

Embargoed – Not for release until Mon. 22 July 2002, 9:30 a.m.

Crafting an Affordable Medicare Prescription Drug Benefit:
Lessons from the Veterans Administration Experience

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Hearing on

The Department of Veterans Affairs Prescription Drug Purchasing Program:
Lessons Learned and
Remaining Challenges to Making Prescription Drugs Affordable

Subcommittee on National Security, Veterans Affairs, and International Relations
Government Reform Committee, United States House of Representatives,
Field Hearing

John W. McCormack United States Post Office and Court House
Courtroom 3, 12th Floor
Boston, Massachusetts
22 July 2002
9:30 A.M.

Disclaimer and acknowledgement:

As always, I testify only for myself, and not on behalf of Boston University or any of its components. I acknowledge with pleasure the contributions of my colleague, Deborah Socolar.

Congressman Shays, Congressman Tierney, and others: Good morning. Thank you for inviting me to appear before you. After distilling six lessons from the Veterans Administration's recent experiences in paying for prescription drugs, and from Congress's experiences in designing a Medicare prescription drug benefit, I will apply these lessons to crafting a different approach to a Medicare drug benefit.

A. Lessons from the V.A. Experience

1. The V.A. has become one of the main lightning rods in the electrical storm caused by the collision of soaring drug prices and lack of adequate insurance.
 - More veterans have understandably sought V.A. outpatient prescription drugs.
 - The number of 30-day-equivalent prescriptions filled by the V.A. FY 2001 was more than two and one-half times greater than in FY 1995.¹
 - The V.A. has shown that winning lower prices is a far more effective way to contain cost than is restricting use of drugs.
2. Owing to rising volumes and prices, the V.A.'s drug costs are expected to double from \$1.6 billion in FY 1999 to a conservatively projected \$3.3 billion in FY 2003.²
3. Costs are projected to soar despite the V.A.'s vigorous cost containment efforts. These include
 - Purchasing almost one-quarter of its drugs through highly competitive national contract prices that can run "as low as 65 percent below AWP" (average wholesale price);
 - Purchasing the remaining brand name drugs at prices averaging less than half of AWP;³
 - Raising co-payments from \$2.00 per prescription to \$7.00; and
 - Encouraging the use of less costly alternatives to expensive drugs like Zyprexa.⁴
4. Unless we develop a method of affordably financing medications for elderly, disabled, or chronically ill Americans, either the V.A. drug budget will continue to explode or human suffering will rise. In the worst case, both are possible. Therefore, most of the V.A.'s efforts to limit its own obligations can succeed only at the expense of adding to the obligations of others. There has been too much of this already. Congress has won lower drug prices for federal agencies and, to a lesser degree, Medicaid programs, while allowing drug makers to charge higher prices for ordinary citizens, especially those without insurance. This is wrong. Congress must look after all of us even-handedly.
5. The V.A.'s own problems would be alleviated by creation of a strong Medicare prescription drug benefit, one with affordable premiums and low out-of-pocket costs. Congressional progress toward such a benefit has been stymied by the combination of a) high drug prices and b) the need to find new federal dollars both to protect people who have not been able to afford drugs in the past and to replace private spending on drugs. This appears to create a choice between continued suffering and much higher spending.
6. Fortunately, there is a third choice: reform. We can design an affordable Medicare prescription drug benefit. **What follows is intended as a rough framework, one open to modification in light of emerging policy concerns and improving evidence.**

Information on other methods of winning affordable prescription drugs while enhancing drug makers' research is posted on the Health Reform Program's web site, www.healthreformprogram.org.

