-mortar” pharmacies. This national pharmacy chain has substantially more market leverage to secure lower prices for generics than independent pharmacies and there are no higher dispensing costs associated with these particular drugs. It appears the Part D plan, and its mail-order pharmacy, are colluding to disadvantage both consumers and the Medicare program through the use of inflated prices. Beneficiaries who use the mail order service during the initial phase of the benefit are likely unaware that they are being pushed into the coverage gap more quickly because higher prices are being used to calculate total drug spending.

Similarly, there is one Part D plan where the plan sponsor, its PBM and a national pharmacy chain, are all related entities. Under the lock-in pricing model, this plan

charges among the highest prices for commonly used generics, according to data on medicare.gov. Under CMS' proposed regulation, such inflated prices could not be used when plan enrollees used a network pharmacy that received a lesser rate as reimbursement. But, the plan sponsor may still be allowed to use these higher prices to calculate the benefit if its in-house mail-order pharmacy, or the pharmacy chain that is part of the PBM, is the entity that is allowed to pocket the spread. This plan still could use lower copayments for mail-order or for "preferred" network pharmacies in the national pharmacy chain to steer enrollees to pharmacies that allow the parent company to benefit from the spread, even as the customer is pushed closer to the coverage gap because these inflated prices are used to calculate drug spending.

Rebates

As research by this committee and others demonstrates, Part D plans do not use the rebates and other price concessions they receive from brand name drug manufactures to lower prices for consumers. As a result, consumers paying prices for brand name drugs that are higher than the net prices actually paid by Part D plans.

Research conducted for the Medicare Payment Advisory Commission shows that the prices charged by Part D plans for drugs that may also be covered under Part B are usually higher than the Part B reimbursement rate. The Part B reimbursement rate is itself 6 percent higher than the Average Sales Prices, a measure which is meant to reflect the price, net of manufacturer rebates, actually received by PBMs, insurers and other providers. The B-D price differential indicates that these manufacturer rebates are not passed through as lower the prices for consumers. Since these drugs are primarily high-cost specialty drugs, and the price differential between Parts B and D is substantial, this

means that beneficiaries who need these medicines to treat cancer or other serious and life-threatening diseases or prevent rejection of transplanted organs, often pay thousands of dollars more per year because of Part D plans failure to use the rebates they receive to lower consumers prices.

Instead of lowering the consumer prices, manufacturer rebates are used to lower premiums, pay administrative costs or increase the profits of Part D plans. Using higher drug prices to pay costs that should be derived from premiums dilutes the insurance principle. Under the insurance principle, the premiums paid by sick and healthy plan members are used to defray the cost of care when a plan member falls ill. Under the Part D pricing system, the reverse occurs. In effect, beneficiaries who purchase brand name drugs generate rebate revenue that Part D plans use to subsidize coverage (through lower premiums) for beneficiaries who do not take these drugs.

Last year I fell into the donut hole in early May. I then had to pay full price for all my medicines. My total prescription bill for 2007 was \$4688.91. That is an average of \$390.74 a month. This year I am getting my name brand medicines from out of the country and only using my Medicare D plan for my generic medicines. I think I will be cutting my average monthly cost down to \$200 a month; a 50 percent savings.

Person with Medicare, Marquette, MI

This effect is particularly pernicious in the case of high cost specialty drugs—medicines that are generally not “discretionary” but, instead provide the only hope for the beneficiary's survival. Already burdened with the high out-of-pocket costs associated with a serious illness like cancer, these patients must pay prices that are higher, because they are not reflective of the price, net of rebates received by the Part D plans. The sickest plan enrollees pay both premiums and the inflated prices of their medicines,

bearing a disproportionate share of the administrative costs and profits of their Part D plan.

A Better Option

The pricing schemes employed by Part D plans—the use of “lock-in” pricing to inflate the cost of generics and the failure to have consumer prices reflect the manufacturer rebates for brand name drugs—mean that consumers pay higher copayments during the initial and catastrophic phases of the benefit and higher prices during the coverage gap. The coverage paid for by premiums and taxpayer subsidies is devalued by prices that are inflated to allow Part D plans and their subcontractors to pocket the “spread” on generics and the rebates on brand name drugs.

Consumers and taxpayers would be better served by a transparent, stable drug pricing system. The system that exists today, however, with its secret rebates and hidden “spreads,” is reflective of the larger marketplace for prescription drugs. When the architects of the Part D benefit decided to use the “power of the marketplace” to control costs under Part D, it is *this marketplace*, with all its instability, perverse incentives and lack of transparency that they decided to employ. The result for consumers is drug prices that continue to spiral higher. The result for taxpayers is a \$1 trillion benefit that fails to provide people with Medicare with the affordable medicines they need.

We have seen how a privatized Part D benefit works and the prices it delivers. Taxpayers and people with Medicare deserve better. Congress should allow people with Medicare the option to obtain drug coverage directly through Original Medicare. That will provide consumers with stable coverage, lower prices, and with the one choice they

now cannot have. It will save taxpayers money and inject price discipline and transparency into a drug marketplace that now has neither.