Consumers Union

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On

Medicare Prescription Drug Benefit: Importance of Curbing Growth of Prescription Drug Expenditures

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Summary: Consumers Union Testimony on
Medicare Prescription Drug Benefit

Whether your preferred method of providing Medicare prescription drug coverage is to expand the role of the private marketplace or to rely on an expanded governmental role, lower growth of expenditures make it is far easier to design a decent benefit. The rapid growth in prescription drug expenditures, combined with a modest Medicare prescription drug benefit, create a troubling reality for Medicare beneficiaries: If prescription drug expenditures continue to increase at the same rate as the past five years, many Medicare beneficiaries would find that their out-of-pocket costs in 2007 are actually *higher* than they are today, even with coverage as provided in H.R. 1. We do not believe that the average Medicare beneficiary will view this legislation as providing meaningful relief from the financial burden of prescription drug expenditures. Specifically:

- the average Medicare beneficiary (without prescription drug coverage) spending $2,318 in 2003 would find that his or her out-of-pocket costs for prescription drugs (including the premium, deductible, co-payments, and "doughnut") are higher in 2007, despite the new prescription drug benefit, and would total $2,954 (in real 2003 dollars).
- A person in the top third of prescription drug spending, with annual costs of $3,000 in 2003, would find that his her out-of-pocket costs reach $4,112 in 2007 (real 2003 dollars).

Drug costs are increasing at an unacceptably high annual rate, forcing U.S. consumers to pay higher prices than consumers in Europe and Canada.

Congress should take aggressive steps to rein in the growth of prescription drug expenditures, including:

- Enact a Medicare prescription drug benefit that puts the full purchasing power of the federal government to work negotiating on behalf of consumers and taxpayers.
- Encourage the purchase of medicines that are the most cost-effective.
- Consider adopting strategies that have been successful in other countries and states to curb prescription drug expenditures without sacrificing quality.
- Speed generics to the marketplace.

If Congress were to enact a Medicare benefit that combines a modest prescription drug benefit without aggressive cost containment, the end result will be skyrocketing prescription drug expenditures, larger federal budget deficits, and continued high profitability for the pharmaceutical industry. The U.S. should establish the goal of achieving greater value per prescription drug dollar as a top priority. Restraining growth of prescription drug expenditures provides a win/win situation for consumers and taxpayers.

Consumers Union Testimony on
Medicare Prescription Drug Benefit

Thank you for inviting Consumers Union[1] to testify on the need to curb the growth of prescription drug expenditures in the context of a new Medicare benefit. As the Medicare prescription drug bills passed by the House and the Senate are considered in the conference committee, a central issue to the success or failure of the bill's ability to rein in the spiraling expenditures of prescription drugs. This issue is important for Medicare beneficiaries who seek relief from high out-of-pocket costs for their medicines (including premium deductible, cost-sharing, and uncovered costs).[2] It is also crucial to taxpayers who will pay a large share of the cost for this benefit.

Whether your preferred method of providing coverage is to expand the role of the private marketplace or to rely on an expanded governmental role, lower growth of expenditures will make it far easier to design a decent benefit. Lower growth in prescription drug expenditures can mean a lower burden on taxpayers, more restrained growth of federal deficits, lower premiums for beneficiaries, and a more generous benefit design. Clearly, restraining growth of prescription drug expenditures provides a win/win situation for consumers and taxpayers.

The benefit design of H.R.1,
combined with rapidly increasing prescription drug expenditures,
will leave consumers with high out-of-pocket costs

The rapid growth in prescription drug expenditures, combined with a modest Medicare prescription drug benefit in H.R. 1, create a troubling reality for Medicare beneficiaries: If prescription drug expenditures continue to increase at the same rate as during the past five years, many Medicare beneficiaries will find that their out-of-pocket costs in 2007 will actually be *higher* than they are today, even with coverage as provided in H.R. 1.

As the Medicare prescription drug bills moved through the House and the Senate, we analyzed the anticipated out-of-pocket costs for consumers with different prescription drug expenditure levels once the bills are fully implemented in the year 2007. Out-of-pocket costs (including premiums, deductibles, cost-sharing, and coverage gaps) are a key measure of the financial burden--or relief from financial hardship-- that consumers will experience when a new benefit is available. For purposes of our analysis, we assumed that the private marketplace would respond as Congress intends it to: there will be coverage available at the estimated average premium assumed in the legislation. We question whether this will indeed be the case, but these issues are put aside for the purpose of our report

and this testimony. While out-of-pocket costs are the key measure of burden for *consumers*, they tell only part of the story, and it is important for Congress to also consider the actual benefit paid, since this determines the ultimate cost to the federal budget. The rate of growth of prescription drug prices is a key determinant of both the projected out-of-pocket costs *and* the projected level of benefits for Medicare beneficiaries.

