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January 27, 2006

The Honorable David M. Walker
Comptroller General
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Walker:

On January 20, 2006, I held a briefing on the new Medicare drug benefit.[1] At this briefing, the members heard testimony from an expert on drug pricing who revealed that the January 1 transfer of drug coverage for dual-eligible beneficiaries from Medicaid to Medicare, which the Republican Congress mandated, will likely result in a multi-billion dollar windfall for drug manufacturers. I am requesting that GAO investigate this issue.

The drug company windfall involves the 6.4 million seniors and people with disabilities who were switched automatically from the Medicaid drug benefit to the new Medicare drug benefit on January 1. This transfer is enriching the pharmaceutical industry because drug prices under the new Medicare drug benefit appear to be significantly higher than the prices previously paid by Medicaid. The policy change is likely to provide tens of billions of dollars in new profits for the drug companies, virtually all of which will come out of the pockets of U.S. taxpayers.

There appears to be no rational policy justification for providing this immense hidden subsidy to the drug industry. As we learned at the briefing, the transfer to Medicare Part D has caused enormous disruptions for seniors, causing many to be unable to get drugs that they were previously receiving through Medicaid. It appears that the only party benefiting in this arrangement are the drug companies that give millions to the Republican leaders who drafted the legislation.

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[1] U.S. House Committee on Government Reform, *Democratic Briefing on Implementation of the New Medicare Drug Benefit* (Jan. 20, 2005).

The Pharmaceutical Industry Windfall

Until January 1, 2006, 6.4 million dual-eligible Medicare beneficiaries had their prescription drugs paid for by the federal government and state governments under the Medicaid program. Manufacturers that take part in the Medicaid program are required, via a rebate system, to guarantee that Medicaid receives the best deal possible on drug prices.[2] The rebate program requires that manufacturers charge the government no more than the lowest negotiated price they offer to other private insurers.[3] Manufacturers are also required to provide rebates to ensure that the drug prices paid by the Medicaid program do not increase at a rate that that exceeds the inflation rate.[4]

After January 1, 2006, the drug benefits of all 6.4 million of these dual-eligible beneficiaries were switched from the Medicaid program to dozens of different Medicare-approved private prescription drug plans. The federal government indirectly pays for the drugs used by these beneficiaries by subsidizing the private plans. This switch has resulted in massive disruption, with millions of beneficiaries unable to obtain the medicines they need.[5] And it also appears to have resulted in a large increase in the prices paid for the drugs.

When dual-eligible beneficiaries enter private plans, the drug manufacturers who sell to these plans are no longer bound by the Medicaid "best price" provisions. They are also no longer bound by the requirements that price increases not exceed the inflation rate. The result is that the dozens of private drug plans are unable to obtain prices that are as low as the prices paid by the federal and state governments under the Medicaid plan.

This hidden drug industry windfall was described by Dr. Stephen Schondelmeyer, a Professor of Pharmaceutical Management and Economics and the Director of the PRIME Institute at the University of Minnesota's School of Pharmacy, at the January 20 briefing.[6] Dr. Schondelmeyer compared published prices for the Medicare drug plans (available on Medicare.gov) to estimates of the prices paid by the federal and state governments under the

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[2] Public Law 101-508 § 1927.

[3] Manufacturers are required to provide the federal government with the lower of either their "best price" or a discount of 15.1% off of the "Average Manufacturers Price" of the drug. See, e.g., CMS, *Medicaid Drug Rebate Program* (Jan. 2006) (online at http://www.cms.hhs.gov/Medicaid *DrugRebateProgram/)*

[4] Public Law 101-508 § 1927.

[5] *Medicare Mess Portends Badly for New Drug Plan*, USA Today (Jan. 19, 2006).

[6] Testimony of Dr. Stephen W. Schondelmeyer, U.S. House Committee on Government Reform, *Democratic Briefing on Implementation of the New Medicare Drug Benefit* (Jan. 20, 2005).

