U.S. SENATE COMMITTEE ON

Finance

SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN

http://finance.senate.gov

Floor Statement of U.S. Senator Chuck Grassley, of Iowa
"Medicare Part D — How Would the Government Negotiate?"
Senate Committee on Finance
Wednesday, January 10, 2007

Mr. President, I am back again today to talk about the Medicare drug benefit and the debate about whether the government would do a better job negotiating with drug companies than the prescription drug plans are doing today.

Over the past two days, I've talked about the fundamental structure of the drug benefit. The heart of that structure is competition. Plans with vast experience in negotiating with drug manufacturers compete to get the best drug prices for Medicare. And to date, we have lower bids, lower beneficiary premiums, lower costs to the government, lower costs to states. Most importantly, we have lower prices on drugs.

Let me give you some examples. A draft Price Waterhouse Coopers study found that in 2006, prescription drug plans achieved higher savings - 29 percent compared to an unmanaged drug benefit expenditures. That's almost 100 percent greater than the 15 percent savings projected by the Centers for Medicare & Medicaid Services and almost 50 percent greater than the savings estimated by the Congressional Budget Office.

Competition is working.

Yesterday, I talked about how this whole debate is based on nothing more than a distortion of language in the non-interference clause - language that was first included in legislation introduced by many of the same people who now oppose it. To be clear, that language does not prohibit negotiation. Negotiations occur between the private plans and the drug manufacturers. You couldn't get the lower prices I just mentioned without negotiation.

I also pointed out that, so far at least, proposals to have the Secretary of HHS negotiate drug prices have not been shown to actually save any money. But nevertheless, here we are in the new Congress discussing this matter.

What I want to do today is put forward a picture of what government negotiation might look like. Doing this will require some speculation. Why is that necessary? Well, it's necessary because Democrats have not provided many details on how they actually envision their requirement that the Secretary negotiate will actually work. This is despite the fact that some opponents of the non-interference clause have demagogued on this issue for nearly three years. But they have given us a few clues as to their thinking on how they want this to work. For the longest time, I've heard it said that the Secretary of Health and Human Services should have the

power to negotiate drug prices like the Veterans Administration does. So, with that as our guide, let's talk about the VA.

And this discussion is going to be somewhat technical, but I urge you to bear with me because we need to get beyond the VA sound bite. Everyone needs to have a good understanding of what this would mean for Medicare.

It is a fact that the VA uses different purchasing arrangements to get discounts on prescription drugs. But there is a big distinction between these purchasing arrangements. The VA has access to Federal Supply Schedule prices. Under the Federal Supply Schedule, the government guarantees by law that it must get the best price in the marketplace. What this means is that the federal supply schedule prices cannot exceed the lowest price that a manufacturer gives under comparable terms and conditions to a non-federal customer, like a health plan or pharmacy benefits manager. Under federal law, manufacturers must list their drug on the Supply Schedule to qualify for reimbursement under Medicaid.

Next, the VA can purchase drugs at the Federal Ceiling Price. Again, the government passed a law to guarantee itself an automatic discount no one else can get. By law, that price is automatically 24 percent less than the average price paid by basically all non-federal purchasers. Nice negotiating tactic, pass a law and guarantee yourself a discount.

The logical questions are: "Why not have Medicare access the Federal Supply Schedule? Why not give Medicare the Federal Ceiling Price?"

Experts have looked at this question. Here's what the Government Accountability Office said in a 2000 report: "Mandating that federal prices for outpatient prescription drug be extended to a large group of purchasers, such as Medicare beneficiaries, could lower the prices they pay, but raise prices for others."

You heard that right. Raise prices for everyone else. Who would face those higher prices? Small businesses, their employees, and their families, just to name a few. Those higher prices would likely force employers to reduce their prescription drug benefit or stop providing health insurance coverage altogether. That's an outcome that I surely hope people would want to avoid.

The GAO reached its conclusion by examining what happened to drug prices after Congress required drug manufacturers to pay rebates to state Medicaid programs. Like the federal supply schedule, the Medicaid rebate program guarantees that the government gets the best price in the marketplace. So what happened after that law was enacted? The best prices went up for everyone else. The practical effects were twofold. First, the size of rebates for state Medicaid programs got smaller. Second, other purchasers paid higher prices.