In Consumers Union's report *Skimpy Benefits and Unchecked Expenditures: Medicare Prescription Drug Bills Fail to Offer Adequate Protection for Seniors and People with Disabilities,*[3] we considered individuals who have no prescription drug coverage in 2003. We focused on individuals at the average level of drug expenditures, in the bottom, middle, and top third of the distribution of health expenditures, and with catastrophic expenditures. We took the total amount they would spend on medicines in the year 2003, and then estimated what their total expenditures would by in 2007 (the year after the program is implemented), assuming that prescription drug expenditures increase at the same average rate that they have increased over the last five years, 17 percent. We deflated the 2007 expenditures for overall inflation, assumed to be the same as it has been for the past 5 years (2.5 percent CPI), to express the figure in real 2003 dollars.

We do not believe that the average Medicare beneficiary will view this legislation as providing meaningful relief from the financial burden of prescription drug expenditures. Our results were alarming:

- The average Medicare beneficiary (without prescription drug coverage) spending $2,318 in 2003 would find that his or her out-of-pocket costs for prescription drugs (including the premium, deductible, co-payments, and "doughnut") are higher in 2007, despite the new prescription drug benefit, and would total $2,954 (in real 2003 dollars).
- A Medicare beneficiary with relatively low expenditures in 2003 of $500 (i.e. the bottom third of spending) would find his or her out-of-pocket payments for prescription drugs are $790 in 2007 (real 2003 dollars).
- A beneficiary in the middle third of spending has prescription costs of about $1,500 in 2003, and would find that his or her out-of-pocket spending for prescription drugs is $1,566 in 2007 (real 2003 dollars).
- A person in the top third of prescription drug spending, with costs of $3,000 in 2003, would find that his her out-of-pocket costs reach $4,112 in 2007 (real 2003 dollars).
- A person with prescription drug expenditures in the catastrophic range, $6,000 in 2003, would face reduced out-of-pocket spending of $4,120 in 2007 (real 2003 dollars).

We tested to see how sensitive our findings were to the assumed rate of growth of prescription drug expenditures, and changed the assumed rate of growth from the recent level (17 percent) to a more moderate level of 12 percent per year. If prescription drug growth moderates from historical levels to 12 percent per year, then the average Medicare beneficiary will face out-of-pocket costs in 2007 of approximately the same level as those of 2003, even after enactment of a Medicare prescription drug benefit ($2,318 in 2003; $2,323 in 2007).

Drug Costs are Increasing at an Unacceptably High Annual Rate forcing U.S. Consumers to Pay Higher Prices than Consumers in Europe and Canada[4]

The fundamental problem that will continue to drive up consumers' out-of-pocket costs *and* taxpayer costs (to fund a future Medicare prescription drug benefit) is the unrestrained double-digit annual increase in prescription drug expenditures. Prescription drug expenditures (which include both price increases and utilization changes) have been increasing at an annual rate of about 17 percent.[5] **2001 marked the seventh consecutive year of double-digit expenditures growth for prescription drugs**.[6] The average consumer uses 10.8 prescription drugs per year. Americans spent $122 billion on prescription drugs in 2000, and $142 billion in 2001.[7] Projections for 2002 and future years are considerably higher.[8] Prescription drug spending represents about 10 percent of health care spending.[9] On average, Medicare beneficiaries use 28.5 prescriptions per year, and this number is expected to increase to 38.5 by 2010.[10] Just last week, Families USA reported that the prices of the 50 drugs most frequently used by the elderly increased at 3.4 times the rate of inflation in 2002.[11]

We can benefit from experiences of other countries that have more successfully addressed the challenge of reining in prescription drug expenditures without sacrificing quality or efficacy. When New Zealand introduced a system of reference pricing in 1993, prescription expenditures had been increasing at a rate of 10 to 20 percent a year. With reference pricing, the rate of increase slowed and stabilized to only 3 percent per year since the mid-1990s.[12] (As described below, reference pricing is a pricing structure that bases prices paid for drugs on the comparative effectiveness of various medicines. It rewards the manufacturers of cost-effective medicines.)