B. Designing a Medicare Drug Benefit—Part Rx

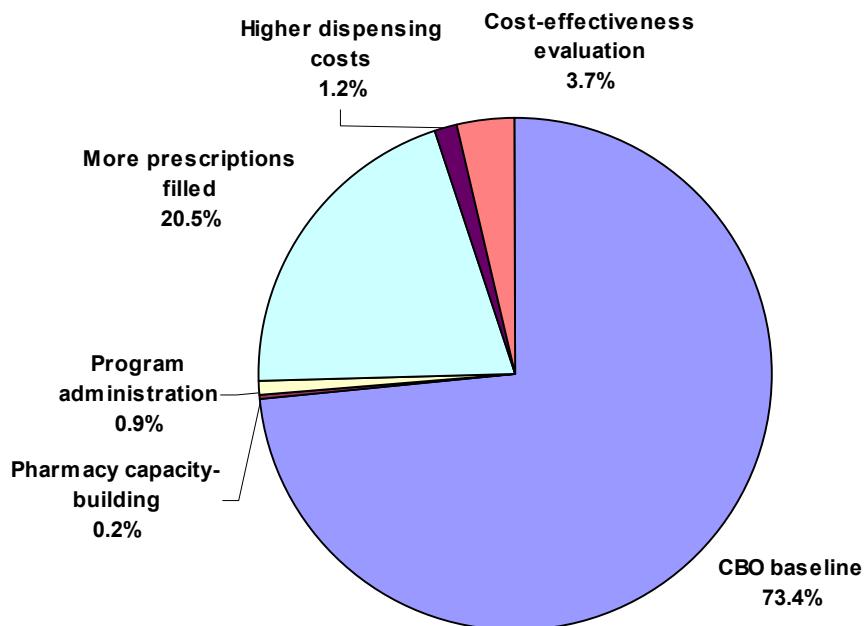
It is easy to design an inferior Medicare drug benefit with high premiums, co-payments, and multi-thousand-dollar patient financial exposure. And it is easy to design a Medicare drug benefit that costs the federal government a great deal of new dollars. The challenge is to design a drug benefit that protects all patients against high out-of-pocket costs and protects the federal treasury. *I am convinced that low patient costs can be combined with holding net federal cost under \$400 billion for the decade.*

1. Costs of a good Medicare prescription drug program. My colleague, Deborah Socolar, and I estimate the gross cost of a good Medicare prescription drug benefit at \$2.2 trillion for the ten years from 2002 through 2011, before factoring in opportunities for savings.

This includes

GROSS COST ELEMENTS, Medicare Part Rx, 2002 – 2011	\$ Billion
A. CBO March 2002 baseline ⁵	\$1,580
B. Higher volume at retail price, with price rising 8% annually	\$441
C. Higher dispensing costs at retail @ \$5.00 per prescription	\$27
D. New drug cost-effectiveness evaluation/dissemination	\$80
E. Program administration @ 1 % of baseline + higher volume	\$20
F. One-time pharmacy/dispensing capacity-building	\$5
Total gross costs, \$ billion	\$2,153

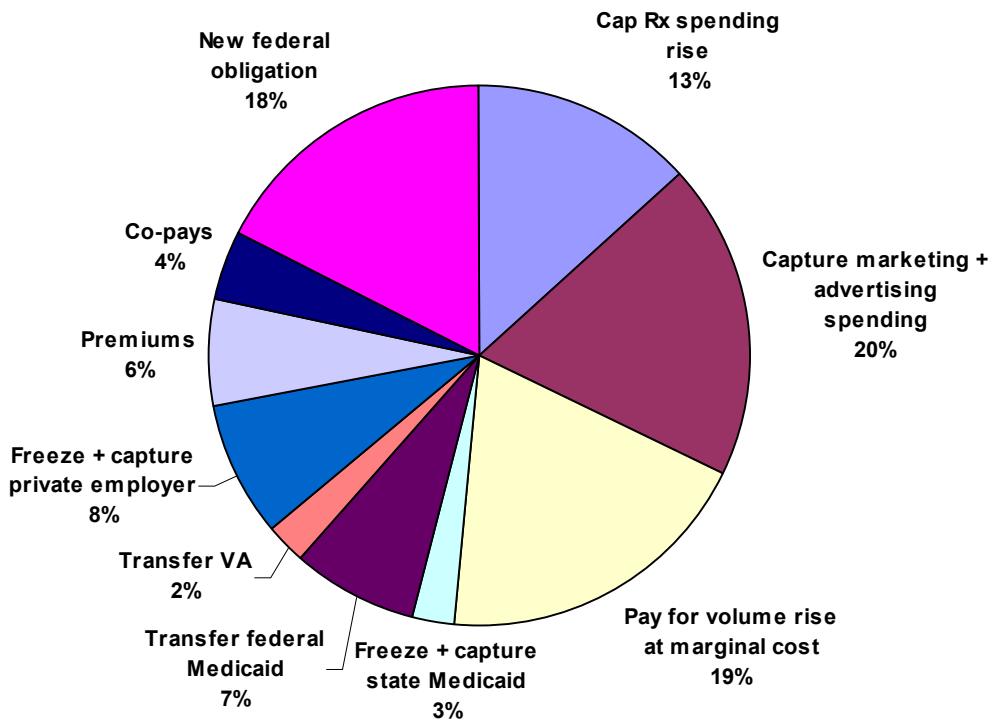
GROSS COSTS OF MEDICARE'S NEW PART Rx, 2002 - 2011



