Trust But Verify

Negotiate If Market Failure

Begin With The Facts

- Are the Part D plans paying more for drugs than VA, Medicaid, and/or Canada?
- Need to know for each drug and by dose

Part D Plans

- What is the lowest price any Part D plan is paying for the drug?
- Represents the lowest prices that can be obtained in the market
- No need to know prices each Part D plan is paying

VA

- Secretary negotiates price with pharmaceutical companies
- Represents the lowest price obtained through negotiation with formulary
- No evidence quality of care suffers in VA formulary

Medicaid

- Combination of formula, best price and negotiation
- Nearly complete formulary
- Government program operating for many years

Canada

- International price paid for drugs
- Large differential between U.S. and Canadian price will induce seniors to buy drugs in Canada

Secretary Report

- Semi annual basis – drug prices change
- Compare lowest price in market (Part D plans) to VA, Medicaid and Canadian price
- Trust in market but verify that market is getting a reasonable price

What Might The Secretary's Report Show?

- We don't know because price information is not available to
  - Analysts at CMS
  - CBO, CRS, etc
  - Researchers
- However, there is data to suggest where there could be market failures

Doughnut Holes and Price Controls

- Paper in Health Affairs, 2004
- Assuming a 20% reduction in AWP, the U.S. consumer was paying:
  - 52% more than U.K.
  - 67% more than Canada
  - 92% more than France

for a market basket of 30 most commonly prescribed drugs in the U.S.

Considerable Variation Across Drugs in Comparative Prices

- Why it is important to compare drug-by- drug and dose-by-dose
- Lipitor (10 doses)
  - 36% more than in Canada
  - 86% more than in France
  - 65% more than in U.K.
- Zocor (20 doses)
  - 42% more than in Canada
  - 190% more than in France
  - 69% more than in U.K.
- Viagra less expensive in U.S.

VA vs Canada, France, U.K.

- Pay similar prices for market basket of 30 most commonly prescribed drugs

CBO Comparisons

- 51% of AWP – Medicaid
- 42% of AWP – VA
- 73% of AWP – Average of Part D Plans

Source: June 2005 report and CMS Actuaries 2006 Report

Price Competition in Future

- 2006 CMS Actuaries Report does not forecast any additional price reductions due to market forces in 2006-2015 period

Key Factors for Part D Expenditure Estimates

Calendar Year	Annual Per Capita Drug Cost Increase	Cost Management and Discounts	Manufacturer Rebates	Plan Administrative Expenses
Intermediate estimates				
2006	7.1%	21.0%	6.0%	12.5%
2007	7.2	21.0	6.0	11.8
2008	7.3	21.0	6.0	11.9
2009	7.4	21.0	6.0	11.6
2010	7.5	21.0	6.0	11.5
2011	7.5	21.0	6.0	11.3
2012	7.6	21.0	6.0	11.1
2013	7.7	21.0	6.0	10.9
2014	7.7	21.0	6.0	10.7
2015	7.7	21.0	6.0	10.4

Generics

- WalMart $4.00
- Patricia Danzon – Prices for generics lower in U.S. compared to other countries
- Market most likely working – no need for Secretary to negotiate

Dual Eligibles

- Price Differential
  - 73% of AWP Part D Plans
  - 51% of AWP – Medicaid
- Medicare program pays the price differential because Medicare insures the dual eligibles

Some Collaborating Evidence From Pharmaceutical Companies

- 10Ks and 10Qs submitted to SEC
- Richard Frank details the 10K submissions
- Pfizer, October 1, 2006, 10Q Report

"Our accruals for Medicaid rebates, Medicare rebates, contract rebates, and chargebacks 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."

Brand Name Drugs

- Especially the unique drugs
- Protected classes of drugs
- 17 year patent – virtual monopoly
- Hard to bargain with a monopoly

When Market Is Paying Higher Prices

- Begin with drugs where Part D plans are paying greatest differential
- Ask pharmaceutical company why is lowest price any Part D plan paying is $10.00 while VA, Medicaid, and Canada are paying in $1.00 range

Bully Pulpit

- Secretary Thompson used it to negotiate price discount for CIPRO

Bully Pulpit May Be Sufficient

- No CEO will want to present/testify and explain large price differentials
- Too many other dealings with government
- Focus on a few drugs with large price differentials
- Not all 4400 drugs
- Congress could hold hearings is Secretary does not act

Backup Strategies to Consider

- Described in CRS Report by Gretchen Jacobson, January 5, 2007
- Reference pricing (cluster drugs by class)
- Price Ceilings (maximum prices)
- Reimportation (use Canada's prices)
- Profit-sharing (U.K. – cap on profits)
- Value Based Purchasing (value added of drug)

Medicare Should Not Pay Highest Prices

- Large purchasers seldom pay highest prices
- Government supporting pharmaceutical R&D through NIH
- Medicare beneficiaries have large gaps in coverage – doughnut hole
- U.S. seniors should not be the primary supporter of pharmaceutical R&D in the world

Goldilocks and The Three Bears

- My reaction to reading the editorials
- Too hot – stifle innovation
- Too cold – ineffective negotiator
- Some editorials made both arguments (in different paragraphs)

Too Hot – Stifle Innovation

- Large Fixed Costs
  - Research and Development
  - Pfizer's $900 million investment
- Low Marginal Cost
  - Each additional pill's cost is very small
- Concern – attempt to pay marginal cost

Too Hot - However

- Signed contracts with VA, Medicaid, Canada
- Less than 15% spent on R&D
- NIH investment doubled

Too Cold – Ineffective Negotiator

- Secretary cannot negotiate without restricted formularies
- Secretary “no want to”

Too Cold - However

- Medicaid large formulary
- Only using “bully pulpit” on a few drugs

Just Right

- Trust but verify -Compare lowest Part D price to VA, Medicaid, Canada
- Negotiate where differentials are greatest