Lessons can also be learned from recent state efforts to get more "bang" for the prescription drug buck. Michigan, for example, began to phase-in its preferred drug list (which requires prior authorization for drugs not on the list) in February 2002. Within four months, well over 90 percent of prescriptions for drugs of most therapeutic categories were from the preferred list. Average weekly pharmacy

cost per claim (in Medicaid fee-for-serve) was cut by $3.39, a reduction of 7 percent from projected costs.[13]

Oregon has done pioneering work in conducting intense public reviews of the scientific evidence regarding the cost-effectiveness of medicines for various therapeutic drug categories, and has used these reviews as the basis for its preferred drug lists in Medicaid. When the Oregon Health Sciences University and the Oregon Health Resources Commission reviewed opiods for treatment of non-cancer pain, they determined that there was insufficient evidence to draw any conclusions about the comparative effectiveness of different medications such as Oxycontin and morphine sulfate (LA). After this finding, sales of the preferred generic and benchmark drug for this category (morphine sulfate) increased by 20 percent.[14]

A recent AARP International Forum on Prescription Drug Policy[15] showcased the United States' costly failure to address the issue of making prescription drugs affordable to all. Among the facts presented by experts from around the world were:

- U.S. drug prices are the highest by far when compared with prices in European countries, ranging (for a 5-year average) from 67 to 143 percent higher than European countries (France, Germany, Italy, Netherlands, Spain, Austria, Belgium, and Finland) (Paul Kanavos)
- Prices paid for patented drugs in 2001 were 69% higher in the U.S. than the prices paid in Canada (Bob Nagakawa)
- European countries have used a wide range of techniques to curb prescription drug expenditures, with an emphasis on attaining "value-for-money" for their prescription drug expenditures and experimenting with policy changes to curb prices. Techniques include: practice guidelines; encouragement of generics; prescription audits; reference pricing; limits on prices for me-too drugs; taxes on promotion expenditure; developing a market for parallel imports; and fixed or revenue budgets for the industry (Paul Kavanos)

Steps that Congress should take to rein in growth of prescription drug expenditures

Congress could provide substantial relief to consumers and taxpayers alike if it took aggressive steps to curb the growth of prescription drug expenditures. In an effort to maximize benefits and minimize financial burden on beneficiaries, Congress should adopt a two-prong policy: it should enact legislation that would rein in prescription drug expenditures, and it should build a prescription drug benefit into Medicare. If Congress were to enact a Medicare benefit that combines a modest prescription drug benefit without aggressive cost containment, the path it

seems to be on, the end result will be skyrocketing prescription drug expenditures, larger federal budget deficits, and continued high profitability for the pharmaceutical industry. As noted above, other countries have aggressively pursued creative policy-making to get more bang for their prescription drug Euro or Pound. The U.S. should establish the goal of greater value per prescription drug dollar as a top priority. Other countries have devised policies that curb expenditures without sacrificing quality of care; the U.S. should learn from their experiences.

Some of the steps that Congress could take to protect taxpayers at the same time that it protects consumers include:

1. **Structure the new Medicare prescription drug benefit in a way that puts the full purchasing power of the federal government to work negotiating on behalf of consumers and taxpayers.**

We can learn a lot from the experience that the federal government had in negotiating a low price for CIPRO with Bayer. While there was criticism that the agreement allowed Bayer to make an extraordinary profit, according to a press release issued by the Department of Health and Human Services, HHS was to pay 95 cents per tablet (with options to buy additional supplies at 85 cents and 75 cents) compared with a previously discounted price of $1.77 per tablet.[16] This was at a time that the average wholesale price of the drug was $4.67, according to the Wall Street Journal. Measured against the average wholesale price, the prices negotiated by DHHS represent a discount of 80 to 84 percent. This reduction in price came at a time of national emergency and concern on the part of Bayer of any appearance of profiteering at the time of crisis, but nevertheless it sets the parameters of what can be achieved through negotiations by the federal government.

A report released earlier this week by U.S. PIRG also demonstrated that the federal government has the ability to negotiate dramatically lower prices when it sets this as a priority. The federal supply schedule price is the price that the federal government pays for prescription drugs for certain government employees and beneficiaries of federal programs such as veterans and employees of the Department of Defense. A U.S. PIRG survey found that uninsured consumers in various regions of the United States pay prices 66 percent to 80 percent *higher* than the federal supply price average.[17]

Developments in the states also illustrate the potential of joining together to expand purchasing power. Vermont, Michigan, and South Carolina joined forces a little over a year ago to get favorable prices for their combined pool of 1.5 Medicaid beneficiaries. A Vermont state staffer recently reported that by joining

together, the three states have managed to save 25 to 50 percent more than they had saved previously, when they implemented preferred drug lists separately.[18]