2. Covering the costs of a good Medicare prescription drug program through modest patient payments, substantial cost cuts, capturing existing revenue, and new federal dollars. I believe that it is possible to design a very comprehensive program that limits out-of-pocket costs to affordable levels but still holds the net rise in new federal obligations under \$400 billion over the decade from 2002 through 2011. The revenue sources are detailed in the text table and are displayed in the pie chart that follows.

COVERING THE GROSS COSTS, Medicare Part Rx, 2002 – 2011		\$ Billion
Patient Payments		
premiums (2.5%-3.5% of Social Security checks, rising 2.5% yearly)		\$140
co-pays (\$5, \$10, with 1/3 forgiven to low-income patients)		\$87
Reductions in Cost		
cap annual rise in total spending after 2002 at 8.5 percent annually		\$286
pay for higher volume at marginal cost, at 7.5 percent of retail		\$408
Capture Existing Revenue		
capture offset marketing and advertising, growing at 12.5 % annually		\$410
capture state Medicaid dollars, frozen at 2002 level		\$59
Transfer federal Medicaid dollars, projected rise		\$159
Transfer federal VA dollars, projected rise		\$54
Capture employer maintenance of effort, frozen at 20% of 2002 level		\$174
Total of above		\$1,775
Gross costs (calculated on previous page)		\$2,153
Net rise in federal obligation, \$ billion		\$378

Financing Medicare's New Part Rx, 2002-2011



Notes on gross costs

Almost three-quarters of the projected gross cost is attributable to baseline use of prescription drugs by Medicare recipients, in the absence of a Medicare prescription drug insurance program. This is as projected by the Congressional Budget Office.

One-fifth of the gross cost goes to buying the additional volumes of medications attributable to the new benefit by people previously uninsured or underinsured for prescription drugs. This additional volume is priced here at retail.

Four percent of spending finances new efforts to evaluate prescription drugs' cost-effectiveness, and to diffuse the evidence compiled. By facilitating better prescribing, these new efforts will enable Medicare to get more its money. Solid evidence on the value and limits of existing drugs will displace marketing-induced misperceptions. Solid evidence on new drugs will encourage quick adoption of genuine breakthroughs while discouraging adoption of costly drugs that lack added clinical value.

Minor sums cover the added costs of retail dispensing, program administration, and one-time payments to expand pharmacy capacity.

Notes on methods of covering the costs

My colleague and I have estimated methods of covering the costs in several ways. The figures reported here are the mid-point of high and low estimates.

First, patient premiums and co-payments cover about one-tenth of gross program cost. These are the only out-of-pocket costs. There is no financial donut and no financial hole. Patients are not forced to choose among costly and inadequate benefit packages. Instead, they pay little for one benefit package that offers freedom of choice of all medications.

- Premiums are scaled progressively with income, ranging from 2.5 percent to 3.5 percent of an individual's Social Security check. For example, individuals with monthly checks of \$250 would pay a Part Rx premium of \$6.25 monthly. Individuals with monthly checks of \$1,300 would pay a monthly premium of \$45.00. The median premium would be close to \$20.00 monthly.
- Total annual co-payments would also rise and fall with income.
- Patients face no other financial exposure.

Second, the net rise in new federal obligations is less than one-fifth of gross program cost, averaging \$38 billion yearly. This is made possible by employing an eclectic range of sources of containing costs and raising revenues.

Third, cost can be contained in two main ways.