Why is that you might ask? Here's why. Drug makers had to eliminate their best prices to private purchasers or face bigger rebates. That happened because if they gave just one purchaser a best price, they then had to give that best price to 50 state Medicaid purchasers. So one discount to a private purchaser could mean millions of dollars that a manufacturer would be forced to pay in rebates to the government. So the drug companies eliminated all those deep discounts so they didn't have to pay as much in mandatory rebates to Medicaid.

A 1996 study by the non-partisan Congressional Budget Office examined the extent to which the Medicaid law resulted in higher drug prices for everyone else. The Congressional Budget office concluded that "best price discounts have fallen from an average of more than 36 percent in 1991 to 19 percent in 1994. Hence, although the Medicaid rebate appears on the surface to be attractive, it may have had unintended consequences for private purchasers." An almost 50 percent reduction in best price discounts. A nearly 50 percent reduction in the discounts received by purchasers such as health plans that serve employers and their employees.

What this means is that when those deep discounts went away, the price that everyone else pays for drugs went up. So those mandated rebates to Medicaid made drug prices for everyone else higher. To state it more simply, when discounts to a large purchasing group are based on discounts to another, no one really gets a good discount. And that's exactly what the GAO said in its 2000 report: "…extending the Federal Supply Schedule . . . could also raise the prices paid by private and federal purchasers, as increases in the prices manufacturers charged their best customers would, in turn, increase Federal Supply Schedule prices."

Ironic, isn't it? When the government uses price controls to mandate discounts to itself, it makes actually makes prices go up.

During a 2001 hearing before the Senate Committee on Veterans Affairs, my colleague, the senior Senator from Pennsylvania, posed a question on this very matter. He asked whether adding Medicare to the VA and Department of Defense purchasing mix would produce greater bulk discounts. The VA Chief Consultant for its Pharmacy Benefits Management Strategic Health Group answered that adding Medicare to the Federal Supply Schedule umbrella would result in increased drug prices for the VA and DoD.

So now, in addition to the GAO and the CBO, straight from the VA's mouth itself - extending VA's prices to Medicare would make the VA's own drug prices increase. The basic point they are making is that if you try to mandate discounts to everyone then no one gets a discount. Now, I am no economist, but this is basic economics. And not only that, it's common sense.

I think I've pretty much laid out why including Medicare in the federal supply schedule is not as good an idea as its proponents have made it out to be. Now I want to turn back to how the VA uses competitive bidding to get discounts. And let me start by giving you an important piece of information.

The VA has its own pharmacy benefits manager.

More than a decade ago, as part of a major initiative to improve the care it delivered, the VA formed a pharmacy benefits manager, better known by many as a PBM.

Why did it do that? Because as stated in a VA news release, it wanted to maximize a strategy used by the private sector. A primary responsibility of the VA's PBM was to develop a national formulary. That's right - a national formulary. A formulary is the list of drugs that a plan will cover. Basically, if your drug is not on the list, it is not covered.

A 2005 article in the American Journal of Managed Care co-authored by VA staff and

university-based researchers stated that the VA created the national formulary to achieve two main goals. First, the VA wanted to reduce variation in access to drugs across its many facilities. The wanted to out a VA beaurcrat between the patient and the doctor. Second, it wanted to use the VA's formulary as leverage to get lower prices for drugs.

Let me repeat that because it's an important point. The VA created a national formulary to create the leverage it needed to get lower prices for drugs.

This goes back to the point I made a couple of days ago. The ability to get good discounts does not result from the sheer number of people a purchaser buys for. The ability to get good discounts comes from how the purchaser leverages those numbers. That leverage comes from a purchaser threatening to exclude a drug from the formulary. The VA uses its formulary to say give me a better price or else-we are not buying your drug at all.

As I said earlier, the VA was intentionally adopting a private-sector strategy when it started using a formulary to get lower drug prices. The Medicare prescription drug plans also use formularies to negotiate lower drug prices. The most important thing about the VA formulary is that it is one big national formulary. The biggest difference between the VA and Medicare is that beneficiaries have choices. They can choose different plans with different formularies. They can enroll in a plan that covers their drugs. The can enroll in a plan that allows them to use their neighborhood pharmacy. And the VA doesn't do business with every pharmacist in America so you're hurting your local pharmacists when you do business that way.