The House bill's reliance on the participation of numerous private insurance industry participants also rules out the possibility of putting the purchasing power of the federal government to work on behalf of consumers and taxpayers. Individual companies, each with several hundred thousand to several million enrollees, will not have the leverage to negotiate the deep discounts that would be achievable by the federal government. The House and the Senate bills actually include language that prohibits the federal government from negotiating low prices for prescription drugs for Medicare beneficiaries (other than for the fallback provision in the Senate bill).[19]

2. **Increase the "bang for the buck" for taxpayer and consumer prescription drug dollars by encouraging the purchase of medicines that are the most cost-effective (as opposed to the most heavily advertised).**

Neither the House nor the Senate bills incorporated a provision that could have dramatically increased the information available to the public about the comparative effectiveness of different medicines. Bipartisan legislation introduced by Congressman Allen and Congresswoman Emerson would provide a source of evidence-based information about the comparative effectiveness of drugs. H.R. 2356, the "Prescription Drug Comparative Effectiveness Act of 2003," would authorize the National Institute of Health and the Agency for Healthcare Research and Quality to conduct research and studies in order to provide doctors and the public with valid, evidence-based information about various medications. This amendment builds on a model that has been developed in the state of Oregon to free state governments and consumers from reliance on often misleading direct-to-consumer advertising for their information about the effectiveness of prescription drugs. It replaces biased information with scientific, evidence-based information. The Allen/Emerson amendment was rejected by the House Rules Committee.

Senator Clinton offered a similar amendment to the Senate bill, amendment number 1000, and this was defeated in the Senate. It is difficult to understand why both the House Rules Committee and the Senate would reject the development of objective, scientific information that would help accomplish more cost-effective prescription drug expenditures. We note that the House accepted a more modest but related amendment (offered by Congressmen Bereuter) as part of the Labor/HHS appropriations bill on July 10, 2003, and we urge you to work to keep this provision in the final appropriations bill.

Better evidence-based information in the public domain is vitally needed in the prescription drug marketplace to make it possible to get better value for our prescription drug dollars. This type of information would make it possible for consumers to achieve savings that they now can get by buying drugs from Canada. It would free consumers from the biased information that comes to them over the airways and in magazines in direct-to-consumer (DTC) advertising.[20] It would also help doctors by providing them with information about cost-effectiveness of drugs and decrease their reliance on marketing information provided by the pharmaceutical industry. When it comes to drugs, newer isn't necessarily better … but it is likely to be more expensive and more heavily advertised.

3. Consider adopting strategies that have been successful in other countries to curb prescription drug expenditures without sacrificing quality.

While the basic research (as outlined above) is the first essential step, the next logical step is to design a cost-sharing structure that provides consumers with incentives to use the most cost-effective medication. Private insurance companies are increasingly using tiered-copayments to encourage enrollees to use relatively low-cost generics, or alternatively drugs that are on a "preferred drug list." Many countries have successfully lowered their expenditures by adopting "reference pricing" systems. With reference pricing, independent researchers study the comparative effectiveness of alternative drug therapies (e.g., Vioxx, Celebrex, or ibuprofen for arthritis), select the most effective treatments, negotiate low prices, and develop preferred drug lists that provide the most effective drugs at the lowest cost, thereby maximizing the cost-effectiveness of health spending.

Research shows that reference-based pricing in British Columbia has achieved substantial savings. For example, after implementation of reference pricing, there was a 29 percent decline in the use of higher-priced ACE inhibitors (which control high blood pressure), with savings to the government and consumers of $6.7 million in the first 12 months, without a change in the overall utilization of antihypertensives.[21]

4. **Speed generics to the marketplace.**

Perhaps the easiest "cost-effectiveness" case can be made for increasing the use of generic drugs instead of high-priced brand drugs, whenever generics are available.[22] Fortunately, both the House and the Senate Medicare prescription drug bills include provisions that would close the loopholes that delay the introduction of generics. In the past, the Congressional Budget Office has scored the potential savings of similar provision to be $60 billion over ten years.[23] This provision is important, and benefits not only Medicare beneficiaries but all consumers.

Conclusion

The steps outlined above merely scratch the surface of policy options that Congress should consider to ensure that the prescription drug marketplace better serves *all* consumers – not only those fortunate enough to have prescription drug coverage or the means to pay the high prices charged for medicines that can save lives and dramatically improve the quality of life. We urge you to call on experts in this country and from around the world to help you shape options this year and in future years that will allow *all* consumers to afford the medications that they desperately need.