- We would save almost \$300 billion by capping the average annual rise in baseline spending (before considering higher volumes of medication use induced by improved coverage) at 8.5 percent yearly. This is somewhat below the Congressional Budget Office (CBO) baseline estimates, which average 12.3 percent yearly over the decade. We believe that this cut is essential to make medications affordable for all Americans, and that it can be accomplished in ways that both preclude cost-shifting and **protect manufacturers' returns on equity and research.**
- More important, **paying for the increased volume of prescriptions at marginal cost saves over \$400 billion**. This covers manufacturers' actual cost of producing higher volumes of medications. They do not earn additional profits—windfall profits—on the higher volume, but their profits do not fall, either. Paying marginal cost on the higher volume does mean a drop in average price paid, but this is offset by the rise in volume of medications sold, keeping drug makers financially whole.

Finally, five existing sources of spending can be captured and pooled to help finance the new benefit.

- The most important (\$410 billion) is capturing drug makers' existing marketing and advertising spending. Since information would be disseminated by a new federal effort to compile evidence on efficacy, safety, and cost, and since drug makers' returns on equity on existing medications would be protected at current levels, they would not need to waste money on marketing and advertising. One approach would be to require that participants in the Medicare Rx program would need to sign over their projected marketing and advertising spending to the trust fund from which Part Rx would be financed.
- Dollars that would otherwise pay for current and future federal participation in purchase of prescription drugs by state Medicaid programs for Medicare patients would be channeled to the new Part Rx trust fund. This would garner almost \$160 billion.
- Relieving states of a soaring cost, states' Medicaid spending on prescription drugs for Medicare patients would be frozen at 2002 levels, and this sum would also be paid into the new trust fund, harvesting about \$60 billion. The Medicare prescription drug program would also relieve states of the huge administrative burdens and tough political decisions that they now face as they struggle to care for these needy patients while containing costs.
- Projected V.A. payments for prescription drugs for Medicare patients (\$50 billion) would be transferred to the new trust fund. V.A. patients would be protected from any diminution in current benefits. I believe that transferring most of the burden of financing increasingly costly outpatient prescription drugs to Medicare will strengthen the V.A.'s long-term ability to finance its core hospital, physician, and other services.

- Finally, private employers who now provide retiree benefits for people on Medicare would make annual payments to the new trust fund. These would be frozen at the level of their 2002 expenditures, granting employers immediate financial relief from existing contractual obligations, and sparing them the pain and damage to reputations that would follow from reneging on promises to employees or retirees. This would raise almost \$175 billion.

Conclusion

The nation faces two decisions.

The first is to choose among suffering, paying more, and reform. That should be easy.

The second is to choose between today's fragmented and weak attacks on high drug prices, and tomorrow's concerted efforts to negotiate a prescription drug peace treaty that protects the core needs of each stakeholder.

Too many efforts today are devoted to peripheral fights over re-importing drugs from Canada, patent duration, generics, formularies, PBMs, and the like. The more important core fights concern how much money drug makers shall earn, and what value they must create in order to earn it.

Some believe that the peripheral fights will be easier to win. This has not yet been demonstrated. Moreover, winning the peripheral fights will be a distraction, because the victory—if won—will be hollow. Drug makers would respond to a re-importation law, for example, by emptying their Canadian warehouses, leaving little to re-import.

The longer the drug makers paralyze durably affordable reform, the greater the chance that they will elect the world's angriest Congress—one that will gut their prices in ways that actually do disrupt breakthrough research.

That is why we must do more than protect ourselves from the drug makers. We must protect the drug makers from themselves.

NOTES

¹ 167.6 million prescriptions were filled in HFY 2001, compared with only 65.4 million in HFY 1995. Estimates prepared by John Ogden, Chief Consultant, Pharmacy Benefits Management, Veterans Administration, telephone communication with Deborah Socolar 2 April 2002.

² Data compiled by John Ogden, Chief Consultant, Pharmacy Benefits Management, Veterans Administration, telephone communication with Deborah Socolar 2 April 2002. Some consider that these projections may be under-estimates.

³ William H. von Oehsen, III, *Pharmaceutical Discounts under Federal Law: State Program Opportunities*, Public Health Institute, Pharmaceuticals & Indigent Care Program, May 2001, pp. ii and 16.

⁴ David Rogers, "Veterans Affairs' Bid to Trim Costs May Anger Pharmaceutical Firms," *Wall Street Journal*, 13 February 2002.

⁵ Dan L. Crippen (Director, Congressional Budget Office), "Projections of Medicare and Prescription Drug Spending," testimony before the Committee on Finance, United States Senate, 7 March 2002, table 3.