Medicaid program.[7] He concluded that the Medicare prices negotiated by the private plans are "20 to 30 percent above the Medicaid prices."[8]

Other sources seem to confirm Dr. Schondelmeyer's analysis. Last month, industry analysts concluded: "it is clear that Part D prices in 2006 will generally be higher than the fully discounted Medicaid price."[9] These analysts estimated that the elimination of the inflation rebate alone could result in a $2 billion windfall for manufacturers in 2006.[10] A Prudential Securities analyst found that manufacturers' increased revenues from just three anti-psychotic drugs — Seroquel, manufactured by AstraZeneca; Lamictal, manufactured by GlaxoSmithKline; and Zyprexa, manufactured by Eli Lilly — would exceed $1 billion.[11] In fact, this analyst concluded that the price increase for just Zyprexa would increase Eli Lilly's earnings per share by 5%.[12]

A report I released in November showed that prices for brand-name drugs under the new Medicare drug benefit are 84% higher than the prices that the Department of Veterans Affairs negotiates for the federal government.[13] An analysis that GAO did for me in October 2000 showed that on average, Medicaid's prices for brand-name drugs were 43% higher than the prices negotiated by the VA.[14] Combining these estimates provides another means to compare the Medicaid and Medicare drug prices. The result is similar to Dr. Schondelmeyer's: the drug prices under the new Medicare program would appear to be 29% higher than prices under Medicaid.[15]

The net result is a multi-billion dollar windfall for the drug manufacturers. According to the Congressional Budget Office, over the next ten years the federal government share of drug

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[7] *Id.*; Electronic Mail from Dr. Stephen W. Schondelmeyer to Minority Staff, House Committee on Government Reform (Jan. 25, 2005).

[8] Testimony of Stephen W. Schondelmeyer, *supra* note 2.

[9] *Dueling for Duals: Why the Poorest Medicare Recipients Should be Pharma's Top Priority in 2006*, RPM Report (Dec. 2005).

[10] *Id.*

[11] *Id.*

[12] *Lilly Makes Part D Pay*, RPM Report (Jan. 2006).

[13] House Committee on Government Reform, Minority Staff, *New Medicare Drug Plans Fail to Provide Meaningful Drug Discounts* (Nov. 22, 2005).

[14] GAO, *Drug Prices Paid by VA and DOD Are, On Average, Lower Than Those Certified to HCFA AS Best Price* (GAO-01-175-R) (Oct. 31, 2000).

[15] For example, if the average VA-negotiated price is $100, the average Medicaid price would be $143, and the average Medicare "best price" would be $184. $184 is 29% larger than $143.

costs for the 6.4 million dual-eligible beneficiaries will be an average of approximately $2,500 per beneficiary per year, which is equivalent to $160 billion over the decade.[16] If Dr. Schondelmeyer's estimates are accurate and these drug prices are 20% to 30% higher than the prices paid under Medicaid, the magnitude of the windfall could reach more than $30 billion over the next ten years.[17]

The Impact on the Taxpayer

Ultimately, it is the federal taxpayer who will pay most of the drug industry windfall. For middle- and upper-income seniors, the costs of the new Medicare drug benefit are shared between the senior and the federal government, with the federal government subsidizing 75% of the costs of the basic Medicare drug plan, and seniors paying the remaining 25%.

For low-income seniors, however, the vast majority of the costs are picked up by the federal government. Under the new Medicare program, dual-eligible beneficiaries are not required to pay any of the plan premiums, and they are subject to only a $1 to $3 copay on covered drugs. The remainder of their drug costs are paid by the federal government in the form of subsidies to the private insurers who cover these beneficiaries. If insurers are paying manufacturers more than the "best price" for the drugs used by these dual eligibles, these additional costs will be directly reflected in increased subsidies paid for by taxpayers.

The end result is that the new Medicare drug benefit will cause a massive transfer of revenues from the taxpayer to the drug industry for no discernable benefit to anyone but the drug companies.

Questions for GAO

I am requesting GAO assistance to help Congress more fully understand the impact of the provisions described by Dr. Schondelmeyer. Specifically, I am requesting that GAO:

(1) Determine if prices paid by private Medicare prescription drug plans for dual-eligible beneficiaries are higher than the "best prices" obtained for the same drugs under the Medicaid system.

(2) Investigate the magnitude of the cost differences for individual drugs; and

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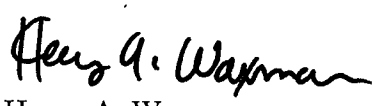
[16] Congressional Budget Office, *A Detailed Description of the CBO's Cost Estimate for the Medicare Prescription Drug Benefit* (July 2004). This average includes both the direct subsidies for drug payments and subsidies for plan premiums.

[17] The $30 billion figure assumes that average drug costs for dual eligibles are 25% higher than the Medicaid best prices, the midpoint of Dr. Schondelmeyer's estimate.

(3) Determine the total magnitude of these cost differences for federal taxpayers in 2006 and over the next ten years.

Thank you for your attention to this request. My staff contact on this issue is Brian Cohen, who can be reached at (202) 225-5051.

Sincerely,



Henry A. Waxman
Ranking Minority Member