There is an urgent need for Congress to take steps immediately to rein in the growth of prescription drug expenditures. By using taxpayer and consumer dollars to buy more cost-effective medications, billions of dollars could be saved. **If our nation could cut the rate of growth of these expenditures, we would create a win for consumers and a win for taxpayers**. If we fail to rein in the growth of expenditures, any new Medicare prescription drug benefit will be hard-pressed to provide meaningful relief to Medicare beneficiaries, whose out-of-pocket costs will continue to grow. Congress would be breaking a promise to beneficiaries, and it will fail to meet their expectations that a new benefit will provide much needed relief.

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[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance. Consumers Union's income is solely derived from the sale of *Consumer Reports*, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports,* with approximately 4.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions that affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2] This testimony and our report focuses on those consumers who have no coverage for medicines in 2003. The impact of HR 1 on those with coverage through past employers, through medigap, or through Medicaid is different and depends on a number of factors including whether employers cut coverage. The Senate and House bills differ in how they treat dual eligibles with both Medicaid and Medicare coverage. Consumers who currently have medigap drug coverage (paying extra premiums higher than anticipated benefits) will view the benefits of the legislation differently than those without any coverage today.

[3] This report is posted at our website, www.consumersunion.org.

[4] See also, "Backgrounder: The Pharmaceutical Industry and Consumers – Key Factors Affecting Affordability of Prescription Drugs," Consumers Union, February 2003, available at www.consumersunion.org.
[5] Page 5, *Prescription Drug Trends: A Chartbook Update,* Sonderegger Research Center, School of Pharmacy, University of Wisconsin – Madison, and The Henry J. Kaiser Family Foundation, November 2001. The National Institute for Health Care Management (NIHCM) estimated that retail spending on prescription drugs grew at an 18% rate in 1998, a 19% rate in 1999 and 2000, and a 17% rate in 2001. *Prescription Drug Expenditures in 2001: Another Year of Escalating Costs*, NIHCM Foundation, May 6, 2002.
[6] Levit, Katharine et.al. "Trends in U.S. Health Care Spending, 2001", *Health* Affairs, vol. 22, no. 1, January/February 2003, p. 155-156; Steinbrook, Robert, M.D. "The Prescription Drug Problem," *New England Journal of Medicine*, Vol. 346, No. 11, March 14, 2002, p. 790.
[7] "Inflation Spurs Health Spending in 2000," *Health Affairs*, Volume 21, no. 1, January/February 2002, p. 173.
[8] IMS Health estimates that expenditures were $192 billion in 2002. Robert Langreth, "The New Drug War," *Forbes*, March 31, 2003.
[9] "States and Insurers Find Prescriptions for High Drug Costs," *Wall Street Journal*, Sept. 11, 2002.
[10] Medicare Current Beneficiary Survey.
[11] "Out-of-Bounds: Rising Prescription Drug Prices for Seniors," Families USA, July 2003.
[12] "Post-Election Briefing on the Minister of Health," August 2002, Pharmaceutical Management Agency (PHARMAC), New Zealand, p. 24. Available at http://www.pharmac.govt.nz/download/2002_PEB.pdf .
[13] Remarks of James K. Haveman, Jr., Director, Michigan Department of Community Health, "Michigan's' Pharmaceutical Best Practices Initiative," October 10, 2002. Available at www.oregonrx.org.
[14] Oregon Health Resources Draft Report and Remarks of Alan Bates D.O., Oregon's Evidence-Based Approach to Prescription Drugs. Remarks of Governor John A. Kitzhaber, M.D. Oregon Drug Conference, October 11-12, 2002. Available at www.oregonrx.org.
[15] Information about the presentations is available at http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=882.
[16] HHS, Bayer Agree to Cipro Purchase, press release, United States Department of Health & Human Services, October 24, 2001.
[17] P. 11, "Paying the Price: A 19-State Survey of the High Cost of Prescription Drugs," U.S. PIRG Education Fund, July 2003.
[18] Savings from Multi-State Pools Described in Presentation to Legislative Drug Group," BNA's Health Care Policy Report, July 7, 2003.
[19] *See* H.R. 2473, Title VIII, Medicare Benefits Administration.
[20] For more information about misleading DTC advertising, see *Free rein for drug ads? Consumer Reports*, February 2003.

[21] Sebastian Schneeweiss et.al., "Impact of Reference-Based Pricing for Angiotensin-Converting Enzyme Inhibitors on Drug Utilization," CMAJ, March 19, 2002, 166 (6), p. 737.

[22] For more information on generics, see "The stalling game: Sweetheart Deals and Patent Extensions Keep Lower-Cost Generic Drugs from Consumers," Consumer Reports, July 2001.

[23] CBO has not yet scored HR 1 as passed by the House, and we do not have an estimate of the savings from this year's generics provision. It is likely to be lower than $60 billion because of some regulatory steps taken administratively.