Under the VA program, veterans can't choose a different plan and they have to use the VA's own pharmacy - not the retail pharmacy down the street. Using a limited number of VA-controlled pharmacies and mail-order pharmacies also helps keep VA costs down. Limited access to drugs. Limited access to retail pharmacies. That's how the VA works.

The *Los Angeles Times* put it best in an article on November 27th of last year. You can see it on this chart. According to the *LA Times* story, "VA officials can negotiate major price discounts because they restrict the number of drugs on their coverage list . . . In other words, the VA offers lower drug prices but fewer choices." That's not what we wanted when we developed the Medicare benefit.

So what would it mean if the government negotiated for lower drugs prices for Medicare in a national system like the VA? It would mean having a more limited formulary.
This chart shows what that would mean. It would mean that instead of having 4,300 drugs available to them, beneficiaries would have about 1,200. If Medicare used a national formulary like the VA it would mean that 70 percent of prescription drug could not be covered by Medicare. Only 30 percent of the drugs covered today would be covered.

And what about drugs for diabetes or cholesterol? There too, if the government negotiated for Medicare like it does for VA, it would mean fewer drugs covered by Medicare. This chart compares the drugs that Medicare covers for diabetes and cholesterol with those covered by the VA. If the government used the VA model for negotiating, 46 percent fewer cholesterol drugs would be covered and 35 percent fewer drugs for diabetes would be covered. And in many cases, those realities have led Medicare-eligible veterans to enroll in the Medicare drug benefit so that they'll have coverage for drugs not covered by the VA.

That's right. Even though many veterans have very good drug coverage, almost 40 percent of veterans with VA benefits and Medicare coverage are enrolled in Part D. So when you get beyond the easy sound bites, when you get to the facts, applying the VA system to Medicare is neither as easy as it sounds nor will it likely have the effect that its proponents suggest. And it now appears that even they have begun to figure this out. Because now, when the rubber hits the road, when they have to produce something, they introduce a bill - and I'm referring to a bill in the other body - that explicitly prohibits the Secretary from creating a formulary.

In fact, the *Los Angeles Times* reported last week that a House Democratic Leadership Aide said, "We felt we couldn't go as far as Veterans Affairs does." Under the House Democrats bill, Medicare can't have a formulary. And as I have tried to make clear here today, the drug formulary is the key to negotiating lower drug prices. The House Democrats' bill prohibits the government from having a national formulary. No formulary means no negotiation. No leverage over drug companies. In reality, the Democrat proposal on negotiation actually prohibits the government from negotiating.

Under their plan for government negotiation, the government won't be able to say no to a drug company. With no formulary to bargain with, the drug company could say "No, why should I give you that price if you can't exclude me or charge higher cost-sharing?" At the same time, the House Democrats' bill repeals the prohibition on the government setting a pricing structure.

So if the government cannot negotiate because it can't have a formulary, if there is no prohibition on a government price structure, where does that leave us? Sounds like prices controls to me. And experience shows that when the government sets prices for itself, when it gives itself a mandatory discount, prices go up for everyone else. Higher prices for everyone else.

Why would anyone want that?

Now, everyone always asks why not have the Medicare work like the VA to get lower drug prices. I think I've laid out why that idea might not be as good as its proponents have made it out to be. Having Medicare work like the VA could mean: fewer drugs covered; restricted access to retail pharmacies; more use of mail order pharmacies; and higher drug prices for everyone else.

I just can't imagine the that's what people really want. So where does that leave us? The Medicare plans are working today. They are delivering the benefits to Medicare beneficiaries. These private-sector plans have the experience in negotiating better prices. These Medicare negotiators have proven their ability to get lower prices. The Medicare plans are negotiating with drug companies using drug formularies within the rules set in law.

Last week on the Senate floor, the senior Senator from Illinois said that the law "took competition out of the program so that [the drug companies] could charge what they want." "Took competition out of the program?" Competition is what this program is all about. And that competition is working. Costs are lower. Premiums are lower. These organizations remain in the best position to get lower prices for Medicare beneficiaries and taxpayers. Mr. President, I yield the floor.